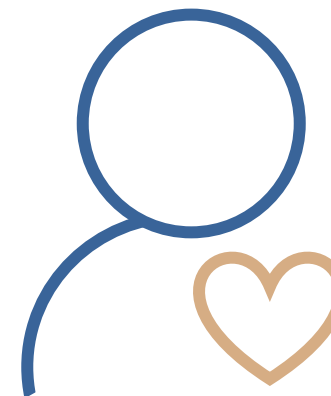


Performance update for Hywel Dda University Health Board as at 30th June 2020

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| COVID-19 impact | Essential services |
| Unscheduled care | Delayed transfers of care |
| Stroke and cancer | Planned care and therapies |
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Executive summary

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

| COVID-19 | | | |
|--|--|--|---|
| Confirmed COVID cases as at 30 th June 2020 | Suspected & confirmed COVID patients admitted 1 st -30 th June | Confirmed COVID patients discharged 1 st -30 th June | Confirmed COVID patients who died in one of our hospitals in June |
| 1,120 | 384 | 317 | 4 |

Non-COVID

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

- **Where are we meeting target?**
 - The percentage of non-urgent suspected cancer patients who commenced treatment within 31 days of referral has exceeded target (98.8%);
 - The 65% target was met for ambulances arriving within 8 minutes to calls for patients with life threatening conditions (71.3%);
 - Between January and March, 95.5% of babies had the recommended 3 doses of the '6 in 1' vaccine by their 1st birthday;
 - The 75% target was met for complaints receiving a final or interim reply within 30 working days;
 - 68.9% of stroke patients were admitted to a stroke unit within 4 hours in June 2020, compared to 64.4% in May;
 - In June, 95.1% of stroke patients were assessed within 24 hours by a specialist stroke consultant.
- **Where have improvements been made?**
 - 31 ambulance handovers were reported as taking longer than 1 hour during June 2020;
 - 84.3% of patients were seen within 4 hours in A&E/MIU (target 95%) and 113 patients spent longer than 12 hours (target 0);
 - The percentage of urgent suspected cancer patients who commenced treatment within 62 days of referral improved by 2.9% to 68.8% from the previous month but is significantly below the 95% target due to the impact of COVID 19;
 - 12 planned procedures were cancelled by us in May for non-clinical reasons;
 - Staff appraisals are 15% below target but a 3% improvement has been made from the previous month;
 - 83.5% of staff have completed their mandatory training;
 - There has been a 0.8% reduction in sickness absence between April (6.24%) and May (5.44%).
- **Where is improvement needed?**
 - The 12 month improvement target was not met for speech and language therapy for stroke patients, declining by 20% from the same month in 2019;
 - Performance in respect of the Single Cancer Pathway declined by 1% from the previous month;
 - Between January and March, 90% of children had 2 MMR doses by age 5;
 - 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;
 - Due to COVID-19, no medical job plan reviews have taken place since mid-March and compliance for consultants and SAS doctors to have a current job plan has declined to 58% (target 90%);
 - Reporting has been stood down until Sep'20 for of Non-mental health patients with delayed transfers of care. However, census day patient count for Mental Health has continued and saw 9 patients delayed in June '20. i.e. they were medically okay to leave hospital but needed another form of support in place for them to leave;
 - In June we reported 16 C.difficile infections, 17 E.coli infections and 7 S.aureus infections;
 - Although the number of patients waiting more than 8 weeks for a diagnostic test decreased from 7,669 in May to 7,293 in June 2020, this has increased from 115 in June 2019 due to the impact of COVID 19;
 - The number of patients waiting more than 14 weeks for a specific therapy increased from 1,528 in May to 1,613 in June;
 - There were 35,968 patients in June having a delayed follow up outpatient appointment;
 - The percentage of patients waiting less than 26 weeks from referral to treatment declined by 23% from the same month in 2019;
 - The number of patients waiting over 36 weeks from referral to treatment increased from 5,311 in May to 8,758 in June '20;
 - In May 22.8% of children/young people received a neurodevelopmental assessment within 26 weeks, declining by 20.4% from the same month in 2019;
 - In May 40.6% of adults waited less than 26 weeks for a psychological therapy, declining by 23% from the same month in 2019;
 - We have a financial plan with a year-end projected deficit of £25.0m. The current financial position at the end of June is £16.2m deficit against a deficit plan of £6.3m.
- **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.

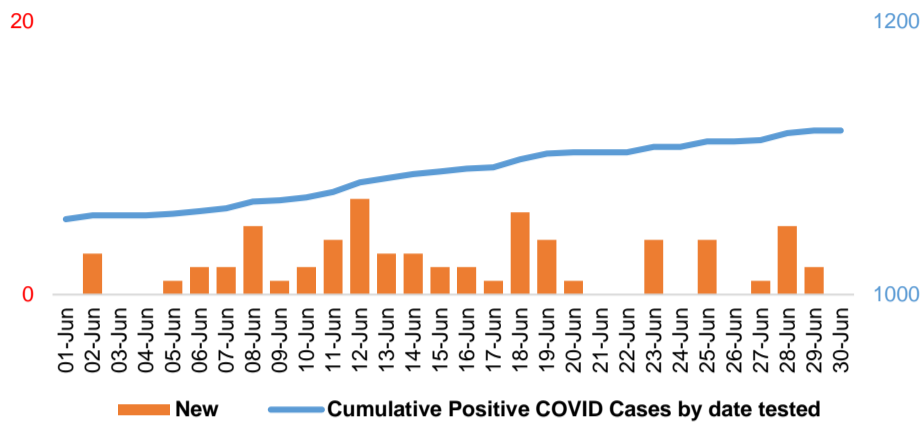


The COVID-19 pandemic has already had a massive impact on our staff and services and we expect that this will continue well into 2020/21. As an organisation we are rising to the challenge and we will do so for as long as is needed.

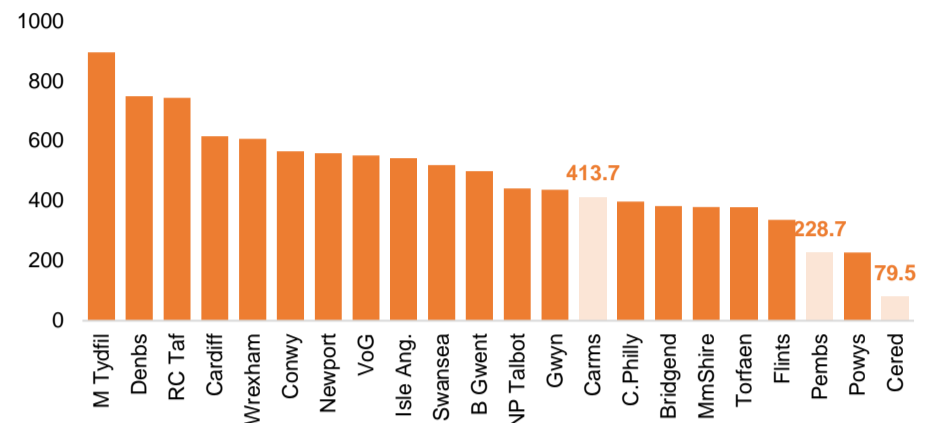
Confirmed cases

As at 30th June 2020, there were 1,120 confirmed cases of COVID-19 for Hywel Dda residents, an increase of 65 cases from 31st May 2020. The highest number of new positive cases tested was on 12th June with 7 new cases. Population rates for confirmed cases are seen to be lower in Hywel Dda than in many other local authority areas. On 30th June 2020, Ceredigion had the lowest local authority rate in Wales (79.5 per 100,000 population). It is important to note that the local authority rates may be skewed due to testing variation in each area and therefore should be used as a proxy.

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



Confirmed cases per 100,000 resident population



Supporting our staff

We have established a COVID command centre which is open from 8am to 5pm every day. Staff are able to contact the command centre by email or phone with all COVID related queries e.g. staff testing, personal protective equipment (PPE), wellbeing support. In June the command centre had on average, 85 calls per day from staff (1,808 in June overall). In addition, our Staff Psychological Wellbeing Service has changed the way they work to offer one to one support services to staff.

Personal Protective Equipment (PPE)

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

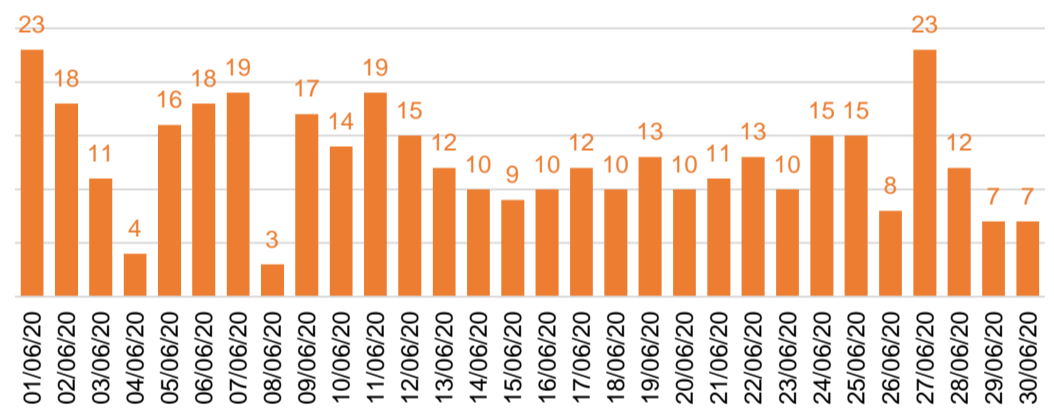
Admissions

Between the 1st and 30th June there were 384 COVID (confirmed and suspected*) admissions to our acute hospital sites; 26 in Bronglais General Hospital (BGH), 187 in Glangwili General Hospital (GGH), 43 in Prince Philip Hospital (PPH) and 128 in Withybush General Hospital (WGH). This is an average of 13 COVID admissions a day across the Health Board and approximately 13.5% of all inpatient admissions. Non-COVID inpatient admissions averaged 82 per day over the same period.

