

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	30 July 2020
TEITL YR ADRODDIAD: TITLE OF REPORT:	Update on Hywel Dda University Health Board response to the COVID-19 pandemic including local plans to address the requirements of the NHS Wales Operating Framework for Quarter 2 (2020/21)
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Steve Moore, Chief Executive and Andrew Carruthers, Executive Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Steve Moore, Chief Executive and Andrew Carruthers, Executive Director of Operations

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

This report provides the Board with an update on the ongoing response to the COVID-19 pandemic within the Hywel Dda area. As well as updating on a range of issues since the last Board report, it includes the local response to the requirements set out in the NHS Wales Operating Framework for Quarter 2 2020/21. This was issued by Welsh Government on 18th June 2020, submitted in draft on 3rd July 2020 and approved by the Gold Command Group on 7th July 2020.

Cefndir / Background

This report provides an update to the Board on the work that has been progressed since the Board meeting on 28th May 2020.

Asesiad / Assessment

1. Latest planning requirements

On 18th June 2020, Welsh Government issued guidance to support Health Boards in planning for the on-going delivery of essential services and the cautious restart of services on a clinically prioritised basis. The Tactical Group within the Health Board, led by Andrew Carruthers, Director of Operations and Jill Paterson, Director of Primary Care, Community and Long Term Care, have drawn up plans to address all areas of the guidance. This plan is attached at **Appendix 1**.

In developing this plan, the operational teams have been mindful of the following:

- The pandemic has not yet come to an end, making planning for the restoration of services complex, requiring a cautious approach and recognising that staff need to rest after a very busy 4 months;

- Linked to this, operational teams have been giving early, detailed consideration to planning for the Winter under the assumption that COVID-19 continues to circulate and future peaks are possible;
- Non-COVID emergency activity has largely returned to pre-COVID levels whilst hospital capacity is reduced due to infection control requirements;
- Cancer referrals have now returned to pre-COVID levels;
- All essential services, as defined in the Welsh Government guidance, are being delivered across all Health Board Services.

The plan provides an update in the following areas:

- Test, Trace, Protect
- Progress update on compliance with Essential Services and key quality and safety issues
- Progress on implementation of guidance on infection prevention and control, including environmental factors and social distancing
- Refreshed surge capacity plans based on updated modelling assumptions – to include NHS surge as well as ongoing requirements for field hospitals and independent sector facilities
- Update on unscheduled care and planning for winter preparedness
- Progress update regarding routine services, including paediatrics
- Workforce plans, including use of additional temporary workforce
- Support plans for care homes and social care interface
- Financial implications - testing our planning assumptions to minimise the financial implications wherever possible
- Risks to delivery and mitigations
- Mechanisms for stakeholder engagement, including staff side and Community Health Councils

Finally, the plan builds upon on our Quarter 1 submission (May 2020) and the feedback received from Welsh Government which called out areas of risk and general comments that needed to be taken into consideration.

2. Cell updates

PPE Cell

The Gold Command group established the PPE Cell in March 2020 and it is led by the Director of Nursing, Quality & Patient Experience. It reports into the Gold Command Group and continues to provide reassurance that levels of PPE remain adequate across the Health Board. All PPE stocks are rated as “green” meaning levels of stock are sufficient for many days’ supply (range from 15 days to 158 days depending on the specific item). Updates are provided on the daily dashboard published by the Command Centre.

Modelling Cell

The Gold Command group established the Modelling Cell in March 2020 and it is led by the Director of Operations. It has undertaken detailed work to forecast non-elective demand for the coming winter which is supporting the development of comprehensive COVID/Non-COVID Quarter 3 demand forecasts for existing hospital and Field Hospital beds. It has also developed a community COVID demand model to assist the Health Board’s community teams to plan services and is working on a more accurate “near-casting” model to improve

the accuracy of the Functional Capacity analysis. This is used by the Gold Command Group to address potential short-term capacity requirements and enable the Health Board to react quickly to outbreaks notified by the Public Health Cell, which is responsible for the Test, Trace, Protect regional team.

Public Health Cell

The Gold Command group established the Public Health Cell in May 2020 and it is led by the Director of Public Health. Much of the work to date has focussed on establishing the local and regional Test, Trace, Protect process and a full update is contained in the Quarter 2 plan attached at **Appendix 1**.

Social Distancing Cell

This is a new cell established by the Gold Command Group in June 2020. It is led by the Director of Nursing, Quality & Patient Experience and is responsible for ensuring social distancing measures are in place across the Health Board in all operational, office and other Health Board Premises. As this is a new group, a verbal update will be provided to Board on progress to date at the meeting.

3. Considerations for the coming winter - planning for future peaks and the implications for Field Hospital Capacity

Looking forward to the coming winter period, operational teams are working through a set of complex considerations regarding likely bed capacity and demand. To assist with this, the Director General, Health and Social Services at Welsh Government has written to all Health Boards setting out COVID-19 capacity requirements upon which we should base our plans. It should be noted that these requirements are based, not on definite forecasts but in order to ensure there is a level of contingency in the system.

The operational teams and local Modelling Cell are building this assessment into our local plans and adding to this an on-going assessment of the impact of social distancing on bed numbers in all locations and the need to provide capacity differently this winter due to COVID-19 transmission risks. It is also building in an assumption that the COVID-19 peak will coincide with the expected non-COVID winter peak in order to ensure that the risk of breaching available capacity is minimised.

As a result of these on-going calculations, the Tactical Group has recently advised the Gold Command Group that there is likely to be a need for **501 Field Hospital beds** this winter. Work is on-going to refine the modelling but with the decommissioning of the Field Hospital Beds in Penweddig School, and a reasonable expectation that some field hospital capacity will be lost as lockdown eases restrictions on leisure activities, the availability of Field Hospital beds is converging on the likely forecast demand.

It is in this light that the Board is asked to ratify the decision made at the Finance Committee to extend the Bluestone contract. Although some concerns remain regarding water quality, (recognising that requirements for Health Care facilities are higher than for other settings), and the facility has a higher cost per bed than the other sites, the loss of 128 beds would increase the risk that demand would exceed capacity at points during this winter. Any decision to extend will require approval from Welsh Government in addition to ratification from the Health Board. In order to provide the very latest position, a verbal update on water quality issues will be provided by the Director of Operations at the meeting.

Further updates on demand modelling and bed availability will be provided to the Board and relevant Committees as Quarter 3 plans are progressed.

4. Learning from the Pandemic – update on the work of the Transformation Steering Group

The Transformation Steering Group continues to meet on a fortnightly basis in order to drive forward the Health Board’s ambition to learn from the unprecedented events of the last four months and use this learning to enhance and accelerate its strategy as set out in *A Healthier Mid and West Wales: Our Future Generations Living Well*.

Its initial focus has been twofold:

- To capture the changes that have been made locally, nationally and internationally as well as learning from previous pandemics. The first product of this work is presented today in our “Discovery Report”
- To establish an ongoing process of discovery to build transformational change into all aspects of our work. This was launched at 2 half day virtual events held on the 15th and 17th July, the outputs of which are included in the Discovery Report

The work of this group will continue to evolve and develop and it intends to bring new, practical ideas to Board on a regular basis regarding how our services, and the way we operate and organise ourselves can change. These proposals will be expressed through the use of Teulu Jones or our own staff as both a way to bring them to life and ensure they are focussed on the most important considerations – the people who work here and the population we serve.

Argymhelliad / Recommendation

The Board is asked to:

- Ratify the Quarter 2 operational plan, noting Gold Command support and full discussion at the Board Seminar held on 25th June 2020;
- Ratify the decision to extend the Bluestone contract, noting both Finance Committee support and the remaining risk regarding water quality.

A further iteration of the attached document, outlining a Quarter 3 response, will be prepared for future review and consideration.

Amcanion: (rhaid cwblhau)

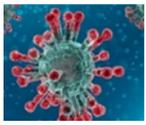
Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	853 854 855
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included within the report
Rhestr Termiau: Glossary of Terms:	Included within the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Hywel Dda University Health Board Gold Command Hywel Dda University Health Board Silver Tactical Hywel Dda University Health Board Bronze Group Chairs

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



Covid-19



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Appendix 1

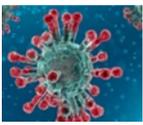
Hywel Dda University Health Board

Coronavirus (COVID-19) NHS Wales Operating Framework for Quarter 2 (2020/21)

July 2020 Version 8

DIOGEL | CYNALIADWY | HYGURCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND





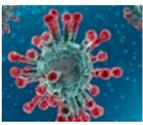
Introduction

This paper sets out the Hywel Dda University Health Board (UHB) quarter 2 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:

- Test, Trace and Protect
- Progress update on compliance with Essential Services and key quality and safety issues
- Progress on implementation of guidance on infection prevention and control, including environmental factors and social distancing
- Refreshed surge capacity plans based on updated modelling assumptions – to include NHS surge as well as ongoing requirements for field hospitals and independent sector facilities.
- Update on unscheduled care and planning for winter preparedness
- Progress update regarding routine services, including paediatrics
- Workforce plans including use of additional temporary workforce.
- Support plans for care homes and social care interface
- Financial implications
- Risks to delivery and mitigations
- Mechanisms for stakeholder engagement, including staff side and Community Health Councils

Our quarter 2 response builds upon on quarter 1 submission (May 2020) and the feedback received from WG that called out areas of risk and general comments that needed to be taken into consideration.

This document is subject to Board approval in July 2020



Dashboard

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

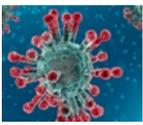
- Testing – daily tests; daily positive tests; cumulative positive tests
- Number of cases
- Staff sickness rates
- Availability of Personal Protective Equipment (PPE)
- Admissions (by acute site)
- Bed occupancy rates (by acute site)
- Bed occupancy rates – invasive ventilated beds (by acute site)
-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

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

Work is underway to collect daily community data and we are developing the Gold Command dashboard to also include the following during quarter 2:

- Primary care – number of GP practices at levels 1–4 (by cluster)
- Community district nurse provision – number of planned visits/levels of acuity and RAG rating (by county)
- Intermediate care / community hospital beds – total beds and occupancy (by county)
- Domiciliary care provision – level of escalation 1–5 (by county)
- Care homes – level of escalation 1–5 vacancies (by county)

This document is subject to Board approval in July 2020



Functional Capacity

As part of entering the second phase of the health board's response, the UHB agreed to move its planning assumptions away from the original PHW model to the PHW version 2.4 40% compliance model. This was used to finalise Health Board plans for its response to the NHS Wales COVID 19 Operating Framework in Quarter 1. This model proposed a number of smaller peaks as a result of the lockdown restrictions being implemented across Wales. Throughout the outbreak, Hywel Dda has seen a lower level of COVID 19 activity than forecast. In reaching the initial peak of the outbreak, the health board averaged in the week ending the 24th April 96 hospitalised COVID patients, with the highest day seeing 109 COVID patients. This equated to just over 30% of the demand predicted in the v2.4 model, which didn't really represent the actual local experience closely.

It has been made clear that any further Covid 19 demand models nationally will only be theoretical and not predictive or provide actual forecasts of what is expected to happen and when. That future national view will be based on understanding "what is the demand if R_t is xyz?", so will simply give a view of what a realistic worst case scenario will look like and therefore how quickly the system would need to respond to a level of surge capacity.

Locally, the UHB modelling cell have developed a COVID-19 model that enables an analysis of the impact of different R_t numbers. It has also been working on a model for forecasting the likely non-COVID (unscheduled care demand) for the rest of the financial year to give a view as to the potential additional capacity the local system will need to manage our usual winter demand at a time when there is an ongoing level of COVID 19 activity. In terms of modelling the Covid 19 element of that, the health board have used an $R = 1.1$ for 3 months model to identify the potential peak demand that it needs to plan capacity for. This is consistent with the letter the health board received from the Director General on the 24th June 2020.

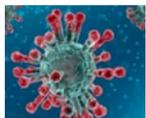
In addition to the challenge of predicting the COVID-19 demand going forward, national guidance that has recently been issued on ensuring social distancing rules are implemented in health care settings which will have the potential impact of reducing the functional capacity on each of the health boards community and acute sites as well as across the 9 field hospitals that were initially established in response to original demand predictions. This will add to the additional surge capacity requirement required for Quarter 2.

Personal Protective Equipment (PPE)

Continuing with our response to the COVID-19 crisis, the PPE Cell has continued to operate throughout Quarter 1, and will remain in place at the start of Quarter 2, to support the acute sites with a timely and controlled process to distribute the vital PPE supplies to our staff and patients alike. Daily reporting on local stock levels and goods issues has been embedded and an executive summary is being fed into the daily command centre dashboard.

Our remodelled internal ordering and logistical process has significantly reduced the number of requestors and delivery points, to allow for an increased service to operate across non acute services, with robust controls in place, managed by each service point of contact. Ongoing review and escalation processes are in place, as are combined local and national procurement sourcing activities and infection prevention and control guidance adherence discussions.

During Quarter 2, we will review the sustainability of our current approach with the stakeholders involved, and look to provide a clear medium term solution on the basis that an increased need for PPE will remain for the foreseeable future, and if we can safely move into process that follows our standard ordering and delivery routines.



Performance

Our performance data for the end of Month 2 (May 2020) can be found in our Integrated Performance Assurance Report (IPAR):

<http://www.wales.nhs.uk/sitesplus/862/page/99899/>

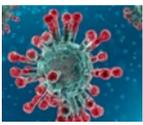
COVID-19

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

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

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



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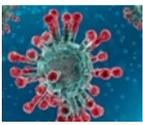
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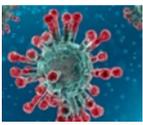
Track, Trace and Protect

The Hywel Dda Test, Trace & Protect Service

- The Hywel Dda Track, Trace and Protect (TTP) Service is a whole system, integrated service delivered through collaboration across the UHB, Carmarthenshire County Council, Ceredigion County Council, Pembrokeshire County Council and Public Health Wales (PHW)
- The Executive Lead for the Hywel Dda TTP Programme is Ros Jervis, Director of Public Health (DPH). The Executive Lead for the Hywel Dda Testing Programme is Alison Shakeshaft, Director of Therapies and Health Science (DoTHS)
- UHB governance for TTP (and testing) including oversight rests with the Public Health Gold Cell (led by the DPH and DoTHS) which reports to the UHBs Gold Command
- As TTP is a collaborative service, oversight from a partnership perspective is being managed through the Regional Oversight Group with Director and operational lead representation from each of the three County Councils, the UHB and PHW. Escalation would be through relevant Gold Command structures (please see structure chart)
- The Testing Group, led by the DoTHS has been active since beginning April 2020 and reports into Hywel Dda Tactical Command and the Public Health Gold Cell.
- Although contact tracing trials had begun prior to formal TTP launch date of the 1st June 2020, most notably in Ceredigion, the original group that formed into the Regional Oversight Group began meeting on 1st May 2020 in response to the draft Public Health Protection Response Plan
- Developments in testing policy:
 - There have been significant and rapid developments to the antigen testing policy and requirements from Health Board Testing Teams and PHW laboratory services throughout Quarter 1. As lockdown is easing, the NHS is reactivating along with some public services and commercial services and the offer from testing and sampling services, including the pathways that underpin an effective TTP service will have to support this.
 - A Testing Plan for Wales, which will include the testing element of TTP is due to be published the last week of June / beginning July 2020. Supported by the Testing Technical Advisory Cell, in terms of the rapid dissemination of learning, evidence and its recommendations for testing, this new testing plan for Wales will help to set out the purpose of testing and help to manage expectations about when and who we would should be testing. This document will be critical to informing Quarter 2 plans in order to respond and plan our testing activity.

As referenced above NHS organisations are playing a pivotal role in delivering the NHS Wales Test, Trace, Protect service which was implemented in Quarter 1 at great pace, and which requires ongoing focus in Quarter 2 to ensure the appropriate capacity for the effective delivery of this service.

- The initial part (first month) of Quarter 2 will require ongoing implementation of the TTP. Although significant achievements have been made with the TTP pathway, the national Case Management & Contact Tracing system (to be known as the CRM system) came on line on 9th June 2020 and access, data flows, data views and reporting and many other key issues are continually being worked through between national and regional teams to provide the functionality required for an effective TTP service
- Further modelling will also take place during month 1 (Quarter 2) to determine/enable:
 - Workforce capacity planning for local and regional teams to manage the increase in population number expected with the re-opening of the tourism sector across West Wales and surge demand for the effective management of clusters/outbreaks or sustained transmission with an $R_t=1.1$
 - Sampling capacity to manage clusters / outbreaks of infection where mass antigen testing is a recommended response action
- Sharing the learning from complex cases/closed setting type cases currently managed and overseen through the Regional Response Cell to all the workforce across the whole system (including local contact tracing teams) to enable us to prepare surge capacity, offer resilience in the face of multiple clusters / outbreaks, utilise all trained workforce effectively and maintain skills

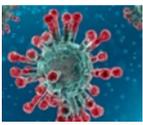


This includes:

- Sufficient antigen test sampling capacity to enable members of the public who are symptomatic to access a sampling site without delay (same day access)
- Our sampling and testing capacity plans for Quarter 2 must include the geographical footprint of the Health Board and be accessible to the population we serve, it must also consider the potential impact of re-opening of our tourist industry in West Wales and the return of our University Students at the end of Quarter 2.
- Planning assumptions for adequate antigen test sampling capacity include:
 - The estimated antigen sampling capacity has been based on an $R_t = 1.1$ for a period of three months. Although the R_t value remains under 1.0 and we have clearly not reached day 1 $R_t = 1.1$ we could assume, for planning purposes a date range between July 1st and 30th September 2020
 - This will be used to estimate symptomatic cases in our communities that could require access to rapid antigen testing
 - Individuals that require pre-operative screening
 - Individuals that require antigen testing on hospital admission and discharge
- Our current capacity for antigen testing is available across a number of locations i.e. in hospital, in one of five Coronavirus Testing Units (CTU), in Primary Care or in the persons own home. There is also an option to book a test on line, via the UK Portal, for home delivery and collection.
- The LHB has 2 CTU Drive Through models, which are UHB managed, operating out of Withybush General Hospital and Trostre Industrial Estate in Llanelli. The Health Board will be required to continue to resource these units up to 7 days a week to meet demand during Quarter 2.
- The LHB also has two walk in CTUs located in Aberystwyth and Cardigan Towns. Both these facilities are not currently utilised as efficiently as the Drive Through models or to their maximum capacity. The 'walk in' model requires longer appointment slots to allow for environmental decontamination between patients. The preferred model going forward would be to establish two mobile units for the populations in these areas to improve accessibility and efficiency.
- The largest testing facility is the Department of Health (DoH) Drive Through Population Sampling Centre (PSC) in Carmarthen with an option to increase capacity in response to demand by extending operating hours and opening up a further lane. This facility is currently operated by the UHB and a third party provider (Sodexo). Consideration will be given in the early part of Quarter 2 regarding the longer term plans for operating the site, with the potential for some or all samples to be managed via the UK Lighthouse labs. An options appraisal is currently underway and the final decision will be informed by a number of considerations, including flexibility of the site to support the Hywel Dda footprint, changing testing requirements (both antigen and antibody), ease of access to the site, laboratory capacity and turnaround times for results. There is a potential issue with the site's ability to function in bad weather and the longer term solution will need to consider the site's applicability as we move into the winter period.
- The future hybrid model will ensure that a COVID-19 antigen/PCR test for symptomatic individuals and for those who require a test prior to admission to hospital/clinical procedure, is accessible to them. Please note however that sampling and testing capacity required to respond to large clusters of infection / outbreaks has not yet been modelled.

Capacity and organisational arrangements to deliver testing turnaround times (test request to lab authorisation of 24 hours) consistent with international evidence of best practice for contact tracing. This requires that samples reach laboratories and that laboratory capacity and throughput is consistent with the expected turnaround time.

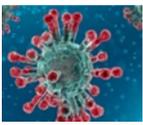
- To improve timescales for testing & contact tracing in line with evidence of best practice there must be significant improvement in the testing turnaround times going forward into Quarter 2. Working with the Test, Trace, Protect NHS Wales Operational Team (relevant to a number of their key objectives) we will review our existing process map for testing and identify areas for improvement. The process mapping exercise will incorporate the end to end testing process starting with identifying efficiencies in the appointment booking systems and automation.



- For antigen testing the UK online booking portal is more efficient than the in-house booking system, however, it does have limitations regarding who can access testing via this route. We will also need assurance from the DoH regarding turnaround times for results before any decision is made to move to this system in its entirety using the Lighthouse labs.
- For antibody testing there is not an on-line booking system available to date and there is a significant administrative function required to collect the necessary information to book the appointment and contribute to the sero-surveillance. The DoH is developing an on-line booking system but this will not be available until mid-August at the earliest. This issue has been escalated to Welsh Government colleagues as an urgent development that is required.
- We will continue to offer mutual aid provision to our neighbouring Health Boards/Trusts and other Critical Workers adopting the 'All Wales' approach with the aim of enabling individuals to access testing within 30 minutes if necessary.
- We will aim to assure that urgent samples will be prioritised and processed wherever possible within our local PHW laboratory capacity, we will also aim to increase utilisation of the Lighthouse laboratories to increase analysis capacity, pending assurance regarding turnaround times during Quarter 2.

In collaboration with partners to deliver regionally coordinated local contact tracing teams – a mix of clinical and non-clinical staff who can support those who have tested positive and their close contacts to stay safe.

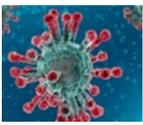
- Further to the general comments highlighted above we will continue to embed a regionally co-ordinated contact tracing service that seeks to iron out issues as they emerge, supports the ongoing development of an effective fully functional CRM system and engages in the rapid sharing of learning and intelligence that supports resilience moving forwards
- Prepare the Region for a TTP service that moves from contact tracing on a positive case to an individual who is reporting on symptoms during Quarter 2
- Base demand & capacity (including workforce) planning for local contact tracing and the Regional Response Cell on $R_t=1.1$ for three months. Further work is required to add to our current modelling the impact of the re-opening of the tourism sector (staying over holiday makers) with the exception of second home owners which has already been included in the community modelling along with established population flows from North Wales and Powys.
- Implement the surveillance system in the Regional Response Cell that has been developed during Quarter 1 and work through the Information Governance issues to enable Local Contact Tracing Teams direct access to this real time intelligence system and early warning system
- Continue to develop the daily and weekly whole system communication flows (daily huddles and weekly learning and training sessions) that have become so important to effective regional co-ordination. This is going to be paramount to enable a swift and dynamic response to local clusters/outbreaks. System-wide use of the National CRM system
- Continue to prepare, train and develop local and regional surge capacity. Workforce capacity currently includes:
 - Carmarthenshire Contact Tracing and Advice Team:
 - Two Environmental Health Practitioner Team Leaders with a core team of 5 Contact Tracers and 12 Contact Advisors (and surge capacity of up to 38 Contact Tracers and 60 Contact Advisors)
 - Ceredigion Contact Tracing and Advice Team:
 - Two Environmental Health Officer Contact Tracing Managers (with an additional Officer for surge) with a core team of 5 Contact Tracers and 12 Contact Advisors (and surge capacity of up to 8 Contact Tracers and 24 Contact Advisors)
 - Pembrokeshire Contact Tracing and Advice Team:



- Five Environmental Health Practitioners and four Lead Officers, each role rostered to provide leadership to the Local Contact Tracing Team and Regional Response Cell on a daily (8-8, 7 days a week) with a core fully operational team of 12 Contact Tracers and 12 Contact Advisors. For surge preparation, those currently undertaking training, a further 18.52 (FTE) Contact Tracers (includes 5 FTE shift leads) and 49.03 (FTE) Contact Advisors
- Regional Response Cell:
 - Operational 8am to 8pm, 7 days per week
 - Dedicated telephone line: 01267 283263 and email address: contacttracing.hdd@wales.nhs.uk
 - Daily response overseen by Consultant in Public Health (additional Consultant capacity has been deployed by PHW centre as limited local capacity)
 - Built on COVID-19 Command Centre infrastructure with access to all specialist stations including the Testing and Screening Team; the Care Home Team; Infection Prevention & Control; Public Health advice; microbiology; and primary care.
 - Rapid, single point of access to Specialist Health Protection Service (including the Consultant in Communicable Disease Control and Health Protection Nursing Service)
 - Clinical contact tracing & advice team (additional nurses recruited through re-deployment into the RRC to act as Clinical Leads for advice provision and contact tracing for all cases and incidents escalated to the RRC)
 - Public Health Specialist advice service to support complex contact tracing and advice services and cluster/incident management
 - Single point of access for Local Authority Public Protection leads (EHOs/EHPs on a daily rota) for the provision of health protection leadership into the RRC and on-going support to Local CT Teams
 - Surveillance system to provide case tracking and early warning of potential clusters and potential high risk premises alert
 - Administration support for complex case management, incident and cluster support
- Taking learning from the first month of operation of the TTP system in Wales is going to be essential for Quarter 2 delivery. The vast proportion of Hywel Dda cases being escalated to the RRC due to complexity, association with an enclosed setting or incident related created immediate capacity issues which were exacerbated further by system access challenges. Additional capacity has been rapidly recruited and trained to support the RRC however on-going system-wide planning over the first few weeks of Quarter 2 will be critical to enable the TTP service to manage a surge in numbers and/or potential clusters and outbreaks as a result of the lifting of lockdown restrictions particularly the opening of West Wales to holiday makers and associated changes to the hospitality sector
- In relation to an effective TTP communication plan we have been proactive in our approach to communicating the Welsh Government's Test Trace, and Protect strategy. We have a local Communications Implementation Plan which is supported by regional partners from the local authorities, police, and fire service. The Welsh Government's activity has been bolstered locally with additional case studies, media releases, poster campaigns, and radio adverts. Paid for social media advertising has also been purchased to support reaching targeted communities, and by way of an example used to link with local communities in which there are meat processing plants, such as those associated with recent outbreaks in North Wales.

Provision of environmental and public health responses to local outbreaks and clusters or preventative action in areas regarded as high risk.

