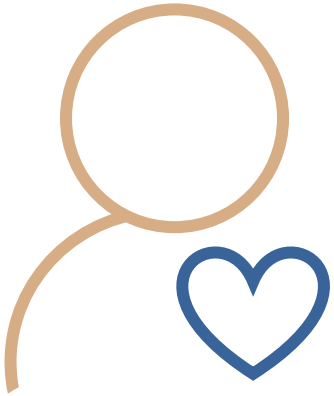
Performance update for Hywel Dda Univerity Health Board

as at 31st October 2020



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

Executive summary

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

COVID-19

Confirmed COVID cases as at 31st October 2020	Suspected & confirmed COVID patients admitted 1st-31st October	Confirmed COVID patients discharged 1st-31st October	Confirmed COVID patients who died in one of our hospitals in October
2,869	357	107	7

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?**
  - In October, 96.6% 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;
  - 98.9% of non-urgent suspected cancer patients commenced treatment within 31 days of being referred.

- **Where have improvements been made?**
  - Stroke patients receiving speech and language therapy increased to 54% this month, compared with 33.6% in September;
  - The percentage of patients waiting less than 26 weeks from referral to treatment improved from 48.9% to 53%;
  - The number of patients waiting more than 14 weeks for a specific therapy improved for the 4th sequential month from 1,613 in June to 659 in October;
  - During April '20 to June '20, 1.04% (582) of adults attempted to quit smoking and became a treated smoker using a smoking cessation service. This is higher than the same period in the previous year;
  - 69% of complaints received a final or interim reply within 30 working days, this is a 6% improvement from last month;
  - There has been a small reduction in sickness absence between August (5.25%) and September (5.23%).

- **Where is improvement needed?**
  - The 65% target was not met for ambulances arriving within 8 minutes to calls for patients with life threatening conditions (58.9%);
  - 226 ambulance handovers were reported as taking longer than 1 hour during October 2020;
  - 78.2% of patients were seen within 4 hours in A&E/MIU (target 95%) and 452 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 14 patients delayed in October '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 6.3% from the previous month to 76.5% and Single Cancer Pathway performance decreased by 7% from the previous month;
  - 30 planned procedures were cancelled by us in September for non-clinical reasons;
  - There were 40,953 patients in October who had a delayed follow-up outpatient appointment, this is an increase of 2,554 from the previous month;
  - 40.4% of high risk Ophthalmology patients waited no more than 25% over their clinical target date which is well below the 95% target;
  - The number of patients waiting over 36 weeks from referral to treatment increased from 17,857 (September) to 22,571 (October);
  - 37.7% of stroke patients were admitted to a stroke unit within 4 hours in October 2020 (target 54%), this is a decline of 17.7% from the previous month;
  - In September 17.7% of children/young people received a neurodevelopmental assessment within 26 weeks, a 2% decline from the previous month and considerably below the 80% target;
  - In September 26.2% of adults waited less than 26 weeks for a psychological therapy, declining by around 2% from the previous month;
  - In October we reported 5 C.difficile infections, 31 E.coli infections and 9 S.aureus infections;
  - Between April and June, 90.3% of children had 2 MMR doses by age 5;
  - Staff appraisals are below target at 69%, the same as the previous month;
  - 84.4% of staff have completed their mandatory training (target 85%);
  - Performance for Consultants and SAS Doctors with a current Job Plan rose by 2% this month to 38%. Due to the impact of COVID, this is still 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 October is £14.6m deficit against a deficit plan of £14.6m.

- **Impact of COVID-19**
  - Staff absence increased due to COVID initially but this is slowly reducing, around 1.7% of staff are self-isolating and 0.48% 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;
  - From mid-November, to better manage patient flow, 30 beds will be used from the Health Board field hospitals for non-COVID step down patients;
  - Mental Health and Learning Disability patients have had reduced leave (i.e. attending social activities or shopping) to limit their risk of exposure.

- **Additional Reports**
  - Equality and good relations update
  - Accessible information for people with sensory loss update
  - Health and well-being of homeless and vulnerable groups update
  - Welsh language 'More Than Just Words' update
  - Learning disability 'Improving Lives' programme update
  - Dementia learning and development framework update
  - Service user experience and improving services update

Our 36 key deliverable measures

Latest data

25	2	4

All Wales rank

All Wales data is available for 31 of the 36 key deliverable measures. Of these, Hywel Dda UHB ranked in the top 3 for 48% of measures:

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

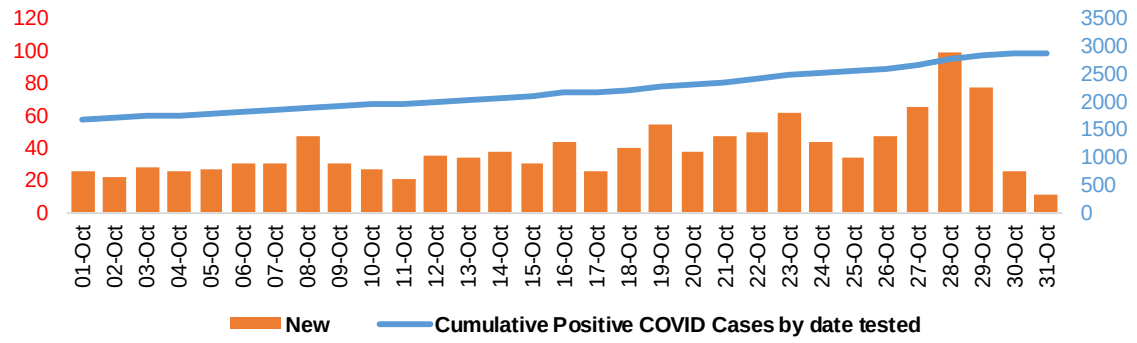
COVID-19

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

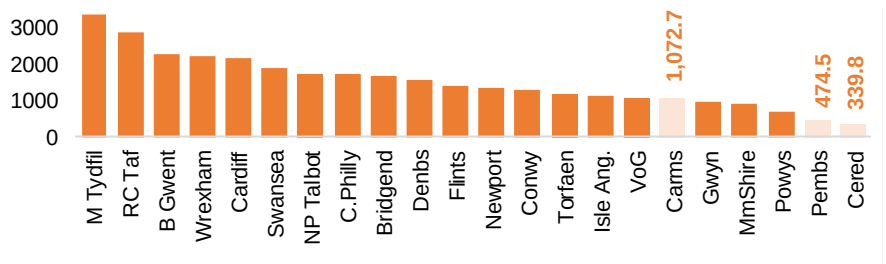
Confirmed cases

As at 31st October 2020, there were 2,869 confirmed cases of COVID-19 for Hywel Dda residents, an increase of 1,212 cases from 30th September 2020. The highest number of new positive cases tested were on 28th October with 99 new cases reported. Population rates for confirmed cases are seen to be lower in Hywel Dda than in many other local authority areas. On 31st October 2020, Ceredigion and Pembrokeshire had the lowest local authority rates in Wales (Ceredigion: 339.8 per 100,000 population, Pembrokeshire: 474.5 per 100,000 population). It is important to note that the local authority rates may be skewed due to testing variation in each area and therefore should be used as a proxy.