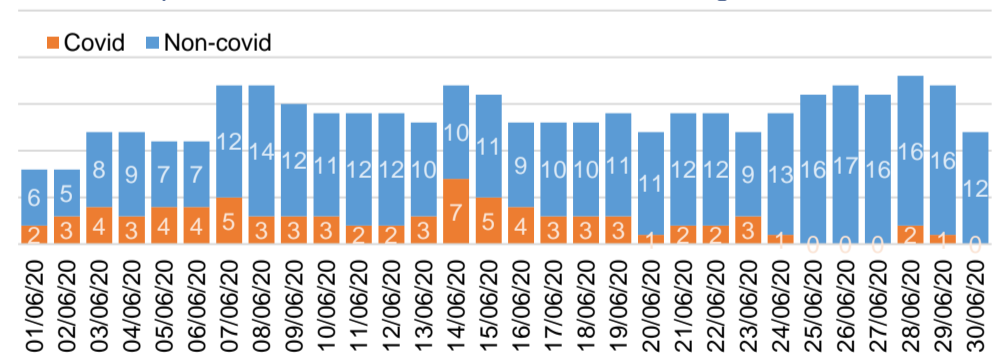
We have worked hard over the last 3 months to create 9 field hospitals across Hywel Dda. These new sites offer important flexibility for us to care for additional patients if the demand for acute hospital capacity exceeds threshold levels. Carmarthen Leisure Centre is now partially operational with 24 open beds to support non-COVID patients.

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

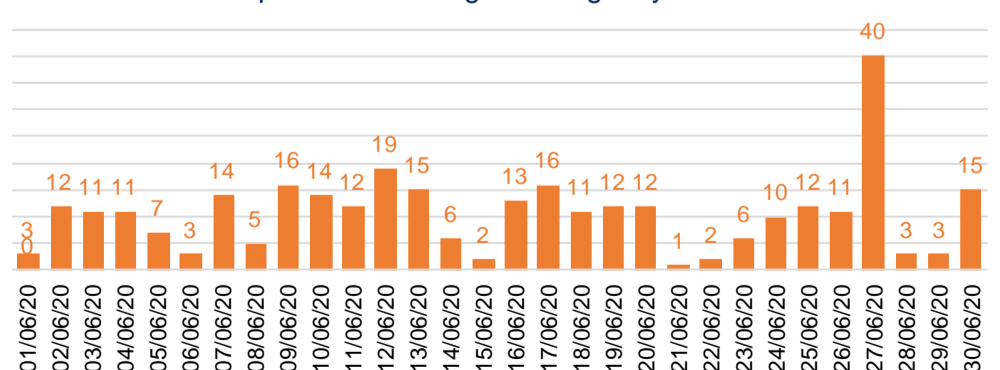
Hywel Dda daily COVID* admissions during June 2020



Number of patients in an invasive ventilated bed during June 2020



Number of COVID patients discharged during May 2020





Key performance areas (during COVID)

This section includes summary information on some of the key areas that we prioritised to make improvements in 2019/20. We continue to monitor these in 2020/21 during the COVID-19 pandemic and are providing data updates for all available indicators. [The impact of COVID and our plans to reset](#) section of this report outlines the impact the pandemic is having on our performance and our plans for service delivery moving forward. The reporting time period and frequency differs by indicator. See the [performance overview matrix](#) for details.

| | Target | 12m previous | Previous period | Latest data | Met plan? | Notes ** | |
|----------------------------|--|--------------|-----------------|------------------|----------------|----------|---|
| Unscheduled care | Ambulance red calls | 65% | 67.8% | 55.8% | 71.3% | Yes | Carms 72.81%, Cere 62.2.4%, Pembs 74.5%. |
| | Ambulance handovers over 1 hour | 0 | 284 | 21 | 31 | Yes | Ambulance arrivals decreased considerably from June 2019 (-253), however, handover to clear has increased due to the need to remove PPE and clean vehicles. |
| | A&E/MIU 4 hour waits | 95% | 83.5% | 86.7% | 84.3% | No | In June '20 there was a 27% reduction in the number of new attendances compared to June '19. GGH had the highest 4 hour performance in June '20 (88.7%) and we met trajectory for 12 hours performance. Where appropriate, some patients received extended clinical assessments within Emergency Dept. beyond the 4 hour threshold which has limited further improvement in this area |
| | A&E/MIU 12 hour waits | 0 | 816 | 56 | 113 | Yes | |
| | Non-mental health DTOC | 12m↓ | 58 | 43 | N/A | n/a | Due to COVID-19, DTOC census patient number monitoring has been suspended until Sep'20. Latest Mental Health data is based on unverified numbers from the National DTOC database. |
| | Mental health delayed transfers of care (DTOC) | 12m↓ | 3 | 11 | 9 | n/a | |
| Stroke and cancer | Admission to stroke unit <4 hours | 59.8% | 61.7% | 64.4% | 68.9% | Yes | Stroke performance data continues to be collected locally. Although we are meeting HB targets for admission to a stroke unit within 4 hours and assessment by a stroke consultant within 24 hours, there has been a decline in performance for speech and language therapy, with 13.8% compliance at GGH, 15.7% at PPH and 24.8% at BGH. |
| | Assessed by stroke consultant <24 hours | 84.2% | 88.9% | 95.9% | 95.1% | Yes | |
| | Stroke patients - speech and language therapy | 12m↑ | 40.0% | 47.5% | 20.2% | No | |
| | Urgent suspected cancer | 95% | 80.0% | 65.9% | 68.8% | No | Reported performance relates to May '20. Performance improvement for urgent suspected cancer was limited due to the impact of COVID 19. |
| | Non urgent suspected cancer | 98% | 96.8% | 95.9% | 98.8% | Yes | |
| | Single cancer pathway | 12m↑ | 79.5% | 74.0% | 73.0% | No | |
| Planned care and therapies | Hospital initiated cancellations | 5%↓ | 148 | 700 | 12 | Yes | During May '20, 4 of the 12 cancellations within 24 hours were in response to the pandemic. |
| | Delayed follow-up appointments (all specialties) | 12m↓ | 40,627 | 35,471 | 35,968 | No | The number of delayed follow-up appointments has increased due to non-urgent outpatient appointments being postponed in light of the pandemic, although the rate of deterioration has been limited due to the advent of alternative virtual / digital solutions. |
| | Ophthalmology patients seen by target date | 95% | 64.9% | 52.6% | 44.6% | No | Despite an 8% drop in performance, which is primarily due to patient cancellations, high risk treatment is continuing. |
| | Diagnostic waiting times | 0 | 115 | 7,669 | 7,293 | No | The cancellation of routine appointments has significantly increased the number of patients waiting beyond 8 weeks for Radiology & Cardiology diagnostic tests compared to pre-COVID levels Both services have confirmed that clinically led validation arrangements are in place to prioritise urgent |
| | RTT – patients waiting 36 weeks+ | 0 | 122 | 5,311 | 8,758 | No | In line with the WG instruction to Health Boards, non-urgent pathways have been suspended. The number of patients waiting > 36 weeks for treatment increased by 3,447 from May to June '20 and is 8,636 higher than June '19. |
| | RTT – patients waiting <=26 weeks | 95% | 89.8% | 71.4% | 66.7% | No | |
| | Therapy waiting times | 0 | 262 | 1,528 | 1,613 | No | Highest rates for Podiatry (623) & Physio (437). Audiology has risen to 402 due to the impact of COVID. |
| Quality and safety | C.difficile | <=25 | 34.80 | 36.6 | 50.48 | No | Cumulative reduction rate reporting has been stood down until July '20. As an interim measure we are reporting the in month rate per 100,000 population of infections. |
| | E.coli | <=67 | 82.26 | 76.3 | 53.64 | Yes | |
| | S.aureus | <=20 | 22.15 | 15.3 | 22.09 | Yes | |
| | Serious incidents | 90% | 7.1% | 12.5% | 12.5% | n/a | In May '20, 3 out of 4 SIs were closed within the WG timescale. There were no never events reported. |
| | Complaints | 75% | 75% | 63% | 75% | Yes | Response times have improved this month, particularly in regard to the less serious complaints received. |
| MH + | Children/young people neurodevelopment waits | 80% | 43.2% | 25.8% | 22.8% | No | The service is expected to have an increased waiting list going forward as the number of therapeutic intervention face to face appointments has been reduced. Where suitable assessments have continued by telephone. |
| | Adult psychological therapy waits | 80% | 63.6% | 45.5% | 40.6% | No | |
| Population Health | '6 in 1' vaccine | 95% | 92.8% | 96.3% | 95.5% | Yes | The risk of COVID-19 has raised concerns among parents/guardians, who may delay bringing their child for routine childhood immunisations, leading to a decrease in uptake of all childhood immunisations, including the 6 in1 & MMR. |
| | MMR vaccine | 95% | 90.6% | 91.7% | 90.0% | No | |
| | Attempted to quit smoking | 5%(ytd) | 3.49% | 2.65% | 3.5% | n/a | COVID-19 presents a risk to smokers accessing cessation support services and to be CO validated as quit. |
| | Smoking cessation - CO validated as quit | 40% | 49.7% | 48.4% | 30.3% | n/a | |
| Workforce & finance | Sickness absence (R12m) | 12m↓ | 4.88% | 5.29% | 5.35% | No | Covid-related pressures impact on workforce performance: • Limited Occupational Health capacity but carrying out assessments for staff identified as vulnerable as required • Medical appraisals remain suspended • 4.2% increase in fire safety compliance (72.8%) in June |
| | Performance appraisals (PADR) | 85% | 79.0% | 67.4% | 70.4% | No | |
| | Core skills mandatory training | 85% | 81.6% | 82.7% | 83.5% | Yes | |
| | Consultants/SAS doctors - current job plan | 90% | 66% | 58% | 58% | No | No job plan reviews since mid-March due COVID-19, to be resumed as soon as possible. |
| | Finance - deficit | £25m | £8.9m deficit | £14.734m deficit | £16.2m deficit | No | Board's financial position at the end of June is £16.2m deficit against a deficit plan of £6.3m. Welsh Government have funded certain additional costs incurred as a direct consequence of COVID-19 however, there is no certainty of future funding arrangements. |



The impact of COVID and our plans to reset

THE COVID pandemic has had a considerable impact on our services, the way we work and our performance; with both positive and negative impacts witnessed. This section outlines some of the changes we have had to make along with our plans to reset and move forward within the ongoing restrictions that COVID brings.