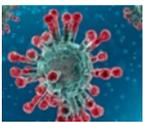
- Overarching framework for the management of outbreaks through the Communicable Disease Outbreak Plan for Wales to be known as the Wales Outbreak Plan (the OCP)
- This clarifies roles and responsibilities for the escalation, declaration and management of outbreaks including an outbreak of COVID-19 and supports understanding of the roles of the:
 - Strategic Co-ordinating Group (SCG) in managing wider and civil contingency issues
 - Outbreak Control Team (OCT) in determining and managing outbreak control measures



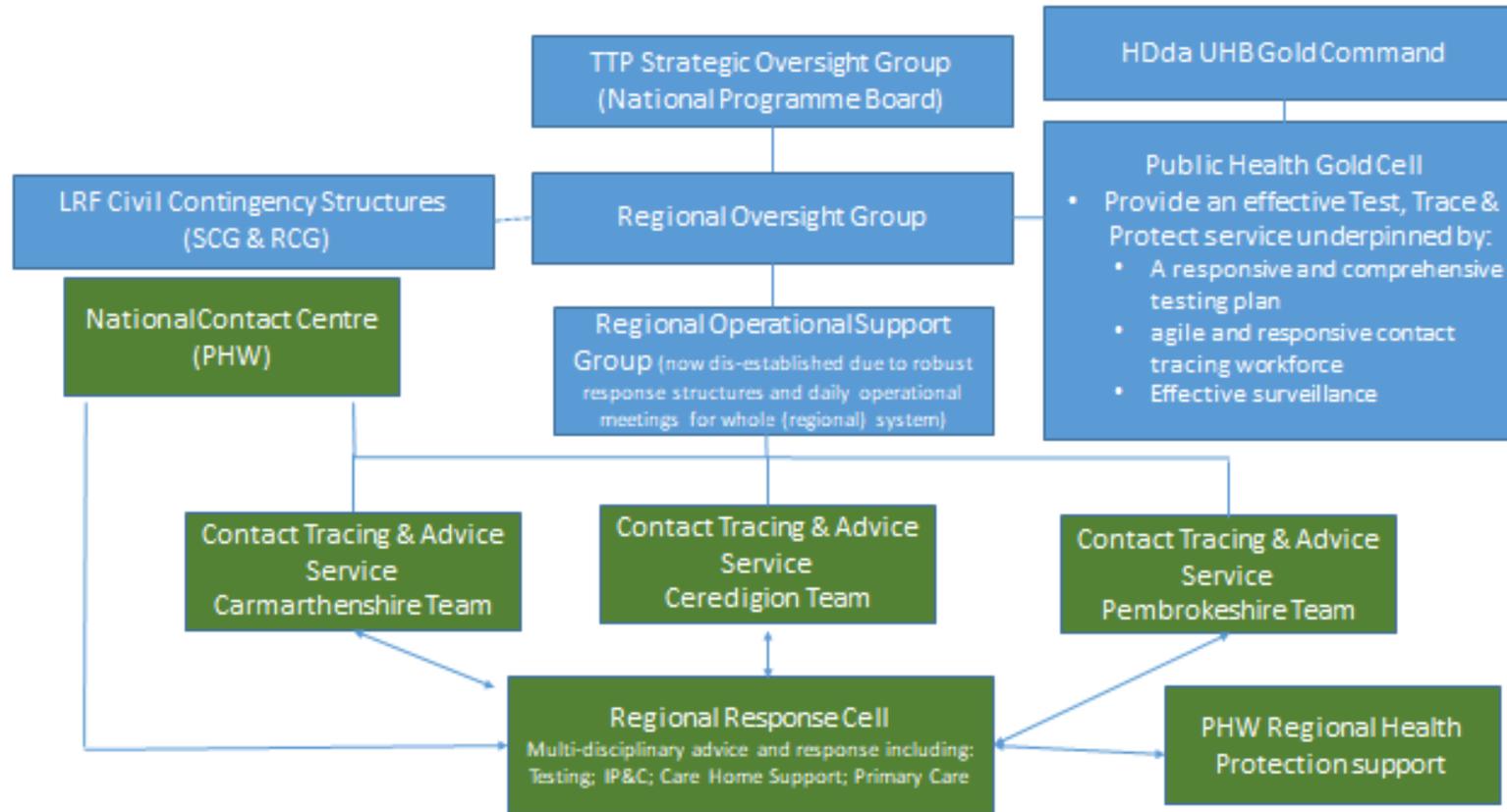
- And local multiagency delivery teams co-ordinated through the Regional Response Cell to deliver the day to day response to outbreaks (when declared) and incidents
- All other COVID 19 incidents identified through the TTP process managed through the Regional Response Cell
- Governance structures such as the Regional Oversight Group is key in supporting surge capacity planning adequate to manage multiple incidents and outbreaks and take proactive action to prevent incidents and outbreaks based on wider learning with multi-agency response

Testing supports purposes other than contact tracing. The NHS will need to have capacity to support these other testing purposes - diagnosing the disease to help with treatment and care; population health surveillance, so that we understand the spread of the disease; business continuity, enabling key workers to return to work more quickly and safely; knowing who has had the infection in the past, when antibody testing is widely available.

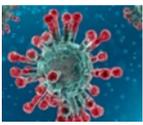
- Antibody testing services are beginning to embed across Hywel Dda and we will continue to support the ongoing roll-out of the antibody tests, including lateral flow once it becomes more widely available.
- The national systems to support serology antibody testing are still being developed, with issues still to be resolved regarding results reporting and as mentioned previously there is an urgent requirement for a national on-line booking system for antibody testing.
- Until the knowledge base is further developed so there is a clinical utility to the antibody testing, care needs to be taken about the potential impact of a positive or negative result on peoples' behaviour with regard to social distancing, hand hygiene and infection prevention and control as a positive result cannot yet be taken to infer immunity.
- Serology antibody testing is resource heavy and roll-out needs to continue in a phased and pragmatic way. Whilst we will continue to further roll out antibody testing, as demands increase, the provision of rapid access and turnaround of antigen testing services to support an effective TTP Service must remain the priority for the Hywel Dda Region.
- Our serology antibody testing for COVID-19 commenced on 15th June with the first cohort being a sample of teaching staff working in the school hubs as directed by the Chief Medical Officer. We then commenced antibody testing to the second priority cohort of Healthcare Staff working in red areas and are about to widen this offer to all Health Board and Primary Care staff, ahead of further cohorts likely to be identified in the National Testing Strategy to be published soon.
- On the 16th June the Health Board gained approval to open the first DoH Antibody Drive Through facility in the UK. This is a 5 lane facility with capacity currently to take 250 blood tests a day 7 days a week. This capacity could increase if longer operating times were introduced, however, is dependent on sustained laboratory capacity to process the tests in our local laboratories. The UHB has also allocated some of its CTU capacity for antibody testing, this is available due to the low prevalence of individuals presenting with COVID symptoms currently (and hence lower demand for Antigen/PCR testing), however it cannot be guaranteed long term. The preferred model going forward for our populations in parts of Pembrokeshire and Ceredigion would be to establish two mobile units to conduct antibody testing for the populations in these areas to improve accessibility and efficiency. We are aware that this model could also provide further efficiencies if the models were to be developed in collaboration with Primary Care.



Test, Trace & Protect: Hywel Dda oversight governance and response structures



This document is



Progress update on compliance with Essential Services and key quality and Safety Issues

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

Primary Care and Community

Primary Care

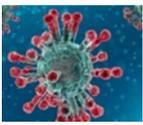
In moving to support essential services across the UHB, a series of key initiatives and decisions are noted below

GMS

- All GP Practices are using technology to support video consultations with patients;
- E-Consult (funded through the Pacesetter programme in 2019/10) is in place in 36 (75%) of Practices, with an additional 5 due to come online shortly. Usage data has recently been made available and has been shared with the Local Medical Council (LMC), Practices and Clusters to inform future working models;
- Local guidance issued to GP Practices to assist in resetting Long Term Condition management safely and to protect vulnerable groups;
- Use of the BMA/RCGP guidance on Essential services to inform discussions with GP colleagues and the LMC;
- 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 for EOI to commence from 1 July 2020;
- Guidance and checklists being developed to support GP practices in the resetting of work from July to October;
- Local communications statement and video around access to all primary care services has been developed and released; further work on FAQs for each specific contractor area around access to services is being developed;
- Flu planning starting to take place;
- Fit testing for Resus being undertaken across all GP Practices as part of a rolling programme

Community Pharmacy

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



- Rolling programme for Personal Protective Equipment (PPE) provision in place;
- Flu planning starting to take place; need to consider the potential for fit testing

Dental

- Green sites identified within the Community Dental Service;
- Three AGP sites in General Dental Practices brought online at the end May 2020 to assist with the demand and capacity being experienced; EOIs sent out to further expand this programme from end June onwards;
- Fit testing roll out plan developed for UHB identified AGP sites;
- Red site developed to bring in patients who require urgent/emergency treatment that are Aerosol Generating Procedures (AGPs);
- Minor Oral Surgery service relocated to deliver services within UHB premises with FFP3 provided to ensure continuation of services;
- Discussions around the paediatric dental pathway and the development of the future model

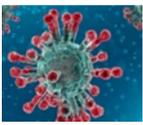
Optometry

- Green sites established and working, suspension of routine care; urgent and emergency cases only;
- Red site identified and available;
- Domiciliary service established;
- All Wales acute eye care telephone advice line agreed and in place through the UHB Low Vision Service;
- Four acute eye care hubs established treating and managing acute eye care problems which would previously have required a referral into secondary care; proposal to continue with this model into Quarter 2 and the future. 400 patients seen during Quarter 1 with 88% managed within the service with no onward referral.

Community Plans

Our approach to population health and equitable outcomes for individuals is defined in partnership across the West Wales Care Partnership region with Local Authorities and third sector partner organisations through the Health and Social Care COVID -19 Planning Group (HSCCPG).

A Healthier Mid and West Wales (our strategic health and care strategy) outlined Hywel Dda's commitment to innovating and transforming our services to deliver on the collective commitments outlined in 'A Healthier Wales'. The five domains within the plan (See Figure Below) provided a framework for organising our plans for the whole system of health and care and has provided the foundation for our COVID response. To ensure consistency in delivery at local level, in Quarter 1. we have developed Regional principles and standards based on national guidance specifically in relation to Discharge Requirements and Intermediate Care. These are then implemented locally in each County system to ensure and embed integrated working across health and social care that reflects population needs, geography, available assets and the configuration of the acute services which reflect local assets and service availability at County level. Regional principles and standards for Proactive Care and Palliative Care will be completed and approved by the HSCCPG by the end of July. A Performance Assurance Framework has been approved which will ensure that each component of our system reports on their performance in order to understand and analyse the collective impact of the system on an agreed population outcome indicator – 'Increased Time Spent at Home and Independent'.



In addition to the Regional pathways outlined above and, in acknowledgement that health and social care provision will be compromised unless we take a system approach to managing risk across the whole system we have developed and implemented Risk and Escalation Management policy for Care Homes. A similar policy will be completed and approved by the end of July.



West Wales Region Frameworks & Standards for Delivery

Help Long Term

- Principles and Standards for Palliative Care provision for the Region – in development
- Regional Escalation and Risk Management Policy for Care Homes – agreed.
- Regional Escalation and Risk Management Policy for Domiciliary Care – in development.

Help When you Need It

- Principles and Standards for Intermediate Care provision for the Region - agreed
- Regional West Wales Discharge Requirements Guidance - agreed

Help to Help Yourself

- Principles and Standards for Proactive Care provision for the Region – in development.

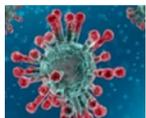
Help for Strong Communities

- Principles and Standards for Preventative Care & Wellbeing provision for the Region – in development.

Sitting across these five domains is our response to the Urgent and Emergency Care needs of our population, this need always presents first in our communities and changes to the Lockdown requirements are likely to bring temporary residents back to our region. The table below provides a summary of our regional response to the 6 priorities:

To enable the population and place based delivery the following key enablers have been enhanced through Quarter 1 and in Quarter 2 we plan to deliver:

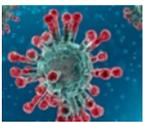
- **Workforce** – applying the principles of social distancing to support return to routine activity for more individuals and teams along with ongoing support for psychological and wellbeing support. Staff deployed on temporary contracts will be reviewed and extended to support the need to recover services and remain ready for surge and escalation should this be required. A review of alternative working models is underway with principles and lessons learnt being shared and embedded in Quarter 2.



- **Digital** – building on virtual consultation, originally adopted by GMS, for community based teams to support patient care and multi-disciplinary working. Where additional hardware and software is still required this will be prioritised to support productivity, safety and to reduce harm. The CONNECT regional transformation programme continues to expand to support wellness and connectivity within our communities. Building on the success of remote oximetry monitoring in Quarter 1., a number of other Telehealth opportunities have been identified to enhance proactive care monitoring in the community. Plans for these will progress throughout Q2 with the aim that this will be integral to delivery of essential services throughout Quarter 3.
- **Infrastructure** – all community buildings have been risk assessed to support a recovery of activity in community settings where appropriate and safe. Utilisation and estate allocation will support delivery of prioritised services, particularly where teams and services have been displaced to create additional bedded or separate COVID and non-COVID clinical areas. A further review of staff displaced from acute sites will be conducted in Quarter 2 with a view to enhancing or developing community assets to also support the delivery of our Healthier Mid and West Wales strategy.
- **Finance** – we will work collaboratively with partners across the region to re-profile and maximise the impact of ICF and Transformation Fund. We will use Palliative Care Implementation Board funding to enable a Discover, Design and Deliver programme for Palliative and End of Life Care across the region. Where additional resources are required we will work in system finance groups across primary, community, therapy and unscheduled care to maximise the impact of our core budget first to ensure sustainability of system change. There remains a risk that the potential withdrawal of ICF and Transformation funding could present challenges for some of the community based change delivered at the end of Quarter 4 and exit plans and evaluation of the change will be commenced in Quarter 2.

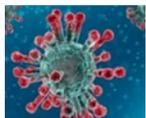
It is our ambition to ensure that there is both the workforce and the infrastructure to ensure we can respond to any future scenarios requiring additional surge capacity or community based solutions to growing need within our population. To do this we will ensure essential service delivery and act cautiously in the recovery of routine services. It should be noted that community activity, whether routine or through our intermediate care virtual wards, has grown throughout Quarter 1. Some teams and areas have been compromised through staff shielding or self isolating for vulnerable family members, and these team members have contributed to service delivery through telephone or virtual assessments and follow up calls. The work of the three Local Authorities has been essential in supporting our communities and on an integrated County footprint, systems have evolved to align crisis and routine service delivery with the new community based support groups.

Essential Service	Compliance with principles outlined in Framework	Comments
Community Nursing & Allied Health Professionals services	Compliant	<ul style="list-style-type: none"> • Long term conditions – telephone and virtual consultations are being held for patient with face to face assessment reviews happening in patients own homes where there is an identified risk of decompensating. Hospital based clinics and routine care where there is no risk of harm continues to be suspended. The number of face to face appointments has reduced during this period however this is growing again with capacity and delivery being monitored through the daily SITREPS. • Proactive monitoring of patients at risk of decompensating – All patients on caseloads, and new referrals, are risk assessed to establish the level of support required. Where there is an identified risk of decompensating, home visits are undertaken. Other patients deemed not at risk are followed up by phone and given contact information should there be any changes in condition or function. • Palliative Care to support people at home – see below.



		<ul style="list-style-type: none"> Maximising recovery & discharge from hospital – intermediate care co-ordination is available for all the Discharge to Recover and Assess Pathways however, some of these are more established than others. Work is ongoing to ensure delivery against the national and regional standards. Local escalation plans are also reviewed and revised according to scenarios and the information on activity to ensure the community can respond accordingly to support both hospital flow and care home vulnerabilities.
Rehabilitation	Compliant	<ul style="list-style-type: none"> Day therapy and day care facilities remain close to conform to social distancing requirements however alternative models of care have been implemented through telephone contact and assessment, video consultations and face to face clinic or home based appointments where necessary.
Palliative & End of Life Care	Compliant	<ul style="list-style-type: none"> Support to people at home - services continue to be delivered for risk assessed patients. Home based care is available to support people to die at home if that is their preferred place of care through multi-disciplinary care teams. Fast track access to enhanced home based care is available. Advance & Future Care Plans – teams continue to offer care planning and DNACPR, especially to Care Homes, however there remains some patients and families who do not want to engage. Paul Sartori Foundation has been commissioned to provide training, particularly for patients with dementia. Access to inpatient specialist palliative care expertise - Our in-patient Specialist Palliative Care Unit was closed to admissions at the onset of the Emergency Period with the workforce being redeployed to support a greater number of patients requiring end of life support by community nursing. We are currently assessing options to ring fence 4 specialist palliative care beds in Prince Philip Hospital. In the meantime, Specialist Palliative Care Consultants continue to deliver their expertise flexibly across acute and community settings and according to demand. Community assistive equipment – this continues to be available to patients in the community and to support them to stay at home. Multi-disciplinary team access – although in some areas access to the whole MDT may have been challenged through individual staff shielding, there remains active MDTs in place for our palliative care patients.

This document is subject to Bora approval in July 2020



Acute

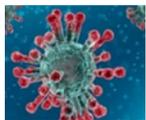
The following table provide a review of the essential services and are compliance against them and our approach to individual services

Essential Service	Compliance with principles outlined in Framework	Comments
Urgent Surgery	Compliant	<ul style="list-style-type: none"> All patients are being risk-assessed in accordance with the 5 categories and alternative (interim) treatment approaches are being considered where deemed clinically appropriate
Urgent Cancer Treatments	Compliant	<ul style="list-style-type: none"> Services currently delivered in accordance with WG guidance. Detailed Cancer Service contingency plan published. Regional aid arrangements in place with tertiary centre surgeons providing outreach surgery. Endoscopic diagnostic services have been restricted in accordance with national guidance for individual procedures / pathways
Life-Saving Medical Services	Compliant	<ul style="list-style-type: none"> All patients are being risk-assessed to balance risks of cross – infections and deferred treatment. Individual endoscopic diagnostic procedures available for life-savings scenarios where alternative diagnostic approaches are not available / clinically appropriate
Life-Saving / Life-Impacting Paediatric Services	Compliant	<ul style="list-style-type: none"> Urgent illness, screening, Immunisations & Vaccinations and high clinical priority community paediatric services are continuing. Specialist services provided at tertiary centres.
Maternity Services	Compliant	<ul style="list-style-type: none"> Antenatal, Intrapartum, post-natal & risk-assessed community midwifery care continuing.
Neonatal Services	Compliant	<ul style="list-style-type: none"> Level 1 Neonatal care continues to be available. Glangwili Neonatal Unit separated into RED & GREEN pathways. Neonatal transport services available as per normal.
Urgent Eye Care	Compliant	<ul style="list-style-type: none"> Urgent eye care pathways continue. Local Independent sector hospital commissioned to support urgent eye care pathway Regional clinical concerns raised regarding some aspects of WG guidance
Termination of Pregnancy	Compliant	<ul style="list-style-type: none"> Service provided in accordance with WG guidance
Other Infectious Conditions	Compliant	<ul style="list-style-type: none"> Services available for urgent / emergency sexual health assessments / treatments
Renal-Care Dialysis	Compliant	<ul style="list-style-type: none"> Service provided by external providers

Hip Fracture Surgery

Throughout the pandemic, patients presenting with hip fracture have been managed in accordance with the UHB's hip fracture pathway and NHFD guidance as normal. This is in accordance with the British Orthopaedic Association and Royal College guidance and this has been possible due to the low prevalence experienced in Hywel Dda.

Interestingly we have experienced higher admissions for this condition during the last few months, in comparison to the same time last year at Bronglais and Withybush – this



has only been the case with three hospitals in Wales (so we were advised by the DU). The operational team are currently reviewing this to see if there is any learning as to why this may have occurred in Hywel Dda like this.

Trauma

The South and West Wales Major Trauma network was due to go live in April 2020. Due to the COVID-19 pandemic and impact on hospitals the introduction of the network was postponed. The project has now recommenced work towards establishing the Major Trauma Network, including establishing the Operational Delivery Network team and recommencing meeting of the Network Implementation Board and project subgroups.

The Hywel Dda Major Trauma Task and Finish group had been meeting on a monthly basis up until February 2020. Significant progress towards meeting the requirements for go-live had been made up to February 2020 and this was reviewed at a readiness visit undertaken by the network project team on 3rd March 2020, which resulted in a favourable report. A number of recommendations were made, graded as to urgency – Critical/Essential/Recommended.

The network programme is being re-invigorated, and Implementation board met again for the first time since the COVID crisis on 15/6/20 at which it was strongly suggested that a new go live date of mid-September 2020 was likely. Advice from the National Clinical director for Major Trauma in England presented highlights of how the English systems have coped with the challenges of COVID and this, along with a risk assessment of delaying go live further presented an argument in favour of establishing the network in South Wales. It is expected that CEO's will be updated on progress at their meeting next week, including the work being undertaken in Cardiff & Vale UHB necessary to establish the Major Trauma Centre. This still represents a risk to the timeline, however it is hoped sufficient assurance will be in place on their preparations for the WHSSC Joint Committee to endorse the suggested network commencement date at their meeting on the 14th July 2020.

Our Director of Planning Performance and Commissioning has been the Senior Responsible Officer for the duration of this project. However, in anticipation of the move from the planning phase to operational phase it has been established that this should change to the Chief Operating Officer.

Cancer

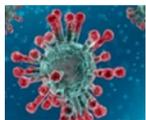
The section below summarises the UHB's current assessment in respect of the 8 actions outlined in the NHS Wales Health Collaborative guidance / framework document for Cancer Services in Wales during COVID-19:

Action 1:

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

Diagnostics

- All imaging requests are being assessed for appropriateness by the Consultant Radiologists.
- 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. Detailed information as to what treatment the patient is undergoing is required at the time of request.



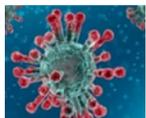
- CT Colonography investigations currently cannot be undertaken. These have been changed to CT abdomen as per national guidance. Reinstating this investigation is being discussed, but would severely limit radiology capacity at this stage.
- Bronchoscopies have been limited in line with national guidance. This service was recommenced on the Prince Philip site week commencing 11th May 2020.
- As the national bowel screening programme has been suspended, there are currently 231 patients awaiting a colonoscopy. This service is due to be reinstated in July 2020.
- 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 is being explored as an alternative due to the current severe restrictions on the normal diagnostic pathways. As a pragmatic approach to triage the most high-risk patients for the early detection of cancer, individual Health Boards across Wales are advised to explore options for commissioning the adoption of FIT10 screening for the prioritisation of USC patients. This is currently in the procurement phase within the UHB. Agreement on the pathway agreed in Bronze COVID-19 meeting on 20th May 2020. FIT10 screening commenced week 8th June 2020.
- The UHB is reinstating endoscopy services for cancer patients across our hospital sites. This will be reinstated via a phased approach starting on 18th May 2020 at Prince Philip with other sites to follow on the 22nd June 2020 pending completion of logistical changes to Red/Green zones.
- 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 from Prince Philip, supported by the Oncology CNS team.
- Phlebotomy services have been set up in 2 community centres in Carmarthenshire and Pembrokeshire for pre- treatment blood tests and central line care for cancer patients. These services are available Monday, Wednesday and Friday every week.
- Bronglais service remains as normal.
- Chemotherapy is currently administered on 3 hospital sites. Glangwili, Bronglais & Withybush.
- Treatment is administered as per the National Institute for Health and Care Excellence (NICE) COVID-19 RAPID guidance for the delivery of SACT. This is being monitored very carefully.

Surgery

- Cancer OPD clinics and surgery have been relocated to Werndale Hospital with the exception of major H&N and Gastro Intestinal (GI) surgery (not suitable for the facilities at Werndale Hospital).
- LGI clinicians undertake any life threatening surgery via the emergency pathway.
- Upper Gastrointestinal (UGI) acute UGI cancer problems are delivered through the emergency service.
- H&N surgery continues at Glangwili at present.
- Two sessions of operating capacity have been agreed on the Glangwili site for those patients who do not meet the criteria for Werndale and may require Intensive Treatment Unit/High Dependency Unit (ITU/HDU). Further capacity is being planned dependant on demand.
- Scoping work currently underway in accordance with the recently issued WG Operating Framework to assess opportunities to recommence cancer surgery at the Prince Philip sites from the 29th June 2020, and Bronglais and Withybush sites from early July 2020.
- Joint working progressed with regional MDTs for tertiary centre surgeons to provide outreach surgery in Hywel Dda for Gynaecology and Urology. 8 Gynaecology patients on a tertiary pathway have received their surgery locally during the course of the COVID-19 pandemic, with the support of the Swansea Bay University Health Board (SBUHB) MDT Lead, with a further 4 operations planned. 4 Urology cases have also been operated on locally.



Action 2:

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

- Detailed diagnostic demand & capacity modelling has been carried out as part of Single Cancer Pathway planning. This specified the volume of diagnostic activity required prior to the COVID-19 pandemic, equivalent to what might be expected during the reactivation phase.
- In accordance with UHB planning for restart and recovery from the acute COVID-19 phase, diagnostic capacity will be prioritised for urgent and cancer referrals. As pathways for routine elective work are not expected to recommence before Quarter 2 (Quarter 2), we anticipate that the prioritisation of diagnostic capacity for cancer referrals will improve diagnostic turnaround times compared to the pre COVID-19 pandemic.
- Planning of diagnostic capacity for the reactivation phase is subject to further evaluation to be considered as part of the UHB's Quarter 2 plans in line with the WG Operating Framework.

Action 3:

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

- A 9-5 helpline for concerned cancer patients has been set up in the Oncology unit at Withybush, supported by the Oncology CNS Team in terms of ensuring the advice given continues to be valid and up to date.
- The CaPS (Cancer Psychological Support Service) is being run from Ty Cymorth as a telephone service for psychological support for patients and staff for the foreseeable future. This service will combine with the bereavement counselling service for this period to provide support where needed.
- A patient information leaflet for cancer patients including helpline numbers has been developed and widely circulated.
- Tumour site CNSs / Key worker contact patients who currently have their cancer treatment delayed or altered and those patients self-isolating due to COVID-19, are contacted every 4 weeks to check on their wellbeing and to ensure they have not developed any further symptoms or issues.

Action 4:

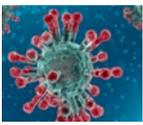
During the acute phase it is accepted that there will be disruption to acute care. This also applies to teaching, training, research and improvement programmes:

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

Urgent and emergency care continues as usual.

Action 5:

Health Boards must work with the Cancer Network through their service specific and site-specific Cancer Site Groups (CSGs) to determine:



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

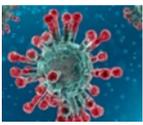
- Since the 6th April 2020 surgery for 6 Gynaecology, 8 ENT, 13 Urology, 4 LGI and 1 General surgery case have been carried out across the UHB. These are High acuity patients that did not meet the criteria for Werndale Hospital, as they required HDU/ITU support. This is being monitored on a weekly basis via our cancer tracking process.
- Joint working has progressed with regional MDTs for tertiary centre surgeons to provide outreach surgery in Hywel Dda for Gynaecology and Urology. 12 Gynaecology patients on a tertiary pathway have received their surgery locally during the course of the COVID-19 pandemic, with the support of the SBUHB MDT Lead. 4 Urology cases have also been operated on locally, following the same governance process.

Action 6:

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

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

- Virtual & telephone OPA Oncology clinics are being held supported by the Oncology CNS team.
- Phlebotomy services have been set up in 2 community centres in Carmarthenshire and Pembrokeshire for pre-treatment blood tests and central line care for cancer patients. These services are available Monday, Wednesday and Friday every week. Bronglais service remains as normal.
- Chemotherapy is currently administered on 3 hospital sites. Glangwili, Bronglais & Withybush. Treatment is administered as per the NICE COVID-19 RAPID guidance for the delivery of SACT.
- As of Monday 30th March 2020, all Carmarthenshire SACT has been provided at Glangwili. This ensures we can provide appropriate social distancing between treatment chairs. Additionally, as staff become sick, workforce capacity will be maximised. All units are upskilling to provide capacity for the transfusion of blood products to cancer patients also, should this be necessary.
- As per the 6 levels of SACT, all levels are still currently being treated across the UHB.
- Hywel Dda has continued to provide the majority of elective cancer surgical care utilising the current national tumour site specific guidance. Until 14th April 2020, this care was provided on all sites within the UHB.
- To ensure that Hywel Dda could continue to support and protect the elective cancer capacity and be in line with the NHS recommendation principles to provide a COVID-19 free hub, Hywel Dda identified Werndale Hospital as a dedicated elective cancer operating site and this became operational on 14th April 2020.
- The Werndale Hospital plan minimises the risk of patients contracting COVID-19 as this is a dedicated clean area. There are limitations to the plan as Werndale Hospital is unable to accommodate those patients who require HDU/ITU support post-operatively and there are further restrictions in that there is clinical criteria that apply e.g. those patients whose BMI exceeds 35 and have existing comorbidities.
- Plans are being developed to reintroduce elective cancer care for those patients who do not meet the criteria for Werndale Hospital or require HDU/ITU support on the Glangwili site. This plan commenced during April 2020 with one weekly Thursday and one fortnightly Tuesday operating lists reinstated on the Glangwili site. Proposals to



reinstate cancer surgery on our acute sites from 29th June 2020 are currently being developed, in accordance with the WG Operating Framework. This will necessitate the provision of dedicated green elective surgery zones within each hospital site, with green ITU/HDU support.