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



Confirmed cases per 100,000 resident population



Supporting our staff

We have established a COVID command centre which is open 7 days a week. Staff are able to contact the command centre by email or phone with all COVID related queries e.g. staff testing, personal protective equipment (PPE), wellbeing support. In October the command centre had on average 75 calls per day which is a decrease from 150 per day in September (2,332 calls in October overall). The COVID call centre line is used by all key workers and families, the rise in calls in September was due to children returning to school and the increase in cases in Llanelli. In addition, our Staff Psychological Wellbeing Service has changed the way they work to offer one to one support services to staff.

Personal Protective Equipment (PPE)

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

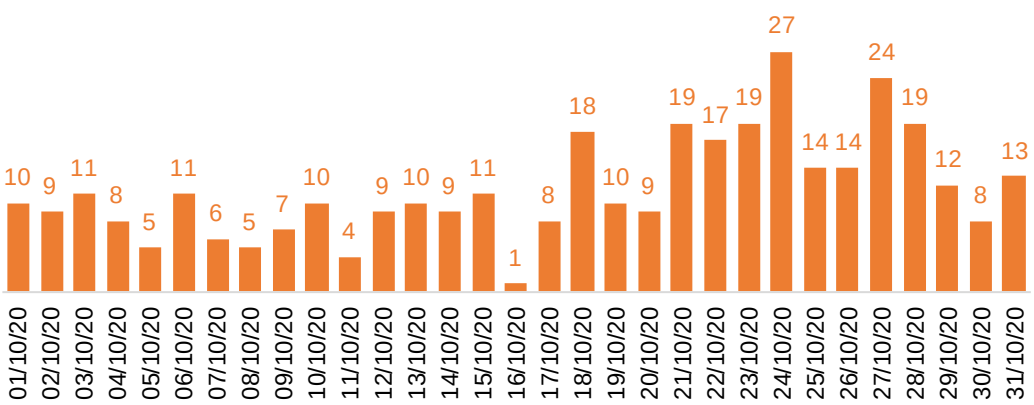
Admissions

The number of COVID (confirmed and suspected) admissions to our four acute hospital sites increased from 157 in September to 357 in October; 4 in Bronglais General Hospital (BGH), 61 in Glangwili General Hospital (GGH), 182 in Prince Philip Hospital (PPH) and 110 in Withybush General Hospital (WGH). This is an average of 12 COVID admissions a day across the Health Board during October and approximately 11% of all inpatient admissions. Non-COVID inpatient admissions averaged 97 per day over the same period.

The Health Board have 5 field hospitals across Hywel Dda to provide increased capacity should the need arise. From mid-November, around 30 beds will be opened between the Ysbyty Enfys Selwyn Samuel in Llanelli and Ysbyty Enfys Carreg Las in Pembrokeshire. These beds will be used for non-Covid step-down patients, which will enable us to better manage patient capacity and flow in our acute hospital sites.

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

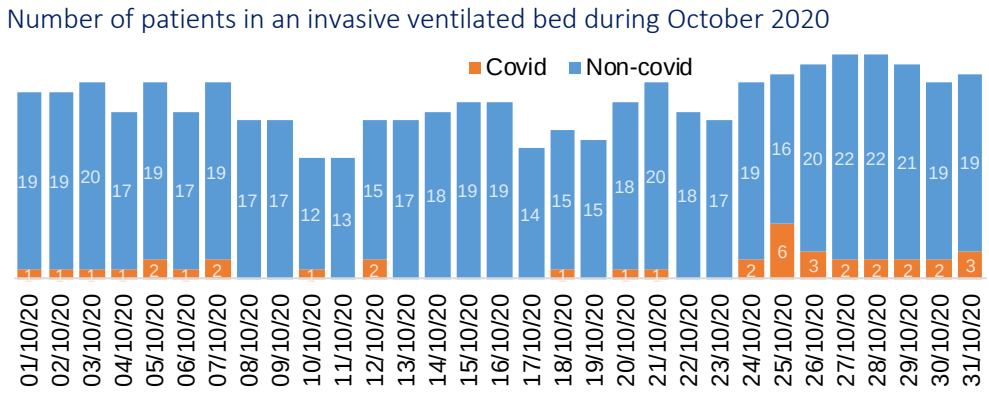
Hywel Dda daily COVID* admissions during October 2020



Critical care

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

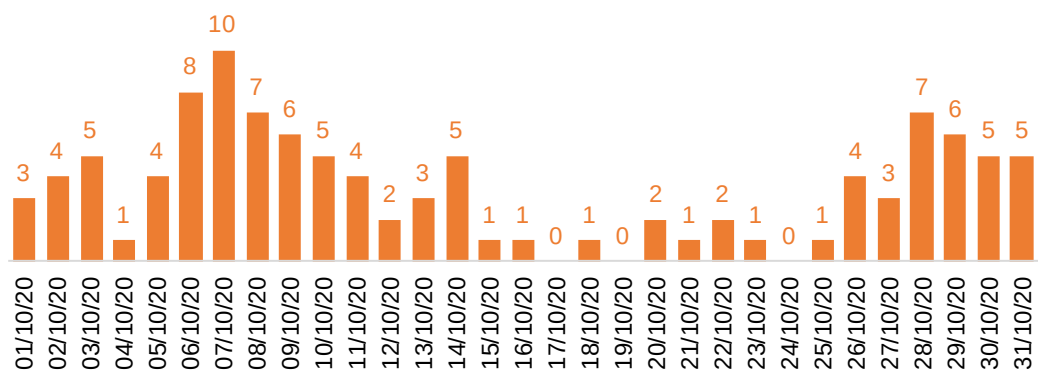
Number of patients in an invasive ventilated bed during October 2020



Discharges and deaths

Between 1st and 31st October, 107 COVID (confirmed and suspected) patients were discharged from hospital alive. Sadly 7 patients died in our hospitals during October after being admitted and subsequently having a confirmed diagnosis of COVID-19.