The accompanying [Performance Trend Charts](#) document provides data on how our performance has been affected by COVID-19 and how this compares to our planned trajectories for 2020/21.

| Area | Impacts to performance (both positive and negative) and new ways of working | Our reset plans |
|---|---|---|
| Ambulance red calls | <ul style="list-style-type: none"> Performance has been negatively affected by COVID infection control requirements. The service has incorporated the following new ways of working: <ul style="list-style-type: none"> Working/partnership across teams to problem solve and innovate; Ensuring communicating channels are clear and regular; Huge steps forward in digital – roll out of Office 365, IPads, (which will be complete within Hywel Dda by mid- August) Teams, Zoom, home working, video, education; The redesign and transformation of recruitment and training processes. | <ul style="list-style-type: none"> Recruit and train more staff as agreed in demand and capacity (D&C) review: 136 within this financial year (on target); Respond to and work with Hywel Dda on major service changes; Set up planning for electronic patient care record system and 111 IT system; tender process now complete; Continue to work on major capital schemes e.g. Aberaeron and Pembroke Dock; (now under review); Complete Clinical Contact Centres and Non-Emergency Patients Transport Service D&C reviews; Secure resources to replace over 100 vehicles in our fleet and refresh fleet plans for the future; Build on work such as website and expand clinical advice; Further expansion of Advanced Practitioner recruitment. |
| Ambulance handovers and Accident & Emergency/Minor Injury Unit (A&E/MIU) waits | <ul style="list-style-type: none"> Ambulance handover: <ul style="list-style-type: none"> 1 hour handover delays have significantly reduced; WGH: ambulance delays have reduced significantly with improved performance against the offload target; BGH: having seen an overall improvement, recent pressures necessitated a further review of the site COVID plan and the opening of Bay C in the Clinical Decision Unit (CDU) to green capacity. This should support improvement in this area of performance. A&E/MIU waits: <ul style="list-style-type: none"> GGH: 4 and 12 hour performance have improved due to additional medical staff and senior clinicians at the front door; BGH: at the start of COVID, BGH moved to ward based, consultant led teams in order to reduce footfall. The impact on this in CDU has been positive as the acute physicians no longer have assigned ward based patients and therefore focus all of their time on patients that have been admitted in the previous 24 hours to the acute admission unit, which improves communication, decision making and flow. Capacity limited by: <ul style="list-style-type: none"> Maintaining COVID and non-COVID streams at front door and on the wards. Creation of a 3rd stream for elective surgery; Time efficiencies - donning and doffing, COVID swabs results taking up to 3 days if they have to be sent to Cardiff; Maintaining social distancing for staff and patients - reduced bed capacity by approx. 25%; Staffing - absence through shielding and nurse vacancies (pre-COVID issue); Non-COVID emergency demand returning to normal levels; Early evidence from clinical staff of higher acuity of patients who have presented late – potentially due to fear of COVID. | <ul style="list-style-type: none"> Continue to maintain segregated red & green streams in Emergency Departments (EDs) and hold regular reviews to reduce COVID designated areas; GGH: Continue Senior A&E consultant and medical support to the front door (A&E and CDU). Consultant presence at x3 daily bed meeting to ensure all pathways have capacity and correct proportion of red and green beds. 24/7 COVID consultant on call to provide advice on all COVID related matters and patient assessment and transfer; Prioritise hospital space for acute services and develop plans to move non-acute and administrative services off hospital sites; WGH Streaming Unit to be relocated GGH Streaming Unit to be developed to replace current streaming tent; PPH new streaming unit to be finalised and ordered; BGH streaming tent has been removed, however, the site have planned a replacement portable cabin streaming unit in time for the winter period when increased COVID numbers are expected. Consider options to change the infrastructure of wards to minimise the number of beds lost due to social distancing; Development of local COVID testing in GGH, BGH and WGH; Address registered nursing recruitment; Work with the community to develop escalation plans that may include use of increased community capacity, including field hospitals; WGH establishment of Red and Green Clinical Decisions & Ambulatory Care Units will improve flow out of the ED and provide a facility for assessment within an ambulatory care setting, avoiding the need for admission; Re-opening of PPH Acute Medical Admission unit to non-COVID emergencies during July to allow direct admissions for a number of emergency patients; Elective surgery re-commenced at PPH on 6th July focusing on cancer patients. This is a positive development but has reduced capacity for unscheduled care; PPH - Re-establishment of stranded patient reviews during July; PPH - Develop plan for short stay and day-case medical patients and develop plans for a same day emergency care service as the previous ambulatory care unit cannot function due to social distancing; PPH Advanced Nurse Practitioners to commence in MIU; PPH Re-opening of discharge lounge during July. |
| Delayed transfers of care (DTC) | <p>Positive Impact:</p> <ul style="list-style-type: none"> Experiencing a community response allowed our population to develop a trust and understanding that care can be delivered safely at home. We have also cared for an increased number of people at end of life at home; Increased capacity for Intermediate Care assessment and rapid response to care provision, also to support patient 'turnaround at front door' and increased care availability to maintain people in their own homes; Relaxation of lawful/regulatory frameworks has reduced DTC resulting from the assessment and commissioning processes, this has led to reduced DTC from family disputes; The service has retained its robust response to the provision of care and support across all three counties. <p>Negative Impact:</p> | <ul style="list-style-type: none"> Work collaboratively with Local Authority to further develop capacity within D2RA pathways; Review and sustain 'Bridging Care'; Increase Intermediate Care beds for return to embargoed Care and Residential Homes; Hospital based swab testing and processing; Integrate essential service provision between Primary Care and Community services in relation to Long Term/Chronic Conditions management; Telehealth solutions to support the Intermediate, Palliative and Proactive Care pathway; Develop population approach to D2RA pathways and our Discharge Teams. <p>Additional detail can be found in the delayed transfer of care report (page 12).</p> |

| Area | Impacts to performance (both positive and negative) and new ways of working | Our reset plans |
|------------------------------------|--|---|
| | <ul style="list-style-type: none"> • Fragility of the independent care sector could be further compromised due to workforce retention; • Resilience of the care home sector has been compromised due to outbreaks (financial and workforce issues). It has been further impacted due to no admissions until 28 days after last positive test result and meeting Infection Prevention and Control requirements; • Staff absences; • Limited capacity for rapid processing of swab testing prior to discharge compromises patient discharge and flow; • Lack of Elderly Mental Illness nursing bed availability. | |
| Stroke | <ul style="list-style-type: none"> • Across all 4 sites the team have been doing virtual follow-up clinics for both stroke and TIA patients; • Some teams feel that patients have been discharged safely but may have poorer outcomes due to a lack of in-patient rehabilitation as a result of the COVID pandemic. They have started to follow up in the community; • New instructions in the use of PPE during SALT may affect therapy time; • Work is ongoing with the Thrombectomy service in Bristol at an All Wales level; • There are new challenges at BGH, however, a robust plan is in place with the support of PPH and WGH. | <ul style="list-style-type: none"> • All 4 sites have now returned to their own standalone units; • All 4 sites have now started completing the full SSNAP data set; • SALT continues to be an issue; • To reinstate the Stroke Steering Group for the UHB. |
| Cancer | <p>COVID has had a negative impact on performance due to the following:</p> <ul style="list-style-type: none"> • Suspension of any aerosol generated diagnostic tests and surgery in line with Royal College guidance has caused delays; • Tertiary centre delays; • Suspension of local surgery for those patients requiring HDU/ITU support post operatively and further restrictions in clinical criteria that apply e.g. patients whose BMI exceeds 35 and have existing comorbidities; • 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 pandemic, as an alternative due to the current restrictions on the normal diagnostic pathways; • Although urgent and USC imaging investigations are still being undertaken, they are reduced to being within the parameters offered by national clinical guidance for certain aerosol generating procedures; • Bronchoscopies have been limited in line with national guidance. <p>The following outlines how the service has incorporated new ways of working:</p> <ul style="list-style-type: none"> • As per the 6 levels of Systemic Anti-cancer Therapy (SACT), all levels are still currently being treated across the Health Board; • Werndale Hospital has been commissioned to support cancer outpatient & surgical pathways during April & May 2020; • Joint working progressed with regional multi-disciplinary teams for tertiary center surgeons to provide outreach surgery in Gynaecology and Urology. | <ul style="list-style-type: none"> • 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 GGH site. This plan commenced on 30th April 2020 with one operating list per week reinstated on the GGH site; PPH commenced elective cancer surgery with a dedicated green ITU/HDU on the 6th July 2020. The same green surgical model will commence on the WGH and BGH site week commencing 13th July 2020. • Bronchoscopy service to recommence on the PPH site week commencing 11th May 2020; • The Health Board will reinstate endoscopy services for cancer patients within the next 3 weeks across our hospital sites. This will be reinstated via a phased approach starting on 18th May 2020 at PPH with other sites to follow pending completion of logistical changes to Red/Green zones. |
| Referral to treatment times | <p>COVID has had a negative impact on performance due to:</p> <ul style="list-style-type: none"> • Services do not resemble previous service we are able to deliver and initial recovery of the 2019/20 position will be slowed by lack of capacity, infection control requirements and continued peaks of COVID; • At the point of the COVID response the Health Board were positioned to maintain the RTT 36 week target and the efforts that were made to ensure delays were minimized across the planned care system for 2020; • At present (June 2020) the Health Board has over 8,000 breaches, a figure not recorded since 2014/15. • Decreased capacity due to stringent infection control requirements; • The need to prevent patients having major surgery while they have coronavirus except for life, limb or sight-saving procedures, as their outcomes are likely to be poor; • Significant public concern about attending acute hospitals; • All Standard Operating Procedures for surgical services, operating theatres and critical care will need careful review and adjustment as necessary; • The impact on tertiary treatments. | <ul style="list-style-type: none"> • Functional capacity of both bed and diagnostic space is required to assess the capability and test the system to restart planned care; • Reset plans for Q2 currently focus on urgent & cancer surgery due to the limitations on available capacity due to the impact of COVID 19; • The Health Board is working towards implementation of a centralised Critical care plan; • Streaming patient flows using patient shielding before admission and testing such that COVID-19-positive and COVID-19-negative pathways are created and used appropriately. All standard operating procedures for surgical services, operating theatres and critical care will need careful review and adjustment as necessary; • Consideration of streamlining members of the surgical, anaesthetic and theatre teams such that those teams doing elective work are separate to those doing emergency and on call work. |
| Eye care | <p>As a result of the COVID-19 pandemic, the provision of Ophthalmology services have been swiftly reconfigured to meet essential urgent care where required. However performance has been affected by:</p> <ul style="list-style-type: none"> • All routine ophthalmic surgery and face to face outpatient activity being postponed; | <p>Reset plans include:</p> <ul style="list-style-type: none"> • 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 |