- It is essential that when planned care is resumed at all stages of the pathway, that it takes place safely, efficiently and in a sustainable manner, taking into account the staffing, environment and equipment needed, and also the continuing impact of care of COVID-19 patients on postoperative critical care capacity. This is being planned in accordance with appropriate Royal College guidance.
- The only way this can be delivered is to ensure there is a green pathway completely separated from the rest of the hospital and that staff are ring-fenced for this area and do not work in other areas that are not purely elective where patients have been isolated for 14 days, screened 48 – 72 hours before admission and have a COVID-19 test, plus CT Scan of the chest, carried out 24 hours before admission.

Action 7:

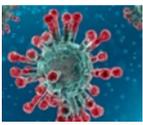
Health Boards and Velindre should work with the Cancer Network through their service specific and site specific CSGs to determine:

- a) the quantity of cases that are likely to come into the categories prioritised**
 - b) agree evidence based reduction in regimen and doses that maintain activity but reduce hospital attendance for elective and unscheduled care during the acute phase**
 - c) how they plan to provide this capacity throughout the acute phase, including considering on a regional basis, and the use of the independent sector where appropriate.**
- Radiation therapy is provided regionally by SBUHB
 - All patients that can be treated or are currently within the planning system, have been delayed and started on hormone treatment for (minimum) 12 weeks and are back to 'pre CT simulation planning' appointment stage. They will need repeat CT simulation Planning in due course.
 - Radiotherapy altered fractionation being implemented immediately for: Breast and Prostate
 - All other treatments are ongoing for both Radiotherapy and SACT unless patient choice.
 - All Linac machines are functioning
 - Mould Room – for patients receiving radiotherapy for certain tumour sites, a mould is required to ensure that the radiotherapy is only administered to the relevant area. This service has now reduced to Wednesdays, Thursdays and Fridays only 11am-3pm. No new electron end plates are to be made.
 - Physics – which is where the planning for administering the radiotherapy directly to the affected area, staff have been cross-skilling themselves and further enabling off site working.

Action 8:

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

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



a) As above.

b)

- For UGI/LGI endoscopy, activity is confined to urgent cases only. Emergency GI cases are being treated on the emergency CEPOD lists.
- Cystoscopy is continuing to be undertaken for USC Haematuria patients.
- Endobronchial Ultrasound (EBUS) is only being undertaken following PET Scan and only if accurate staging essential for any treatment.
- The UHB is has reintroduced Bronchoscopy with strict safety criteria in Prince Philip.
- Within the UHB, urgent and USC investigations are still being undertaken.
- As of 14th April 2020, USC clinics have been undertaken in Werndale Hospital (except H&N and GI).

Cardiology

The initial response to the COVID-19 pandemic resulted in the reduction of services to essential outpatient services only:

- Cardiac and respiratory assessment for cancer or other urgent treatment
- Patients with severe disease and new symptoms
- Patients with symptoms of severe disease

Critical Care

In Hywel Dda there is an intention to centralise the location of the current small number of COVID19 positive and likely COVID19 positive patients located within our Critical Care facilities, to Glangwili.

Transfer triggers:

- Local consistent decision making on patient triggers for transfer is essential. There has been dialogue between UHB Critical Care lead and all site leads.

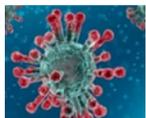
Transfer readiness:

- Patient should remain in isolated location until transfer. There is risk of limited availability of Critical Care side rooms; however, work is progressing to support addressing of this.
- Patient should be intubated and have all invasive lines sited as required.
- Transfers to take place in daylight hours unless there is higher risk to holding overnight.

The new modelling provides an adjusted requirement for critical care bed numbers. We need to continue to protect and enhance critical care services to ensure that they have the capacity and resilience to deliver both essential services and COVID 19 activity. Organisations need to confirm in Quarter 2 plans that they are able to:

1. Activate surge capacity plans for critical care within 2 weeks.

- In line with UHB Quarter 2 and Quarter 3 Capacity and Demand assumptions of the availability of 20 COVID, the Critical Care plan would be to maintain the centralized COVID location at Glangwili. The Glangwili site, due to its size and modern layout, would allow for full expansion to 20 beds. There is capacity to utilise the right section of



the unit for up to 17 patients by placing 2 patients side by side in a cubicle. The left side could be retained for Non COVID. Should COVID / Non COVID demand exceed this, the Non COVID patient cohort would move to Main Theatre Recovery.

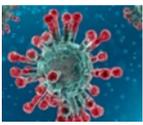
- Likely constraints: Sustained availability of adequate staffing without compromising home locations of satellite workforce. Critical Care would seek access to Critical Care bank staff, recent workforce upskilled to support, and Agency to supplement rosters.
2. Designate areas between COVID and non COVID
 - Centralising of COVID Critical Care at Glangwili will continue. The Critical Care locations within Prince Philip, Withybush and Bronglais will be predominantly Non COVID; with all sites having a, stabilize, treat and transfer side room. There are concerns around the management of additional patients requiring isolation with only single side rooms available on each site. Options are being explored to address this.
 3. Continue a zero tolerance approach to delayed discharges.
 - Critical Care will continue to fast track patient ward readiness decision making to Site Patient Flow teams. However, whilst Critical Care can, and does, press for prompt patient flow, it is under the constraint of suitable bed availability, as can be facilitated by Patient Flow.
 4. Maintain the critical care skills of the wider workforce to support surge plans
 - As many services are seeking to work towards return normal work processes, and in view of the low volumes of Critical care patients, the majority of staff have returned to substantive roles.
 - A collaborative approach is proposed where staff might return to Critical Care for a single shift per month to refresh and support maintenance of skills. The organisation of this will sit with the Heads of Nursing.
 5. Undertake a readiness assessment before resuming routine surgery
https://www.ficm.ac.uk/sites/default/files/ficm_bridging_guidance_for_critical_care_during_the_restoration_of_nhs_services_-_22_may_2020.pdf (FCIM)
When benchmarking the UHB against the FICM paper, Critical Care Services as a whole all sit in Stage 1. In that:
 - The Service is working within baseline funding of beds, with no surge capacity open.
 - Service provision across the UHB has been able to separate COVID and NON COVID patient flow.
 - Critical Care staffing ratios are maintained at appropriate 1 : 1 for Level 3 patients, and 1 : 2 for Level 2 patients.

Planned Care – including Out-Patient Department (OPD):

- During Quarter 1 the majority of Cancer and Urgent Outpatient and Theatre activity was undertaken at Werndale.
- The UHB are now scoping the options to recommence Urgent and Cancer work within our Acute Sites during quarter 2.

OPD:

- To ensure we have a continued effective response to COVID-19, whilst providing essential services with a cautious approach within Outpatient services, the introduction of face to face clinic consultations has required careful consideration, in order to adhere to WG government guidance on social distancing and to avoid unnecessary visits to hospital settings.
- Lead Clinicians have been asked to identify this cohort of patients including patients at stage 1 who require face-to-face interaction at Outpatients.



- All 'face to face' outpatient session requests are reviewed by the OPD Senior Management team where a number of factors are considered, including the reduction of capacity to maintain Social Distancing measures.
- 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 UHB are exploring new digital services, including virtual clinics, SOS and clinical validation. These services are a key element within The WG National outpatient's strategy and have the potential to transform the way we manage outpatients in the UHB in the future, as well as supporting patients during the current pandemic.
- Outpatient nursing teams have adapted to new working arrangements and traditional working patterns have altered to allow for the new adapted services and are operating a two shift system, covering from 8am-8pm.
- The UHB is exploring opportunities to move some OPD services that need to remain face to face off of the acute sites to further mitigate potential infection risks.
- Protocols set in place for OPD settings on the four main sites include:
 - To reduce footfall, one way systems have been set up in outpatient departments on the four main sites.
 - Screening of all patients visiting the department.
 - No relatives allowed in, except for children / vulnerable, where parent/chaperone would be screened also.
 - To reduce crowding in waiting rooms, 2 metre measurements per chair has been introduced.
 - If waiting room is at capacity, patients may be asked to wait in their car and rang to come into the department once clinician is ready to see them.

Theatre:

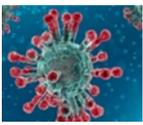
- All urgent routine & cancer cases have been scoped out to enable planning across each acute site. A site based assessment has been undertaken with a plan to commence this activity from 6th July 2020

Eye Care Plan:

Ophthalmology services were swiftly reconfigured to meet essential urgent care where required, the following action was taken during quarter 1:

- All Emergency and Urgent OPD work continued Monday – Friday 9a.m. – 5p.m. in BMI Werndale
- Aged Macular Degeneration (AMD) continued in Crymych, Aberaeron Integrated Care Centre and Amman Valley Hospital. There has been an increased capacity at AVH during COVID and all interventional treatment has been on time.
- Consultants prioritised all cases and continued to treat VR patients.
- The response to COVID had let the services to explore and develop alternative ways of working, and includes training Optometrists to work collaboratively with the Hospital Eye Service.
- There have been opportunities to explore the use of telemedicine and build links with community IT structures to develop new practices.
- In addition to the Acute Eye Service response the Community response involved closing all practices apart from 13, which stayed open for emergency eye care only.
- A dedicated phone line, supported by the Low Vision Screening Wales Team opened to direct patients to services.
- 4 prescribing hubs set up across the UHB were successful in reducing the number of patients requiring Hospital Eye Services.
- Of the 400 patients who accessed the hubs, the independent prescribers managed 88% within the hubs. A paper had now been developed to provide this service on a cluster basis across the UHB.

New ways of working include:



- An AMD consultant letter advising patients of the risk of non-attendance to their sight which has increased attendance;
- The telephone triage of Emergency Eye Casualty by a Senior Clinician which has reduced attendance at this clinic by 50% with patients being managed via other routes, including Independent Prescribers in Optometric Practices;
- Increased collaborative working with Community Optometric practices due to COVID-19 quarter 2 Priorities

Quarter 2 Plans, reset plans include:

- A comprehensive Situation, Background, Assessment, Recommendation (SBAR) has been prepared which outlines the reset process. It includes detailed plans that cover the complexities each sub-specialty presents during the pandemic. It is in line with the Royal College of Ophthalmologist COVID-19 clinical guidance and outlines how the service will work towards a five phased plan based on patient safety and clinical guidelines;
- Prior to COVID-19 the service has been under pressure to meet its growing demand, therefore, additional redesign services post-COVID-19 will include:
 - Reviewing all waiting lists;
 - Developing AMD services by recruiting nurse injectors;
 - Running dedicated General Anaesthetic whole list days and reviewing theatre timetables;
 - Developing nurse led services and upskilling staff;
 - Rolling out the glaucoma review services and various hubs established during COVID-19;
 - Continue working with community optometrists;
 - Delivering remote triage/use technology to minimise face to face appointments;
 - Reviewing data to streamline mixed specialties;
 - Validate follow up lists;
 - Ongoing review of staffing levels due to shielding and COVID-19 symptoms.

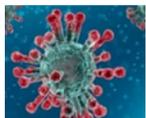
Endoscopy Services:

- During quarter 1 - We continued to undertake all urgent and emergency procedures, there have been upper and lower GI pathways developed to utilise FIT testing to determine those patients most appropriate for an Endoscopy procedure. Tests have been sent out and will be processed by the lab in Cwm Taf. This will determine the demand going forward so that we can plan the lists required.
- We've managed to maintain our Urgent Cancer Endoscopies throughout COVID & plans are now in place to recommence lists, however, detailed timescales on delivery will not be possible until we understand the impact FIT will have on our waiting list (end of quarter 2).

Critical Care Medicines

Welsh Government recommends that no organisation should assume any procedure which requires an anaesthetic, sedative, analgesic or neuromuscular blocking agent can go ahead without first ensuring either:

- The required medicines for use during and following the procedure are available and can if necessary, be replenished;
- The required medicines if it cannot be replenished, can be safely substituted by alternative medicine which is of similar clinical efficacy and for which supply is less constrained; or



- Stocks of the required medicine are sufficient for use in other potentially more urgent situations including being readily available in case of increased demand from new cases of COVID-19.

The UHB (using its local demand and capacity modelling which is aligned to the national COVID planning assumptions) are currently planning for working on a potential peak COVID demand of 20 ventilated patients in Critical Care beds. The stock level within the UHB of the following groups of medicines are being monitored closely by Pharmacy:

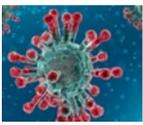
- Neuromuscular Blocking agents
- Sedation
- Vasopressors
- Opioids

Current stock will be monitored against the need to support 20 ventilated beds for 4 days and compared to the *average 10day usage during 2019*. If stock levels of one or more of the above groups fall below this predetermined level the Acute Bronze Group will be informed so that a clinical decision can be made on what action should be taken with regards to upcoming planned care, following the suggested decision making framework below.

Stock level > Critical Care functional capacity*	Supply chain active	Supplies above the estimated COVID requirement should be made available for routine care
Stock level at functional capacity*	Supply chain active	Supplies above the estimated COVID requirement should be made available for routine care
Stock below functional capacity*	Supply chain active	Medicines stock should be allocated to support routine care and replenished. Where stock cannot be fully replenished, use where medicine is needed to support priority procedure types/lists
Stock level at functional capacity*	Supply chain issue with 1 or more group(s) of medicines	Medicines stock should be allocated to support routine care and replenished. Where stock cannot be fully replenished, use where the medicine is needed to support priority procedure type/lists
Stock below functional capacity*	Supply chain issue with 1 or more group(s) of medicines	Supplies should be allocated to support routine care on a patient by patient basis and where it is determined there is an immediate need for the medicine and no clinically suitable alternative is appropriate or available.

Out of Hours (OOH)

In response to critical staffing positions that have been identified and reported over several months and in order to reduce potential risks to patients (associated with reduced access to OOH clinicians) the service has partially redesigned the overnight operation by rationalisation of bases, as supported by the Executive Team. This means that overnight, OOH now man's 3 bases (instead of 5). The Llandysul resource has been transferred to Glangwili and in Llanelli, face to face assessments are absorbed by the MIU



GP stream where possible. For surgical, gynaecological and paediatric referrals, patients in Carmarthenshire and south Ceredigion are now streamed to Glangwili where specialist services are collocated on site.

In response to COVID-19, the service has been successful in significantly uplifting its GP staffing level, but this should be considered a temporary position and as such, the staffing risk remains "high" and sits on the corporate risk register. Prior to the Pandemic, the service was working with transformational leads on a service-redesign project. Discussions were progressing around the detail of a future workforce plan, recognising the fragility of the service and the limitations associated with essentially a GP- manned rota. The consensus around the development of a multi-disciplinary team had been agreed. As soon as the current situation allows, it is anticipated that this working group will reconvene.

During the pandemic rotas have improved across Pembrokeshire and Ceredigion. Despite initial improvements, Carmarthenshire is problematic once more in terms of staffing and especially at weekends. There are more GPs who are due to be cleared for work imminently and it is hoped they will have a positive impact on the Carmarthenshire rotas.

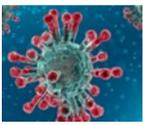
The Service has now brought "Attend Anywhere" online to support virtual consultations, thus reducing potential risk for staff and patients alike. Furthermore, additional IT equipment has been procured to support more flexible working in an attempt to increase service readiness. The benefits of this investment is unlikely to be seen prior to Winder pressures where risks to service provision are likely to increase- especially if any reduction in lockdown restrictions is announced.

111 Service

The 111 strategic plan is currently under review and due to the ongoing pressures and challenges presented by COVID 19 it remains imperative to provide timely access to urgent primary care advice and to capitalise on modern technology to transform the way patients access and receive advice. 111 Wales will continue to refine and develop the current on line symptom checker utilising best practice from other Urgent care systems. Demand and capacity modelling is embedded within the programme structure and prior to the pandemic additional call handlers were appointed to meet demand. During the pandemic a new model of call handling "the reception model" was introduced and remains operational. We will review and evaluate the effectiveness and benefit to patients of the model to determine if this model should continue. In order to address the growing need for telephone consultation skills to clinicians through the work being undertaken as a result of the development of a UPC competency frameworks the 111 team in collaboration with HEIW and UPC Clinical leads are developing a "bespoke" course on telephone consultation skills. This course will be initially rolled out to GP trainees this Autumn.

The MDT Clinical support hub (CSH) which has proven to be effective in managing flow and dealing with complex cases and in some cases providing support to UHB services at times when shift fill rates have been low must be embraced by all Health Boards. Local UPC GP's must adopt and accept the workings of the CSH and processes adopted if Health Boards wish to fully realise the benefits that a central "flight controller" and MDT approach can bring to patients and local UPC services. The 111 Programme team have always advocated extending the MDT by introducing specialist roles in the CSH. The most notable being the use of Mental Health practitioners. A small pilot occurred within Hywel Dda and discussions are ongoing to extend this pilot. Whilst the volume of cases were low the quality of care received by patients was exceptionally high and the time taken for the MHP to consult with patients allowed GP's to deal with other urgent cases presented on the out of hours advice queue. Whilst these pilots were aimed at a local level the 111 team are working in collaboration to adopt a more centralised approach.

The benefits of this approach are that it will:



- Improve callers experience and outcome
- Provide early intervention in mental wellbeing and emotional health
- Provide information and options for self-care and support
- Reduce demand on ED/GP/Police/WAST/MH crisis services
- Makes seamless referrals to crisis teams
- Provide navigation to appropriate services

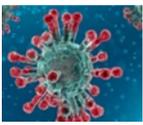
In addition, the 111 team are working with clinical colleagues exploring the benefits of introducing paediatric specialist roles and palliative care specialist roles in the CSH. During these challenging times it also remains imperative to provide timely access to Urgent primary care advice and guidance for care homes both in and out of hours to complement services already in existence, while providing the opportunity to connect care homes to appropriate allied health professional teams, social services or other support teams when appropriate.

Nursing homes are directly supported by UHB out-of-hours professional advice lines in the 'out of hours period and although reported response times were reported to be good, access has not always been fully reliable across all LHBs. It is not a standardised access point for professional advice, but where it is used, feedback has shown that service users appreciate its ease of use with rapid access to advice. Consultant Connect is a private enterprise company, which has been commissioned by NHS Wales to support, primarily, communication between primary and secondary care services by creating a simple single-number access point to a cascade rota of clinicians available to provide specialist advice. As part of the wider service planning for COVID and future resilience for Care Homes, 111 and Urgent Primary Care (OOH) Services have been asked to support the wider rollout for and directly support Consultant Connect, LHBs and Care Homes to ensure an optimal response to urgent queries. Where appropriate, clinicians recruited for the Workforce Hub to support 111 /OOHs as part of the COVID response could be used to support a national response back up – pending on the outcomes from the first wave pilots.

With the Investment in a new integrated 111 system (implemented in 2021) this will make more effective use of skills and resources by streamlining call handling and clinical triage thus reducing duplication and data entry. It will prioritise care for those with the greatest need and will provide a platform for a more sustainable model for the delivery of Urgent Primary Care Services.

Mental Health

- Older Adult Mental Health services are beginning to implement recovery plans to return to service delivery as usual; Acute Hospital Dementia Wellbeing Service in particular are looking at returning to DGH locations.
- Development of Emergency Liaison Service is continuing at pace. Service specification being agreed through Older Adult and Adult Teams, pilot will commence in Carmarthenshire.
- Perinatal team have continued to undertake core business screening and assessing all high risk referrals in the community
- Pressure is increasing on Adult Mental Health inpatient settings, but mitigated through development of temporary Central Assessment Unit/ Central Treatment Unit aligned to Transforming Mental Health Strategy and 3rd sector prevention and early intervention services supporting community teams. Specifically, the development of soft/alternative 136 provisions across Hywel Dda, hospitality beds and sanctuary services run by the third sector are expected to reduce the demand on primary and secondary services.



- Medicine Management and MH Assessments are being carried out as usual through the utilisation of digital platforms.
- Psychological Services piloting digital platform Attend Anywhere in order to prepare recovery plan and undertake psychological therapies
- Learning Disability services are conducting face to face appointments with those service users with complex needs or who may present with high risk. Also the service is rolling out telemedicine clinics to help cope with demand going forward and beginning to increase face to face appointments where appropriate and necessary e.g. in care home environments where COVID testing has shown no infection.

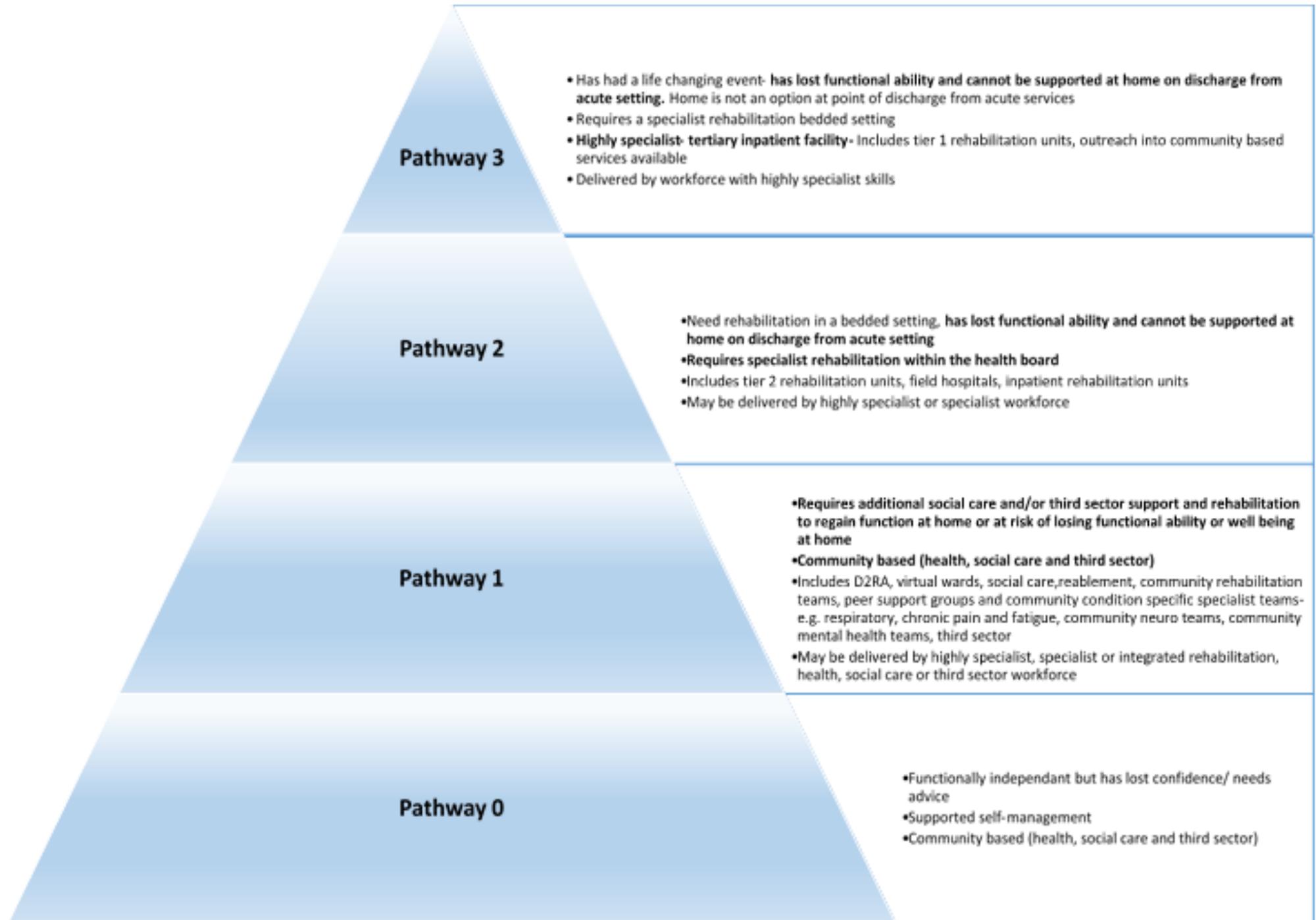
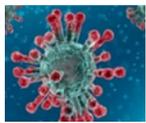
Rehabilitation Services

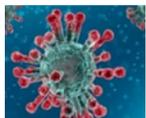
Internationally COVID-19 pandemic has already led to a marked increase in the burden of disease and disability and will continue to do so. Rehabilitation and recovery forms a critical component of the care pathway by improving functional independence, psychological wellbeing, societal reintegration, 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 predicted scale of the pandemic, the level of the rehabilitation response required for the survivors will need to be on a far greater scale than the current provision of rehabilitation and recovery services within Hywel Dda.

A well-planned and effective response will provide long-term benefits that will capitalise on the efforts made during the acute response to the pandemic, and it will continue to reduce pressure on the unscheduled care system by managing and preventing secondary complications. Current structured rehabilitation and recovery pathways for patients with multiple rehabilitation needs from different professional groups are mainly limited to patients diagnosed with specific single organ conditions (pulmonary rehabilitation, cardiac rehabilitation, neuro rehabilitation) or condition specific (stroke, Parkinson's). 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 is needed. The UHB have established a quality and service improvement project involving key MDT stakeholders to:

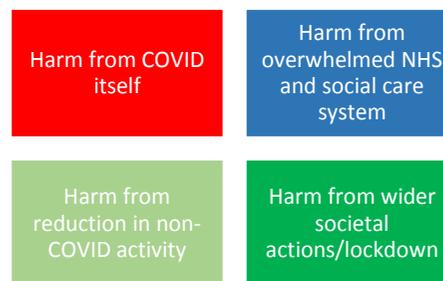
- Map and review current rehabilitation/ recovery services available across Hywel Dda that could potentially be adapted to meet the needs of COVID-19 survivors (including current capacity and predicted demand, gaps in service provision)
- Develop and agree easy accessible advice and resources for patients/relatives/carers to aid COVID-19 recovery
- Develop and agree seamless pathways for COVID-19 patients alongside, and incorporated within, wider rehabilitation and recovery service provision





Harm Reduction

The NHS Wales Operating Framework outlines the need to maintain essential services, retains flexibility and adaptability to changes in community transmission rates of COVID-19 but also reflects the need to consider 4 types of harm and address them all in a balanced way.

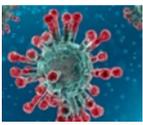


A Healthier Mid and West Wales (our strategic health and care strategy) outlined Hywel Dda’s commitment to innovating and transforming our services to deliver on the collective commitments outlined in ‘A Healthier Wales’. We presented this wellbeing offer to our population across five key tiers of provision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

Patient Experience

The Patient Experience Team has continued to obtain feedback during the Pandemic in a number of ways. The PALs team has continued to provide a physical support and presence at individual sites and the patient support contact centre has operated 7 days per week to answer queries, discuss concerns and receive feedback by telephone or e-mail. In response to concerns from families about lack of communication and the visiting policy, family liaison officers have been appointed to work on wards to facilitate communication between patients and their families, provide virtual visiting and undertake patient experience activities, including surveys. We have continued to operate the Friends and Family Test (FFT) survey throughout the period, albeit the numbers of responses have been lower, due to the reduced level of activity which is currently 45% lower than usual. From the responses received to the FFT, 90% have rated their experience as positive and would recommend the service to friends and family.