Number of COVID patients discharged during October 2020



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

Key performance areas

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

		Target	12m previous	Previous period	Latest data	Met plan?	All Wales rank	Notes **
Unscheduled care	Ambulance red calls	65%	61.9%	50.6%	58.9%	No	7th out of 7	Carms 61.5%, Cere 55.8%, Pembs 56.8%.
	Ambulance handovers over 1 hour	0	465	222	226	No	2nd out of 6	Ambulance handover delays decreased considerably from October 2019 (-239).
	A&E/MIU 4 hour waits	95%	81.1%	78.1%	78.2%	No	3rd out of 6	In Oct '20 there was a 26% reduction in the number of new attendances compared to Oct '19. Trajectory was met for 12 hour waits.
	A&E/MIU 12 hour waits	0	882	491	452	Yes	2nd out of 6	
	Non-mental health delayed transfers of care	12m↓	54	n/a	n/a	n/a	3rd out of 7	Due to COVID-19, DTOC census patient number monitoring has been suspended. Latest Mental Health data is based on unverified numbers from the National DTOC database.
	Mental health delayed transfers of care	12m↓	6	5	14	No	5th out of 7	
Stroke and cancer	Admission to stroke unit <4 hours	54.0%	51.2%	55.4%	37.7%	No	1st out of 6	Compliance for admissions to a stroke unit within 4 hours is significantly below target for GGH (5.9%) and PPH (16.7%). All 4 sites exceeded the target for assessment by a stroke consultant within 24 hours.
	Assessed by stroke consultant <24 hours	85.3%	100%	93.8%	96.6%	No	2nd out of 6	
	Stroke patients - speech & lang. therapy	12m↑	33.6%	34.6%	54.0%	No	n/a	
	Urgent suspected cancer	95%	73.9%	82.8%	76.5%	No	2nd out of 6	In September there was 1 Non-urgent and 23 Urgent Suspected Cancer breaches. SCP compliance has decreased by 7%.
	Non-urgent suspected cancer	98%	97.1%	92.2%	98.9%	Yes	2nd out of 6	
	Single cancer pathway	12m↑	67.2%	81%	74%	n/a	1st out of 6	
Planned care and therapies	Hospital initiated cancellations	5%↓	118	10	30	No	4th out of 7	Cancelations due to staffing (12) admin error (1), Emergency Admission (5) & Other (12).
	Delayed follow-up appointments (all specialties)	12m↓	34,989	38,399	40,953	No	n/a	Reduced outpatient capacity due to social distancing requirements.
	Ophthalmology patients seen by target date	95%	56.1%	43.8%	40.4%	No	5th out of 7	Lower performance primarily due to patient cancellations, high risk treatment is continuing.
	Diagnostic waiting times	0	164	5,918	5,407	No	2nd out of 7	511 fewer breaches. Clinically led validation arrangements are prioritising urgent referrals.
	RTT – patients waiting 36 weeks+	0	476	17,857	22,571	No	2nd out of 7	The number of patients waiting > 36 weeks for treatment increased by 4,714 from Sep '20 to Oct '20 and is 22,095 higher than Oct '19.
	RTT – patients waiting <=26 weeks	95%	87.5%	48.9%	53%	No	3rd out of 7	
	Therapy waiting times	0	277	793	659	No	3rd out of 7	Audiology 101 fewer patients waiting (237 Oct), Podiatry 31 fewer patients waiting (319 Oct)
Quality and safety	C.difficile	<=25	38.14	37.76	34.50	Yes	5th out of 6	The cumulative reduction rate compared to Apr 19 – Oct 19: • C.diff cases reduced by 9% • E.coli cases reduced by 24% • S.aureus cases reduced by 25%
	E.coli	<=67	106.89	79.14	81.38	No	6th out of 6	
	S.aureus	<=20	32.38	23.79	24.33	No	4th out of 6	
	Serious incidents	90%	38.1%	67%	25%	n/a	n/a	In Oct '20, 1 out of 4 SIs were closed within the WG timescale. There was 1 Never Event.
	Complaints	75%	77%	63%	69%	No	4th out of 9	More cases 'managed through putting things right' were closed in October.
MH +	Children/young people neurodevelopment waits	80%	34.6%	19.7%	17.7%	No	6th out of 7	The service is expected to have an increased waiting list going forward as the number of therapeutic intervention face to face appointments has been reduced.
	Adult psychological therapy waits	80%	57.9%	28.3%	26.2%	No	6th out of 7	
Population Health	'6 in 1' vaccine	95%	95.1%	95.5%	96.0%	Yes	5th out of 7	The schools immunisation programme was restarted on 29th June 2020 as schools reopened.
	MMR vaccine	95%	92.2%	90.0%	90.3%	Yes	7th out of 7	
	Attempted to quit smoking	5%(ytd)	0.87%	3.45%	1.04%	n/a	4th out of 7	COVID-19 presents a risk to smokers accessing cessation support services and due to the pandemic, CO levels are not currently recorded.
	Smoking cessation - CO validated as quit	40%	30.3%	n/a	n/a	n/a	3rd out of 7	
	Childhood obesity	n/a	n/a	n/a	n/a	n/a	4th out of 7	Carms 13.0%, Pembs 10.6% and Cere 10.3%
Workforce & finance	Sickness absence (R12m)	12m↓	4.95%	5.25%	5.23%	Yes	4th out of 10	Slight decline in in-month sickness from 4.88% in September '19 to 4.71% in September '20.
	Performance appraisals (PADR)	85%	76.9%	69.0%	69.0%	No	1st out of 10	Despite a fall in compliance, highest in Wales since June.
	Core skills mandatory training	85%	83.4%	84.2%	84.4%	No	4th out of 10	Lowest compliance in fire safety (73.8%), IG (77.4%) and L1 moving and handling (79.5%).
	Consultants/SAS doctors - current job plan	90%	61%	36%	38%	No	n/a	Increased COVID activity in October has impacted performance.
	Finance - deficit	£25m	£14.5m deficit	£12.5m deficit	£14.6m deficit	Yes	n/a	Board's financial YTD position at the end of Oct is £14.6m deficit against a deficit plan of £14.65m.

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

Essential services update as at 31st October 2020

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

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

Out of Hours services

- The Carmarthen base rota remains stable with the support of GP coordination, however, the Pembrokeshire position remains unstable with significant shortfalls identified predominantly at weekends. Contributing factors include sickness absence within the salaried workforce and staff who need to isolate due to COVID. The overall service risk remains elevated. Cover at the Llanelli base is starting to improve during weekend hours, but cover remains limited here;
- *Attend Anywhere* online software has been purchased to support virtual consultations, reducing potential risk for staff and patients. 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;
- The decision to support rationalisation of overnight base cover has been a success in improving service stability in the overnight period, however, there remains a limited increase in the amount of general evening and weekend day cover;
- Ongoing shortages in shift fill remain mitigated by a continued focus amongst 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. A potential of delays in patient care/service delivery remain possible, however, should fill rates reduce;
- Work by service leads to procure a new IT rota system solution is continuing. This will enhance access to vacant sessions for Out of Hours (OOH) clinicians and improve governance of rota provision within the OOH teams.