| Area | Impacts to performance (both positive and negative) and new ways of working | Our reset plans |
|---------------------|---|--|
| | <ul style="list-style-type: none"> Due to the population demographics, the majority of patients require hospital transport which has affected attendance; Although Aged Macular Degeneration (AMD) services continue, initially a number of patients were reluctant to attend; Ophthalmology relocated to Werndale to support the emergency service, however, Werndale is only licensed to see adults, therefore Paediatric arrangements continued at GGH. <p>New ways of working include:</p> <ul style="list-style-type: none"> 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. | <p>the service will work towards a five phased plan based on patient safety and clinical guidelines;</p> <ul style="list-style-type: none"> Prior to COVID-19 the service has been under pressure to meet its growing demand, therefore, additional redesign services post-COVID-19 will include: <ul style="list-style-type: none"> 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. |
| Therapy waits | <ul style="list-style-type: none"> The COVID-19 pandemic has had a negative impact on the 14 week target because most services (i.e. Podiatry and Physiotherapy) require hands on therapy; Urgent/Essential service only being provided currently; A positive impact has been seen through our virtual and remote service provision being successfully trialled within therapy services. This has been successful in managing waiting times in therapy services such as Speech & Language and Dietetics; Audiology GP Assessment waiting list have suffered, but the feedback from patients who have had virtual consultation has been positive; It has allowed a review of current Audiology pathways and subsequent streamlining to provide a more efficient service; We have significantly reduced Audiology Follow-Up airing lists in multiple areas; It has allowed staff to trial and develop new ways of working. | <ul style="list-style-type: none"> All services detailing PPE, Activity and Clinical requirements to restart; Increase in availability of Information and Communication Technology to support agile and remote working and as an alternative to face to face patient contact; Scoping of rehabilitation requirements of individuals affected by COVID 19 directly i.e. Covid survivor, and indirectly i.e. deteriorating functional ability due to impact of shielding. This will be used to identify potential areas of increased demand and service requirements to address the demand; Audiology have requested refurbishment work within the ENT/Audiology area to provide 2 additional rooms to support additional capacity; A gradual reintroduction of Audiology services will begin in August, which will be based on risk and need. Band 4 staff will see those patients who need face to face Follow-ups. Band 5/6 staff will see 'GP Assessment' patients for their hearing tests and subsequent hearing aid fitting. This will now be done as a one-stop appointment to reduce footfall and time in out-patients; We are starting to see children (under 4) who are cases for concern. |
| Delayed outpatients | <ul style="list-style-type: none"> Performance has been affected negatively following the Welsh Government announcement to "contain" the "delay" phase of COVID 19 by suspending all non-urgent outpatient appointments and non-urgent surgical admissions but ensuring urgent appointments are prioritised; This was executed across Health Board and included the cancellation of all non-urgent outpatient, diagnostics and planned surgery with the exception of life threatening cancer surgery, urgent sight threatening Ophthalmology care and Endoscopy. Outpatients clinics have been suspended apart from urgent, fracture, multi-disciplinary team, do not cancel patients and unscheduled care clinics; Notwithstanding this, the rate of deterioration has been limited due to the advent of virtual & digital consultation/review platforms; All specialties have undergone rigorous clinical validation of clinic lists to prevent access to the acute sites which are considered at risk of COVID-19 spread. | <ul style="list-style-type: none"> All outpatient face to face appointments are being clinically reviewed with a view to the majority of work becoming virtual in order to minimise face to face contact. |
| Diagnostics | <p><u>Radiology</u></p> <ul style="list-style-type: none"> Radiology maintained the services for urgent and suspected cancer work; Some AGP investigations have been changed to alternative imaging; All other referrals have been kept and are monitored and reviewed regularly in discussion with other services; We have maintained dialogue with colleagues across Wales for a review of the overall picture and possible solution to assist with the recovery; Imaging capacity has significantly reduced due to infection control procedures required; Positives include the opportunity to evaluate referral pathways and ways of working to establish the new normal. <p><u>Endoscopy</u></p> <p>New ways of working included:</p> <ul style="list-style-type: none"> Implementing Faecal Immunochemical Testing (FIT) in unscheduled care groups as an interim arrangement for managing prioritisation of deferred procedures; Development of a tracking document for patients on high-risk pathways to collate the data in order to contribute to the | <p><u>Radiology</u></p> <ul style="list-style-type: none"> Radiology maintained the services for urgent and suspected cancer work; Some AGP investigations have been changed to alternative imaging; All other referrals have been kept and are monitored and reviewed regularly in discussion with other services; We have maintained dialogue with colleagues across Wales for a review of the overall picture and possible solution to assist with the recovery; Imaging capacity has significantly reduced due to infection control procedures required; Positives include the opportunity to evaluate referral pathways and ways of working to establish the new normal. <p><u>Endoscopy</u></p> <p>We are now planning for the Endoscopy departments to return to their original footprints and how services will resume, utilising the following advice:</p> <ul style="list-style-type: none"> Pre-procedure testing of asymptomatic patients being booked for endoscopy is not recommended in Wales; Currently it is not feasible or appropriate to routinely test |