Negative feedback is largely related to communication, communication between wards and families, and more recently, people not expecting our services to be presented in the way that they are, for example patients waiting in cars to be called for appointments, delays in receiving appointments, waiting times at clinic, and perceived poor appointment planning. Whilst ward based surveys were initially suspended, these have recently been introduced and are being undertaken by our new family liaison officers and PALS officers. Over 300 surveys have now been undertaken. The majority of patients surveyed, reported their overall experience to be 9 or 10 (out of a possible 10). Any concerns or immediate issues are addressed with the ward staff at the time.



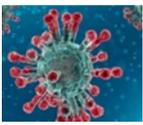
Progress on Implementation of guidance on Infection Prevention and Control, including environmental factors and social distancing

The guidance sets out measures to maintain safe working practices in the UHB's buildings in order to reduce the possibility of transmission of COVID-19 in the workplace, now and as and when lockdown restrictions are eased. The document is intended to provide practical guidance on how our facilities can be reconfigured to provide public confidence, and allow the NHS to return to a "new normal". A Task and Finish Group was set up at the request of the Director of Nursing and chaired by the Head of Health, Safety & Security. Membership of the group consisted of representatives from the following directorates/departments: Communications, Estates and Facilities, Primary/Community Care, Scheduled and Unscheduled Care, Trade union, Infection, Prevention & Control, Occupational Health and Workforce and Organisational Development. The guidance provides information under the following headings:

- Legal Position
- Managing the risk
- Responsibilities
- Implications for Patients and Visitors
- Control Measures including use of screens, personal protective equipment
- Information Technology
- Resource materials – Posters, signs, protective screens

Some teams & departments have already taken steps to start scoping their working environments for potential adjustments and much of the advice contained in this guidance has already been introduced in several departments and sites. Further scoping work needs to be undertaken across areas, both clinical & non-clinical, and information collated. The guidance recommends each department scopes their area against the advice contained along with help & support of the Health and Safety, Infection prevention, management or Estates teams as required.

Once the Directorate/Department assessments are completed, a coordinated approach is required by individual Hospital/Community/Primary care teams in order to prioritise the use of control measures, for example installation of protective screens. Social distancing applies to both clinical and non-clinical environments and the guidance reflects this. Reduction in bed capacity in some areas has already been considered in order to meet these challenges. Welsh Government has very recently agreed a National standard regarding social distancing signage. Posters and floor signs have been ordered and once received, these will be installed by the Estates department in consultation with individual management teams. Additional signs may be required as the material being provided by the Welsh Government is limited. The Estates Department have already produced and installed a large number of bespoke Perspex screens to prioritised areas. Recently the material has been in short supply as well as suppliers charging higher prices.



Refreshed Surge Capacity Plans based on updated modelling assumptions –to include NHS surge as well as ongoing requirements for field hospitals and independent sector facilities

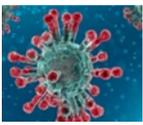
- The field hospitals were originally designed to manage a COVID positive patient profile based on the original model that had indicated the acute system would very quickly become overwhelmed as the virus spread as had been seen in Italy. As the situation has evolved, and based on the revised modelling assumptions, it is clear that it will not only be COVID 19 (red) patients in those Field Hospital Sites and so the advice of IP&C was sought.
- This advice identified that without further estates work to put in place some higher physical barriers behind beds, then the potential impact on capacity could be as much as a 30% (300 beds) reduction. It was felt that estates work could mitigate this to around 15 to 20% (150 to 200 beds lost) but would require a further capital spend. This is being worked up and costed.
- The UHB plans to continue the use of Werndale for elective procedures to support urgent elective work and may also enable some of the urgent routine work to recommence. There is also a joint discussion with Swansea Bay around the potential use of Werndale for spinal cases.
- Continued development of Community Hospital beds and community admission avoidance and intermediate care beds to support Discharge to Recover and Assess pathways. An additional 33 community hospital based beds have been proposed that will help mitigate the future potential Field Hospital requirement.

Demand Planning Assumptions

- The UHB uses Hywel Dda Modelling Cells $R=1.1$ for 3 months Upper Control Limit (UCL) scenario as its new realistic worst case (RWC) scenario for planning its response to the COVID 19 pandemic. This aligns with the letter received from the Director General on the 24th June 2020.
- The tactical capacity plan needs to account for a peak in August of non COVID demand of 841, plus a potential 150 COVID patients and 65 planned care cases equating to 1,056 beds.
- The 155 bed equivalent deficit that the UHB has faced in each of the last 2 winters is assumed to be a potential physical bed requirement in 2020/21 from November 2020 to March 2021.
- Based on 2 further peaks in non COVID demand over the winter, in October (820) and February (821) and a 3 month lead in time for any peak in the COVID 19 RWC, tactical need to plan for a RWC total bed requirement of 1,337 beds to reflect the winter peak in non COVID demand aligning with a peak in COVID demand over the winter.

Capacity Planning Assumptions

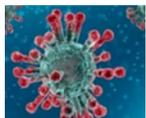
- Implement the social distancing guidelines in ward areas, which would result in a potential loss of up to 192 beds, and that wherever possible in the context of deliverability and value for money, that maximum bed loss is mitigated down to a lower level by quarter 3.
- Implement plans that enable the operationalisation of the additional bed capacity at Tregaron (8 beds) South Pembrokeshire Hospital (25 beds) so that they can be utilised at 7 days' notice from the middle of July if needed.
- Review the annual 155 winter plan bed deficit requirement whether this can be mitigated.
- Ensure plans are in place to accommodate a potential 20 COVID 19 patients on ventilation in ITU.



- Assume a Field Hospital requirement of 501 beds at a potential peak over the quarter 2 and 3 period but structured into 3 delivery phases:
 - To establish 192 beds that enables the implementation of the social distancing guidance in ward areas in July 2020;
 - To establish a further 150 beds that could be mobilised at 7 to 14 days' notice by the middle of August 2020 if needed due to a rise in the R value to 1.1 for 6 weeks following lockdown easements at the end of June/early July;
 - To develop by the end of August, a proposed plan to establish a further 159 beds that could be operational at 7 to 14 days' notice in October 2020 when peak non-COVID demand and peak COVID demand could feasibly align.

The health board continues to review its local modelling work following the receipt of the Director General's letter on the 24th June 2020 which specified that Hywel Dda should develop capacity plans for a potential Covid peak of 46 patients requiring ventilation in ITU and 613 requiring hospitalisation. Whilst the local modelling outputs look different in terms of breakdown, the overall additional Field Hospital requirement for surge capacity of 501 beds should provide sufficient capacity flexibility in Hywel Dda should the Covid peak of 613 be reached. Although the local clinical view is that the ITU demand would be lower, the Q1 plan previously identified that the health board had ITU surge plans to get to 47 ITU beds at peak. Those ITU plans remain available within the Q2 context.

This document is subject to Board approval in July 2020



Update on Unscheduled Care and planning for winter preparedness

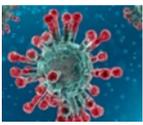
The Urgent and Emergency care needs of our population spans the five domains and care pathways outlined in figure 1. above. The Six Goals Framework for urgent and emergency care provision allows us to describe our whole system approach to optimising patient flow through acute hospitals and enhance access to emergency services routinely and at times of escalated demand and pressure.

The table below provides a summary of our regional response to the 6 Goals:

Goals		Outcome
1	Co-ordination, planning and support for high risk groups	Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care
2	Signposting, information and assistance for all	Information, advice or assistance to signpost people who want - or need - urgent support or treatment to the right place, first time.
3	Preventing admission of high risk groups	Community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.
4	Rapid response in crisis	The fastest and best response at times of crisis for people who are in imminent danger of loss of life; are seriously ill or injured; or in mental health crisis.
5	Great hospital care	Optimal hospital based care for people who need short term, or ongoing, assessment/treatment for as long as it adds benefit.
6	Home first when ready	A home from hospital when ready approach, with proactive support to reduce chance of readmission

This will include:

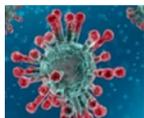
- Intention to clearly maintain Red and Green Pathways
- Considering the introduction of an Amber pathway for step-down and step up of COVID patients
- Work continues to understand the shift of Red to Green demand profile across our estate, and the inherent inefficiencies that will be present from having to run multiple ring-fenced pathways
- Triage to continue at hospital front doors but reviewing the use of ‘tents’ with the intention to replace them with portakabins as we enter the winter period
- Medical rotas had originally been split to provide red and green zone cover. Once it became clear the nature of the outbreak length was changing it was necessary to review this as the arrangement was unsustainable. Single rotas have now been reinstated with some adjustments to ensure the red and green zone issue can still be managed.
- The site teams are actively reviewing our estate configuration to identify further opportunities that will potentially reduce the impact of social distancing requirements on our bed capacity.
- Reviewing our critical care plan such that all Red patients are sent to Glangwili; Withybush and Prince Philip remain as green for critical care as described earlier in this plan.
- Reviewing the use of community hospitals e.g. opening a ward in South Pembrokeshire Hospital (25 beds) and additional beds in Tregaron Hospital (8 beds) for step-down and discharge



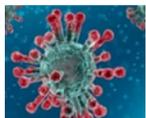
Winter Planning Assumptions:

- In developing the UHBs winter plan over the last 2 years, an assessment has been made of the equivalent bed capacity shortfall based on the number of patients lodged in A&E overnight, the number of medical outliers, plus the number of surge beds used. In the plan for 2019/20 signed off by the Board in November 2019, a 155 bed equivalent deficit was identified.
- The plan was to mitigate some of this based on actions aimed at admission avoidance and improved flow. Even with those actions though, the demands, social care capacity and acuity seen last winter meant that the same issues in terms of medical outliers, overnight patients in A&E and surge bed usage were evident throughout the winter.
- This was the case until February when the health and social care system begun its preparations for a potential overwhelming surge in COVID demand, and the lockdown restrictions, plus a general public reluctance to access health services at that time, saw an emptying of acute capacity and a reduction in demand.
- That demand has recovered since that point and remains on track to reach normal levels for the rest of the year. With this in mind, and given the extra pressure across the system that the COVID 19 outbreak both directly and indirectly places on capacity, it is suggested that in 2020/21, that bed equivalent deficit is assumed to be a physical bed requirement.
- This would include making allowance for the revised discharge pathways to social care as a result of pre-discharge COVID screening and isolation.
- The operational team will continue to work to see if there is any way that this bed deficit can be mitigated but It is proposed that at this stage, this plan provides for 155 Field Hospital Beds being required to manage the winter.

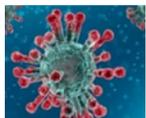
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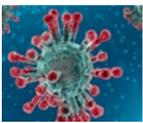
Glangwili	Prince Philip	Withybush	Bronglais
1: Co-ordination, planning and support for high risk groups			
Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care			
<p>We are scoping consultant advice to GP's where they can contact the on call consultant 9am – 5pm and cardiologist between set hours in the afternoon. Timescale during Quarter 2 to be in place by the end of the quarter</p>	<p>This is mainly a requirement for primary and community care however we are planning to support by scoping consultant advice to GP's where they can contact the on call consultant 9am – 5pm</p>		<p>This is mainly a requirement for primary and community care however we are going the following:</p> <ul style="list-style-type: none"> • Telephone advice for PGs from consultant on call or acute on duty (9-5). Formal agreement for BCU MIUs • Exploring consultant connect for a more formal approach • Bi weekly operational meeting with primary care
2 Signposting, information and assistance for all			
Information, advice or assistance to signpost people who want - or need - urgent support or treatment to the right place, first time.			
<ul style="list-style-type: none"> • To support care in the right place and enable social distancing in Emergency Departments. Phone system booking for A&E is not suitable due to governance issues this presents. We also do not have the staff to support this as they would need to be clinical to ensure 999 was not required and they were appropriate to wait until a booked timeslot. • We have a waiting room which can house 8 patients with space isolation. A system where suitable patients can wait in the car is being scoped. Reviewing nearby accommodation if the waiting room needed to be extended if there was excess demand/ inpatient capacity 	<p>To support care in the right place and enable social distancing in the Minor Injury Unit during Quarter 2 we are:</p> <ul style="list-style-type: none"> • Reviewing the guidance for phone system booking which was sent out on 24th June. Will require investment in staff, clear protocols in place and new electronic booking systems. To deliver safely will require clinical input so that emergency cases are not inappropriately booked into a later timeslot. 	<ul style="list-style-type: none"> • Clinical Decisions & AEC Unit in place for Red stream. Replica unit opening on 22nd June for Green stream to support flow of patients waiting general medical review or diagnostic investigations to facilitate a decision to admit or discharge. • Front door streaming to continue and redirection to become embedded as services reopen in the community eg dental, pharmacies, podiatry 	<ul style="list-style-type: none"> • Social distancing plan in progress including signage, floor tape etc • To support care in the right place and enable social distancing in the Emergency Department including Minors and CDU. • Phone system booking for A&E is not suitable due to the governance issues this presents. There are workforce constraints related to achieving this as well as significant concern about wider community communication and how the public will use this. • Systems for patients can wait in the car for both ED and OPD are being scoped. Signage to enable social distancing in the waiting room has been set up.



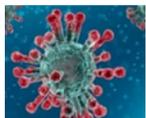
Glangwili	Prince Philip	Withybush	Bronglais
<p>issues and delays back to ED by the end of Quarter 2</p>			
<p align="center">3 Preventing admission of high risk groups</p> <p align="center">Community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.</p>			
<p>Consultant connect is being explored however the concern is that this passes from consultant to consultant. We are looking at the on call consultant being available to discuss cases 9am-5pm and an agreed time for cardiology enquiries. There are GP leads in the community who support prevention of admissions</p>	<p>Consultant connect is being explored however the concern is that this passes from consultant to consultant. We are looking at the on call consultant being available to discuss cases 9am-5pm and an agreed time for cardiology enquiries. There are GP leads in the community who support prevention of admissions</p>	<ul style="list-style-type: none"> • Consultant Connect implemented to support the model of referrals to acute services from GPs or WAST being screened by a dedicated medical team. Consultant Geriatrician visiting care homes jointly with a GP. • Chronic Conditions Advanced Practitioner commenced in April 2020 to support the front door 'turnaround' or timely discharge of those with chronic respiratory conditions. 	<ul style="list-style-type: none"> • Consultant connect is being explored however the concern is that this passes from consultant to consultant. We are looking at the on call consultant being available to discuss cases 9am-5pm and an agreed time for cardiology enquiries. There are GP leads in the community who support prevention of admissions • Additionally our recently appointed Frailty Consultant is starting to build useful relationships with key nursing homes in Ceredigion to help them to prevent admissions. This will lead to "hot clinic" slots for advice about specific cases. • Other teams – surgery, medicine specialties etc are running hot clinics to avoid the need for attendance and admission. These are about to be set up in W&C and T&O
<p align="center">4 Rapid response in crisis</p> <p align="center">The fastest and best response at times of crisis for people who are in imminent danger of loss of life; are seriously ill or injured; or in mental health crisis.</p>			
<p>Direct access pathways for respiratory, palliative care, stroke, STEMI and #NOF will be established and consistently delivered to support improved</p>	<p>Direct access pathways for respiratory, palliative care, stroke, STEMI and will be established early in quarter 2 ahead of the WG requirement. This will be achieved with</p>	<p>Ambulatory Emergency Care Clinic recommencing 22nd June</p>	<ul style="list-style-type: none"> • Direct access pathways palliative care, stroke, STEMI established early in quarter 2 ahead of the WG requirement.



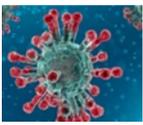
Glangwili	Prince Philip	Withybush	Bronglais
<p>outcomes, and reduce unnecessary crowding and ambulance patient handover delays by the end of Quarter 3. There are pathways in place for #NOF and stroke. STEMI is via Swansea Bay. Due to COVID there will not be direct admissions to the respiratory ward these will go to ambi care/CDU to be assessed. Ambi care needs to be redeveloped as currently a staff area due to separate areas for red and green staff on the ward by the end of Quarter 2.</p>	<p>the re-opening of the AMAU entrance to ambulances in July 2019</p> <p>Note:</p> <ul style="list-style-type: none"> • STEMI is via Swansea Bay. • Due to COVID risk there will not be direct admissions to the respiratory ward these will go to AMAU to be assessed. 		<p>Note:</p> <ul style="list-style-type: none"> • STEMI is via Swansea Bay. • Due to COVID risk there will not be direct admissions to the respiratory ward these will go to AMAU to be assessed. • A formal neutropenic pathway (dedicated ring fenced assessment area and bed) was established early in the COVID plan to ensure at risk patients do not have to wait in the emergency department.
<p>5 Great hospital care Optimal hospital based care for people who need short term, or ongoing, assessment/treatment for as long as it adds benefit.</p>			
<ul style="list-style-type: none"> • Given the requirement to conserve acute bed capacity during the pandemic, same day emergency care' (or Ambulatory Emergency Care) without need for an overnight stay will be rolled out across all acute hospitals with approx. 30% of medical take to be treated via AEC / SDEC, increasing the proportion of people typically discharged on day of their attendance to around 90% where possible. Timely rehabilitation/ reablement interventions must be consistently available to support rapid, sustainable discharge by the end of Quarter 3 . Ambulatory care area already in place although non-functioning due to COVID. This 10 	<ul style="list-style-type: none"> • Same day emergency care: This requirement will require capital investment. The previous ambulatory care service was in a small bay with no waiting area and was already insufficient pre-COVID. • With social distancing this would provide for 1 patient at a time. To date no alternative location has been identified. Plan for q 2: <ul style="list-style-type: none"> ➢ Embed the principles of SDEC throughout the AMAU and aim to achieve 30% of medical take discharged on same day ➢ Submit capital bid for SDEC unit • From Quarter 2, Health Boards should maximise opportunities for creating physical and / or visible separation between clinical and non-clinical areas 	<p>non clinical areas in ED are separated from clinical areas</p>	<ul style="list-style-type: none"> • Same day emergency care will require capital investment. The previous ambulatory care service was in a portion of CDU which is now dedicated COVID (amber / red) area. • Longer term site plan is to create a purpose build Ambulatory Care Area • Establishing a Frailty Bed Base (Elderly Care Short Stay within Quarter 2) • The principles of ambulatory care will continue to be progressed through CDU with the aim of achieving circa 30% of take discharged on the same day



Glangwili	Prince Philip	Withybush	Bronglais
<p>bay assessment area will reduce to 6 in order to maintain 2m distancing and relocation of the staff area. All Speciality GP referrals will be screened and sent here to COVID screen and reduce the risk of COVID transmission within the hospital.</p> <ul style="list-style-type: none"> From Quarter 2, Health Boards should maximise opportunities for creating physical and / or visible separation between clinical and non-clinical areas used by patients in Emergency Departments. Solutions must be flexible and sustainable as demand and activity levels change over the next few months. A&E clinical area is separated from the non-clinical area and access to the clinical area is managed for staff access only. Additional waiting room capacity is being assessed. In Quarter 2, Health Boards should develop robust capacity and demand plans that include surge capacity in independent sector and field hospitals at a regional level if value is added, to enable occupancy levels in acute hospital sites to remain below 85% throughout 2020/21. Routine and urgent surgery is being performed in the independent sector with complex USC being managed in the acute 	<p>used by patients in Emergency Departments. Within Prince Philip our plans include:</p> <ul style="list-style-type: none"> Looking at social distancing in the waiting rooms. We have a waiting room which can house 10 patients with space isolation. A system where suitable patients can wait in the car is being scoped. Reviewing nearby accommodation if the waiting room needed to be extended if there was excess demand/ inpatient capacity issues <ul style="list-style-type: none"> Health Boards should develop robust capacity and demand plans: <ul style="list-style-type: none"> In Prince Philip we are: <ul style="list-style-type: none"> Reviewing our ward areas to establish if bed lost due to social distancing can be re-provided with modifications to the estate Develop an implementation plan for a field hospital in Llanelli taking learning form the Carmarthen leisure centre project. Looking at how we can address the deficit of registered nurses that limit our options to increase capacity. 	<p>Board approval in July 2021</p>	<ul style="list-style-type: none"> From Quarter 2, Health Boards should maximise opportunities for creating physical and / or visible separation between clinical and non-clinical areas used by patients in Emergency Departments. <ul style="list-style-type: none"> Social distancing plans and enabling requirements are in hand Capital bids are being submitted for additional triage/assessment space Health Boards should develop robust capacity and demand plans: <ul style="list-style-type: none"> At Bronglais ward areas have been reviewed to ensure 2m distancing between in-patient beds can be achieved. The site loses 7 beds which includes 2 surge beds. No capital spend or modifications, aside from some agreed Perspex screening which has been costed, will be required to achieve this. The Ceredigion team are progressing plans to open additional capacity (green) at Enfys Fach (26 bedded discharge to assess model) and Tregaron (increase from 12-20 beds). As well as potential for FH capacity to open as an

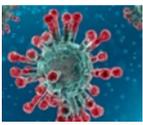


Glangwili	Prince Philip	Withybush	Bronglais
<p>setting where the independent sector do not have the facilities to treat these patients. The Carmarthen field hospital has a go live date 29/6/2020 with a capacity of 24 beds enabling 2m space isolation. Further capacity is available at the field hospital sites. There is a closed ward on the acute site which is ready to take patients however both are dependent on securing additional trained nursing staff.</p>			<p>amber zone. The challenge will be qualified nurse staffing, therefore it is likely that we will not be able to achieve all 3 of these options.</p> <ul style="list-style-type: none"> ➤ The site has a 38% RN nursing deficit; however, this is mitigated by our Partnership Nurse arrangement with 3 agencies whose nurses are permanently rostered on to ward rotas. This provides stability until such time as recruitment can be achieved. 9 NQ nurses are joining in September.
<p>6 Home first when ready A home from hospital when ready approach, with proactive support to reduce chance of readmission</p>			
<ul style="list-style-type: none"> • UHBs and LAs, working with the third sector and independent providers, should adopt a 'home first' approach to enable more people, who have attended an Emergency Department or have been admitted to hospital, to be assessed and recover in their own homes to avoid unnecessary long stays in hospital beds. This will be achieved through delivery of four 'discharge to recover and assess' active therapeutic pathways, embedded locally. TOCALLS service is in place where frail older patients who can be managed in the 	<p>UHBs and LAs, working with the third sector and independent providers, should adopt a 'home first' approach to enable more people, who have attended an Emergency Department or have been admitted to hospital, to be assessed and recover in their own homes to avoid unnecessary long stays in hospital beds. This will be achieved through delivery of four 'discharge to recover and assess' active therapeutic pathways, embedded locally. In Prince Philip</p> <ul style="list-style-type: none"> • TOCALLS service is in place where frail older patients who can be managed in the community with support are assessed and discharged with support. 	<p>Pathways being developed with pilots commenced 15th June 2020</p>	<ul style="list-style-type: none"> • HBs and LAs, working with the third sector and independent providers, should adopt a 'home first' approach to enable more people, who have attended an Emergency Department or have been admitted to hospital, to be assessed and recover in their own homes to avoid unnecessary long stays in hospital beds. As referenced above: • Frailty input to care homes in progress • Enfyys Fach discharge to assess facility • Engagement and agreement with South Gwynedd (proportionately



Glangwili	Prince Philip	Withybush	Bronglais
<p>community with support are assessed and discharged with support. British Red Cross will be resuming their service (date to be agreed) in Quarter 2 to support timely discharge.</p> <ul style="list-style-type: none"> • UHBs and LAs working with the third sector will increase the focus on the provision of rehabilitation, reablement and recovery in Quarter 2 plans, and ensure there is sufficient capacity to support the increasing number of people who will need support during the pandemic, with long term conditions, and frailty, who require support to prevent: • revised medically fit review in Glangwili commences July 2020 led by the acute HON/GM and Head of Integrated Services which will be supported by the long term care team and mental health/Learning disabilities. Complex patients will then be case managed by a senior manager with escalated actions. 	<ul style="list-style-type: none"> • Embedding discharge guidance in the hospital e.g. re-starting board rounds • A revised medically fit review in Prince Philip commences July 2020 lead by the acute HON/GM and Head of Integrated Services which. Complex patients will then be case managed by a senior manager with escalated actions. • Identify location for discharge lounge 		<p>this is where our delays are most common) to achieve improvement to discharge processes</p>

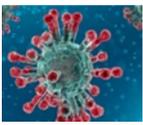
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Glangwili

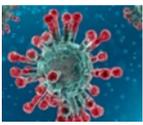
Area	Current Situation	Next Steps (July implementation)	Further Development July to September
COVID Pathway	<p>Compliant with All Wales Guideline:</p> <ul style="list-style-type: none"> • Triage and assessment in ED Tent • Green & Red resuscitation in place • Tysul COVID ward for CPAP & NIV • Glangwili ITU is now the Red ITU for the UHB 	<p>Preseli ward deep cleaned and return to Green surgical ward, This will allow Preseli to return to its pre-COVID functionality.</p> <p>Commence process for repatriation non-COVID +ve, ITU Level 1 patients to local hospital.</p>	<p>Dependant on emerging evidence and prevalence of COVID-19 in the Carmarthen area.</p> <p>Daily review of ITU capacity and L1/2/3 patients.</p>
Non-COVID USC pathways	<ul style="list-style-type: none"> • All emergency attendances including 999s attend Green ED. • All patient triaged to ensure they are non-COVID & redirected to the Tent if ? COVID. • Minor Injuries operating from OPD 	<ul style="list-style-type: none"> • All GP referrals including surgical specialties seen on CDU Green/Purple. • Surgical speciality agreement to revised pathway • Review suitable alternative accommodation for minor injuries outside of ED • Glangwili accommodation task group 30/6/2020 to assess all clinical space requirements on the site. Review office accommodation and location. Access and entry points across all areas A&E,OPD, Costa, Wards and departments. 	<p>Key areas for development</p> <ul style="list-style-type: none"> • From WG goals for unscheduled care <ol style="list-style-type: none"> 1. A 'wait and care' service concept is being considered to prevent unnecessary conveyance to Emergency Departments 2. Reintroduce ambulatory care service

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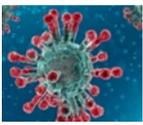


			<p>3. Explore options for consultant connect in USC services</p> <ul style="list-style-type: none"> • Work with community to further embed WGs discharge requirements • Work within community to further develop escalation plans. • Potential relocation minors pathway as OPD increases activity
Field Hospital	<ul style="list-style-type: none"> • Carmarthen leisure centre field hospital (CLC) opening 29th June 2020 for appropriate green medically fit patients from Glangwili 	<ul style="list-style-type: none"> • Daily identification of suitable medically fit patients (Carmarthen) who can transfer to CLC • Implement WH discharge letters regarding choice/transfer 	Assess the need for additional beds against capacity planning and COVID projections
COVID Testing	<ul style="list-style-type: none"> • 2 hour testing available on site. 	<ul style="list-style-type: none"> • Antibody testing for staff working in COVID areas. 	Await further direction from Public Health Wales.