❷ Essential services that are being maintained in line with guidance

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

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

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

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

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

Palliative care

Blood and transfusion services

Safeguarding services

Acute services
Urgent eye care
Urgent surgery
Urgent cancer treatments

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

Termination of pregnancy

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

Renal care-dialysis

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

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

Diagnostics

❸ Intermediate services that are being delivered

Maternity services

❹ Normal services that are continuing

Emergency ambulance services

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

Unscheduled care

Executive Lead: Director of Operations **Senior Responsible Officer(s):** General Managers

How did we do in October 2020?

58.9% of ambulances arrived to patients with life threatening conditions within the 8 minute target. 61.4% arrived within 9 minutes and 66.4% within 10 minutes.

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

9,875 patients attended an A&E/MIU in October as a new attender. Of these patients, **78.2%** were seen and treated within 4 hours of arrival but **830** patients waited longer and **452** patients waited over 12 hours; There has been a 26% reduction in the number of new attendances compared to Oct '19 and 29% year to date.

In October there were **3,241** emergency admissions compared to 3,832 in Oct '19, to our hospitals of which 1,932 (60%) were admitted via A&E/MIU. On average, medical emergency patients stayed in hospital for 10 days (Oct '19 - Oct '20).

How do we compare to our all Wales peers?

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

Impact of COVID

- Ambulance Service

- Additional COVID infection control requirements affect efficiency;
- Staff shielding (following Welsh Government (WG) risk assessment) and an increase of staff reporting COVID like symptoms, which has further reduced our ability to deploy the maximum number of resources. The number of staff abstracted has on occasion been higher than the abstraction rate seen during the 1st wave of COVID;
- Modelling has shown that on average, responding to calls requiring full level 3 Personal Protective Equipment (PPE) will add 4 minutes to a red call as a result of the donning process.

- Unscheduled Care

There is an increase in COVID confirmed cases as predicted with a concurrent increase in hospitalisation rates, although these remain significantly lower than other Health Boards at the present time.

- During October, the number of inpatients with a confirmed COVID diagnosis exceeded the first wave. This is a combination of increased COVID admissions from the community and outbreaks within PPH and BGH;
- GGH taking COVID patients for Pembrokeshire and Ceredigion who would potentially need intensive care facilities if their condition deteriorated;
- Maintaining COVID and non-COVID streams at front door and on the wards. Creation of a third stream for planned (elective) surgery;
- COVID swabs results taking up to 36 hours;
- Staffing - absence through shielding, self-isolation and sickness;
- Early evidence from clinical staff of higher acuity of patients who have presented late – potentially due to fear of COVID especially elderly patients;
- Increasing COVID testing demand from residential/care homes and nursing agencies, is reducing flow, causing discharge delays and additional workload pressure on the acute sites for COVID testing;
- Increasing number of medically optimised patients and some delays in re-ablement and Long Term Care (LTC) package availability due to both COVID concerns, staff shortages and LTC assessment and placement delays;
- Nursing and residential homes under pressure with staff sickness and unable to accept patients back from the acute hospitals;
- Staff are reporting increased stress, anxiety and exhaustion.

Risks

- Ambulance Service

- Ambulance staff must don PPE for all calls and higher specification PPE where procedures produce airborne particles or respiratory droplets;
- Lost hours from notification to handover, has remained consistent and resulted in the equivalent of 43 x 11.5 hour double manned shifts being lost from production. GGH presented particular challenges with 292 hours lost during the month with a number of delays over 2 hours. 34 hours were lost at Morriston Hospital;
- Military support withdrawn and vehicles needing deep clean have to go to Tredegar;
- The time taken for ambulances to become operational post patient handover extended due the need to remove PPE and vehicle cleaning;
- Increasing staff numbers reporting COVID like symptoms and therefore self-isolation. Increased abstractions following the opening of schools, with children being sent home with COVID like symptoms.

- Unscheduled Care

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

What are we doing?

- Ambulance Service

- Local and senior pandemic teams have been stood up;
- Revised performance plan has been introduced;
- An accelerated role out of *Public Access Defibrillators* continues;
- The decontamination site at Singleton has reopened which will reduce down time of vehicles requiring deep cleaning;
- The *Tactical Plan to Production* has been signed off. Mid and West Wales Fire and Rescue utilised to up lift our resource levels.

- Unscheduled Care

- Portable cabins for external streaming facilities to work in conjunction with A&E. WGH, PPH and GGH arriving on 7th November '20 and BGH the end of November;
- Further ongoing planning reviews to implement *Same Day Emergency Care* (SDEC) service to reduce emergency admissions awaiting WG approval;
- Revised major incident plans (addendums) devised for COVID;
- Winter plans agreed and are being operationalised. Staff are being recruited for additional services;
- Joint planning with GGH, PPH and Carmarthenshire County services to operationalise Selwyn Samuel Field Hospital for 17th November '20. At PPH this may increase the risks to service delivery as nursing and medical staff are released from PPH to support the field hospital;
- Consultant and triumvirate (clinical, nursing and management leads) presence at bed management meetings in GGH and PPH, to aide flow and decision making in regard to confirmed/suspected COVID patients and weekend plans.

Bronglais

- Recruitment – Acute Consultant post out to advert, likely to appoint;
- Planned care activity going very well. Running dual lists on Monday and Tuesday to increase throughput and enable patients to have surgery;
- Working closely with Powys Teaching Health Board in regard to elective work;
- Telemedicine progress report to go to the Mid Wales committee in November;
- Additional staff will be deployed across weekends with an additional Doctor in A&E over night;

Glangwili

- Detailed patient reviews (deep dives) in place as '*to treatment and discharge*' plan reinstated, led by the triumvirate with community and local authority presence;
- COVID escalation plan in place and second COVID ward identified to manage increased admissions and delay in discharging patients who are medically optimised;
- SDEC being progressed to reduce patients attending A&E and to facilitate earlier discharge.

Prince Philip

- On-site testing for COVID will start in PPH during November;
- Due to increased COVID activity in the Llanelli area another ward will be converted into a COVID ward during November;
- Encouraging MIU patients to wait in cars if possible to maintain social distancing in the waiting room;
- A pilot of the new SDEC service will run for one week in November.

Withybush

- Green/Red Clinical Decision Units established, reducing attendance and length of stay in the ED. Continued screening of General Medicine (GM) referrals and ambulance conveyances to avoid unnecessary admissions;
- An additional GM junior doctor requested to cover weekend day shift to reduce patient waits for assessment and onward referral/discharge;
- Exploring potential to secure staff to run Ambulatory Care 7 days a week;
- *Pit Stop* model and safety huddles implemented into the ED in week commencing 12th October, to improve timely assessment processes and flow. This needs further focus and reinforcement;
- Strong drive continues on medical recruitment;
- Evaluation currently being undertaken for Acute Frailty Assessment Unit as some delays in patient outflow due to shortfalls in intermediate care team availability and care home fragilities to support timely discharge.