| Area | Impacts to performance (both positive and negative) and new ways of working | Our reset plans | | | | | | | | | | |
|---|--|---|--------------|-----|---------------|----|------------|----|------------|----|----------|----|
| | <p>learning in this area on an All Wales basis;</p> <ul style="list-style-type: none"> Implementation of FIT in low risk groups (as per NICE 30 Guidance) to assist with triaging of referrals from primary care. <p><u>Cardiology</u></p> <ul style="list-style-type: none"> Some Cardiology services have been moved off site e.g. cardiac monitors to facilitate 2m distancing for staff and patients. Performance has been affected because the number of patients that can be seen are reduced due to COVID precautions. | <p>asymptomatic staff working in endoscopy with swab (antigen) testing;</p> <ul style="list-style-type: none"> The optimal duration for self-isolation prior to endoscopy procedures is 14 days; In circumstances where the clinical situation (e.g. in-patients, dysphagia etc.) or specific individual circumstances make it difficult for the patient to comply with this self-isolation period or clearly may result in a potential adverse outcome, procedures should not be withheld, delayed or denied. This assessment by clinical teams should be based on individual clinical risk and benefit assessment; Lower GI Endoscopy is not considered an aerosol generating procedure (AGP). <p><u>Cardiology</u></p> <ul style="list-style-type: none"> Cardiology diagnostic services are now reviewing outstanding cardiology diagnostics and addressing the backlog. The service is looking at additional locum support to increase the numbers of patients that can be treated during the summer months of low COVID activity. | | | | | | | | | | |
| Healthcare acquired infections | <ul style="list-style-type: none"> A number of Professional Development Nurses, Sexual Health Nurses and School Nurses have worked closely with the Infection Prevention Nurses developing knowledge to take back to their specialities; Increasing engagement with services as they reset, increased discussion and understanding of service requirements; Purchase of Hydrogen Peroxide Vapour (HPV) environmental decontamination systems x4 (one for each acute site). | <ul style="list-style-type: none"> Quarterly Indicator Audits are underway on all acute sites; Infection Prevention Group meetings have recommenced across the HB; Work continuing with Procurement to manage PPE and improve use of reusable equipment; All staff able to access and use Microsoft Teams to improve team communication; Discussion commenced with shielding staff to return to normal practise once allowed; Working with the Assurance, Safety and Improvement Team to investigate Hospital Acquired Infections (HAI) of COVID-19; Need to develop Root Cause Analysis for investigation of HAI COVID-19. | | | | | | | | | | |
| Complaints | <ul style="list-style-type: none"> As previously reported, the Patient Support services team are continuing to work from home; Clients continue to be offered audio/video meetings instead of face to face meetings and these have been successful to date. | <ul style="list-style-type: none"> The Team has quickly adapted to the changes and have successfully maintained the service during this challenging time; Many of the new innovations will continue to be offered as a way of providing prompt resolution to complaints. | | | | | | | | | | |
| Neurodevelopmental and psychological waits | <p>COVID has had a negative impact on ASD and ADHD performance due to no face-to-face clinics being held since the end of March 2020.</p> <ul style="list-style-type: none"> The ADHD service has processed new referrals, by sending parents/guardians a position letter outlining that there are no face-to-face clinics and signposted to other agencies/resources for support (e.g. Team around the Family & ADHD foundation). Anyone with an urgent concern or emergency is advised to contact their GP. The ASD service have continued to receive new referrals. All families on the waiting list have been contacted and sent information on strategies to manage anxiety and behaviour. Also advice has been provided on services available in a crisis. <p>COVID has had a negative impact on performance for psychological waits due to delayed recruitment to vacant posts and anxiety to engage in face to face assessments. Positive ways of working include increasing the number of telephone assessments undertaken and piloting Attend Anywhere as an alternative platform to deliver services.</p> | <ul style="list-style-type: none"> Neurodevelopmental ADHD services are trialling virtual platforms to re-commence follow up and new appointments and exploring the use of technology to assist with diagnosis. The ASD service has been undertaking telephone assessments to assist the diagnostic pathway for when services are reinstated and recruitment has commenced for vacant posts. <p>Psychological services</p> <ul style="list-style-type: none"> To actively recruit suitably skilled additional staff; Have established a rolling rota for staff to be in work and work from home; Have established a date to resume face to face activities; Will continue to see patients with a mixture of face to face/telephone assessments and therapy interventions; The service is piloting the use of virtual platforms to offer a range of assessment platforms; Identify suitable accommodation for the delivery of face to face interventions that comply with social distancing. | | | | | | | | | | |
| Childhood immunisations | <ul style="list-style-type: none"> Routine childhood immunisation programmes are a high priority and have continued, albeit in line with social distancing and PPE requirements in place; The schools immunisation programme is temporarily suspended. | <ul style="list-style-type: none"> Reset plans for the childhood immunisation programme are not required at present as the programme is continuing to be delivered. Enhanced uptake surveillance of childhood immunisations is being carried out by PHW during this COVID period, and any areas of poor uptake or concern can then be identified quickly and measures put in place; School immunisation programmes have recommenced on a small scale, concentrating on secondary schools where the year 9 routine scheduled immunisations had not started prior to the closure of schools in March. The school nursing team have worked in collaboration with local authority partners to identify venues both in school and out of school to vaccinate children. Planning is also ongoing with regard to the feasibility of holding immunisation sessions during the summer break in order to catch-up on missed school vaccination sessions. | | | | | | | | | | |
| Smoking | <ul style="list-style-type: none"> All consultations are now provided via telephone; Smokers are no longer CO validated at 4 weeks post quit date due to the potential risk of COVID-19 transmission in exhaled air; Medical Humanities Research Centre (MHRC) approval was received to supply Nicotine Replacement Therapy via post just in case there was an issue with access to community | <ul style="list-style-type: none"> Despite a decline in referrals since lockdown the number of treated smokers has remained stable: <table border="1" data-bbox="1249 2686 1661 2834"> <tbody> <tr> <td>January 2020</td> <td>109</td> </tr> <tr> <td>February 2020</td> <td>71</td> </tr> <tr> <td>March 2020</td> <td>84</td> </tr> <tr> <td>April 2020</td> <td>98</td> </tr> <tr> <td>May 2020</td> <td>72</td> </tr> </tbody> </table> | January 2020 | 109 | February 2020 | 71 | March 2020 | 84 | April 2020 | 98 | May 2020 | 72 |
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| May 2020 | 72 | | | | | | | | | | | |

| Area | Impacts to performance (both positive and negative) and new ways of working | Our reset plans |
|--|--|--|
| | <p>pharmacies and supply. This has yet to be fully implemented. Those unable to access Nicotine Replacement Therapy (NRT) via a local pharmacy are being posted their medication directly by their advisor by recorded delivery. Calls were made to each pharmacy to check their capacity and all stated they are still happy to process pharmacy letters for the smokers' clinic;</p> <ul style="list-style-type: none"> Following the transfer of Stop Smoking Wales staff from Public Health Wales to the HB, a new integrated smoking cessation service has been created to provide continuity of care across secondary care, primary care and community. | <ul style="list-style-type: none"> Telephone support has proved popular with patients and drop out has been extremely low. Administration has asked each new referral whether they would have been interested in receiving support via Microsoft Teams. To date there has been very little interest and following poor outcomes from a pilot in Swansea we have not progressed this at the current time; The service has completed a Situation, Background, Assessment and Recommendation (SBAR) and standard operating procedures to progress the direct supply of Nicotine Replacement Therapy to patients via the Hospital Pharmacy in Glangwili. This is yet to commence; Continue to implement the Wellbeing/Health Coach model, staff training is planned to upskill existing staff and recruitment is underway; Undertake research to understand the impact of COVID-19 on smoking behaviour – ongoing. |
| Workforce (includes sickness, core skills and PADR) | <ul style="list-style-type: none"> There has been an increase in Covid-related absence levels with an in-month sickness rate of 5.44% in May 2020 compared with 4.78% in May 2019; The core skills compliance rate has remained relatively stable across mandatory training modules with a 0.3% increase in overall compliance since before the Covid outbreak in February 2020; The PADR compliance rate has fallen for non-clinical roles to under 70% for first time since October 2018; All clinical supervisions have been suspended until September 2020. | <ul style="list-style-type: none"> County Workforce teams have started to reinstate their normal sickness absence reviews with Line Managers. Attendance Management training will also commence as soon as training rooms become available; Staff absence reviews with occupational health will be reinstated as soon as capacity in the Occupational Health Service allows; Occupational Health continues to provide assessments for staff that fall within the vulnerable and extremely vulnerable categories as required; Preparation for the flu season and the flu vaccine roll out is also underway for rollout in the next couple of months Managers are being asked to support staff to continue mandatory training; Online mandatory fire safety training is now available on ESR. The Occupational Development (OD) team have sent out communications reiterating the need for continued performance conversations and yearly PADRs. The messages highlight how these conversations support staff wellbeing; The OD team are currently reviewing how they can deliver classroom learning virtually. The team are in the process of reviewing platforms such as Skype, Microsoft Teams and virtual classrooms to make an informed decision on which is best suited for this type of learning; The team have started reviewing the performance management session and breaking this down to meaningful 30-60 minute learning sessions. The roll out of these sessions should begin July/August 2020, depending on a suitable platform being identified. |
| Finance | <ul style="list-style-type: none"> Align the strategic response to current demand modelling indicators between Welsh Government, Gold Command and operational teams. | <p>Work is currently on-going to:</p> <ul style="list-style-type: none"> Gain clarity as to what current escalation measures can be safely and appropriately de-escalated/decommissioned and which ceased/deferred services/activities can be recommenced; Carry out an extensive review of savings and establish cost reduction opportunities as we plan the return to exit the current pandemic; Continue to work with Welsh Government to understand the level of additional revenue and capital funding available. |



Essential services update as at 30th June 2020

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

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

Out of Hours services

- During the pandemic GP Out of Hours rotas have improved across Pembrokeshire and Ceredigion. Despite initial improvements Carmarthenshire is problematic once more in terms of staffing, 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;
- "Attend Anywhere" online has been purchased to support virtual consultations, thus reducing potential risk for staff and patients. Furthermore, additional IT equipment has been procured to support more flexible working in an attempt to increase service readiness. The benefits of this investment is unlikely to be seen prior to winter where risks to service provision are likely to increase - especially if any further reduction in lockdown restrictions is announced;
- The decision to support rationalisation of overnight base cover has been a success in improving service stability for 6 nights of the week. Saturday is the exception and predominantly in Carmarthenshire. A reduction in overall service risk for most of the operating hours has been noted and a reduction in base closures observed;
- Efforts to secure medical staffing for the Carmarthenshire rota are continuously reviewed. At time of reporting, service leads are generating options to ensure that the more arduous sessions are allocated alongside more palatable hours. One option is to see if the GP community can develop their own rota, working collaboratively to devise a pattern that works well for them professionally and personally. The second is to look at shift bundling where sessions which are less popular will be allocated to staff who support periods of lower demand. To support rota provision and improve communication, the service is also investigating the potential to procure a new IT solution known as RotaMaster. This will support GPs in selecting available sessions without the need to discuss with a member of the administrative team.

Additional services: school nursing service

- This service does not operate during the 6 week school summer holidays.

2 Essential services that are being maintained in line with guidance

Access to primary care services

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

Life-saving or life-impacting paediatric services

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

Other infectious conditions (sexual and non-sexual)

Other infectious conditions
 Urgent services for patients

Mental health (MH), learning disability services & substance

Crisis services (including perinatal care)
 Inpatient services at various levels of acuity
 Community MH services that maintain a patient's condition stability
 Substance misuse services that maintain a patient's condition

Therapies

Palliative care

Blood and transfusion services

Safeguarding services

Acute services

Urgent eye care
 Urgent surgery
 Urgent cancer treatments

Life-saving medical services

Interventional cardiology
 Acute coronary syndromes
 Gastroenterology
 Stroke care
 Diabetic care
 Neurological conditions
 Rehabilitation

Termination of pregnancy

Neonatal services

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

Renal care-dialysis

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

Additional services

Health visiting service - early years
 Community neuro-rehabilitation team
 Self-management & wellbeing service

Diagnostics

3 Intermediate services that are being delivered

Maternity services

4 Normal services that are continuing

Emergency ambulance services

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



How did we do in June 2020?