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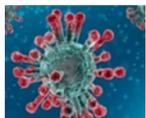


<p>Inpatient and days case Surgical & Diagnostics Delivery</p>	<ul style="list-style-type: none"> Emergency surgical pathways in place. Limited USC operations. 	<ul style="list-style-type: none"> Preseli ward will become Green surgical. ENT USC cases at Glangwili. Colorectal moves to Prince Philip. Gynae surgery under review Diagnostics (cardiology and radiology) 																																																																																																
<p>ITU capacity</p>	<ul style="list-style-type: none"> 11 ITU beds (2 Red, 8 Green + 1 Isolation Room currently with ability to flex to Red accordingly) 	<ul style="list-style-type: none"> COVID positive ITU: Transfer from Prince Philip, Withybush & Bronglais 																																																																																																
<p>Ward configuration and staffing</p>	<p>Current bed configuration:</p> <table border="1" data-bbox="322 504 1106 1460"> <thead> <tr> <th>Ward</th> <th>Specialty</th> <th>Bed Estab</th> <th>Blocked Beds</th> <th>Closed Beds</th> </tr> </thead> <tbody> <tr> <td>CDU (Purple)</td> <td>COVID</td> <td>10</td> <td></td> <td></td> </tr> <tr> <td>Tysul</td> <td>COVID</td> <td>14</td> <td></td> <td></td> </tr> <tr> <td>ITU</td> <td></td> <td>11</td> <td></td> <td></td> </tr> <tr> <td>Merlin</td> <td>ENT/AGP</td> <td>18</td> <td></td> <td></td> </tr> <tr> <td>Teifi</td> <td>T&O</td> <td>30</td> <td></td> <td></td> </tr> <tr> <td>Preseli</td> <td>Elective surgery</td> <td>22</td> <td></td> <td></td> </tr> <tr> <td>Derwen</td> <td>Gen Surg</td> <td>25</td> <td></td> <td></td> </tr> <tr> <td>Cleddau/SAU</td> <td>Gen Surg</td> <td>14</td> <td></td> <td></td> </tr> <tr> <td>Picton</td> <td>Gynae</td> <td>10</td> <td></td> <td></td> </tr> <tr> <td>Padarn</td> <td>Gen Med</td> <td>19</td> <td></td> <td></td> </tr> <tr> <td>Steffan</td> <td>Gen Med</td> <td>19</td> <td></td> <td></td> </tr> <tr> <td>Cadog</td> <td>Gen Med</td> <td>20</td> <td></td> <td></td> </tr> <tr> <td>Dewi</td> <td>Gen Med</td> <td>20</td> <td></td> <td></td> </tr> <tr> <td>Towy</td> <td>Gen Med</td> <td>20</td> <td></td> <td></td> </tr> <tr> <td>Gwenllian</td> <td>Gen Med</td> <td>20</td> <td></td> <td></td> </tr> <tr> <td>Ceri</td> <td>Gen Med</td> <td>20</td> <td></td> <td>20</td> </tr> <tr> <td>CDU (Green)</td> <td>Gen Med</td> <td>14</td> <td></td> <td></td> </tr> <tr> <td>CCU/Stepdown</td> <td>Gen Med</td> <td>13</td> <td></td> <td></td> </tr> </tbody> </table>	Ward	Specialty	Bed Estab	Blocked Beds	Closed Beds	CDU (Purple)	COVID	10			Tysul	COVID	14			ITU		11			Merlin	ENT/AGP	18			Teifi	T&O	30			Preseli	Elective surgery	22			Derwen	Gen Surg	25			Cleddau/SAU	Gen Surg	14			Picton	Gynae	10			Padarn	Gen Med	19			Steffan	Gen Med	19			Cadog	Gen Med	20			Dewi	Gen Med	20			Towy	Gen Med	20			Gwenllian	Gen Med	20			Ceri	Gen Med	20		20	CDU (Green)	Gen Med	14			CCU/Stepdown	Gen Med	13			<ul style="list-style-type: none"> Daily review at bed meeting ensuring sufficient green and red beds Daily review of RN staffing across the site 	<p>Capital bid to address ward deficits: +increase side rooms. +Reduce beds lost for social distancing + Address other problems such as break rooms, MDT rooms, changing rooms etc Actions to address registered nursing vacancies Long term agency block booking</p>
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84 Registered nursing vacancies (excluding ITU and Picton)					
Environmental	Assessments modifications ongoing	Work on main unresolved accommodation issues:		Develop site plans to address key issues	
		Ref	Priority		Detail of Issues
		1	Displaced clinical services		EPAU and A&E minors in OPD template which need to be re-located. Tysul Ward (Ophthalmology Day Unit) to be re-located.
		2	Medical Day case and ward attenders		Acute medical wards bring a number of patients onto the ward for elective procedures and follow-up. This practice reduces length of stay and (esp respiratory) admissions but cannot continue
		3	Ambulatory Care facility		WG requirement for Quarter 3. Current area being used as staff base will need to relocate
		4	Consultant and Clinical Nurse Specialist offices		As a result of social distancing requirements and the re-use of office space for other requirements there is an immediate need for additional office spaces. The ward requirements may also impact on this as some office space adjacent to the wards will have to be used for other purposes.
		5	Management Team offices		Due to social distancing 3 staff displaced
		6	Meeting Space		Board room limited to 10 people
7	Storage	A number of storage issues have been identified including additional drugs and equipment for COVID.			

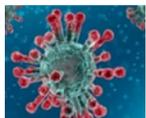
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Prince Philip

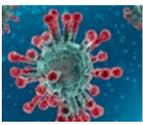
Area	Current Situation	Next Steps (July implementation)	Further Development July to September
COVID Pathway	Compliant with all wales guideline <ul style="list-style-type: none"> • Triage in porta cabins • Initial treatment in AMAU resus • Ward care in CPCAP and NIV on ward 1 	Deliver initial treatment in side rooms on ward 1. Will be complaint with all wales guideline This will allow AMAU to return to its pre-COVID functionality	Dependant on emerging evidence and prevalence of COVID 19 in the Llanelli area
Non-COVID USC pathways	All emergency attendances including 999s and GP arranged admissions going through the Minor Injury Unit	<ul style="list-style-type: none"> • Re-open AMAU entrance to non-COVID activity. • Ambulance Arrivals and GP admits will go directly to AMAU. • MIU will return to seeing walk in patients only Benefits <ul style="list-style-type: none"> • Will improve 4 & 12 hour performance and ambulance offload • Direct access will meet one of the unscheduled care goals 	Key areas for development From WG goals for unscheduled care <ul style="list-style-type: none"> • Develop a 'phone first before attending ED' targeted at patients who could be safely assessed elsewhere or through a planned approach • A 'wait and care' service concept is developed to prevent unnecessary conveyance to Emergency Departments • Identify location, staffing and protocols for same day emergency are service • Explore options for consultant connect in USC services • Explore options for medical day cases and ward attenders • Work with community to further embed WGs discharge requirements • Work within community to further develop escalation plans
COVID Testing	Testing in Glangwili. On site testing available on all other sites	Increase frequency of specimen transport to Glangwili to move service more in line with 2 hour turnaround on all other sites in the health board	

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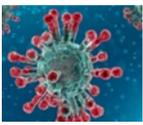
<p>Inpatient and days case Surgical Delivery</p>	<p>No current activity</p>	<p>Current plan from 14/07/20:</p> <ul style="list-style-type: none"> • Ward 7 will become surgical ward. • Potential for 21 beds but staffing for 14 in place • Initial cases will target cancer backlog 																																																										
<p>ITU capacity</p>	<p>Non-COVID ITU; 4 beds in ITU COVID-ITU; 3 beds in old CCU unit</p>	<p>Elective ITU: Ward beds Non-elective ITU: On CCU COVID positive ITU: Transfer to Glangwili</p>																																																										
<p>Ward configuration and staffing</p>	<p>Current bed configuration:</p> <table border="1" data-bbox="309 499 779 978"> <thead> <tr> <th>Ward</th> <th>beds</th> <th>Speciality</th> </tr> </thead> <tbody> <tr> <td>Ward 1</td> <td>18</td> <td>COVID</td> </tr> <tr> <td>Ward 3</td> <td></td> <td>Closed</td> </tr> <tr> <td>Ward 4</td> <td>18</td> <td>Cardiology / Respiratory</td> </tr> <tr> <td>Ward 5</td> <td>15</td> <td>Endocrine</td> </tr> <tr> <td>CCU</td> <td>3</td> <td>Cardiology</td> </tr> <tr> <td>Ward 6</td> <td>20</td> <td>COTE</td> </tr> <tr> <td>Ward 9</td> <td>29</td> <td>Stroke</td> </tr> <tr> <td>MMRU</td> <td>13</td> <td>Rehab</td> </tr> <tr> <td>Ward 7</td> <td>13</td> <td>Gastro</td> </tr> </tbody> </table> <p>42 Registered nursing vacancies</p>	Ward	beds	Speciality	Ward 1	18	COVID	Ward 3		Closed	Ward 4	18	Cardiology / Respiratory	Ward 5	15	Endocrine	CCU	3	Cardiology	Ward 6	20	COTE	Ward 9	29	Stroke	MMRU	13	Rehab	Ward 7	13	Gastro	<p>Next configuration:</p> <table border="1" data-bbox="835 499 1570 882"> <thead> <tr> <th>Ward</th> <th>Beds</th> <th>Speciality</th> </tr> </thead> <tbody> <tr> <td>Ward 1</td> <td>18</td> <td>COVID</td> </tr> <tr> <td>Ward 3</td> <td>19</td> <td>Respiratory / Gen med</td> </tr> <tr> <td>Ward 4</td> <td>18</td> <td>Cardiology / Gen med</td> </tr> <tr> <td>Ward 5</td> <td>15</td> <td>Endocrine / Gen med</td> </tr> <tr> <td>Ward 6</td> <td>20</td> <td>Gastro / Gen med</td> </tr> <tr> <td>Ward 9</td> <td>29</td> <td>Stroke</td> </tr> <tr> <td>MMRU</td> <td>13</td> <td>Rehab</td> </tr> <tr> <td>Ward 7</td> <td>21</td> <td>Surgery</td> </tr> </tbody> </table> <p>Reason for change</p> <ol style="list-style-type: none"> 1. Create surgical ward 2. Split respiratory and cardiology due to demands for these specialties 	Ward	Beds	Speciality	Ward 1	18	COVID	Ward 3	19	Respiratory / Gen med	Ward 4	18	Cardiology / Gen med	Ward 5	15	Endocrine / Gen med	Ward 6	20	Gastro / Gen med	Ward 9	29	Stroke	MMRU	13	Rehab	Ward 7	21	Surgery	<p>Capital bid to address ward deficits: +increase side rooms. +Reduce beds lost for social distancing + Address other problems like break rooms, MDT rooms, changing rooms etc</p> <p>Develop plans to expand surgical capacity Orthopaedics</p> <p>Actions to address registered nursing vacancies</p>
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		7	Ambulatory Care facility	Previous room in AMAU not fit for providing ambulatory care service.
		8	Consultant and Clinical Nurse Specialist offices	As a result of social distancing requirements and the re-use of office space for other requirements there is an immediate need for 12 office spaces. The ward requirements may also impact on this as some office space adjacent to the wards will have to be used for other purposes. The demand will be further increased from the need to provide office space for surgeons from Glangwili as we move elective surgical work from Glangwili to Prince Philip.
		9	Management Team offices	Due to social distancing 5 staff displaced
		10	Meeting Space	Board room limited to 6 people and currently being used as a 2 nd doctors mess due to social distancing in current doctors mess
		11	PALS accommodation	There is no PALS accommodation on the site. Pre-COVID this was the sites priority accommodation issue. Needs to be addressed as this will be a vital function during the ongoing period of complexity in service delivery.
		12	Storage	A number of storage issues have been identified including additional drugs and equipment for COVID.
		13	Discharge lounge	Currently used for storage
		14	Lymphedema Clinic	Insufficient space for service. Also currently located in the area that will become dedicated surgical area so will need to be relocated.
		15	Clinical Engineering	The COVID situation compounds the risk within the current workshop
		16	Fracture Clinic	Fracture clinic previously shared space with MIU including waiting area. To maintain social distancing within the waiting room and clinical rooms it is unlikely that fracture clinic can work out of this area in the future

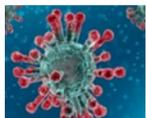
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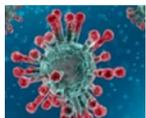
Bronglais

Area	Current Situation	Next Steps (July implementation)	Further Development July to September
Covid Pathway	Compliant with all wales guideline <ul style="list-style-type: none"> • Triage in designated red/amber zones within ED & CDU • Initial treatment in designated CDU • Y Banwy Ward is designated Covid Ward 	<ul style="list-style-type: none"> • Deliver initial treatment in CDU rooms 8 (negative pressure room) and Rooms 7a and b. • Bay C is currently Amber zone (4 beds spaced >2m apart). • Covid ambulance arrivals go directly to dedicated bay with direct access to the CDU red assessment zone • The remainder of ED, CDU and Minors area are able to operate as per normal. • Bay C will be reviewed in order to revert to Green zone if required 	Dependant on emerging evidence and prevalence of Covid 19 in Ceredigion as well as over the border from South Gwynedd and Powys (35% of Bronglais non elective workload comes from outside HDUHB)
Non-Covid USC pathways	All emergency attendances including 999s and GP arranged admissions going through the remainder of ED, CDU and Minors area (separate entrance, triage process etc)	<ul style="list-style-type: none"> • Physical designation and pathways likely to remain as is with the exception of Bay C • Ambulance Arrivals and GP admits have and will continue to go directly to ED/CDU. <p>Benefits</p> <ul style="list-style-type: none"> • Flexible use of Bay C will improve 4 & 12 hour performance and ambulance offload • Direct access will meet one of the unscheduled care goals and enable ambulatory care activity to recommence depending on demand 	Key areas for development <ul style="list-style-type: none"> • From WG goals for unscheduled care <ol style="list-style-type: none"> 4. Develop a 'phone first before attending ED' targeted at patients who could be safely assessed elsewhere or through a planned approach (there are concerns attached to this in terms of wider community communication and the potential to increase the overall ED attendance of patients who could be cared for elsewhere (similar to experience of 111) 5. A 'wait and care' service concept is developed to prevent unnecessary

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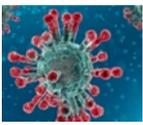


			<p>conveyance to Emergency Departments</p> <ol style="list-style-type: none"> 6. Identify location, staffing and protocols for same day emergency care service 7. Explore options for consultant connect in USC services <ul style="list-style-type: none"> • Explore options for medical day cases and ward attenders • Work with community to further embed WGs discharge requirements • Work within community to further develop escalation plans 						
COVID Testing	Testing on site in Bronglais.	<ul style="list-style-type: none"> • Monday to Friday in hours, turnaround is between 45 minutes and 2 hours depending on demand • At weekends test results still go to Cardiff 							
Inpatient and days case Surgical Delivery	Elective cancer and other urgent work recommences on site at Bronglais from 6 th July 20	<p>Current plan:</p> <ul style="list-style-type: none"> • Rhiannon Ward becomes dedicated elective ward – commences from 6th July with 8 of 15 beds open • Potential for 15 beds if required. Staffing available. • Initial cases will target cancer backlog & clinically urgent non-cancer. For Bronglais this will include some T&O 							
ITU capacity	ITU – 5 funded beds with potential to separate 1 patient (side room for Covid)	<ul style="list-style-type: none"> • Additional pod being installed at Bronglais will provide 2 spaces for isolation (Covid) • If required potential to set up a second ITU (subject to staffing) in one theatre recovery area • Covid ITU – plan is to stabilise and transfer to GGH 							
Ward configuration and staffing	<p>Current bed configuration:</p> <table border="1" data-bbox="313 1380 846 1468"> <thead> <tr> <th>Ward</th> <th>beds</th> <th>Speciality</th> </tr> </thead> <tbody> <tr> <td>CDU</td> <td>6</td> <td>COVID</td> </tr> </tbody> </table>	Ward	beds	Speciality	CDU	6	COVID	<p>Next configuration:</p> <p>Will remain as is.</p>	Capital bid to address ward deficits:
Ward	beds	Speciality							
CDU	6	COVID							



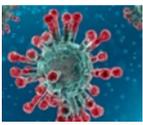
<p>48 Registered nursing vacancies (38% vacancy rate)</p>		8	Non Covid	<p>Further growth of capacity for elective surgery from 8 to 15 beds on Rhiannon if needed</p> <p>Note: Ystwyth and Rhiannon were phases 2 and 3 of Covid plan and have already reverted to non covid capacity</p> <p>Rhiannon will create a dedicated elective bed base which is not mixed with surgical non elective and will provide a safe option for planned care patients.</p>	<p>Some requirement of perspex screening etc to reduce beds lost for social distancing. Only 5 + 2 surge beds at Bronglais to maintain and assurance of 2m distancing between beds.</p> <p>Bronglais has a partnership arrangement with 3 nurse agencies, which effectively mitigates the nurse vacancy problem whilst all actions to improve recruitment are undertaken. The significant difference is that a known number of regular framework agency nurses are assigned and rostered to wards to provide stability etc. These nurses receive local training to ensure they can support safe and high quality care on their ward base.</p> <p>Longer term plan is to have a Faculty of Health Sciences with Integrated School of Nursing attached to Aberystwyth University from approx. September 2021</p>						
	Y Banwy	18	Covid/Suspected Covid								
	Ystwyth	18	Acute Stroke/Stroke Rehab/Frailty								
	Dyfi East	14	Respiratory/Endocrine								
	Dyfi West	12	Cardiology (CMU)								
	Meurig	15	Oncology/Gastro								
	Ceredig East	15	General Surgery								
	Ceredig West	14	T&O								
	Rhiannon	15	Elective Surgery								
Environmental	Assessments modifications ongoing	<p>Work on main unresolved accommodation issues:</p> <table border="1"> <thead> <tr> <th>Ref</th> <th>Priority</th> <th>Detail of Issues</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>ITU adjustments</td> <td>Prior to re-start of cancer surgery. In order to provide cancer surgery an elective ITU is required, therefore a pod system is to be installed to enable separation. This will be located in the same footprint as ITU.</td> </tr> </tbody> </table>			Ref	Priority	Detail of Issues	1	ITU adjustments	Prior to re-start of cancer surgery. In order to provide cancer surgery an elective ITU is required, therefore a pod system is to be installed to enable separation. This will be located in the same footprint as ITU.	<p>Develop site plans to address key issues</p> <p>Some as noted, are in hand</p>
Ref	Priority	Detail of Issues									
1	ITU adjustments	Prior to re-start of cancer surgery. In order to provide cancer surgery an elective ITU is required, therefore a pod system is to be installed to enable separation. This will be located in the same footprint as ITU.									

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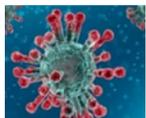
			Elective work will however commence prior to this work being completed but will focus on cases not requiring ITU and to clear day case backlog
		2	Ambulatory Care facility The AEC facility at Bronglais is compromised due to Covid as it sits within a small part of CDU. A larger facility is planned as part of the site plan
		3	Management Team offices Due to social distancing 5 staff displaced
		4	Cardiorespiratory Urgent need to move cardresp to larger premises. This was in the Bronglais plan but has been held up by Covid. The relocation site is currently occupied by another team and actions are in train to resolve this
		5	Storage A number of storage issues have been identified including additional drugs and equipment for Covid. Ward space is limited for storage and a shared storage option which was held up due to Covid is being progressed
		6	Postgraduate medical staffing accommodation This is in a woeful condition though some investment has been made to improve undergraduate accommodation. A costed plan to rectify this is in development
		15	Clinical Engineering The COVID situation compounds the risk within the current workshop. The EBME service requires relocation but site options are limited

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		16	Fracture Clinic Breaking bad news room	Both these areas within OPD are sub optimal and require attention. The Breaking Bad News space has become a store room and the fracture clinic is challenging to relocate due to drainage requirements.	
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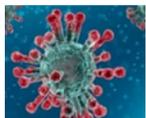
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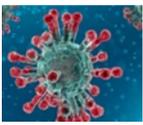
Withybush

Area	Current Situation	Next Steps (July implementation)	Further Development July to September
COVID Pathway	Compliant with all wales guideline <ul style="list-style-type: none"> Streaming prior to registration Allocated area in ED Ward care in CPAP and NIV on Adult Clinical Decisions Unit 	Deliver treatment in side rooms on ACDCU. Will be compliant with all wales guideline	Development of a Red Ambulatory Emergency Care Unit
Non-COVID USC pathways	All emergency attendances including 999s and GP arranged admissions going through the Green ED or Puffin Ward (Green Ambulatory Care Unit & Clinical Decisions Unit). All GP referrals and ambulance requests for conveyance to hospital are streamed through a 'Blue' medical team using Consultant Connect, enabling some patients to remain in their own homes with support & review as appropriate.	Evaluate Blue Team activity, intervention, admission avoidance & referrals to the intermediate care team Maintain separate Non COVID Clinical Decisions Unit & Ambulatory Emergency Care Unit Benefits <ul style="list-style-type: none"> Will improve 4 & 12 hour performance and ambulance offload Direct access will meet one of the unscheduled care goals 	Key areas for development <ul style="list-style-type: none"> From WG goals for unscheduled care <ol style="list-style-type: none"> Develop a 'phone first before attending ED' targeted at patients who could be safely assessed elsewhere or through a planned approach Explore options for further digital system use in USC services Work with community to further embed WGs discharge requirements through Discharge to Recover & Assess Pathways Work within community teams to further develop escalation plans
COVID Testing	On site symptomatic patient testing commenced in June 2020. General turnaround time of 6-8hrs.	Await delivery of a larger testing unit with a view to testing all patients admitted to hospital. Commence pre-operative patient testing in readiness for elective surgery from 13 th July 2020.	
Inpatient and days case Surgical Delivery	No current activity	Current plan from 13/07/20: <ul style="list-style-type: none"> Ward 4 will become surgical ward. Potential for 21 beds but staffing for 14 in place Initial cases will target urgent referral backlog 	

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ITU capacity	Non-COVID ITU; 5 beds in ITU COVID-ITU – confirmed cases to be stabilised and transferred to Glangwili Side room available for suspected cases	Submit request for installation of medical air into Ward 4 to support the ability to run a separate Non COVID ITU in the event of increased COVID activity and the need to return this pathway from Glangwili																																																																															
Ward configuration and staffing	<p>Current bed configuration:</p> <table border="1" data-bbox="304 387 806 1437"> <thead> <tr> <th>Ward</th> <th>beds</th> <th>Speciality</th> </tr> </thead> <tbody> <tr> <td>ACDU</td> <td>15</td> <td>COVID CDU & Inpatient area</td> </tr> <tr> <td>DSU</td> <td>8</td> <td>COVID – Surgery & Orthopaedic Pathway</td> </tr> <tr> <td>Ward 1</td> <td>16</td> <td>Non COVID Orthopaedics</td> </tr> <tr> <td>Ward 3</td> <td>20</td> <td>Non COVID Surgery & SAU</td> </tr> <tr> <td>Ward 7</td> <td>28</td> <td>Non COVID Gen Med, Gastroenterology & Diabetes</td> </tr> <tr> <td>CCU</td> <td>6</td> <td>Non COVID Cardiac</td> </tr> <tr> <td>Ward 8</td> <td>20</td> <td>Non COVID Gen Med, Cardiology</td> </tr> <tr> <td>Ward 9</td> <td>13</td> <td>Non COVID Acute Stroke Unit & Rehabilitation</td> </tr> <tr> <td>Ward 10</td> <td>16</td> <td>Non COVID Gen Med, Oncology, Haematology & Palliative Care</td> </tr> <tr> <td>Ward 12</td> <td>16</td> <td>Non COVID Gen Med, Cognitive Impairment, Frailty</td> </tr> <tr> <td>Puffin Ward</td> <td>14</td> <td>Non COVID Clinical Decisions Unit & Ambulatory Care Unit</td> </tr> </tbody> </table> <p>79WTE Registered nursing vacancies</p>	Ward	beds	Speciality	ACDU	15	COVID CDU & Inpatient area	DSU	8	COVID – Surgery & Orthopaedic Pathway	Ward 1	16	Non COVID Orthopaedics	Ward 3	20	Non COVID Surgery & SAU	Ward 7	28	Non COVID Gen Med, Gastroenterology & Diabetes	CCU	6	Non COVID Cardiac	Ward 8	20	Non COVID Gen Med, Cardiology	Ward 9	13	Non COVID Acute Stroke Unit & Rehabilitation	Ward 10	16	Non COVID Gen Med, Oncology, Haematology & Palliative Care	Ward 12	16	Non COVID Gen Med, Cognitive Impairment, Frailty	Puffin Ward	14	Non COVID Clinical Decisions Unit & Ambulatory Care Unit	<p>Next configuration:</p> <table border="1" data-bbox="831 387 1653 1166"> <thead> <tr> <th>Ward</th> <th>Beds</th> <th>Speciality</th> </tr> </thead> <tbody> <tr> <td>ACDU</td> <td>15</td> <td>COVID CDU & Inpatient area</td> </tr> <tr> <td>DSU</td> <td>8</td> <td>COVID – Surgery & Orthopaedic Pathway</td> </tr> <tr> <td>Ward 1</td> <td>16</td> <td>Non COVID Orthopaedics</td> </tr> <tr> <td>Ward 3</td> <td>20</td> <td>Non COVID Surgery</td> </tr> <tr> <td>Ward 7</td> <td>21</td> <td>Non COVID Gen Med, Gastroenterology & Diabetes</td> </tr> <tr> <td>CCU</td> <td>6</td> <td>Non COVID Cardiac</td> </tr> <tr> <td>Ward 8</td> <td>14</td> <td>Non COVID Gen Med, Cardiology</td> </tr> <tr> <td>Ward 9</td> <td>14</td> <td>Non COVID Acute Frailty Unit</td> </tr> <tr> <td>Ward 10</td> <td>16</td> <td>Non COVID Gen Med, Oncology, Haematology & Palliative Care</td> </tr> <tr> <td>Ward 11</td> <td>13</td> <td>Non COVID Acute Stroke Unit & Rehabilitation</td> </tr> <tr> <td>Ward 12</td> <td>16</td> <td>Non COVID Gen Med, Cognitive Impairment, Frailty</td> </tr> <tr> <td>Puffin Ward</td> <td>14</td> <td>Non COVID Clinical Decisions Unit & Ambulatory Care Unit</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Reason for change</p> <ol style="list-style-type: none"> 3. Realign beds across the site to open an acute frailty assessment unit 4. Realign beds to meet social distancing requirements 	Ward	Beds	Speciality	ACDU	15	COVID CDU & Inpatient area	DSU	8	COVID – Surgery & Orthopaedic Pathway	Ward 1	16	Non COVID Orthopaedics	Ward 3	20	Non COVID Surgery	Ward 7	21	Non COVID Gen Med, Gastroenterology & Diabetes	CCU	6	Non COVID Cardiac	Ward 8	14	Non COVID Gen Med, Cardiology	Ward 9	14	Non COVID Acute Frailty Unit	Ward 10	16	Non COVID Gen Med, Oncology, Haematology & Palliative Care	Ward 11	13	Non COVID Acute Stroke Unit & Rehabilitation	Ward 12	16	Non COVID Gen Med, Cognitive Impairment, Frailty	Puffin Ward	14	Non COVID Clinical Decisions Unit & Ambulatory Care Unit				<p>Full scoping of accommodation & clinical space requirements on site +Reduce beds lost for social distancing + Address other problems like break rooms, MDT rooms, changing rooms etc</p> <p>Continued focus on recruitment to registered nursing & medical staff vacancies</p>
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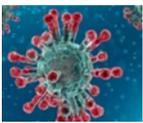


Environmental	Assessments modifications ongoing	Work on main unresolved accommodation issues:			Develop site plans to address key issues
		Ref	Priority	Detail of Issues	
		1	Cardio Physiology Department requirements	Relocation of plaster room services have taken some space from Cardio Physiology Dept. This will need to be recovered to enable urgent diagnostic investigations to be carried out	
		2	Clinical Staff office space	Full scoping exercise being undertaken. Space will need to be identified through relocation of services which do not need to be on an acute hospital site.	
		3	Storage	A number of storage issues have been identified including additional drugs and equipment for COVID.	
4	Discharge lounge	Currently used for alternative service provision			

Therapies

A therapies plan to support these 6 national USC priorities, has been developed

This document is subject to Bwrdd Iechyd Prifysgol Hywel Dda July 2020



Progress update regarding Routine Services, including paediatrics

USE OF DIGITAL SOLUTIONS TO SUPPORT OUR SERVICES



Digital COVID Journey

Setting the Digital Landscape for Health



Working From Home



- 1,254 new remote access tokens deployed
- 550 smartphones purchased and deployed



Accelerated Rollout of National Products



- 826 users of WCP Mobile
- MTeD further rollout to 52 wards
- PACS Mobility rolled out
- COVID testing on LIMS
- Additional WCP functionality



Empowering Staff to Work Digitally



- Kit Deployed (Oct 2021):**
- Acute – 1,021
 - Community – 531
 - Mental Health – 3351
 - Corporate – 317
- 8,745 (83%) of users have been migrated to OSES
 - 589 Headsets provided
 - 478 Webcams installed



Supporting Patient Flow



- 58 Mobile Carts for care at the bedside
- Developed extract routines for COVID Data Modelling
- Electronic COVID SITREP report
- Live bed state developed to provide live reflection of bed occupancy and COVID status
- Interim Electronic eObservation collection designed and deployed



Virtual Meetings and Digital Consultations



- Microsoft Teams deployed to 7,483 devices
- 483 Microsoft Teams created
- Microsoft Teams booking app is in pilot in Respiratory
- **Attend Anywhere** pilot undertaken in a number of specialties with virtual outpatients being undertaken
- **Consultant Connect** – launched and operational



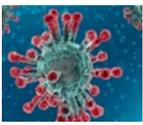
Connecting Patients and Their Families



- 234 Tablets deployed to wards for patients to **keep in touch** with relatives and friends.