Delayed Transfers of Care

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

How did we do in October 2020?

Due to the COVID pandemic, non-mental health DTOC census patient number monitoring has been suspended.

Mental Health DTOC census delays are being captured, there were **14** in October 2020.

How do we compare to our all Wales peers?

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

Impact of COVID

As we are now entering the second wave of COVID, the full impact of COVID on DTOC can be demonstrated in the following areas:

- Changes to regulatory frameworks – with the introduction of WG Hospital Discharge Service Requirements. *Discharge 2 Recover and Assess* (D2RA) pathways have enabled us to expedite the implementation of these new ways of working. Capacity of the Long Term Care team has an impact on patient flow;
- Staffing - staff groups across all services have been affected by COVID transmission. Self-isolation periods, quarantine, test, trace, and protect will all have an effect on the staff resource available to support patient care, which may ultimately have an impact on DTOC into those services;
- Care home sector – there have been a number of homes who have been unable to accept new admissions. This could be as a result of awaiting test results, outbreaks within the home, positive result of a resident or staff member which has resulted in a period of time where admissions are delayed. Following an outbreak, Public Health Wales guidance states no admissions into care homes until 28 days after the last positive test result and limited admissions during recovery period once the 28 days is lifted;
- COVID testing – capacity within acute sites is increasing to accommodate testing of patients prior to discharge into care homes. To ensure protection of residents within care homes, a COVID negative swab must be obtained prior to transfer from a hospital setting to that of a home. Occasional delays in obtaining same day results which can delay arrangement of transport, medication etc. in enabling transfer;
- Health and social care staff availability has been impacted due to the lack of structured availability and timely COVID test and results;
- Capacity of services and acuity of patient's care requirements – insufficient capacity to meet demand. During the first peak of COVID and lockdown, a number of domiciliary care packages were ceased by patients shielding, as family were able to provide care etc. The demand has now returned to reflect pre-COVID times with people awaiting care provision, some of whom are in hospital. Capacity within Community Hospitals, Care Homes and Intermediate Beds to facilitate step down from acute care is often affected due to care at home not available. Many patients require high levels of care support due to complexity of condition together with high numbers of end of life patients receiving care at home;
- Impact of Lockdown/Firebreak - health protection zones have been introduced in pockets of the Health Board. Community transmission has increased in this area, which is having an impact on available staffing in the community. The return of the student population has resulted in pockets of COVID positive groups with impact on local services and workforce;
- New increase in COVID positive cases in hospitals – each acute site needs to increase their Red zones due to increased cases in hospital. This is putting increased pressure on timely hospital discharge to release Green capacity, and there needs to be sufficient community capacity

Risks

Non-mental health

- Retaining staff in the domiciliary care sector;
- Any new COVID outbreaks in the care home sector;
- 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 in a timely manner of being discharged from an ED;
- Staff absence due to COVID test trace protect guidance;
- 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;
- 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;
- Patient pathway delay due to COVID patients requiring a 28 day window of negative tests prior to transfer or admittance.

What are we doing?

Non-mental health

- Working collaboratively with the Local Authorities to further develop capacity within D2RA pathways, to ensure attainment of standards as outlined in the Welsh Government Discharge Requirements and Primary Care & Community Framework (PCCF);
- Continuing to support our staff through this second wave of COVID;
- Enhancing rapid response to bridging care and sustain by embedding into D2RA pathway;
- Strengthening intermediate care response in the community through embedding of standards outlined in the National Institute for Health and Care Excellence, the National Audit of Intermediate Care and COVID-19 PCCF to support conveyance/admission avoidance where appropriate;
- Increasing Intermediate Care beds for people not yet able to return to embargoed care and residential homes;
- Implementation of hospital same day based swab testing and processing for patients requiring placement;
- Integrating essential service provision between Primary Care and Community services for Long Term/Chronic Conditions management;
- Embedding *Telehealt*h solutions where possible and appropriate to support Intermediate, Palliative and Proactive Care pathway;
- Improved integration of end of life care across the healthcare system and ensure adherence to palliative care principles and standards;
- Scoping is being undertaken looking at the capacity within the existing provider in supporting individuals with greater complexity;
- Working collaboratively with the Universities, Public Health and Local Authorities to manage any outbreak in the Student population;
- Targeted approach of winter funding to support patient flow across the system.

Mental health

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

Stroke

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

How did we do in October 2020?

37.7% of patients presenting at our hospitals in October with a stroke were then admitted to a dedicated stroke unit within 4 hours (a further 17.7% decline from September 2020).

96.6% of patients admitted with a stroke in September were assessed by a specialist stroke consultant within 24 hours (a 2.8% increase from September 2020).

54.0% of stroke patients had the recommended amount of speech and language therapy (SALT) in hospital during October (an increase of 19.4% from September 2020).

How do we compare to our all Wales peers?

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

Impact of COVID

- All sites adapted to virtual clinic appointments during the COVID pandemic, however, we have now started face to face clinics across all sites;
- Work is now in progress to recover out-patients buildup for stroke and transient ischemic attack (TIA) patients across the Health Board;
- Community teams are reviewing post discharge to provide additional rehabilitation at home where appropriate;
- There had been a reduction of Stroke admissions during the first wave of the pandemic. Currently all sites are reporting normal admissions figures;
- There are concerns regarding a second wave of the pandemic, sites may see another decline in admissions due to public/patients concerns of contracting COVID whilst being an in-patient.

Risks

- One of our sites reported an outbreak of COVID in their stroke unit, this has led to the unit being closed to new admissions and patients being redirected to another ward;
- Discharging complex patients back into the community remains a major issue. This can mean some patients that no longer require in-patient care are at risk of contracting COVID on the units;
- All sites are reporting high unscheduled care activity placing further pressure on the stroke units to admit medical patients;
- Only 37.7% of stroke patients were admitted onto the units within 4 hours. This demonstrates the increasing pressure units are under;
- Due to increase prevalence of COVID there is a risk of decreased staffing levels due to self-isolating and sickness;
- There is still an issue with insufficient therapy resource to provide the recommended levels of rehabilitation support.

What are we doing?

- A new Clinical Lead has been appointed;
- Funding has now been agreed to support the *Early Supported Discharge* project through winter planning at WGH;
- Awaiting feedback from Therapy leads on the workshop *How best to provide therapy and improve outcomes for patients*;
- Discussion underway with the Psychology team and Service Delivery Manager on how to provide a psychology service for stroke patients;
- Discussion between WHSCC and the HB regarding improving the IT platform for images sent to North Bristol for Thrombectomy.

How did we do in September 2020?

During September 2020, **76.5%** (75/98) of cancer patients who were referred by their GP as urgent with suspected cancer, commenced treatment within 62 days of their referral. This represents a 6% decrease compared to the previous month.