71.3% of ambulances arrived to patients with life threatening conditions within the 8 minute target.



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



9,533 patients attended an A&E/MIU in June as a new attender. Of these patients, **84.3%** were seen and treated within 4 hours of arrival but **423** patients waited longer and **113** patients waited over 12 hours; There has been a 27% reduction in the number of new attendances compared to June '19 and 41% year to date.



In June there were 2,999 emergency admissions compared to 3,686 in June '19, to our hospitals of which 2,002 (67%) were admitted via A&E/MIU. On average medical emergency patients stayed in hospital for 8 days (Jun'19-Jun'20).

Risks

Ambulance Service

- Ambulance staff must don Personal Protective Equipment (PPE) for all calls, and higher specification PPE where procedures produce airborne particles or respiratory droplets;
- Ambulance handovers of patients >1 hour have reduced, however the time taken to become operational again has extended due the need to remove PPE and clean vehicles;
- Ambulance staff availability due to COVID19 related self-isolation and/or sickness and shielding; has improved slightly.

Unscheduled Care

- Existing vacancies and staffing of the additional field hospitals with Registered Nurses (RN) and Health Care Support Worker (HCSW) for both the new Red (suspected COVID19 symptoms) and Green (no suspected COVID19 symptoms) zones in the EDs;
- Deployment of staff unaccustomed to ED can impact patient flow;
- Staff availability due to COVID19 related self-isolation and sickness; loss of regular agency/partnership nurses due to social distancing travel requirements; Junior doctors assigned to ED are being called back to their speciality rotas which will increase waiting times in ED;
- Vacancies and sickness in Community Teams/Hospitals negatively impact the efficient transfer of some patients from acute sites. There are some delays in reablement and long term care package availability due to both COVID19 concerns and staff shortages;
- Daily differences in Red and Green zone capacity to treat patients and the number of patients needing the service;
- Establishment of Green ED has created a second access pathway for ambulances. There were some handover delays due to additional infection prevention processes undertaken by ambulance crews to protect staff and patients;
- Emerging increase in 'contact' patients who need a designated 'Amber' area since the Welsh Government implementation of 'Test, Track, Protect';
- Increase in number of patients who have a low COVID positive test, who need to be isolated and need a repeated swab and then test negative;
- Significant registered nurse vacancies which are now 84 WTE at GGH;
- GP OOHs often not covered at the weekend leading to base close overnight at GGH.

What are we doing?

Ambulance Service

- A deep dive analysis undertaken by Welsh Ambulance Service Trust (WAST) will be shared shortly with the HB;
- WAST trained military personnel to help undertake several roles such as driving the ambulance, support the WAST clinicians, deep cleaning of vehicles before becoming operational, deployed with our Advanced Practitioners and rapid response vehicle to support the don and doffing PPE process. A number of Mid and West Wales Fire and Rescue staff also trained to support WAST clinicians;
- Collaboration with the Blue Team in Pembrokeshire has resulted in the best month on month performance within the locality, with patient conveyance to hospital reducing to 62.6%, treat patients at the scene 13.9% and refer to alternative service providers such as mental health 12.8%.

Unscheduled Care

- Detailed COVID19 plans on each site having Red and Green zones in the ED and defined inpatient wards;
- Patient streaming system implemented at the front door to screen for symptoms of potential COVID19;
- HCSW recruitment above normal levels to provide staff for acute and community hospitals;
- Reduced COVID19 incidence has allowed conversion of Red back to Green capacity;

Withybush

- Established a Green 'Non COVID' Clinical Decisions Unit mid-June 2020 to enable GP direct and ED medicine referrals to access this facility directly, reducing the attendance and length of stay in the ED;
- Screen all referrals to General Medicine and ambulance conveyances to hospital to avoid unnecessary admissions;
- Establish a rapid access ambulatory care unit in early July 2020;
- Our Chronic Conditions Advanced Nurse Practitioner is supporting the establishment of more focused reviews of patients with prolonged stays, turnaround from short stay unit and enhance links with community chronic conditions teams for those patients in WGH;
- Orthopaedics returned to their dedicated facility. This has significantly improved Trauma flow in and out of the hospital;
- Return of Orthopaedics has enabled the Surgical Assessment Unit (SAU) to open. This facilitates avoidance of/quicker flow out of the ED;
- Weekly Respiratory multi discipline team meetings between General Medical team, Physiotherapist and Specialist Nurse in WGH and Respiratory Team in PPH where appropriate case studies are discussed. Meetings are recorded and used as a teaching tool;
- Work continues to establish discharge pathways, e.g. discharge with voluntary sector support, discharge to assess, discharge to care home or intermediate care bed, discharge to community hospital, early supported discharge for patients post Stroke.

Glangwili

- Consultant led COVID19 hub to provide follow up of COVID19 patients;
- Joint Clinical leads/management and Nursing meeting to ensure flow of emergency and elective pathways;
- Reviewing a portable cabin to replace the tent for ED, to ensure all patients who are potentially COVID19 positive are assessed outside of the Green ED department;
- Ring fenced beds for Urgent Cancer patients requiring;
- 2 hour COVID testing now in place;
- Joint A&E/CDU meeting to reinstate ambulatory care maintaining red and green pathways and to progress Welsh Government urgent and emergency pathway guidance;
- Field hospital Ysbyty Enfys opened 29th June with senior nursing and medical staff to take medically fit patients from GGH;
- Revised medically fit patient review with escalation meeting jointly led by acute/community and local authority.

Prince Philip

- Re-opening of the Acute Medical Admission unit to non-COVID emergencies during July;
- Consultant geriatric support to care homes has been available since March 2020;
- Elective surgery re-commenced on 6th July focusing on cancer patients. This is a positive development but has reduced unscheduled care capacity;
- Re-establishment of "stranded" patient (length of stay >7 days) reviews during July;
- Develop plan for short stay medical patients;
- Develop plans for a same day emergency care service as the previous ambulatory care unit cannot function due to social distancing;
- Encourage Minor Injury Unit patients to wait in cars if possible to maintain social distancing in the waiting room;
- Bi-weekly clinical meeting to review pathways and service changes;
- Advanced Nurse Practitioners to commence in MIU;
- Re-opening of discharge lounge during July;
- New Red and Green streaming pathway unit to be finalised and ordered, to replace temporary structure;
- Prioritise PPH space for acute services and develop plans to move non-acute and administrative services off hospital sites;
- Consider options to change infrastructure of wards to minimise the number of beds lost due to social distancing;
- Plans to address registered nursing recruitment;
- Work with Community to develop escalation plans that may include use of Field Hospitals.

Bronglais

- The team have maintained 1 active ward of 18 side rooms to manage any suspected COVID cases and for safe isolation of confirmed cases should they arise.
- The Clinical Decisions Unit area within A&E remains split in to Green area and Amber/Red, though Bay C is now used flexibly to allow improvement in ambulance offload and to provide more space for non COVID patients;
- Elective work, initially to clear the cancer waiting list and urgent non cancer patients waiting, commenced on 6th July;
- The Endoscopy service recommenced during the month;
- Developing the 'return to new normal' plan for BGH which encompasses much of the learning we have gained from rapid change due to COVID19;
- Consultant adverts are active for 1 Acute Stroke and 2 Colorectal Surgeon posts.

See the Delayed Transfers of Care section below for further details.



How did we do in May/June 2020?



Due to COVID-19, non-mental health DTOC census patient number monitoring has been suspended until September 2020.



Mental Health DTOC census delays are being captured, there were 9 in June 2020.

Risks

DTOC Non Mental Health

- Retaining staff in the independent care sector;
- COVID outbreaks in the care home sector;
- Public Health Wales guidance for no admissions from care homes until 28 days after last positive test result;
- Residential and care homes requiring:
 - residents to have a negative COVID19 test before they are returned from hospital (ward or ED);
 - residents to have a negative COVID19 test before discharge home with reablement or a long term package of care;
 - residents to be returned to the home within 10 hours of being discharged from an ED;
- Staff absences (shielding, vulnerable, child care) across community;
- Length of time it takes to receive swab results compromises patient discharge and flow;
- Off-site COVID19 testing, significantly delayed results (up to 72 hours) and cross border 'discharge to assess' challenges;
- WGH has seen a rise in patients who are medically optimised remaining in acute beds, with access to long term packages of care re-emerging as a significant constraint to discharge;
- Lack of Elderly Mental Illness nursing beds causing delays for these vulnerable individuals with specialist needs.

DTOC Mental Health

- Challenges around identification of placements resulting from actions to reduce spread of COVID-19;
- Increased acuity levels within inpatient settings alongside limited medical cover due to staff absence and vacancies;

What are we doing?

DTOC Non Mental Health

- Work collaboratively with the Local Authorities to further develop capacity within D2RA pathways, to ensure attainment of standards as outlined in the Welsh Government Discharge Requirements and PCCF;
- Review 'Bridging Care' and sustain by embedding into D2RA pathway;
- Increase Intermediate Care beds for people not yet able to return to embargoed care and residential homes;
- Implementation of hospital based swab testing and processing;
- Strengthen intermediate care response in the community through embedding of standards outlined in the National Institute for Health and Care Excellence, National Audit of Intermediate Care, Covid-19 PCCF to support conveyance/admission avoidance where appropriate;
- Integrate essential service provision between Primary Care and Community services for Long Term/Chronic Conditions management;
- Embed Telehealth solutions where possible and appropriate to support Intermediate, Palliative and Proactive Care pathway;
- Improved integration of End of Life Care across our whole healthcare system and ensure adherence to palliative care principles and standards;
- Develop population approach to D2RA pathways and our Discharge Teams i.e. ensure they are equally applicable to vulnerable adults, frail older patients and those with Mental Health/Learning Disabilities.