You can follow us on Twitter @HddInformatics #arwainarfoesidigidol #leadingdigitalinnovation

This document



Digital Priorities for Quarter 2

As part of the response to COVID the Digital Team have looked to accelerate a number of projects, around a specific set of functional requirements outlined on the previous slide in to bring the Digital Programme Plan forward with pace.

- **Virtual Meetings and Digital Consultations** – As part of the improved use of technology the following products have been rolled out:
 - Attend Anywhere is live within 12 services, across Acute (inc. Paediatrics / Gynaecology / Heart Failure and Rheumatology) and Mental Health services
 - The Bookings App is in use within the Respiratory Service, with other services such as Orthopaedics interested in the proof of concept
 - Consultant Connect was formally launched on the 15th June 2020. To date the following services are available : - Cardiology, Elderly Care , ENT, Gastroenterology, Gynaecology, Haematology, Paediatrics, Respiratory, Trauma and Orthopaedics, Urology, Acute Medicine (The Blue Team)*, Intermediate Care Hub*, District Nursing Hub* (*Pembrokeshire only)
 - Dr Doctor. We are looking to rapidly deploy the PROMs element of Dr Doctor to Cardiology (Heart Failure and Chest Pain), Orthopaedics (Hips and Knees, and Shoulder and Elbow) to improve the feedback to the service
- **Empowering Staff to Work Digitally** - Along with the rollout of over 2,000 additional devices to Health Board staff the Health Board has made the decision to accelerate the following systems:
 - Malinko – Community Scheduling Tool has been approved for procurement to deliver an interim scheduling tool, which can maximise the response of the Community Services during COVID-19
 - Welsh Community Care Information System (WCCIS) – Hywel Dda has begun the planning to extend the use of WCCIS into the other counties within the Health Board. Currently we have over 200 staff utilising the system within Ceredigion and we plan to implement within the other Counties within the next 12-18 months.
 - Office 365 – Migration Status – to date we have migrated 93% of all staff (9,743) onto Office 365 which will provide the agility for staff to work from home.
- **Patient Knows Best (PKB)** – we have expanded our use of PKB into the Dermatology and Sexual Health Services, which has already seen benefits around the self-management agenda within respiratory. To expand the use within the Health Board we have written to all respiratory patients (circa 2,800) asking them whether they wish to participate within the PKB Programme, which will allow them access to their appointment letters, clinic letters, care plans and also communication with the clinical teams.

National / Local System Implementation

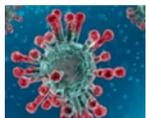
National

We as a Health Board have also looked to accelerate the rollout of National Systems within the Health Board, namely:

- A further release of Welsh PAS to respond to COVID (version 20.1)
- WCP Mobile was released and widely accepted by the clinical teams. At the last time of reporting (May 2020) Hywel Dda was the largest user of the system, in terms of users, viewing of results, and images

Also as part of our response we also have undertaken the following actions

- GP Record Access – this has been released to all WCP users
- Transfers – made available to all Consultants, Juniors etc
- Additional MTed wards have been released at the request of Pharmacy
- PROMs functionality has been released



- Electronic Test Requesting for the CTUs

Local

- **Development of a system for Electronic Observations** - A SharePoint site has been developed for all COVID wards to undertake electronic observations at the bedside. This has been introduced in lieu of the national solution being available
- **Real-time, high quality data at ward level to enhance ward efficiency and assist bed management** - The Information Team have provide a live bed state of all wards within the Health Board, and are in the process of finalising the readiness work for the recording of field hospitals within the Patient Administrative System (PAS)
- **SharePoint Developments - As part of the response to COVID-19, the Digital Team have designed the following:**
 - COVID – this SharePoint site has been developed for the command centre to record and administrative
 - Medical Devices – this is a training site for the medical devices
 - Oncology – SharePoint site for the triaging of oncology telephone calls
 - Phlebotomy booking system – for the booking of appointments to ensure social distancing
 - Community Phlebotomy System – for the booking of appointments to ensure social distancing
- **Improvements in the PSBA Links** - As part of the enabling work we have utilised the BT offer of upscaling PBSA links, and we have programmed in improvements to Hafan Derwen, and Bronglais Hospital to bring them in line with the other Sites.
- **Progression of RightFax** - As part of the response to COVID we will be looking to begin the removal of faxes and replace with an electronic solution that will allow the safe electronic transfer of information

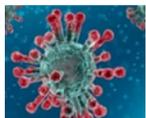
Quarter 2 actions

In Quarter 2, the Digital Team will be looking to progress the following:

- Digital Support in order for recovery of services, such as Therapies, Mental Health etc
- Rollout preparation of the commencement of the Welsh Nursing Care Record (WNCR)
- WCCIS Mobile Application rollout
- Digital Dictation/ Voice recognition
- Electronic Clinical Documents to GPs
- Initial scoping for a full patient observation system
- Initial scoping for Electronic Patient Flow / White Board system – possible pilot site of Prince Phillip.
- Rollout of Malinko Scheduling System to Community
- Continue the work around the robust network infrastructure, switchboard modernisation and telephony

In order to progress the above a number of new positions have been agreed. These will range from 18 month fixed term contracts to permanent positions. Below are some of the roles that will be released:

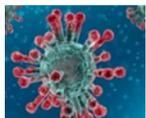
- Additional roles within the WCCIS programme (project management, project support etc.) in order to rollout the programme with pace.
- Boosting Cyber Security
- Improvements within Telecoms / Switchboards



- Increasing the number Application Support Trainers within the Health Board
- Bolstering ICT Service Desk
- Strengthening the Clinical Coding Team with additional clinical coders and clerks
- Introducing Digital Change and Project Managers into the Team to progress projects like Electronic Test Requesting, and those highlighted above.
- Introduction of additional support into the Desktop and Infrastructure Teams to support the new ways of working.

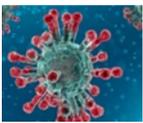
Paediatrics, SCBU and Maternity Services

Service suspended/Change	Contingency in place from Quarter 1 progressing preparedness for Quarter 2
All face to face outpatient appointments for Community & General Paediatrics	<ul style="list-style-type: none"> • Telephone Clinics, piloting digital platforms for consultations. 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. In addition, to continue with the triaging of referrals to identify those referrals who will require essential services. Also to monitor the requirement for the provision of medications and supplies for ongoing management of chronic conditions. • Diabetes: Drive-thru clinics 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	<ul style="list-style-type: none"> • 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. • Review of temporary closed cases and case by case assessment to support introduction back into education
<ul style="list-style-type: none"> • Bronglais General Hospital, Angharad Ward. • 2 separate areas to accommodate red and green zones. 	<ul style="list-style-type: none"> • 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. • An inpatient are that admits Suspected /Positive COVID and NON COVID with designated isolation rooms and co-horting facilities
<ul style="list-style-type: none"> • 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 - Staffed by Community and 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. 	<ul style="list-style-type: none"> • Acute Paediatrics will continue to be diverted to Glangwili Hospital to the Acute Hub. • Continuation of streaming in Child health department.



Service suspended/Change	Contingency in place from Quarter 1 progressing preparedness for Quarter 2
<ul style="list-style-type: none"> Glangwili – Cilgerran Ward area red and green zones for Paediatric Ambulatory care, inpatient and Paediatric High Dependency Care Provision of paediatric ED admission via paediatric assessment tent except for minor injuries and trauma. 	<ul style="list-style-type: none"> Continuation of separate COVID and Non COVID Area. Assessment for review of paediatric Emergency temporary service, its purpose and sustainability to support Emergency services. Urgent surgical specialities care including Urgent Radiology.
<p>Glangwili, Children’s Centre for essential assessments re: oncology, immunisations (BCG), ECHO and paediatric urgent assessments/investigations/interventions.</p>	<ul style="list-style-type: none"> To maintain urgent OPD
<p>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.</p> <ul style="list-style-type: none"> Neonatal outreach 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 	<p>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)</p> <ul style="list-style-type: none"> 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.
<p>Maternity services</p> <ul style="list-style-type: none"> 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 Normal Labour Care Pathway. Overall 50% increase in home births 	<ul style="list-style-type: none"> 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.

This document is subject to Board approval in July 2020



Service suspended/Change	Contingency in place from Quarter 1 progressing preparedness for Quarter 2
<ul style="list-style-type: none"> All routine gynaecology outpatients suspended. 	<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Early Pregnancy Assessment Unit reduced provision of ultrasound assessment Clinics suspended in Withybush 	<ul style="list-style-type: none"> Centralised telephone assessment and support of all cases. Ultrasound provision for urgent cases in Glangwili and Bronglais with identified red and green areas.
<ul style="list-style-type: none"> Pregnancy Advisory Service maintained. In patient abortion service suspended in Withybush. 	<ul style="list-style-type: none"> 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.
<ul style="list-style-type: none"> Routine gynaecology surgery suspended. Low risk USC and urgent surgery provided in Werndale Hospital. High risk USC and urgent surgery suspended. 	<ul style="list-style-type: none"> Drive to reduce USC and urgent backlog Continuation of pathway. Interim hormonal therapy commenced in line with RCOG guidelines.

Special Education Needs and Additional Learning Needs

Special Educational Needs and Tribunal Wales Act

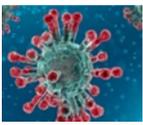
Whilst the Coronavirus Act 2020 has been passed, public bodies remain under obligation to comply with the law and regulations regarding Special Educational Needs. There is no immediate change to the duties on public bodies has and the Welsh Government directs public bodies to continue to meet their statutory duties under the Act in a flexible and practical manner.

The Coronavirus Act 2020 does provide the possibility of a temporary relaxation of duties (Schedule 17, part 1 – Notices temporarily removing or relaxing statutory provisions).

The Welsh Government is in the process of developing such a Notice. It is expected that the Notice will modify certain rules and regulations of the Act. Modification means that the provision impacted is subject to a ‘reasonable endeavours’ duty, rather than an absolute duty. The Notice and associated guidance setting out what would constitute ‘reasonable endeavours’ was expected to be published towards the end of May 2020.

However, until the publication of the Notice, the Health Board’s statutory duties remain absolute and is expected to meets its statutory duties under the SENTW Act in a flexible and practical manner. The statutory duties under the Special Educational Needs and Tribunal Act (Wales) for the Health Board are:

1. Contribution to the statutory assessment process, including a duty to respond within 6 weeks.
2. Participation in the annual review process



3. Delivery of the provision identified in part 3 and part 6 of the statement of special educational needs
4. Participation in Education Tribunal (as appropriate).

Of the 4 statutory duties, the delivery of the provision identified in part 3 and part 6 of the statement of special educational needs, creates the most challenges as these provisions are often delivered within the school environment and as part of the delivery of the curriculum.

Going forward, as part of the continued planning in response to the COVID-19 pandemic, and the re-establishment of essential services, paediatric services require to include their responsibility for fulfilling their statutory duties in a flexible and practical manner in collaboration with the children/young persons and their parents/carers and the Local Authorities and schools.

In their endeavours to continue with service delivery in a flexible and practical manner, services will require to continue to be innovative, whilst exploiting the opportunities provided by the various digital platforms. However, the blanket decision not to provide face to face appointments, will require to be re-considered, especially in light of the recent announcement of the re-opening of schools. A risk-based approach requires to be introduced, especially for the most vulnerable children which includes children under SENTW, as well as children known to Social Services.

In addition, once the Notice is issued, services will require take into consideration the associated guidance on what constitutes 'reasonable endeavours' when fulfilling their statutory duties and be able to justify that all reasonable opportunities have been considered, in collaboration with the children/young persons and their parents/carers and the Local Authorities and schools.

Additional Learning Needs and Education Tribunal Wales Act

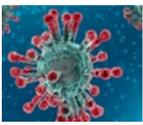
The implementation date of the ALNET Act of the 1st September 2021 will not be delayed. All public organisations require to prioritise its preparations and ensure its readiness by the 1st September 2021. The impact of the ALNET Act on the organisation is widespread and includes clinical services for children and young people between the ages of 0 till 25, but also non-clinical services such as Communication, Welsh Language, Information, Putting Things Right, Engagement and Safeguarding.

The SWMW Regional ALN Transformation Group has developed a robust action plan for 2020-2021, which requires the various services/departments to either participate and/or contribute. In addition, to meeting the challenge of the above plan, further identified actions need to be completed.

Sexual and Reproductive Health Services (SRH)

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

July-September 2020: repatriate staff back to SRH services and begin to expand clinics with booked clinics only. Reclaim clinic venues in all three counties in. Currently we have no access to Madog Suite in Glangwili Hospital and our Pond Street clinic has been developed into our admin and telephone triage hub and the venue for managing all test



results in to the service therefore there is no capacity for patient consultations. Alternative community clinic accommodation in the Carmarthen area needs to be identified in order to offer appointments for residents there.

Remote Clinics: Patients requesting routine testing for Sexually Transmitted Infections (STIs) who are asymptomatic are directed to Frickeywales.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). The remote consultations will be managed via daily 'virtual' lists being created by the phone booking line and staff working from and accessing the virtual list from whichever site is closest to them. The purpose of

- 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.

Remote consultations will be supported by the digital platforms, Patient Knows Best (PKB) and Attend Anywhere. Things that can continued to be managed remotely include:

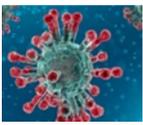
- Oral contraception
- Management of asymptomatic Chlamydia
- Partner notification and contact tracing
- Pre exposure prophylaxis for HIV (PrEP) consultations, new and follow-up
- Sterilisation Clinic
- Menopause Clinic
- Psychosexual Clinic
- Gynaecology referral/redirection Clinic

Continue posting medications via recorded, First class delivery, or arranging collection from clinic venue.

Booked Clinics

Following a remote consultation and triage the following patients can be offered a booked slot at one of the open sites:

- All LARC procedures for those who are vulnerable or high risk of pregnancy on oral methods (eg. <25 years and patients who have previously had an abortion or pregnancy on a non-LARC method. Also patients who are using enzyme inducers or teratogenic medications) Ensure a remote consultation has occurred in the first instance to minimise time in clinic
- All LARC methods where an initial consultation has been taken remotely and this is the patient choice following discussion and benefits outweigh risk to staff or patients in light of the guidance at that time
- Positive Gonorrhoea (GC) needing IM Ceftriaxone and swabs for microscopy, culture and sensitivities.
- Contacts of GC needing treatment as per BASHH guidance
- Examinations of patients identified from the Gynae redirection or Menopause remote Clinics
- Men who have sex with men (MSM) who need blood tests in order to start Pre-exposure Prophylaxis for HIV- PrEP (Ensure initial consultation has been done by phone in the first instance)
- Intrauterine System (IUS) for endometrial protection where an oral progesterone has been declined or not acceptable



- Problem LARC which need examination, Pelvic Pain, Testicular Pain and Symptomatic patients

Face to Face: should remain for <16 year olds and vulnerable groups (following triage)

Advice to patients who are given an appointment

Patients should be advised not to attend their appointment if they develop any symptoms of COVID 19 and to attend alone. This should be documented in their patient record. They should also be advised to arrive at their allotted time and not before to minimise the number of people in the waiting room.

Diagnostic Imaging

In line with the all Wales and Health Board response to the COVID-19 pandemic, diagnostic imaging / radiology services have been limited since the 20th March to urgent patients and USC referrals. All requests have been reviewed and vetted by Radiologists locally, assessing clinical indications /necessity, mitigating against risk of delay in diagnosis ,risk of acquiring infection by being brought in for study (if patients in an at risk group) and in the light of the concurrent delays in treatment pathways. Where appropriate the referral was put on hold for further review.

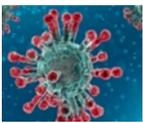
Radiology have met weekly/ fortnightly to plan and alter the response in line with the ever changing clinical scenario. Recent conversations have been held across Wales, and in line with the Welsh Government queries regarding diagnostic capacity, to discuss the return to 'normal 'diagnostic imaging service. These conversations have included contributions from radiology service managers and clinical directors from all Health Boards in Wales

The continuing threat and presence of COVID -19 within the community and within our staff and patient groups means that measures must be taken to protect staff and maintain social distancing in line with government guidelines and site footprints. These measures effectively increase the time required for each patient episode with a subsequent detrimental effect on efficiency as judged by numbers of patients imaged. It is noted that currently activity across the UHB within radiology is significantly lower than last year.

To reintroduce more routine imaging across the Health Board there will need to be an analysis of the current backlog along with an understanding of the probable new referrals from the re-introduction of planned care services and the variation in referral numbers from previous years

Currently, measures implemented to accommodate the potential demand from COVID-19 patients and the increased length of time taken to image the patients means the levels of service currently being delivered are highlighted in the table below. It is important to note that single scan facilities require significantly increased cleaning times/patient preparation in between patients e.g. time slots required for MRI patients has been effectively doubled in length i.e. effectively halving the capacity. Other influences that have been considered include changing staffing rotas, recruitment to bank and improved reporting turnaround times

Modality	Current situation
<ul style="list-style-type: none"> • First line imaging / plain film 	<ul style="list-style-type: none"> • Reduced GP access. Reduced A&E • Current workload predominantly Chest
<ul style="list-style-type: none"> • CT 	<ul style="list-style-type: none"> • Appointments maintained for USC, some cancer follow up patients and urgents along with inpatients • Difficulties as a result of infection control measures reducing capacity



<ul style="list-style-type: none"> • MRI 	<ul style="list-style-type: none"> • Appointments maintained for USC and urgents along with inpatients • Difficulties as a result of infection control measures reducing capacity
<ul style="list-style-type: none"> • Fluroscopy 	<ul style="list-style-type: none"> • Appointments maintained for USC and urgents along with inpatients • Difficulties as aa result of infection control measures reducing capacity
<ul style="list-style-type: none"> • USC 	<ul style="list-style-type: none"> • Appointments maintained for USC and urgents along with inpatients and • Obstetric imaging
<ul style="list-style-type: none"> • Nuclear Medicine 	<ul style="list-style-type: none"> • Imaging mostly confined to USC pathway.
<ul style="list-style-type: none"> • Mammography 	<ul style="list-style-type: none"> • Symptomatic breast clinics (new patients). This is mainly USC patients. • Breast MRI: For staging and breast CA patients, still on.

To further assess the steps needed to reintroduce further diagnostic imaging, the following papers/ documents (among others) have been consulted both locally and nationally.

- COVID -19 interim recovery phase guidance: Royal College of Radiologists
- Radiology Resumption of Clinical Services: Canadian Association of Radiologists
- A Framework for the Reinstatement of cancer services in Wales during COVID -19 :Tom Crosby NHS Wales Health Collaborative

To move into the next stage and further reintroduction of services the referrals currently on hold are being categorised in line with the Royal College of Radiologist guidance

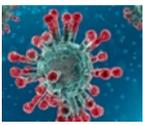
- P1: High probability of potentially life threatening condition.
- P2: High probability of condition potentially causing significant long-term harm
- P3: Possibility of potentially life threatening condition.
- P4: Possibility of condition potentially causing significant long-term harm.
- P5: Unlikely to be life threatening or cause significant long-term harm.

It is considered that we have maintained a level of service for all P1 and P2 referrals, and some P3, Moving into the next stage will include where possible referrals in all categories dependent on capacity and safety.

Any increase in imaging must be in line with other clinical services and their ability to treat. It goes without saying it is based on mitigating the risk of delayed diagnosis. This will apply to both primary and secondary care. It has been acknowledged that this is an ideal opportunity to ‘reset’ diagnostic imaging services and improve pathways and ways of working therefore the reintroduction of services should take this into consideration. There are a number of dependencies and risks that need to be considered and worked alongside.

Dependencies and Risks

- Red and green flow accommodating both types of patient will reduce capacity on all sites. It has been noted that without green specific sites there will be difficulty in fully restoring services with the current departmental set ups and single pieces of equipment in certain modalities (eg CT,MRI,Nuclear medicine). The need to deep clean after COVID patients will impact on how we timetable examinations going forward



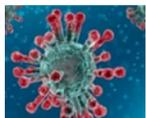
- Acknowledgment of a capacity to respond to a potential second spike
- Long standing Radiologist reporting capacity poses serious challenges to increasing imaging capacity and activity during the recovery and reactivation phases and therefore Radiologists home working solution needs implementation. This will allow home working if Radiologists have to isolate. Should also facilitate ease of increasing sessions over weekends for recovery phase.
- Welsh Government guidance
- Equipment Factors: Single CT and MR scanners at all sites and 1 nuclear med scanner in Wthybush. MRI scanner in Wthybush is due to replace and all CT scanners are at end of life.
- A reduction in surgical and endoscopy activity could mean an increase in demand for image guided intervention in cancer patients. During the recovery phase, presentation with advanced stages of cancer could also contribute to increase in demand for this service.
- There will be an increase in referrals for IR, either as a bridge to surgery or for palliation in high risk surgical patients. Limited interventional radiologist capacity within the UHB will require a possible regional approach
- Increase in demand for alternative potentially curative loco-regional therapies instead of surgery.
- Imaging such as barium swallow/meal and minimal preparation CT as an alternative to endoscopy and CTC to minimise exposure to aerosol generating procedures as per BSG-BSGAR guidance

Implications for current and future capacity

- Extended days –With the capacity reduced in the normal working day radiographic numbers will need to be increased to extend the working day week modifications to the on-call system enforced in order to have more senior staff available during the normal working day.
- Regional working-sub- specialisation amongst radiologists should facilitate reporting studies within their subspecialty from other sites albeit if the issues with IT/radiology Information Systems/PACS can be overcome
- COVID-19 low risk imaging sites will be identified where feasible, and other sites mitigating infection risk by changing patient flow in departments. Potential All Wales Mobile Solutions are being explored. In addition measures will be required to take infection control precautions and maintain social distancing measures e.g. utilising text messaging technology. Asking patients potentially travelling to appointments in cars to wait in the vehicle in hospital car park and be texted to attend for test. This will avoid overcrowding of waiting areas.
- The use of the private sector e.g. Werndale Possibility of east Hywel Dda patients being scanned in ILS2 in Swansea (CT and MR capacity available)
- Planned Upgrade of MRI scanner - Wthybush

Staffing implications

- No radiology staff have been redeployed to other areas so no need to remove back to radiology
- However, changes in rotas has meant staff working differently to support the imaging of COVID patients on wards and this needs to be managed carefully
- Introduction of red sites will allow radiographer rotas to be adapted per site
- Bank staff have employed but they work for both UHBs so availability may reduce
- Current vacancies within radiographic staff need to be filled



- Radiologist capacity: review of reporting workloads/subspecialty workloads should facilitate a more realistic view of number of NHS radiologists required/outsourced reporting/locum consultants. (This can be benchmarked against neighbouring health boards). There is an opportunity for recruitment alongside a potential change in working practices, e.g. if reliable home working software/hardware can be introduced then this may well increase recruitment to the consultant body.

Opportunities that will present during this work

- Reset button. Prior to COVID-19 pandemic work had commenced on the transformation of the radiography workforce and systems of work. This presents an ideal opportunity to take this work forward
- The opportunity to review pathways/ demand manage
- The opportunity to improve cross site working and improve protocols/ consistency
- Reset reporting worklists and radiologist specialties improving reporting turnaround times and reduction in outsourcing

Routine Cardiac and Respiratory Outpatient Diagnostic Activity

The initial response to the COVID-19 pandemic resulted in the reduction of services to essential outpatient services only:

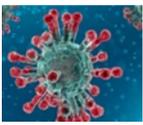
- Cardiac and respiratory assessment for cancer or other urgent treatment
- Patients with severe disease and new symptoms
- Patients with symptoms of severe disease

This has resulted in increased waiting times and increases in the numbers of patients waiting for both cardiac and respiratory diagnostic services.

To mitigate the health risks to patients that are a direct result of longer waiting times for diagnostic tests we propose the managed increase in diagnostic activity. Patients will be offered appointments on the basis of their risk of COVID transmission and their personal risk of developing complications should they contract COVID-19.

Patient selection:

- Essential activity will continue to take priority
- Patients will not be excluded on the basis of the clinical urgency of their test. Appointments will be offered to routine and urgent, new and follow up patients for all diagnostic tests that can be delivered with minimal risk.
- Patients waiting the longest will be offered appointments first.
- Patient will be selected on the basis of their risk of developing severe complications from COVID-19. Appointments will not be offered to
 - o patients identified by WG as extremely high risk,
 - o patients shielding extremely high risk individuals,
 - o patients who self-identify as high risk.
- Patients that are socially distancing will be offered an appointment.
- Patients with symptoms of COVID-19 will not be offered an appointment.



Selection / Triage Process:

Order of selection:

1. Essential activity will continue to take priority
2. Other routine and urgent patients will be contacted in order of waiting time.

Triage Process:

- All patients will be contacted by phone to confirm their risk of developing severe complications from COVID-19 from the current WG guidelines (attached).
- Patients will be asked to confirm their level of isolation (isolation, distancing, shielding)
- Individual risks will be discussed in order to obtain a mutual agreement on how to proceed, including:
 - o Measures to protect them during their appointment
 - o Any choices in venue, or postal appointment, home monitoring options
 - o The level of risk they are exposed to in their normal daily routine
 - o The urgency of their appointment and any changes in their symptoms
 - o Transport options available to them
 - o The result of this will be documented
- Patients will be pre-assessed for COVID-19 symptoms or contact with someone suspected of having COVID-19:
 - o High temperature
 - o New respiratory symptoms
 - o New persistent cough
- Patients not able to attend will be re-assured and remain on the waiting list in their original waiting list position.
- Patients able to attend will be given an appointment in 7 to 14 days and encouraged to isolate within their home for the 7 days prior to their appointment.
- Patients will be contacted on the day prior to their appointment to ensure that they remain free of COVID Symptoms

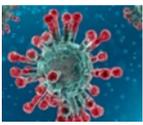
Specific Adaptation:

Ambulatory Monitoring: this will continue as a postal or drive-through service

Pacing Follow up: Where technology is able, patients will be monitored remotely

Other diagnostics:

- Patients will enter and exit via a green route (Withybush and Bronglais sites will need to consider relocation of services)
- Patients will be directed immediately into the clinic room or scheduled into sessions where the waiting areas are empty enough to comply with social distancing.
- Patients will use sanitiser or similar on entry and exit
- PPE: physiologists within 2m of the patient will wear: fluid repellent mask, goggles or visor, gloves, apron, arm protector (echocardiographers only). Patient will wear a surgical mask (issued on arrival)
- Clinic rooms will be stripped of unnecessary equipment
- A minimum of 30 minutes room 'downtime' between each patient, 1 hour for aerosol generating.