98.9% (88/89) of patients who were not on an 'urgent suspected cancer' pathway commenced treatment within 31 days from the date the patient agrees to the treatment plan being offered to them.

In September, **74%** (7% decrease to previous month) of patients covered by the SCP were treated within 62 days of the point of suspicion.

How do we compare to our all Wales peers?

Urgent suspected cancer	2nd out of 6
Non urgent suspected cancer	2nd out of 6
Single cancer pathway	1st out of 6

Impact of COVID

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

Risks

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

What are we doing?

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

Planned care

Executive Lead: Director of Operations

Senior Responsible Officer(s): General Manager Scheduled Care

How did we do?

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

In October **53%** waited less than 26 weeks from referral to being treated (RTT) and **22,571** patients waited beyond 36 weeks.

In September 2020 **40.4%** of eye care patients (4,570/11,307) were waiting in or within 25% of their target date. 98.6% of patients have been allocated a high risk factor (HRF) status leaving 224 (1.4%) patients waiting for an allocated HRF status.

In September **23,911** outpatients waited beyond 100% of their target date for a follow up appointment (all specialities).

How do we compare to our all Wales peers?

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

Impact of COVID

- Hospital initiated cancellations
  - Emergent on the day challenges relating to patient flow and staff availability;
  - Supporting stringent infection control pathways reduces usual flexibility of staff and environment.

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

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

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

Risks

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

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

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

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

What are we doing?

- Hospital initiated cancellations
  - Working to optimise available elective theatre lists, prioritizing on cancer and urgent care pathways. Promoting 'GREEN' pathways for elective surgery flow;
  - Planning and collaborating with local patient flow teams to provide safe havens that promote a safe elective patient stay.

- RTT
  - Capacity is being prioritised for category 1 & 2 patients following urgent pathways;
  - Patients will be offered treatments in-line with policy across the sites to enable equity of time and care delivery;
  - Complex pre-assessment and screening pathways are in place including social isolation pre and post operatively with pre-COVID screens at 72 hours;
  - The Health Board now have a revised post-COVID watchtower monitoring programme.
  - Our plans for Q3/4 will enable the recommencement of urgent orthopaedic treatments;
  - Each patient is being risk assessed in order to prioritise those with the greatest need. Regular review of progress is undertaken at the weekly RTT watchtower meeting. The service aims to report initial risk stratification data from next month, with the long term aim of standardised reporting once WPAS data recording is fully embedded.

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

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

Diagnostics

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

How did we do in October 2020?

5,407 patients waited over 8 weeks for a diagnostic test in September 2020 which is **511** fewer to the previous month.

How do we compare to our all Wales peers?

	Diagnostic waiting times	2nd out of 7

Impact of COVID

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

- Radiology
  - Imaging capacity has significantly reduced due to infection control procedures required;
  - There are increases in referrals marked as urgent or urgent suspected cancer possibly due to late presentation.
- Endoscopy
  - We are currently delivering 46% overall activity in line with the National average of 40-50% post COVID activity;
  - All priority one (P1) patients are dated within 2 weeks;
  - Faecal Immunochemical Tests continue in line with National Endoscopy programme guidelines;
  - Business case completed and approved for introduction of capsule endoscopy service to further support reduce demand for scoping capacity.
- Cardiology
  - Some services have been moved off site e.g. cardiac monitors to facilitate 2 metre distancing for staff and patients;
  - 7 day working has been established to maintain social distancing and increase the number of diagnostic tests undertaken;
  - Recent increased number of referrals for Cardiology Diagnostics following the initial reduction in referrals at the height of COVID;
  - No resumption of Trans-oesophageal Echo or Dobutamine Stress Echo due to staff capacity and space constraints.

Risks

- Capacity pressures, equipment failure and COVID precautions are impacting the service's ability to meet target

What are we doing?

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

- Radiology
  - Maintained services for urgent and suspected cancer work;
  - Most referrals have been kept and are monitored and reviewed regularly in discussion with other services;
  - We have maintained dialogue with colleagues across Wales for a review of the overall picture and possible solution to assist with the recovery. There is opportunity to evaluate referral pathways and ways of working to establish the new normal;
  - Additional capacity for computerised tomography (CT) has been acquired but finding staff to operate via locum agencies has been problematic
  - Staff are undertaking extra sessions on top of their working hours to provide additional capacity but this depends on staff availability and infection rates.
- Cardiology
  - Consultant review of diagnostic referrals on waiting list;
  - Cardiac CT is resuming at BGH and being scoped for PPH to reduce waiting times and avoid an invasive angiogram procedure (where clinically indicated);
  - Current in-sourcing of echocardiograms to support internal capacity to meet demand;
  - Diagnostic Angiography increasing for 3 to 4 patient lists at PPH;
  - Cardio-physiology demand and capacity review on-going to identify prioritised actions to resume cardiology diagnostics.
- Endoscopy
  - We are currently delivering 50% overall activity in line with the National average of 40-50% post COVID activity;
  - Maintaining our target of dating our priority one (P1) patients;
  - Faecal Immunochemical Tests continue in line with National Endoscopy programme guidelines currently only 17% converting to an endoscopy procedure;
  - Business case completed and approved for introduction of capsule endoscopy service to further support reduce demand for scoping capacity.

Therapies

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

How did we do in October 2020?

659 patients waited longer than 14 weeks for a therapy appointment. Services with the longest waits include; Podiatry (319), Audiology (237), Occupational Therapy (101)*.

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

How do we compare to our all Wales peers?

	Therapy waiting times	3rd out of 7

Impact of COVID

- Reduced capacity due to service restrictions have affected waiting times for Podiatry and Occupational Therapy. The Podiatry patients waiting are non-urgent and require physical therapy. There has also been a delay in recruitment due to Occupational Health Check capacity. The services have been deploying use of digital technology to support access e.g. *Remote Environmental Assessments*;
- Virtual and remote digital service provision is now embedded within therapy services.
- Audiology service restrictions remain in place with only 45-50% of pre-COVID appointment slots available;
- Audiology telephone follow-up consultations are now embedded in service provision. Only patients who require a face to face appointments remain on the follow up list;
- Audiology GP Assessment referrals are gradually increasing but are still lower than pre-pandemic numbers;
- The Hearing Aid Re-assessment list continues to grow as only limited appointment slots are available and the appointment type necessitates face to face interaction;
- Reduction in clinical workforce due to non-patient contact for higher risk staff.

Risks

- Reduction in clinical estate availability for therapy services provision due to estates being repurposed as part of acute COVID response;
- Reduction in clinical staff workforce due to shielding, and non-patient contact risk assessments for vulnerable/high risk staff;
- Reduced clinical efficiency due to physical distancing, infection, prevention and control requirements to operate safely;
- Access to technology and suitable digital platforms at scale to support virtual therapeutic interventions,
- Audiology waiting lists that are not reportable continue to grow (adults and paediatrics);
- Audiology balance assessment waiting lists are increasing as full assessments (caloric testing) are currently not being performed (throughout Wales);

What are we doing?