DTOC Mental Health

- Community Teams are focussing on providing support to avoid admission where possible with a multidisciplinary approach to reviewing patient flow;
- Remote working and improved digital technology/platforms have been embraced which has assisted in maintaining links and improving attendance at care planning meetings;
- An ICF bid has been submitted for increased capacity to facilitate discharge and liaison. Improvements have been made to internal and external pathways to reduce delays as far as possible.

**How did we do in April/June 2020?**

68.9% of patients presenting at our 4 acute hospitals in June with a stroke were then admitted to a dedicated stroke unit within 4 hours (a 7.2% improvement over June 2019).



58 of the 61 (**95.1%**) patients admitted with a stroke in June were assessed by a specialist stroke consultant within 24 hours (a 6.2% improvement over June 2019).



Only a fifth (**20.2%**) of stroke patients had the recommended amount of speech and language therapy (SALT) in hospital during June, therefore, the 12 month improvement target was not met.



During May 2020, **68.8%** (44/64) of cancer patients who were referred by their GP as urgent with suspected cancer, commenced treatment within 62 days of their referral. This represents a 1% decline compared to the previous month. This reflects an approximate 50% reduction in the volume of patients treated during the month as a consequence of COVID19.



98.8% (81/82) of patients who were not on an 'urgent suspected cancer' pathway commenced treatment within 31 days of the date the requirement for treatment was agreed with them.



We are working towards implementation of the new single cancer pathway (SCP) to monitor progress of all newly referred cancer patients from the point of suspicion until treatment starts. The new pathway increases the number of patients who will be monitored during the diagnostic phase. In May, 73% of patients covered by the SCP were treated within 62 days of the point of suspicion. This represents a 1% decline compared to the previous month.

RisksStroke

- There continues to be an issue regarding complex discharges back into the community which leads to reduced capacity within the units. No site has an Early Supported Discharge Team that could help with reducing length of stay;
- Since COVID there had been a reduction in admittance, however, we are now seeing normal unscheduled care activity returning and units are unable to ring fence beds;
- Insufficient therapy resource impacts on our ability to provide the recommended levels of rehabilitation support;
- Due to COVID and the infection control measures needed, SALT need to be in full PPE to carry out the therapy which does impact on the time spent with each patient.

Cancer

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

What are we doing?Stroke

Whilst performance through June 2020 saw improvement in some areas we are:

- Redesigning our stroke services and how we use resources in order to make meaningful improvements for our patients;
- Reviewing results on each site via a working group with a view to improving;
- Working on Early Supported Discharge in WGH;
- Working with the Delivery Unit on an All Wales basis.

Cancer

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

**How did we do in June 2020**

7,262 patients waited over 8 weeks for a diagnostic test in June 2020 which is 407 fewer compared to the previous month.



1,613 patients waited longer than 14 weeks for a therapy appointment. Services with the longest waits include Podiatry (623), Physiotherapy (437) and Audiology (402).



12 patients out of 90 booked had their procedure cancelled within 24 hours in May 2020. The low number of booked patients is a reflection of the current restrictions to elective surgery patient flow due to the pandemic.



In June **66.7%** were waiting less than 26 weeks from referral to being treated (RTT) and **8,758** patients waited beyond 36 weeks.



In May 2020 **44.6%** of patients (5,028/11,261) were waiting in or within 25% of their target date which represents a 7.9% decline compared to April 2020 at 52.5% (6,114/11,660). 98.3% of patients have been allocated a high risk factor (HRF) status leaving 268 (1.7%) patients waiting for an allocated HRF status.

Although the percentage performance has declined there are a number of R1 patients who have had immediate appointments and have not been included in the performance calculations. There is a validation exercise being undertaken to rectify this and ensure those patients in the over 50% category have undergone clinical review and are correctly prioritised. Since January there has been a reduction of 876 R1 patients and a 2,635 drop in patients overall on the Ophthalmology waiting list.



In June **35,968** outpatients waited beyond their target date for a follow up appointment. This includes **16,883** patients waiting for a Trauma & Orthopaedics, Ear, Nose & Throat, Urology, Dermatology or Ophthalmology outpatient appointment.

RisksDiagnostics

- Capacity pressures and equipment failure can impact the service's ability to meet the 8 week diagnostic target.

Therapies

- Reduction in clinical estate availability for therapy services due to estates being repurposed as part of acute Covid response.
- Reduction in clinical staff workforce due to shielding, and non-patient contact risk assessments for vulnerable/high risk staff
- Access to suitable digital platforms at scale to support virtual therapeutic interventions.
- Due to the current changes to working patterns created by the pandemic, planned Audiological assessment and subsequent hearing aid fitting work has been paused. This has had a detrimental effect on both the service's ability to meet RTT diagnostic targets and possibly also on patient wellbeing.

Hospital initiated cancellations

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

RTT

- The Health Board now have a revised post COVID watchtower monitoring programme;
- This team are currently identifying risks due to reduced capacity across all stages due to the COVID response inclusive of the reduction on available diagnostics;
- This will clearly identify the gap which will need a Health Board forward plan to resolve once we are confident the cancer/urgent elective care is sustainable
- There is a significant risk regarding ward staffing vacancies to support elective activity.

Eye care

- New patients can wait longer due to a shortage of consultant ophthalmologists. Capacity being used to cover the Emergency Eye Care service can also impact on waiting times.
- Outpatient appointments have been lost with approximately 166 new and 392 follow up appointments not taking place;
- Approximately 190 surgical procedures have not occurred.

Follow-up appointments

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

What are we doing?Diagnostics

- Demand and capacity optimisation, outsourcing, clinical validation, recruitment and revising pathways.

Therapies

- Planning for service restarts to identify appropriate PPE resource, physical distancing compliance and clinical estate availability to address face to face clinical treatment requirements. Where appropriate, services testing restart pathways
- Virtual and remote service provision being successfully trialled within therapy services. Requires additional intensive care treatment equipment and deployment of digital platforms at scale.
- Audiology has continued to provide a postal hearing aid repair service and offers face to face urgent appointments;
- Telephone Follow-Up consultations have been conducted for the entire Hearing Aid Follow-up waiting list (2,068 patients);
- Audiology has provided New Born Hearing Screening appointments for 331 babies since the pandemic;
- All patients on the 'GP Assessment' lists will be contacted for telephone consultations to complete the required a medical history, discuss the psychosocial impact of their hearing loss and their expectations of amplification.

Hospital initiated cancellations

- Working to optimise available elective Theatre lists, focusing on Cancer pathways; planning and collaborating with local Patient flow teams to provide safe havens that promote safe elective patient stay whilst in hospital.

RTT

- There is a work programme in place to establish all urgent and category 1 patients;
- A full appraisal is being undertaken of capacity across the sites and the private hospital with regard to cancer very urgent (category 1) and then residual routine capacity;
- Patients will be offered treatments in line with policy across the sites to enable equity of time and care delivery;
- Complex pre assessment and screening pathways are in place including social isolation pre and post operatively with pre COVID screens at 72 hours.

Eye care

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

Follow-up appointments

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

**How did we do in June 2020**

Clostridioides difficile (*C.difficile*) Infection is due to a bacteria in the bowel that releases a toxin causing diarrhoea and bowel damage. For the period April – June 2020 we have reported 38 cases 10% fewer cases than the same time frame in 2019. 16 cases were reported in June 2020 (6 of which were in WGH) 10 cases reported in April and 2 in May.



Escherichia coli (E.coli) blood stream infection (BSI). For the period April – June 2020 we have reported 67 cases 21% fewer cases than the same time frame in 2019. 17 cases were reported in June 2020, 25 in April and May. From the 25 cases in May, BGH reported 12 cases.



Staphylococcus aureus (S. aureus) BSI. For the period April – June 2020 we have reported 22 cases 27% fewer cases than the same time frame in 2019. 7 cases were reported in June 2020, 10 cases in April and 5 in May.



In June, we reported **1,198** incidents of which **1,054** were patient safety related. Welsh Government ask Health Boards to review and close serious incidents within 60 working days. There were **4** serious incidents due for closure with Welsh Government in June of which **75% (3)** were closed in the agreed timescale. No never events were reported in June 2020.



We achieved target by responding to **75%** of complaints within 30 working days in June. This is a 12% rise since last month and compares exactly with where we were in June 2019.

RisksInfections

- There is a risk that the continuing workload created by COVID-19 may have a detrimental effect on infection rates;
- Patients may delay seeking medical advice for ailments with GPs or through A&E due to anxiety around COVID-19.

Incidents

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

Complaints

- Communication - inability to respond to patient queries about when services are resuming. This is causing a delay in the Health Board's response times;
- Potential for an increased number of complaints to be received in the coming months, particularly with the easing of lockdown, from patients who have not received appointments/treatment during March/April/May and from those (such as cancer patients) who may believe that harm has been caused by a potential delay in diagnosis.

What are we doing?Infections

- Infection Prevention activity in Community and Acute Hospitals continues to be focused on COVID-19 and reset of services.
 - WGH have established an 'Improve Antimicrobial Prescribing Task & Finish group' under Mr Andrew Burns to review and improve antimicrobial stewardship;
 - Faecal Microbiota Transplant (FMT) service has recommenced in the Health Board with one procedure completed in June;
 - Review of the BGH E.coli BSI identified that no cases were hospital acquired, the majority were from a urinary source.

Incidents

A review of serious incident closures has identified a number of factors. We are working closely with Directorates and Welsh Government to improve the number of serious incidents closed within 60 days. The Listening and Learning from Events Sub Committee is newly established and will receive a summary of the formal review and improvement and learning actions plans following a serious incident.