- Equipment and bed / chair will be wiped with alco wipes, floor will be washed between patients (Infection control advice pending)

Plans will be flexible and take advantage of available capacity when COVID numbers are low, but can be scaled back should we experience a second or third peak in COVID patients. The plan will not reduce the reported waiting times but should reduce the rate of increase numbers of patients on the waiting list, making the list easier to manage. Increasing our echocardiography capacity now will make it easier to schedule stress echocardiography when restrictions ease. It is anticipated that many of our patients will be unable to attend because they remain in isolation as advised by WG.

The service is engaging with the Cardiac Network, via the Cardiac Operational Managers Group, in order to deliver a phased return of services and design future services that are consistent with safest practices. Further work is being undertaken to increase future capacity, this will require investment and will be in keeping with recommendations made by the cardiac network:

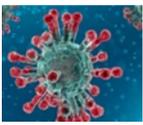
- Identifying alternative venues to the acute site
- Drive through for pacing follow up / move to community / non acute site
- Extending working hours to maximise quite times (7-8am, 6-8pm)
- Relocating postal service for ambulatory ECG from acute sites to community sites
- Increasing the home working / agile working capacity (Ambulatory monitoring analysis, patient triage, Skype / telephone pre-assessment for pacemaker implants, home monitoring of pacemaker patients)

Regional

With Swansea Bay University Health Board

In Quarter 2 an ARCH Partnership meeting is scheduled for early July with the Chief Executives and the focus for regional working between SBUHB and Hywel Dda will continue as follows:

- **Field Hospitals** - in Quarter 2 the two Health Boards will be exploring options for a regional solution for the Bay Hospital, including a regional workforce model
- **Eye Care**
 - the importance of developing regional solutions is recognised and work will be finalised in July to establish a Service Level Agreement (SLA) for paediatric ophthalmology and a similar approach is being used to support Glaucoma services
 - a workshop is planned for end July to establish plans for a regional eye care service that will be considered by both Health Boards by end of Quarter 2
- **Dermatology**
 - A regional work plan is already in place and proposals to recruit an additional plastic surgeon will be reactivated as a priority in Quarter 2
- **Tertiary services**
 - Agreed principle that patient prioritisation will be based on clinical need and on the funding streams available, recognising that WG funding support is finishing and there will be associated costs from Quarter2 onwards
 - Spinal – priority is to understand the range and volume of patients that can be undertaken by Werndale and develop joint funded plans
 - Urology and gynaecology – continue to review what activity can be undertaken in Hywel Dda
- **Vascular** – clinical group continuing to ‘work up’ patients for diagnostics
- **Thyroid services** – scoping of regional opportunities



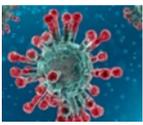
Covid-19

- **Diagnostics** – installation of CT Gantry onto the Glangwili site

Mid Wales

Additionally, the Health Boards covering Mid Wales are working in a collaborative way to ensure the area is covered and patient flow is maintained.

This document is subject to Board approval in July 2020



Workforce plans including use of additional Temporary Workforce

The workforce implications of our strategy have been at the heart of our planning from the onset of the Health Board's approach to the pandemic. We quickly set up at Workforce Bronze which has met throughout the last 4 months. There is also a regular interface with the Acute, Community and Primary Care Bronze groups as well as input into arrangements for Field Hospitals, Mental Health/Learning Disabilities and Facilities. This ensured preparedness in terms of our response to Quarter 1 and will also ensure that we are as well placed as we can be to support essential services and planning for winter pressures.

Staff Wellbeing

In recognition of the importance of providing support for our workforce, a Staff Psychological Wellbeing Plan was developed in order to respond to COVID 19 (end of March). As the pandemic has progressed and we continue to learn from staff experiences and as a consequence, this plan was updated on the 15th May and again on the 8th June.

The plan is fluid in nature to reflect how the pandemic is being experienced by our staff at work and also in response to new guidance impacting on working arrangements as and when it is issued from Welsh Government. Some examples of how the plan has evolved include:

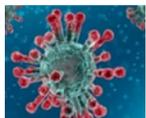
- Increase in provision of counselling support as the first peak of COVID 19 was reached and then subsided. The 'ask' for counselling in the aftermath has increased.
- Further attention and consideration of the needs of staff adapting to challenges of home working due to the implementation of social distancing at work, for example; feelings of isolation and lack of social connection, frustrations with technology and pressures of managing home working and work demands.
- The increase of coaching provision for leaders as they cope with the uncertainty of the peaks and troughs of the pandemic and the requirement to flex and mobilise service delivery and staff working patterns.

An ongoing staff experience and thematic analysis is also in place which has helped the Staff Psychological Well Being team to adapt and respond appropriately to the emerging needs of the moment. Staff Psychological Well Being messages are distributed twice weekly via Global and there is a dedicated COVID page for Staff Psychological Well Being. This page includes easy access to a wide range of Psychological Wellbeing resources and tools including all of those developed as part of the All Wales COVID 19 response. In addition, the Occupational Health team has also contributed significantly to staff wellbeing through the provision of advice and support to managers and staff in relation to staff testing, risk assessment and issues concerning isolation and shielding.

Wider discussions are currently underway to consider the learning from staff experience and staff welfare during this phase of the pandemic. This will inform the development of our culture of compassion going forward and enable staff welfare to be a prime focus in our transformation. All managers have been encouraged to ensure that staff are able to take adequate rest and breaks with the provision of rest rooms being one of the initial objectives of the Wellbeing group. Staff are also being encouraged to take annual leave at regular intervals regardless of the uncertainty over holiday bookings etc. The emphasis is very much on staff wellbeing and the importance of rest.

Risk Assessments

Staff with underlying health conditions have routinely been risk assessed using the Risk Assessment tools available including the recently issued COVID 19 Risk Assessment. Members of the Workforce team have been supporting Managers and individual staff in terms of completion. Some concerns have been raised in that the tool appears to score



differently to the risk assessments initially used and it has not been clear whether the tool should or should not be used for these already in the government defined vulnerable and extremely vulnerable categories.

Members of the Workforce team have made direct contact with all managers with staff identified within the BAME category to inform them of the importance of staff in this category completing the risk assessment. Good progress is being made and the Health Board is committed to building on this by working closely with representatives of the BAME workforce in order to consider how best to enable risk assessment and address any issues if there is reluctance from staff to complete. Where staff are unable to work in a patient facing area then wherever possible, home working or non-clinical area work is recommended with the aid of telemedicine, office 365 and other IT platforms. Some clinical staff have been able to contribute in other ways such as participating in Track and Trace functions from home or participating in Enquiry line working remotely.

FAQ's and Staff Helpline

The All Wales FAQ's have proved invaluable for staff and have been supplemented by the addition of some local FAQ's which have been developed in order to respond to questions raised by Health Board staff. The Workforce team have been an integral part of the Command Centre Enquiry Line and continue to support this initiative albeit remotely now as a physical presence in the hub is no longer necessary. Regular meetings take place with the three Staff Side leads (twice weekly) and Staff Partnership meetings also continue including meetings with the Local Negotiating Committee in respect of Medical staff.

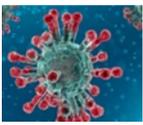
Workforce Indicators

It is evident that there has been a slight deterioration in sickness. Those absent due to short term self-isolation or shielding are recorded separately in ESR and not reflected in sickness absence figures. Regular communications are issued to reinforce the importance of accurate and timely recording of sickness absence.

PADR compliance rates are likely to be influenced by manager capacity to complete in light of the conflicting pressures of work associated with COVID-19 and possibly the availability of the employee if there has been absence due to sickness or self-isolation resulting in a postponement of PADR. It is perhaps not surprising that PADR rates have slightly deteriorated. We expect rates to start to improve again as we begin to return to more business as usual. Mandatory training has improved which is testament to the significant emphasis placed on improving mandatory training compliance and regular reporting of performance at review meetings with Directorates. For staff working at home or self-isolating this has also presented them with an opportunity to improve mandatory training compliance which seems to be reflected in the improved compliance rates.

Measure	Performance May 2019	Performance May 2020	Improvement/ Deterioration
PADR	77.90%	67.40%	Deterioration
Core Training	77.80%	82.70%	Improvement
Dementia	84.60%	86.60%	Improvement
Turnover Rate FTE (12m)	7.34%	7.94%	Deterioration
	April 2019	April 2020	
% of full time equivalent (FTE) days lost to sickness absence for rolling 12 month period	4.86%	5.29%	Deterioration
% of full time equivalent (FTE) days lost to sickness absence – in month	5.14%	6.24%	Deterioration

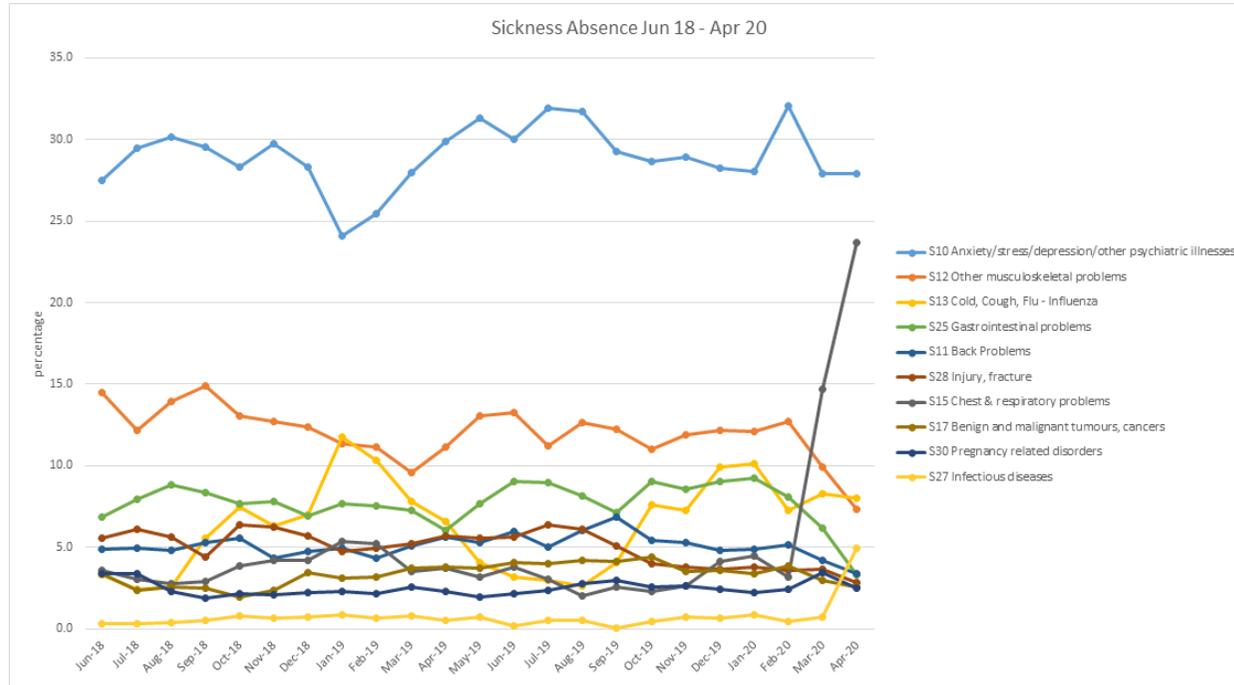
S10 Anxiety/stress/depression/other psychiatric illnesses remains the highest sickness absence reason 27.9% April 20 a reduction from the previous Apr when it was 29.9%



Covid-19

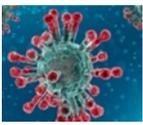
There have been significant increase in the reasons used for COVID absence

- S15 Chest & respiratory problems has increased substantially from 3.7% in Apr 19 to 23.7% in Apr 20
- S13 Cold, Cough, Flu – Influenza 6.6% to 8.0%
- S27 Infectious diseases 0.5% to 5.0%



Retirement age is the main reason for staff leaving the Health Board, followed by Voluntary Resignation – Other/Not Known, Relocation, Work Life Balance for both 12 months periods up to 31st May 2019 and 31st May 2020

Leaving Reason	May 2019	May 2020
Retirement Age	29.5%	28.7%
Voluntary Resignation - Other/Not Known	17.5%	19.6%
Voluntary Resignation - Relocation	12.1%	12.9%
Voluntary Resignation - Work Life Balance	9.6%	7.5%
Other	31.4%	31.2%



Training and Development

The Education team are still delivering induction on a virtual basis and are providing other development such as the bespoke Skills to Care training for HCSW's and the moving & handling training in locations and venues which have been adapted to ensure appropriate social distancing. Mandatory e-learning training level 1 which is normally completed at Induction is now being undertaken at home with the provision of dedicated telephone support. It is proposed that this will continue for the foreseeable future with ongoing support, ensuring checks are carried out on a regular basis.

Other Mandatory training such as, level 2/3 Safeguarding Adult/Children, Fire etc which is normally delivered face to face ceased at the time of the COVID outbreak although new ways of delivery are being examined in order that this can be resumed.

The learning & development department are working with the subject leads to develop a form of Virtual training for these levels alongside securing venues to allow for face to face training for staff who don't have access to IT equipment.

The availability of training venues has posed a challenge as the rooms have to be of a sufficient size to ensure that social distancing is achievable. Training is also being delivered for the redeployed RN's and new starters. This is being held once a month at present as the numbers have reduced although there is provision to escalate all the training should the demand arise. There is also provision to support venepuncture training and additional training has been provided in preparation for antibody testing.

In addition, training programmes are being developed in preparation for the re-commencement of elective surgery.

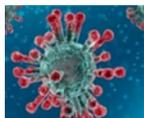
Workforce Planning

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. 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. 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.

Based on Nurse staffing levels assessed to date, and ward configurations it is likely that only a small proportion of our workforce will be able to transfer into the 200-500 surge beds required within our Community and Field hospitals. To understand the scale of our challenge, we have assessed our current workforce availability, and additional WTE need. Estimated workforce need:

- 162 registrants
- 337 HCSW
- 333 Facilities staff

Assessment of workforce availability:



We undertook a significant recruitment campaign and have been able to increase our workforce numbers overall since March 2020 by 912 WTE. Of these c175 WTE Student Nurses and c27 WTE Medical Students will return to academic study. From our new recruits, we anticipate losing approximately 25% from the 3 and 6 month recruits offered, reducing numbers by a further c177 WTE. This leaves us with approximately c532 WTE to continue to develop and retain across our HCSW and Facilities Teams.

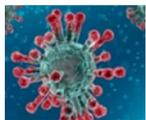
However, we know that we need to look specifically at our registrant workforce. Currently we can identify:

- 91 new nursing registrants who will qualify in September
- Approximately 20 new AHP's, HCS registrants who will qualify in September
- RN recruitment increased in April by c39 WTE (substantive 30 & bank 9)
- RN recruitment ongoing

In analysis of our contingent registrant workforce i.e. bank, agency and additional hours, we have seen a reduction of c30% since January 2020 to June 2020, approximately an equivalent of 200-250 WTE. However, it does provide some intelligence on which to focus our efforts. Further analysis is required going forward to assess the feasibility of these assumptions. To build on and develop our workforce, we are assessing a series of proposals to take forward. These measures have been included in the estimated demand set out above and currently include:

- Development of a "wrap around team" model and will include the development of new roles and ways of working and include a development pathway facilitated by:
 - Creation of 50-100 Band 4 (or Trainee AP) roles
 - Creation of 50-100 Band 3 roles
 - Creation of 50-100 Band 2 roles
 - a focus on developing key competences needed within our workforce i.e. venepuncture, cannulation as appropriate to context: setting, patient acuity
- Further expansion of higher level skills development in key areas i.e. Critical Care, Independent prescribing, ANP/Minor injuries.
- Creation of flexible and rapid response teams for anticipated critical needs at times of escalation
 - Creation of a "mortuary bank" of porters (c40) trained in core skills to support each county
 - Creation of a "rapid response team" cleaning & infection control team across counties for care home, schools, field hospitals etc
 - Creation of a county specific or wide approach to respond to critical escalation at key sites.
- Continue the development and embedding of alternative methodologies for remote working of clinical teams i.e. virtual wards, telephone triage, development of virtual "huddles" of remote workforces to respond to escalation/crisis.
- Consideration of developing a "volunteer" or reservist model with other agencies with skilled clinical staff i.e. Coastguard, Military, Private sector contractors etc.
- Development of a "designation" and "rotational" model for General, Community and Field Hospital deployment to maintain resilience and skills development to be able to flex the workforce at times of escalation.
- Consider the opportunities for a collaborative approach depending on need with local, bordering HB's i.e. Powys and Swansea Bay in relation to flexible and contingent models of workforce.
- Ongoing monitoring of our recruitment and contingent workforce usage alongside assessments of sickness absence, retention and potential retirees/leavers.

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.



In addition, schools reopening may present with an additional challenge of access to childcare facilities and may require an organisational response i.e. commissioning of staff focused facilities.

Postgraduate and undergraduate training

Newly qualified doctors and rotations of training doctors will be joining the Health Board at the end of July and beginning of August. Medical Students will begin their placements from the beginning of September. To ensure we continue to be a training Health Board, we will need to ensure we provide training in safe environments that adhere to the COVID 19 restrictions.

The Faculty will work to deliver Foundation and Royal College curricula for Postgraduate training and work closely with Cardiff and Swansea Medical School to deliver the Undergraduate requirements for each placement. In order to do this, a number of considerations and actions will need to be in place to deliver a hybrid approach:

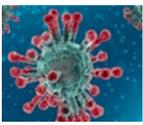
- Delivering remote teaching where social distancing cannot be met. Ensuring all junior doctors and Trainers have access to MS Teams to enable this
- Using virtual opportunities to deliver elements of curricula, ie use of virtual clinics and virtual ward rounds
- Designing clinical skills and simulation to be delivered to small numbers. Ensuring PPE and all safety aspects are taken into consideration. Investing in digital and technical equipment to provide access through remote viewing systems
- Work closely with Royal Colleges, HEIW, GMC and Medical Schools and other recognised bodies to deliver virtual teaching, building up a bank of recognised and approved teaching material
- Regular Junior Doctor Forum meetings to gauge the opinions of the Junior Doctors
- Regular feedback from Medical Students on placement
- To provide appropriate accommodation that safeguards juniors and medical students and can provide self-isolation when needed

Research and Development

Hywel Dda has been participating in national and international research studies as part of HCRW for many years. This enables the residents in the Hywel Dda area to benefit from early access to medications and treatments, as well as contribute to the development of new knowledge that will help others in the future. Research studies have occurred in most of the UHB clinical specialities.

Each acute hospital site has a research delivery team who, before the COVID pandemic, were actively recruiting patients into studies either whilst they were inpatients, or when attending outpatient clinics. During the COVID pandemic the focus of the research changed and many of the existing studies were paused to allow critical COVID research to take place. Now that the acute COVID phase has passed it is important that paused research studies are allowed to restart, and new studies are commenced.

It is recognised that, along with every other service, things will change with the Research and Development (R&D) team moving forwards. It is essential however that these changes are made in conjunction with the clinical services that the research supports. This requires a consideration of how patients will be enabled to participate in research while accessing health services in whatever mode is deemed most appropriate for that clinical service and that patient. This includes, but is not limited to, allowing space for a research nurse to attend an in-person outpatient clinic, enabling research staff to speak to patients about research during virtual clinics, facilitating access to clinic space out of normal working hours to enable research nurses to follow-up patients, and keeping R&D informed of any changes to services at different sites.



Support plans for Care Homes and Social Care Interface

It has been important that the Health Board Long-term Care Team recognise that whilst the COVID Pandemic has been happening, that life goes on in the Nursing Homes, residents are admitted, require general support from a multi-disciplinary team and will naturally pass away. In December 2019 a Care Home Collaborative was established to pull together, showcase and move forward as disciplines to establish a multi-disciplinary working group.

This collaborative has been developed as a multi-agency/multi-professional forum for colleagues who have a special interest in supporting the Independent Care Home Sector across the West Wales region. It has been established with the aim of drawing together a training and development support network covering many aspects of health and social care that residents require when choosing to live in a Care Home. The aims of the Collaborative are to:

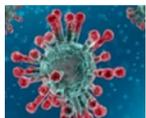
- Communicate and share best practice
- Work collaboratively with multi-disciplinary/Agency Teams
- Increase engagement with Care Homes in a coordinated way
- Seek external funding for training, research and development
- Seek ways of improving governance and standards of care
- Consider and endorse new training programmes
- Eliminate any overlaps in training provision
- Continually scope unmet need
- Problem solving and solution focussed
- To understand the needs of the Sector

The Health Board has a statutory responsibility to review all commissioned residents / patients within the private sector nursing homes. However, during the COVID-19 situation there has been a clear directive from Welsh Government and CIW that professional visits should be kept to a bare minimum. This has restricted the usual practice of the LTC Nurses visiting the homes to undertake a holistic review of the residents care. A shortened version of the review form has therefore been developed and the information gathered over the phone with the home. This process works alongside the daily calls as outlined below

Over this period we have worked closely with the Sector and have recognised the volume of correspondence, phone calls and skype meetings they are expected to be involved with. In order to work more efficiently and to help Nursing Homes in a more manageable, organised manner, the review procedure is set to pick up pace with a newly developed process being launched for consultation with the Nursing Homes from Monday 29th with roll out planned for 6th July. The process is described below

Reviews/Assessments during COVID-19 – For Care Homes

A weekly Skype Review Meeting with your allocated Long term care Specialist Nurses will be arranged. As much as possible the weekly call will remain on the same day and at the same time each week.



The aim is to reduce the number of phone calls homes received each week and provide a structured approach for the reviews which need to be undertaken. Where two Long Term Care Specialist Nurses are allocated to your home both will join the Skype call if available. The Skype call should last up to an hour. A number of residents will be reviewed during each weekly Skype review meeting.

The Nursing Home will be informed each week of the reviews that will be completed the following week. The Agenda for the Weekly Skype Review Meeting will be as follows

- Each of the residents being reviewed will be discussed in turn.
- A brief summary of needs from the last review or completed Assessment for each resident will be discussed
- Next of Kin details will be checked to ensure they have not changed.
- The home will be asked if needs have changed from the summary, including needs relating to the domain of behaviour, and whether physical causes for this change have been ruled out.
- If changes have occurred, what referrals were made to the wider MDT, dates of referrals, assessments, treatment and outcome.
- Any changes to skin integrity, moisture damage or pressure damage has been recorded on the weekly return to the health board.
- Current prescribed medications & compliance
- Record of GP visits & hospital admissions/attendances during review period, including dates, reasons and treatment.
- Current weight
- Any concerns regarding the individual resident being reviewed.
- Next of kin of residents will then be contacted by the Long Term Care Specialist Nurse. Should any feedback from this contact need to be discussed a call will be made outside of this review meeting
- After discussing the residents being reviewed; the home will then be asked if they have any other concerns, queries or comments which the Team can assist with.

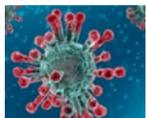
Professional Multi-disciplinary Team Meetings in Outbreak situations

Over the COVID 19 period, it has been important to maintain multi-disciplinary communication to ensure that residents within Care Homes have been adequately monitored and supported. LA partners have arranged meetings for all homes where there has been a COVID outbreak in order to cover the following.

- Establish the Known Facts on the COVID-19 Infections & Staffing
- Infection Prevention & Control measures in place
- Guidance and Advice provided
- Communication and Engagement of the care home
- GP and Community Nursing visits and contact

Manager/Matron Meetings

During the COVID 19 period, the Senior Nurse for Nursing Home Governance has facilitated a weekly, initially, and now bi-weekly, Nursing Home Managers 'Get-together' using Skype. 28 Nursing homes in the Health Board were invited with an agenda that covered issues such as PPE use of and availability, COVID testing, red and green zones, end of life visiting, CPR, verification of life extinct. More importantly, Nursing Home Managers have had the opportunity to talk to each other, share experiences and again give valuable advice and support. The feedback from the homes has been extremely positive and all attendees agree that they wish for this to continue for the foreseeable future.



Daily Care Home Support (Nursing Homes)

The Daily Care Home Support and Monitoring contact covers the three Counties within Hywel Dda, Carmarthenshire, Pembrokeshire and Ceredigion. There are 29 Care Homes across the Counties that Hywel Dda LTC commission care from. During the early stages of the Pandemic phone contact was established with each care home every day.

Developing trusting relationships with staff, listening and advocating shared learning. This interaction provided reassurance that there was a professional link that they could contact during the height of uncertainty. To maintain a governance overview, daily information was gathered on care home activity such as:

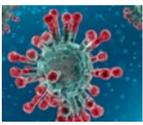
- Bed vacancy & admission/discharge details
- Residents with COVID 19 suspected cases &/confirmed cases & barrier nursing levels.
- Staff with COVID 19 suspected case & /confirmed cases & self-isolation/Shielding
- Staff sickness levels unrelated to COVID 19
- Staffing levels and Agency use
- PPE levels
- Safeguarding
- Staff comments & narrative

Social Care Resilience

The above has been delivered in conjunction with Local Authority partners recognising the complex and changing needs of residents across residential and nursing homes. As outlined in the Primary Care and Community section above, we have adopted an exemplar integrated approach to managing the risks associated with both care homes and domiciliary care provision specifically in relation to COVID-19. A Risk and Escalation Management Policy for Care Homes was developed in Quarter 1. and a policy for domiciliary care is nearing completion (embedded above).

The process associated with these Policies was instrumental in our multi agency management of increasing risks associated with Care Home outbreaks across our Health Board footprint. As part of this management process, daily escalation reporting was established with stakeholders across local authority, health, voluntary and independent sector advising on their level of risk and joint consideration of need for escalation and the implementation of multi agency / multi disciplinary mitigating actions. The daily reporting contributes to a whole system sitrep which provides oversight of 'heat' in each of our County Systems across primary care, community and acute settings. This joint ownership of System Risk and associated mitigating actions has allowed a mutual appreciation across all components of the System of the fragility of our services. It is anticipated that this will continue to ensure we optimise capacity across our system through effective management / use of services and appropriate use of surge capacity identified above.

For further information to support this section, please see documents embedded on page 18



Financial Implications

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, both the gross and net (costs exceeding available funding). WG have provided a monitoring template which is a monthly reporting requirement for 2020/21. The recording and reporting mechanisms that are implemented locally will need to be designed to fulfil this requirement as well as any further internal requirements.

The high level principles are expected to be relatively fixed, subject to material changes in guidance from WG. The methodology of delivering the reported output however, is expected to evolve and be refined, especially in the first quarter of the year. This is due to the pace at which the organisation has needed to respond to COVID-19 and the fluidity of plans as the situation progresses.

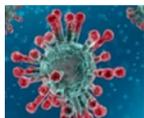
Key Assumptions

- The clinical model is undergoing refinement to reflect the latest demand modelling scenarios and costings are therefore subject to change.
- A level of WG funding has been received for Quarter 1. However, no WG funding is assumed beyond Quarter 1, in line with WG guidelines.