- Service capacity and efficiency provision impacted by the need for physical distancing compliance, infection prevention and control practice, including physical decontamination between patients and clinical estate availability to address face-to-face 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;
- Limited appointment slots available for adult urgent and routine audiology patients. Urgent and 'soon' paediatric audiology appointments continue to be booked;
- Support for ENT clinics at GGH, PPH & WGH. From end of November, supporting an additional ENT clinic at Aberaeron Integrated Care Centre;
- Patients now issued with a year's supply of hearing aid batteries.

Executive Lead: Director of Nursing, Quality and Patient Experience

Senior Responsible Officer(s): Assistant Directors of Quality

How did we do in October 2020?

Clostridioides difficile (C.difficile) Infection is caused by a bacteria in the bowel that releases a toxin causing diarrhoea and bowel damage. October 2020 saw 5 cases reported, this is the lowest number of monthly cases seen in the last two years. This is 9% fewer than in the same timeframe of 2019/20, while the all Wales figure shows an increase of 18% in the number of cases. Cumulative rate for Hywel Dda has reduced for the second month to **34.50** per 100,000 population. GGH reported no cases this month, this follows on from a campaign to promote antimicrobial stewardship.

Escherichia coli (E.coli) blood stream infection (BSI). In October 2020 we reported 31 cases, a total of 184 cases this year in comparison with 241 in 2019/20 equivalent to 24% fewer cases. Cumulative rate for Hywel Dda is **81.38** per 100,000 population, increased from last month. This is similar to the picture being seen across Wales where there has been a decrease of 24% in the number of cases.

Staphylococcus aureus (S. aureus) BSI. October 2020 reported 9 cases, 8 MSSA and 1 MRSA BSI. This gives a total of 55 cases year to date, 18 cases (25%) fewer than in 2019/20, while the all Wales figure shows a decrease of 10% in the number of cases. Cumulative rate is currently **24.33** per 100,000 population.

In October, we reported 1,378 incidents of which 1,179 were patient safety related. Welsh Government asks Health Boards to ensure that there is timely and proportionate investigation of all incidents, and wherever possible, serious incidents are reviewed and closed within 60 working days. There were 4 serious incidents due for closure in October of which 1 was closed in the agreed timescale (**25%**). No Never Events were reported in October 2020.

69% of complaints were closed within 30 working days in October. Over a third of the complaints closed this month were cases which were 'Managed Through Putting Things Right' which required an investigation (typically closed within 3 months). The remainder were the lower graded cases which are resolved without the need for any investigation.

How do we compare to our all Wales peers?

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

Impact of COVID

- Infections
  - The Health Board is currently dealing with 5 hospital COVID outbreaks in addition to having COVID wards on each acute site;
  - There are difficulties in discharging COVID positive patients from areas once patients are over the infectious period.

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

- Complaints
  - Due to the disruption to some services during the pandemic, we are seeing an increasing number of complaints regarding clinical treatment and assessment, communication and appointments. More patients are becoming increasingly anxious about the wait for treatment, lack of communication about their treatment and their current health status.

Risks

- Infections
  - The demand on Personal Protective Equipment (PPE) remains high, the Health Board is currently procuring reusable half masks to support the supply of respirators;
  - We are currently seeing higher case numbers of COVID in hospital and community settings;
  - The difficulties in discharging patients post-COVID will make them more susceptible to developing a secondary infection if they remain in hospital.

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

- Complaints
  - We are seeing a rise in the number of patients who are unhappy with the waiting times/management of their health conditions and this is putting increased pressure on current resources as well as the services, as they do need to provide the relevant information for complaint resolution in a timely manner.

What are we doing?

- Infections
  - Supporting and facilitating safe discharges of patients;
  - We currently have 5 COVID outbreak wards, these are being reviewed and supported on a daily basis, with review of PPE, hand hygiene, social distancing, cleaning and the environment;
  - Care Homes support continues as previously, with support given to homes with identified cases;
  - Staff in outbreak areas are reviewed and advised on the need for social distancing and appropriate use of PPE;
  - Work with Field Hospital Teams to review the environment and prepare for admission of patients;
  - Continue to work with Test, Trace and Protect Teams to support contact tracing in hospital COVID cases in patients and staff;
  - Work done on antimicrobial stewardship in GGH and WGH) has seen a consistent reduction in both areas. GGH reporting no C.difficile infections in October and WGH reporting 1.

- Incidents
  - As at 31st October 2020, there were 21 serious incidents open over 60-days. This is an improvement on the position reported last month where 25 serious incidents were overdue;
  - The Quality Assurance and Safety Team continue to monitor and scrutinise the quality of investigations as well as the robustness of improvement and learning action plans. An audit of timeliness of implementation of agreed actions following a serious incident and evidence of completion is underway.

- Complaints
  - The *Patient Support Services* telephone helpline continues to be supported by other teams within the department to assist with the increased number of phone calls received.

How did we do in September 2020

17.7% of children and young people (246/1,386) waited less than 26 weeks to start a neurodevelopment assessment; combined figure for autistic spectrum disorder (ASD, 21.5%, 219/1,019) and attention deficit hyperactivity disorder (ADHD, 7.4% 27/367).

26.2% of adults (431/1,642) waited less than 26 weeks to start a psychological therapy with our Specialist Mental Health Service.

How do we compare to our all Wales peers?

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

Impact of COVID

- Neurodevelopmental assessments
  - Face to Face ASD appointments have resumed and the waiting list is being prioritised with telephone assessments and Attend Anywhere Digital Appointments being offered;
  - Young people approaching transition are prioritised;
  - Delayed recruitment and anxiety to engage in Face to Face assessments;
  - New ways of working include exploring virtual clinics for new patients (telephone or attend anywhere). ADHD: telephone and Attend Anywhere, urgent Face to Face conducted together with monitoring supported by Health Care Support Workers for efficacy and potential side effects of medication in the Llanelli area.
- Psychological therapies
  - Increased the number of telephone assessments undertaken for adult psychological therapies;
  - *Attend Anywhere* successfully implemented as an alternative platform to deliver adult psychological services.

Risks

- Neurodevelopmental assessments
  - Delays can impact on the quality of life for patients and their families;
  - ASD: growing demand verses resources;
  - ADHD: historical referral backlog and vacancies within the team.
- Psychological therapies
  - Increased demand from primary and secondary care;
  - Vacancies and inability to recruit into specialist posts;
  - High waiting lists for both individual and group therapy;
  - Lack of a robust IT infrastructure.

What are we doing?