Complaints

- To assist the patient support team with the enquiries/complaints that are received; more information has been sought regarding communication about which services are resuming and when;
- The team are concentrating efforts to reduce their individual caseload in preparation for an influx.



How did we do in June 2020



22.8% of children and young people (271/1,188) waited less than 26 weeks to start a neurodevelopment assessment. This is the combined figure for autistic spectrum disorder (ASD, 25.4%, 212/834) and attention deficit hyperactivity disorder (ADHD, 16.7% 59/354).



40.6% of adults (610 out of 1,501) waited less than 26 weeks to start a psychological therapy with our Specialist Mental Health Service. Psychological therapies are used for common problems such as stress, anxiety, depression, obsessive compulsive disorder and phobias.

Risks

Neurodevelopmental assessments

- Delays can impact on the quality of life for patients and their families;
ASD - growing demand verses resources and difficulties in recruitment;
ADHD - historical referral backlog and vacancies within the team

Psychological therapies

- Increased demand from primary and secondary care;
Vacancies and inability to recruit into specialist posts;
High waiting lists for both individual and group therapy;
Lack of a robust IT infrastructure.

What are we doing?

We are transferring our mental health patient records to a new system called Wales Patient Administration System (WPAS) which once implemented will allow timelier reporting. At that point we will undertake a review of the indicators available and enhance this briefing accordingly

Neurodevelopmental assessments

- Each mental health service team is working with the all Wales performance Delivery Unit to undertake demand and capacity exercises;
Waiting list initiatives have been utilised;
Additional hours have been offered to current members of staff to increase capacity;
A part-time speech and language therapist has been recruited;
An investigation has been undertaken and a report written outlining the additional resources required for a sustainable ASD service;
Efficiency and productivity opportunities are being explored;
An additional part-time community GP post has been recruited.
The service is actively reviewing and managing referrals and referral pathways;
A process mapping exercise is underway supported by all Wales performance Delivery Unit;
An active recruitment plan is being developed;
Weekend clinics are being considered to increase assessment;
Commissioning with external providers is being considered to increase the number of available assessments;
Agency practitioners are being utilised to address the waiting list.

Psychological therapies

- A team restructure is underway;
A new service model is being developed;
Referrals from emotional cognitive scale (ECS) are no longer accepted in order for us to concentrate on high intensity therapy;
Waiting list initiatives are being utilised;
A single point of contact has been created for all referrals to ensure improved coordination and response;
A demand and capacity exercise will be undertaken with all staff to ascertain capacity in caseloads;
A review of all modalities will be undertaken to ensure prudent delivery of therapy in line with local and national policies/guidelines;
The use of evidence based group work is being evaluated to consider increasing capacity and reduce time waiting for therapies.

**How did we do?**

Between January and March 2020, **95.5%** of children had received 3 doses of the '6 in 1' vaccine by their first birthday, consistent with uptake in the previous quarter (96.3%).



The MMR vaccine is also given as a single injection and protects against mumps, measles and rubella (German measles). It is given within a month of a baby's first birthday then again when the child is around 3 years 4 months. In Hywel Dda, between January and March 2020, **90.0%** of children received 2 doses of the MMR vaccine by their 5th birthday, compared to 91.7% in the previous quarter.



During April '19 to March '20, **3.5%** (1,922) of adults attempted to quit smoking using a smoking cessation service.



30.3% of smokers who quit had the carbon monoxide (CO) levels in their blood confirm they had quit in January to March '20 2019.



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

RisksVaccines

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

Smoking

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

Obesity

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

What are we doing?Vaccines

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

Smoking

- Posters were produced and delivered to wards along with a programme of training to ward staff and F1 foundation doctors. This work will need to be revisited post COVID as many of the posters have been removed due to infection control concerns. We are also looking into lanyard prompts to assist staff with the pathway and prescribing guidance. Posters have been produced in a plastic covering to allow enable them to be cleaned;
- In Primary Care a revised pathway has been created to remind referrers that the service is still able to provide support during COVID. Following a successful pilot in a GP practice in Llanelli, we worked with 4 further practices to allow instant booking of support through their in-house computer system;
- Paused recruitment of pharmacists and pharmacy technicians into the Pharmacy Level 3 Smoking Cessation Scheme to ensure services are provided across the Health Board area; Referrals usually directed to pharmacies are being processed via Community and Secondary Care who are able to provide telephone support to relieve the burden on pharmacies;
- Local Stop Smoking Wales (SSW) services have been integrated; SSW staff are now fully integrated and known as the 'Community' team in the Healthy Lifestyle & Wellbeing Team – Smoking. As both the Community and Secondary Care teams are offering telephone support the referrals are being spread evenly throughout the teams and weekly team catch ups are taking place via Microsoft Teams;
- The current situation for community pharmacists is CO validation is no longer provided. Level 3 services are continuing where pharmacists are comfortable taking on new clients and have the facilities to hold consultations taking into account the social distancing requirements. Some Pharmacies are developing interesting practice to ensure smoking cessation support continues. For example, one pharmacist asks the clients to park outside the pharmacy so that they can use the pharmacy Wi-Fi and have a video call over Messenger with the pharmacist. The pharmacist then puts the Nicotine Replacement Therapy (NRT) indicated in a bag and takes it outside to the car;
- As CO readings are currently suspended a document has been produced to ensure that support is still offered to pregnant women and that the impact of Carbon Monoxide exposure is still discussed even where a reading is not being taken.

Obesity

- Weight management services are offered to adults with chronic conditions;
- The Health Board is awaiting the publication of a Welsh Government action plan (January 2020) to help implement the priorities in the new *Healthy Weight: Healthy Wales* strategy to develop a local response.

**How did we do in May/June 2020?**

5.35% of full time equivalent (FTE) staff days were lost due to sickness in the cumulative 12 month period May 2019 to April 2020. This represents a deteriorating picture compared to the cumulative position at May 2019 (4.88%). The in-month figure of 5.44% (May 2020) represents an increase against the corresponding in-month sickness rate in May 2019 (4.78%), however it also represents a decrease of 0.80% compared to April 2020 which was 6.24%.



70.39%* of our staff have completed their individual performance appraisal and development review (PADR) with their line manager in the previous 12 months.

*Figure does not include medical appraisals that have been suspended until September 2020 due to Covid 19.



83.5% of our staff have completed their level 1 training which consists of the UK Core skills mandatory training modules such as manual handling, safeguarding and information governance.



58% of our Consultants and Specialty and Associate Specialist (SAS) doctors have a current job plan.



The Health Board's financial position at the end of June is a **£1.5m (year to date (YTD) £16.2m) deficit** against a deficit plan of £2.1m (YTD £6.3m). This is after incurring additional costs of £1.4m directly attributable to COVID-19. Of this, the underlying cost of COVID-19 in the month was £12.3m, however this was offset by the recognition of Welsh Government (WG) allocations for Quarter One pay costs associated with COVID-19 and Field Hospital set-up costs for Pembrokeshire and Ceredigion totalling £10.8m.

Of the £12.3m COVID-19 costs incurred in month, £2.9m is due to the non-delivery of savings having diverted our operational focus to managing the COVID-19 pandemic. In June, we delivered £0.2m of savings schemes against our plans of £0.3m due to the operational responses required to COVID-19.

RisksAbsence

- The current all Wales Management of Attendance Policy offers managers more discretion when escalating staff through the policy and emphasises a more compassionate approach to managing attendance than was permitted in the previous policy – there has been a notable increase in sickness rates since the new policy was introduced. In March 2020 there was an increase in Covid related absence levels.

PADR

- Achieving the PADR target requires managers to overcome conflicting demands on their leadership roles and have adequate knowledge and skills to complete effectively. Additional risks arise from lack of feasible training options.

Core skills

- Overall compliance is impacted by the lack of provision for fire safety training before it was made available as an e-learning module in April (current fire safety training compliance is 72.8%). Whilst the e-learning module has been promoted through the staff Global email, there are challenges around awareness of the e-learning module on ESR.

Job planning

- The process requires a number of phases to achieve finalisation, this needs to be effectively planned and coordinated around clinical time.

Finance

- We have a Financial Plan with a year-end of £25.0m deficit. A full year financial forecast was completed during June in line with the Welsh Government Quarter 2 Operational Plan. Welsh Government have funded certain additional costs incurred as a direct consequence of COVID-19 however, there is no certainty of future funding arrangements. This means that there is a significant risk that the Health Board's financial position may be adversely affected.

What are we doing?Absence

- The Operational Workforce teams have been unable to focus on management of absence throughout the Covid 19 period although are now beginning to re-commence sickness reviews with Line Managers;
- In addition, sickness audits are due to start again shortly. Occupational Health capacity has also been severely limited due to illness.

PADR

- The COVID outbreak is still negatively impacting PADRs, as many are unable to be completed in a timely manner. However, it is encouraging to see a slight increase in the compliance rate for the organisation. This follows messages designed by the Occupational Development team disseminated through various communication channels reminding leaders of the importance of performance meetings;
- The team are currently reviewing a virtual classroom platform, working collaboratively with IT to remove small accessibility issues. Once these have been resolved the team will re-design the managing performance module enabling virtual learning and development. It is vital that all IT issues are removed so once rolled out, attendees have positive experiences and trust the platform for future sessions.

Core skills

- Fire training level 1 has reverted to the e-learning module which is seeing compliance levels rise. Since April fire safety training compliance has increased by 9.2%.

Job planning

- Job Planning updates have been provided to service managers. Support is available and has been offered to complete job plan reviews where possible. The review of service plans and clarity over future provision will impact on the completion of job plans;
- Mental Health & Learning Disabilities and Trauma & Orthopaedics are in the process of reviewing job plans within their departments and once fully signed off, will contribute to a rise in job planning figures over coming weeks.

Finance

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