Field Hospitals

The profiling is based on local modelling assuming the $R_t = 1.1$, as the most realistic 'worst case' scenario, when compared to the current actual numbers of COVID-19 patients. The demand model forecast might also be subject to change based on the local assessment of the likely impact of revised WG guidelines in respect of relaxing 'lock down'. Applying local intelligence extends the Health Board's forecast to the end of March 2021.

- Set up costs for Pembrokeshire and Ceredigion County have been confirmed and recognised in Month 3, however Carmarthenshire costs are not yet confirmed. An estimate of £3.3m has been assumed in Month 4, based on Local Authority Plans.
- Staff costs have been modelled on a substantive cost basis - no premium for Agency workers has been built in. An assessment of whether this model could be fulfilled by the market has not yet been completed, but this is a key risk;
- Staffing ratios assumed in the model could be subject to change should the need arise;
- Non pay costs are based on a Carmarthenshire model of 750 beds scaled up or down where specific site details are not yet known;
- Drugs cost assumption is based on a respiratory ward and does not necessarily reflect the cost of a COVID-19 acuity ward;
- All capital costs and contractually committed costs (i.e licences to operate and associated running costs such as rates) are considered to be sunk costs. If notice were served on Bluestone, it is assumed that it would take 4 months to complete restoration works;
- The planning assumptions are that the Design, Build and restoration costs are being treated as revenue as there will be no long term assets involved;
- In line with discussions at the Capital Review Meetings with WG, the Health Board has currently capitalised the initial equipping of the Field Hospitals in the same way as it would normally capitalise the initial equipping of a new or refurbished ward. The cost of oxygen is also currently listed as a capital cost. Most of the items capitalised will have a use on the acute sites following the pandemic.
- The impact of 2m social distancing in ward areas reduces existing acute capacity by 192 beds. The Field Hospital staffing model is predicated on the assumption that staff can be released from existing sites based on this 192 bed reduction.



Existing Acute Sites

- The latest HR recruitment tracker has been used as the basis for forecasting purposes. The demand requirement as per the HR demand tracker has been used from Month 4 onwards, following validation to Month 3 actual posts. The assumption in the model is that the fixed term cohort will be extended to March 2021 in line with demand.
- Currently the phased restating of some Planned Care activity continues to be discussed. At this moment there is insufficient detail available to cost this accurately, however a return to some level of activity is assumed from Month 5.
- The model assumes that plans are implemented to enable the operationalisation of additional bed capacity at Tregaron (8 beds) South Pembrokeshire Hospital (25 beds) for utilisation at 7 days notice from the middle of July if needed.
- Any bank and agency staff used in May are assumed to continue for the remainder of the year.
- The general position continues to be fluid across a number of staff groups, our working assumptions are being clarified and confirmed as/when decisions are made.
- The impact of the recent Medical and Dental circular regarding out of hours enhanced payments has been costed where the rota impact is known. However, a minimum of 50% of the rotas are **omitted** from the forecast, as the additionality has not yet been validated and quantified.
- Some A4C working areas have amended working patterns to ensure safety in the workplace is maintained. It is not clear if there is a significant financial impact to these changes.
- Non-Pay: The forecast is based on the actual costs incurred in Month 2, less any known non-recurring expenditure. Other specific non pay costs have also been included:
 - Transportation: additional cost of commuting and the continued use of the winter pressures vehicle has been included.
 - Accommodation: any known additional accommodation costs in terms of hotel costs for staff are included.
 - Additional drugs costs: these costs relate primarily to home care drugs where specific information has been provided.

Savings

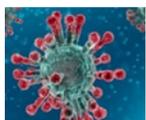
- The non-delivery of the majority of our savings plans for the current anticipated duration of the outbreak.

Contracting

- Includes assessment of the impact of lost NCA income, NCA and English Provider expenditure, loss of over-performance typically achieved in Central Income. WHSSC slippage recognised in Q1 has not been extended as this is not yet confirmed.

Primary Care

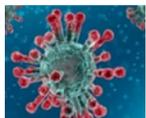
- 'Additional costs in Primary Care':
 - Detailed guidance is awaited from WG to understand how any variation from contract rules is to be treated (with the exception of GDS below);
 - Assumptions for the Dental GDS contract costs have been reduced in line with guidance from WG. This is offset by the recognition of the reduction in dental contract income.
- Accounting treatment of Community Pharmacy increase in dispensing requires input from WG



	MONTH 4		MONTH 5		MONTH 6	
	Existing Sites	Field Hospitals	Existing Sites	Field Hospitals	Existing Sites	Field Hospitals
	£'000	£'000	£'000	£'000	£'000	£'000
Drugs	327	132	282	160	292	171
Equipment costs	161	43	161	43	161	43
Rent	150	700	150	700	150	700
Utility costs	-	62	-	64	-	64
Estates/Security costs	43	115	43	115	43	115
Set up costs (Carmarthenshire)	-	3,300	-	-	-	-
Catering costs	-	130	-	143	-	149
CHC	241	-	241	-	241	-
M&SE consumables	210	44	210	53	210	57
Testing Centres	221	-	221	-	215	-
PPE	81	20	81	24	81	26
Primary Care (net impact)	(148)	-	(148)	-	(148)	-
Commissioning	429	-	429	-	429	-
Lost income	299	-	299	-	299	-
Other	45	77	45	88	45	93
NON PAY	2,059	4,623	2,014	1,390	2,018	1,418
Prof Scientific and Technical	34	-	34	-	34	-
Additional Clinical Support	472	56	381	156	451	197
Healthcare Scientists	8	-	8	-	8	-
Allied Health Professionals	70	248	70	297	70	318
Admin and Clerical	42	67	42	74	42	77
Estates and Ancillary	806	37	715	82	794	103
Medical and Dental	553	17	553	21	553	22
Nursing	1,144	48	1,144	123	1,144	155
PAY	3,129	473	2,947	753	3,096	872
COST REDUCTIONS	(1,750)	-	-	-	-	-
NON-DELIVERY OF SAVINGS	2,565	-	2,433	-	2,672	-
TOTAL	6,003	1,796	7,394	2,143	7,786	2,290
		11,099		9,537		10,076

Approval in July 2020

This



CAPTIAL

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

Expenditure	£m
All Wales Capital Programme	12.503
Discretionary Programme	7.271
Slippage due to COVID- 19 from 2019/20	1.090
COVID-19 – Digital Devices	0.743
Total	21.607

There is also an allocation pending of Advance Fire Compliance works at Withybush General Hospital: £0.350m

No additional capital funding has currently been assumed for 2020/21 for COVID-19 issues or other developments. However if all of the Health Board expenditure plans are delivered in year and no additional funding is available this will lead to a shortfall of £15.076m against the 2020/21 Capital Resource Limit. The value of capital orders placed by the Health Board to date on COVID-19-associated items which is expected to impact on the 2020/21 position is £9.960m. Further potential costs of £5.857m have been identified as costs that may need to be incurred to deal with the impact of the lockdown and the re-opening of services.

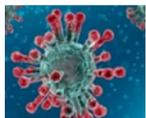
Expenditure	Value Orders placed £m	Potential/ Anticipated Expenditure	Potential Costs 2020/21 £m
Field Hospitals	3.814	0.646	4.459
Acute and Community Sites	6.147	5.211	11.359
Total	9.960	5.857	15.818

The potential/anticipated costs reflect costs that will be incurred on:

- Time delay due to COVID-19 planning and social distancing legislation on Women & Children Scheme in Glangwili.
- Costs of Vacuum Insulated Evaporator (VIE) plant in Glangwili should this progress.
- Works to Intensive Care Unit (ICU) on all sites, if all works are undertaken.
- Works to side rooms and Accident and Emergency in Glangwili, if the work is undertaken.
- Cardiology equipment to enable community working, if the equipment is procured.

The detailed information on the additional costs on the Women & Children Scheme in Glangwili is being shared with NHS Wales Shared Services Partnership: Specialist Estates Services on a weekly basis. The other schemes are being considered at the Bronze Groups for suitability and will require Gold Strategic Group approval and a funding source identified prior to being progressed.

The fact that WG will not be able to progress funding for capital schemes in development in-year, will potentially delay the ability to progress schemes such as Transforming Mental Health and Aseptic Services and deal with issues such as Fire Enforcement Notices.



Risks to Delivery and Mitigations

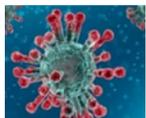
The main principle of risk management is that it adds value to the organisation, by helping it to achieve the best possible outcome and to reduce the uncertainty of outcomes.

Risks to delivery of the Quarter 2 plan have been identified and assessed throughout the development and formation of the plan.

In Quarter 2, the Quality, Safety and Experience Assurance Committee to continue to gain assurance on the quality and safety impact of COVID risks (and risks identified in respect of minimising harm from the reduction in non-COVID activity).

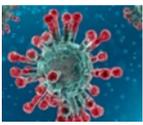
Strategic Risks

Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
Corporate level risks				
Registered Nurse Staffing Constraints impacting ability surge and open services <ul style="list-style-type: none"> There is a risk that patients will come to harm from reduced NHS services. This is caused by 126 WTE nursing vacancies This could lead to a significant reduction in the range of services we can provide at Prince Philip and the ability to open surge capacity 	<ul style="list-style-type: none"> Daily staffing review Recruitment adverts out Bank and agency to fill vacant shifts 	20	<ul style="list-style-type: none"> UHB recruitment campaign Increased HCSWs and Band 4 recruitment Long term contract agency 	12
Estate Capacity Challenges from complying with Social Distancing Measures <ul style="list-style-type: none"> There is a risk that patients will come to harm from reduced NHS services. This is caused by significant increase in estate requirements due to social distancing and requirements needed to ensure safe services This will lead to a significant reduction in the range of pre-COVID services that can be re-established and a reduction of 44 beds going into the winter period. 	<ul style="list-style-type: none"> A review of all ward areas for 2m space isolation Estates costed enabling works 2m space isolation not being met currently 	20	<ul style="list-style-type: none"> Capital approval to commence works Identifying capacity in Field Hospitals, community and independent sector 	8



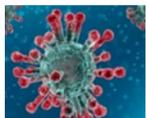
Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
<p>Delayed discharge There is a risk that patients will stay longer in hospital and increased risk of HAI as they cannot be discharged in a timely manner. This will lead to front door being blocked, cancelled operations and use of surge areas which cannot be appropriately staffed.</p>	<ul style="list-style-type: none"> DLN's supported discharge Medically fit meeting to review all patients 	20	<ul style="list-style-type: none"> Review medically fit meeting with senior decision makers to progress the most complex patients 	12
<p>Ability to effectively workforce plan during and after COVID 19.</p> <ul style="list-style-type: none"> There is a risk to Organisational capability and reputation if we are not able to effectively workforce plan and identify the workforce needs across the whole UHB system. This is caused by the unpredictability of the service changes required to manage the pandemic as it progresses which requires workforce planning agility and development of the requisite agility within the workforce. This will lead to difficulties in capacity and capability, from an overall workforce perspective, to be able to respond to the number of possible scenarios which may present. An example of this is the Field Hospital Operations Team and Sites i.e. current operational workforce challenges and wider system implications are presenting. 	<ul style="list-style-type: none"> Workforce Planning Task and Finish Group established 3 June 2020. 	16	<ul style="list-style-type: none"> Agree organisational wide scenarios to test workforce availability. Test modelling scenarios with planning cell. Develop workforce plans based on agreed scenarios. Develop consistent framework for organisational wide WFP including a profiling methods of our COVID & NON COVID workforce. Create agile methods for workforce movement/development & implement workforce plans. Creation of a recruitment plan based on assessment of gaps from above analysis. Enable capacity and capability in WFP. 	4

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Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
<p>Staff who are risk assessed as being on one of the vulnerable groups including BAME staff.</p> <ul style="list-style-type: none"> • There is a risk that the workforce will be depleted due to large numbers of staff having to work in alternative roles, shield, work from home or in non-clinical roles due to underlying medical conditions, pregnancy or ethnicity. • This is caused by the government guidance in relation to assessing those who are unable to work in patient facing roles or COVID areas due to their underlying medical condition, pregnancy or ethnicity. • This will lead to an effect on our ability to provide enough staff to staff our current rotas and inpatient beds along with our ability to surge our capacity into field hospitals if required. 	<ul style="list-style-type: none"> • Risk assessments for those in vulnerable category being undertaken and managers required to review these at regular intervals. • Home-working options, telemedicine and staff deployment options are available. • FAQs developed and updated so staff and managers are made aware of what is required. 	16	<ul style="list-style-type: none"> • Ensure risk assessments are regularly reviewed. • Ensure reviewed governance guidance is communicated and FAQs updated. • PPE when required to offer additional protection is available. • Workforce contacting managers with staff in the BAME group to ensure that appropriate risk assessments are being undertaken for this staff group 	12

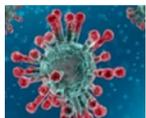
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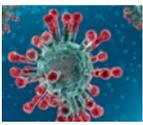
Other risks

These risks will be monitored through the Bronze Groups of our Command and Control Structure, with assurance on deliver of the plan and management of the risks reported to the People, Planning and Performance Assurance Committee (PPPAC). Significant risks to delivery will be escalated by the relevant Director to the Corporate Risk Register for oversight by PPPAC and Board.

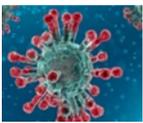
Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
Workforce				
<p>Appropriate response during and after COVID-19 for Staff Psychological Well Being Service.</p> <ul style="list-style-type: none"> There is a risk to the Organisational reputation if staff are felt to be not able to access appropriate levels of Staff Psychological Well Being Services during the crisis, and that a gap of appropriate service provision could exacerbate the likelihood of staff suffering Post Traumatic Stress Disorder (PTSD) in the future. The risk is driven by the unpredictability of the severity, pace and the impact of the pandemic on staff as it progresses. This could lead to difficulties in staff recruitment and retention in the future and potential exposure to litigation claims from any staff considered to be suffering from PTSD. 	<ul style="list-style-type: none"> Staff Psychological Well Being Plan is in place and reviewed monthly to ensure appropriate response is available to support staff and reflect the 'phase' of COVID-19. Employee Assistance Programme set up with Care First to provide 24/7 cover and complement in house Staff Psychological Well Being Service. Coaching provision for Executives, Triumvirate Leaders, Assistant Directors, has been made available. 	9	<ul style="list-style-type: none"> The Staff Psychological Well Being Plan is implemented in the appropriate stages as set out following the monthly reviews set out in Control Measures. Progression Plan for Rightsizing Staff Psychological Well Being Service to be implemented to ensure appropriate long-term trauma response is in place. 	4
<p>Lack of trainers and insufficient training to prepare new staff due to COVID.</p> <ul style="list-style-type: none"> There is a risk of not being able to deliver the required training to new recruits, therefore staff will be inadequately prepared for their role. This is caused by an increase in demand for training provision due to the increased 	<ul style="list-style-type: none"> Delivered increased Skills2Care programmes in each county every week to increased numbers to ensure appropriate training available to new staff to reduce the risk of them being ready for work. Classroom numbers were increased and live streaming facilities were made available in a different venue with larger 	9	<ul style="list-style-type: none"> Continue to offer training but in larger venues to ensure availability of training to adequately prepare staff for work. Identify the training required for registered nurse redeployment and the amount of courses required in order to maintain 	4



Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
<p>recruitment and the need to deliver training to new and substantive staff in line with social distancing guidelines.</p> <ul style="list-style-type: none"> This will lead to an impact/effect on lack of knowledge and support for new staff in post which will effect patient safety and the quality of patient experience. 	<p>rooms to support more training and to ensure social distancing.</p> <ul style="list-style-type: none"> Increased availability of training to weekly courses in each county to enable higher number of staff through training to ensure readiness to work. Organised additional training for Registered nurses redeployment, venepuncture and cannulation, Verification of death for the new recruits in different venues to larger audiences to ensure quality of training suitable and available. 		<p>provision. There is a meeting to discuss this provision and to provide this training on a monthly or bi monthly basis in order to prepare for times of excessive pressures.</p> <ul style="list-style-type: none"> Identification of venues and appropriate level of need per county as rooms large enough required to support social distancing. 	
<p>Mass Recruitment to support increased demand associated with COVID-19</p> <ul style="list-style-type: none"> There is a risk of some of the c.1000 new employees having a lower level of knowledge, skills and experience and potential issues arising linked to their conduct than we would typically expect of a workforce recruited via our established processes. This is caused by the way in which the Health Board needed to recruit a large volume of additional staff in a short space of time by risk assessing the need for pre-employment checks prior to day 1, the method of recruitment and the shortened induction/training programme. This will lead to an impact/effect on patient safety and quality of patient experience. 	<ul style="list-style-type: none"> Telephone Interviews were conducted to an agreed script by 'Interviewers' who had been briefed on the process to be followed. A declaration was required for health issues, previous employment with the Health Board and criminal record. The questions included in the script were considered to be a control measures to minimise the potential impact of appointing candidates inappropriately. Candidates completed a full application form on-line which is recorded on TRAC. Employment history and Qualifications are recorded. A declaration was required for DBS at application stage. An agreed set of pre-employment checks were risk assessed as being acceptable for completion on Day 1 in employment. 	9	<ul style="list-style-type: none"> Ensure all DBS checks are completed as soon as reasonably practicable following offer of employment. Ensure all positive disclosures of DBS are escalated as soon as reasonably practicable to managers to complete a risk assessment as to whether employment should continue. Ensure appropriate 'local induction to role' is provided to all new starters. Audit completion rates of mandatory/statutory training. Revisit content of Skills to Care Training to ascertain if further training can be provided to bridge the gap between what the 	4

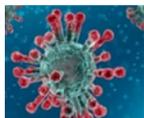


Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
	<ul style="list-style-type: none"> A corporate induction booklet was produced. E-learning of essential training modules were completed. Face to face manual handling and skills to care training was completed for those posts where this was considered necessary. A fast track method is available, using a fair process, to exit new starters who are subsequently found to have capability or conduct concerns. 		<p>standard training package is and the scaled back content needed for the mass recruitment.</p>	
<p>Availability of workforce to support increased demand and need for agile workforce availability associated with COVID-19.</p> <ul style="list-style-type: none"> There is a risk the additional workforce appointed via a mass recruitment campaign in March 2020 will terminate their contracts of employment at the contract end date of 3 months and 6 months. A number of those appointed were only interested in short term appointments as they were students expecting to return to full time academic studies or individuals who were furloughed from their current employer and intend to return to work for that employer when lockdown measures are relaxed. This is caused by the fact that the Health Board issued temporary contracts of employment which will attract those looking for temporary employment and those who accepted those contracts may not be interested in longer term employment. 	<ul style="list-style-type: none"> A number of appointments were made to bank only contracts of engagement. This pool of staff can be called upon to meet service needs as and when required. An option exists to extend temporary contracts if service needs dictate that the workforce is still required. There will be some individuals who may be happy to extend. 	12	<ul style="list-style-type: none"> Complete an exercise to contact all new recruits offered temporary 3 month contracts to confirm their intentions at the contract end date. Complete an exercise to contact all new recruits offered temporary 6 month contracts to confirm their intentions at the contract end date. Regularly review outcomes from the Workforce Planning Task and Finish Group to inform the need for future recruitment campaigns to ensure adequate supply in key roles. Offer extensions to contracts of employment IF service needs dictate supply is required. Review availability of Bank/Agency supply. 	6



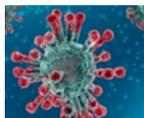
Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
<ul style="list-style-type: none"> This will lead to an impact/effect on there being insufficient staff to care for patients and lead to unsafe staffing levels. 			<ul style="list-style-type: none"> Review the registrants who entered the temporary register to ascertain interest in joining Hywel Dda. Review candidates expressing an interest in joining Hywel Dda via the NHS Wales Hub. Review scope to secure appointments into permanent posts in the budgeted establishment for the HCSW and Facilities staff appointed to temporary contracts. 	
Cancer Services				
<p>There is a risk due to the Tertiary (specialist) centre capacity pressures at Swansea Bay University Health Board (SBUHB), which continue to significantly compromise a number of cancer pathways, and significantly compromise performance of the Cancer Waiting Times targets and the SCP.</p>	<ul style="list-style-type: none"> We are continuing to escalate our concerns regarding tertiary centre capacity and associated delays; Due to all Tertiary Gynaecology surgery in SBUHB being initially suspended, the Heath Board arranged for the Consultant Gynaecology Oncological Surgeon at SBUHB to provide outreach surgery within UHB to help address delays for surgery 	12	<ul style="list-style-type: none"> SBUHB need to address their backlog to ensure that treatments can be carried out in a timely manner. 	6

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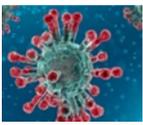


Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
<p>There is a risk due to only urgent endoscopy investigations being carried out during COVID 19. This was due to the majority of endoscopic diagnostic investigations being aerosol generated tests. This has caused delay to a number of patient cancer pathways.</p>	<ul style="list-style-type: none"> • CT Colonoscopy has been replaced with CT Abdomen. • As per the Wales Bowel Cancer Initiative, the use of FIT10 screening in the management of USC patients on a colorectal pathway during the COVID pandemic has been introduced for the early detection of cancer. • Bronchoscopy services have been reinstated in Prince Philip. • Endoscopy services have been reinstated in Prince Philip. 	12	<ul style="list-style-type: none"> • The health board are reinstating endoscopy services for cancer patients across all sites. This is being carried out via a phased approach with the other hospital sites following Prince Philip at the end of June 2020. This is pending completion of logistical changes to Red/Green zones. 	6
<p>There is a risk due to Cancer elective surgery having been cancelled as per Royal College Guidance. This has delayed cancer surgery for certain tumour sites, which has caused a delay in the patient pathways and the patient being treated within target.</p>	<ul style="list-style-type: none"> • Continued to provide the majority of elective cancer surgery. In line with the NHS recommendation principles to provide a COVID 19 free hub, identified Werndale Hospital as a dedicated elective cancer operating site, operational as of 14th April. • There are limitations to the Werndale plan where they are unable to accommodate those patients who require HDU/ITU support post operatively and there are further restrictions in that there is a clinical criterion that applies e.g those patients whose BMI exceeds 35 and having existing co-morbidities. • Plans are being developed to reintroduce elective cancer care for those patients who do not meet the criteria for Werndale Hospital or require HDU/ITU support on the Glangwili site. This plan commenced during April 2020 with one weekly 	12	<ul style="list-style-type: none"> • Proposals to reinstate cancer surgery on our acute sites from 29th June 2020 are currently being developed, in accordance with the WG Operating Framework. This will necessitate the provision of dedicated green elective surgery zones within each hospital site, with green ITU/HDU support. 	6

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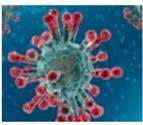


Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
	Thursday and one fortnightly Tuesday operating lists reinstated at Glangwili.			
Prior to COVID 19 there was a risk with regards to the wait for Radiology investigations and reporting, which caused delays to patient pathways.	<ul style="list-style-type: none"> Currently, USC and Urgent imaging requests continue to be carried out, within the parameters offered by national clinical guidance for certain aerosol generating procedures. CT Colonography investigations currently cannot be undertaken. These have been changed to CT abdomen as per national guidance. Reinstating this investigation is being discussed, but would severely limit radiology capacity at this stage. 	12	<ul style="list-style-type: none"> In accordance with planning for restart and recovery, diagnostic capacity will be prioritised for urgent and cancer referrals. As pathways for routine elective work are not expected to recommence before Quarter 2 we anticipate that the prioritisation of diagnostic capacity for cancer referrals will improve diagnostic turnaround times compared to the pre COVID-19 pandemic. Planning of diagnostic capacity for the reactivation phase is subject to further evaluation considered as part of Quarter 2 plans. 	6
Postgraduate Education				
The social distancing impact on the delivery of teaching, clinical skills and core/departmental inductions & sufficient Residential Accommodation	<ul style="list-style-type: none"> Remote solutions agreed across sites/Directorates The Faculty will work to deliver Foundation and Royal College curricula for Postgraduate training and work closely with Cardiff and Swansea Medical School to deliver the Undergraduate requirements for each placement. In order to do this, a number of considerations and actions will need to be in place to deliver a hybrid approach: Delivering remote teaching where social distancing cannot be met. Ensuring all 	9	Working closely with faculties and HEIW to monitor and adjust teaching arrangements.	4



Risk Description	What is already in place	Current level of Risk (LxI=RS)	What needs to be done:	Target level of Risk (LxI=RS)
	<p>junior doctors and Trainers have access to MS Teams to enable this</p> <ul style="list-style-type: none"> • Using virtual opportunities to deliver elements of curricula, ie use of virtual clinics and virtual ward rounds • Designing clinical skills and simulation to be delivered to small numbers. Ensuring PPE and all safety aspects are taken into consideration. Investing in digital and technical equipment to provide access through remote viewing systems • Work closely with Royal Colleges, HEIW, GMC and Medical Schools and other recognised bodies to deliver virtual teaching, building up a bank of recognised and approved teaching material • Regular Junior Doctor Forum meetings to gauge the opinions of the Junior Doctors • Regular feedback from Medical Students on placement 			

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Mechanisms for Stakeholder Engagement, Including staff side and Community Health Councils

CHC

- Sharing of Service Change Log with CHC
- Service Planning Committee
- Attendance at Board Seminar

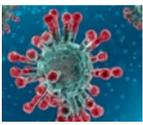
Public

- Production of videos e.g. cancer services
- Press releases highlighting services and asking patients to come forward
- Linking with National Campaigns e.g. Imms and Vaccs

Staff side

- The Workforce team have been an integral part of the Command Centre Enquiry Line and continue to support this initiative albeit remotely now as a physical presence in the hub is no longer necessary.
- Regular meetings take place with the three Staff Side leads (twice weekly) and Staff Partnership meetings also continue including meetings with the Local Negotiating Committee in respect of Medical staff.
- Wellbeing resources
- Global communiques

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Monitoring

Performance

In light of the Welsh Government's reduced performance management requirements and to free up staff time to focus on the COVID-19 pandemic, changes have been made to our monthly performance monitoring / reporting:

- **April** – data was collated and monitored for most performance indicators. An email brief was provided for the Director of Planning, Performance, Informatics and Commissioning to highlight changes in performance for the key deliverable indicators for which data was available along with a summary for which indicators data was not available.
- **May** – Integrated Performance Assurance Report (IPAR) provided but with reduced narrative focused primarily around unscheduled care, cancer, eye care, childhood immunisations and finance. An additional section was also added to explain how COVID-19 had affected the Hywel Dda population, our hospitals and support for staff in April 2020. We continued to collect and monitor data for the large majority of indicators with the exception of stroke and substance misuse; service leads were able to provide assurance that the data would be made available for April and future months.
- **June** – a similar IPAR was produced as May but with an additional section added to explain where performance had been impacted by the pandemic (both positively and negatively), what changes has been made and our plans to reset/recover.

Available: <http://www.wales.nhs.uk/sitesplus/862/page/99899/>

In quarter two an additional section will be added to the IPAR to track our compliance with the essential services framework.

Quality and Safety

The Key identified elements within the framework which considers Essential Services will be further monitored through the People, Planning and Performance Assurance Committee, and any quality concerns identified will be presented to the Quality Experience and Assurance Committee, any exceptions noted at these meetings would be escalated to Board. There are a number of operational quality meetings which are in place and these will continue, should a specific quality issue be identified at an operational level which relates to essential services then the associated Directorate management senior team will be asked to attend a Quality Panel, chaired by the Director of Nursing, Quality and Patient Experience to discuss and give assurance that any actions identified are being taken forward and will be asked to provide assurance of the monitoring arrangements that have been put in place.