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

- Neurodevelopmental assessments
  - Each mental health team is working with the all Wales performance Delivery Unit to undertake demand and capacity exercises;
  - Waiting list initiatives have been utilised;
  - Additional resources identified for a sustainable ASD service;
  - Efficiency and productivity opportunities are being explored;
  - An additional part-time community GP post has been recruited;
  - Actively reviewing and managing referrals and referral pathways;
  - A process mapping exercise is underway alongside the Delivery Unit;
  - An active recruitment plan is being developed;
  - Weekend clinics are being considered to increase assessment;
  - ADHD service advertising for consultant paediatrician. Speciality doctor recruited, due to commence January 2021;
  - Validation exercises are underway within the ADHD service;
  - ADHD, from December 2020, Health Care Support Worker monitoring clinic to commence at GGH site to improve patient flow. Further work required to replicate for Pembrokeshire;
  - Agency practitioners are being utilised to address the waiting list.
- Psychological therapies
  - A team restructure is underway;
  - Assessments are being undertaken either face to face or virtually;
  - Therapeutic appointments have been commenced utilising a blended approach of *Attend Anywhere, Face to Face* and *Walk and Talk* therapy;
  - Waiting list initiatives are being utilised;
  - A demand and capacity exercise will be undertaken with all staff to ascertain capacity in caseloads;
  - A review of all modalities will be undertaken to ensure prudent delivery of therapy in line with local and national policies/guidelines.

Population Health

Executive Lead: Director of Public Health

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

How did we do?

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

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

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

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

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

How do we compare to our all Wales peers?

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

Impact of COVID

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

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

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

Risks

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

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

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

What are we doing?

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

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

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

Workforce and finance

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

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

How did we do?

5.23% of full time equivalent (FTE) staff days were lost due to sickness in the cumulative 12 month period October 2019 to September 2020. The actual in-month rate for September 2020 was 4.71% which represented a slight increase from the previous month (4.45%), although a decrease from the same month last year (4.95%). Our rates remain the lowest of the larger Health Boards in Wales.

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

84.4% of our staff have completed their level 1 training which consists of the UK Core skills mandatory training modules such as manual handling, safeguarding and information governance.

38% of our Consultants and Specialty and Associate Specialist (SAS) doctors have a current job plan.

The Health Board's financial position in the month of October is a **£2.083 deficit** (year to date (YTD) **£14.583 deficit**) against a deficit plan of £2.083m (YTD £14.583m). The additional costs incurred in month 7 due to the impact of the COVID pandemic is £9.9m, with underspends repurposed of £3.6m and Welsh Government (WG) funding drawn into the position to match YTD COVID expenditure totalling £6.3m.

How do we compare to our all Wales peers?

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

Impact of COVID

- Absence
  - There was an increase in COVID related absence levels in April and May 2020, however, this has reduced now to more normal sickness rates.
- PADR
  - Hywel Dda has maintained the compliance rate which has seen the organisation remain first across Wales for this measurement.
- Core skills
  - The core skills compliance rate has improved and is now only 0.6% below the 85% target. Covid phase 2 recruits are being supported through their e-learning using Microsoft Teams, phone calls and emails.
- Job planning
  - The COVID pandemic has meant that Service Delivery Managers and Clinicians continue to have time constraints which are affecting timescales for job plan reviews.
- Finance
  - Aligning the strategic response to current demand modelling indicators between WG, Gold Command and operational teams;
  - Further developing the Opportunities Framework to revisit the way in which our services were delivered pre-COVID in the context of accelerating the Health Board's Strategy.

Risks

- Absence
  - Whilst the COVID pandemic continues, there is a risk that we will experience fluctuations in staff absence.
- PADR
  - It is encouraging to see that despite the challenges facing leaders across the organisation with the ongoing pandemic, such as team members being assigned into other services and local lockdowns, the organisation has maintained its position being first across Wales for PADRs. It was expected that these challenges would cause delays to PADRs being completed to timescale but it is reassuring that performance conversations across Hywel Dda are still being maintained.
- Core skills
  - Despite an increase in core skill compliance, this could drop. The situation will be closely monitored.
- Job planning
  - Consultants and SAS doctors are not working to current job plans.
- Finance
  - We have a Financial Plan with a year-end position of £25.0m deficit. Following confirmation of additional funding from WG, the Health Board is currently forecasting to deliver the planned deficit of £25.0m, recognising the need to manage a number of risks in respect of Winter Planning, reinstating elective services and any unprecedented further impact of the pandemic. Discussions are on-going for recurrent funding to support the non-delivery of the Health Board's savings target.

What are we doing?

- Absence
  - The Operational Workforce teams have re-commenced sickness reviews with Line Managers;
  - Online Managing Attendance at Work training to help support managers with absence commenced in October with 89 managers attending our first 2 Teams training sessions. Further sessions are scheduled for November and December;
  - All staff are encouraged to complete the Risk Assessment tool and discuss it with their managers to ensure that they are adequately supported in the workplace and the right adjustments are in place to support staff as a preventative measure to absence.
- PADR
  - Organisational Development (OD) is continuing to hold informal virtual meetings to support leaders with PADRs where requested. This is in light of the Managers Passport and bespoke Performance Management development opportunities being stood down due to COVID;
  - A PADR training video for managers is being completed with different software and will be available by December. The video will outline the operational process with a little theory to highlight the benefits that regular performance conversations and annual PADRs bring to the organisation;
  - OD held a performance management training session in October which was very successful. The team will be continuing these and has a waiting list of interested leaders, beginning in December due to annual leave in the team.
- Core skills
  - Continuing to offer on-line/telephone support;
  - Reminding managers of the importance of allowing staff the time to complete their mandatory e-learning modules.
- Job planning
  - A further 13% of job plans are awaiting sign off on the online system, with another 26% in draft awaiting completion;
  - The Medical Directorate continue to provide a comprehensive status report of job plan reviews for each service area to Service Delivery Managers, General Managers and Clinical Leads;
  - Service Delivery Managers will be reminded of the need to complete any outstanding job plan reviews and to ensure that initial job plans are in place for new staff members;
  - Technical support and guidance will continue to be provided; Support relating to terms and conditions of service will continue to be provided by Medical Staffing.
- Finance
  - Internal budget holder accountability statements in relation to the 2020/21 budget were replaced with a Delegations and Finance Delivery letter, in light of the COVID pandemic. These clarify the continuation of existing financial control principles and the importance of existing governance processes and frameworks, stating the significance of decision making in response to, and the accurate recording of, the financial impact of;
  - Performance monitored monthly through System Engagement meetings for the highest risk Directorates;
  - An extensive review of savings and cost reduction opportunities is to be established as we plan to return to exit the current pandemic;
  - Feedback/clarity from Welsh Government is being sought as to the levels of additional revenue and capital funding available.