Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	24 November 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Operational Update and Progress Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations Jill Paterson, Director of Primary Care, Community and Long Term Care
SWYDDOG ADRODD: **REPORTING OFFICER:**	Gareth Skye, Business & Governance Manager, Central Operations

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Board with an update on the Operational Delivery team's progress against recovery plans which are built on the clinical delivery priorities set by the organisation for 2022/23. In addition, the report provides a wider and more general operational update.

The purpose of this report is to provide an overview of the context, actions and progress of planned operational objectives. It does not seek to provide an alternative source of performance data to that contained within the Health Board's routine Integrated Performance Assurance Report (IPAR).

Cefndir / Background

The work of the Operations Directorate and its supporting management teams will be involved in progressing each of the eight priorities set by the Board and whilst some are under the full control and influence of the directorate others are less so. Those in the first category are as follows:

1) Planned Care Recovery
2) Urgent and Emergency Care
3) Integrated Communities
4) Mental Health and Learning Disabilities
5) Vaccinations

Whilst progress updates will provide a continued focus on some of the priorities, others may be offered cyclically. Equally, some of the above will inherently be delivered through Health Board infrastructures exclusively, whilst others will require a composite approach with support from the Integrated Executive Group (IEG). The IEG sits under the Regional Partnership Board (RPB) and consists of senior officers from Hywel Dda University Health Board (HDdUHB) and its three associated local authorities. The group advises the RPB on priorities for integration and seeks to address shared operational challenges.

Asesiad / Assessment

Against the key delivery priorities set by the Board, along with the broader system pressures which exist, the following is provided as an amplified update for this report:

ENHANCED MONITORING AND RESPONSE

On 29th September 2022 the Welsh Government confirmed that the escalation status for the Health Board had been raised to 'targeted intervention' for planning and finance. No change has been applied however to the 'enhanced monitoring' status for quality issues related to performance resulting in long waiting times and poor patient experience.

In response to the above a consolidated enhanced monitoring action plan has been developed and was submitted to Welsh Government on 11th November 2022. A copy of the action plan is available at appendix 1 of this paper. Progress against the delivery of this plan will be included in future operational update and progress reports.

STRENGTHENING INTEGRATED QUALITY, PERFORMANCE AND FINANCIAL GOVERNANCE

As part of its overall commitment to patients and staff alike the Health Board is moving into being more data-driven in its approach and has developed several tools over the last 6 months such as the system risk and potential harm dashboard, which allows the rapid triangulation of quality and performance data and identifies areas for improvement. Discussions are underway at an executive level to consider how integrated quality, performance and financial governance can be strengthened further to operationally deliver in a sustainable way.

TRANSFORMING URGENT AND EMERGENCY CARE (TUEC)

Funding received from the Welsh Government 6 Goals Programme to implement Urgent Primary Care (UPC) and Same Day Emergency Care (SDEC) services has been fully utilised to improve our target areas of Conveyance, Conversion and Complexity management.

Impact against the agreed 3Cs outcome measures is as follows:

- **Conveyance** - the number of people attending emergency departments by ambulance continues to demonstrate a downward trajectory, whilst the balancing measure of total emergency department attendance is higher than pre COVID levels. The number of patients being managed by our Urgent Primary Care (this includes intermediate care) is also greater than pre COVID levels.
  Evaluation of the UPC Clinical Streaming Hub has confirmed a positive conveyance rate reduction (40% reduction) specifically in relation to our UPC medical review of patients pending ambulance conveyance in the community in Carmarthenshire. This pilot is now being rolled out across the other counties.
- **Conversion** - the number of admissions continues to reduce for all ages across all admissions with an increasing number of patients being assessed within our SDEC services.
- **Complexity** – The length of stay (LoS) continues to increase alongside the number of patients who have an average length of stay of over 21 days. The latter is particularly the case for our frail elderly patients who consequently require a level of care and support in the community. The demand for care and support exceeds capacity in the

community and consequently bed occupancy rates for this population continue to increase in tandem with their associated LoS in hospital.

Impact analysis
Data analysis suggests there is a greater proportion of patients who would benefit from UPC and SDEC that are arriving at our Emergency Departments. Furthermore, the data indicates that a proportion of these patients are complex and frail and could be supported at home on 'virtual wards'. There is currently no nationally agreed definition of 'virtual ward'. Broadly it describes the care people in the community are receiving that would otherwise require a secondary care bed. This includes acute level interventions such as IV therapy. Patients may also be admitted onto the virtual ward and receive their clinical monitoring remotely via a digital platform and the patient's condition monitored utilising telehealth devices. A senior manager review of discharge planning and coordination across all 4 acute hospital sites has demonstrated the need for improved practice in this area. In respect of the number of patients utilising virtual wards specifically for telehealth monitoring, the current figures are set out as follows:

- 145 heart failure patients
- 73 COPD patients
- 104 pre-habilitation patients (those pending orthopaedic surgery)

A workshop held with nursing and therapy team leaders was held in October and was positively received. Feedback demonstrated the commitment to improving the care management of our complex patients particularly in relation to adopting a Home First approach through considering safe alternatives to hospital admission at the front door and also reducing length of stay of frail patients.

Next Steps

- Explore opportunities to scale up the Clinical Streaming Hub to accommodate Pembrokeshire and Ceredigion patients pending ambulance conveyance. This is anticipated to take place throughout December, pending confirmation from WAST
- Explore opportunities to scale up the Clinical Streaming Hub to accept GP referrals and provide scheduling provision to SDEC services
- Review Redirection Policy for redirecting patients who attend Emergency Departments and whose needs could be supported safely with alternative pathways
- Developing a digital platform that will support ward managers and inpatient multidisciplinary teams to implement best practice discharge planning and coordination
- Programme work aligned to improvement trajectories
- UEC Performance Outcomes framework and key measures agreed for weekly reporting to Executive Team

Other programme developments of note

- We continue to increase the number of patients supported by Technology Enabled Care (TEC) in the community as part of our 'virtual ward' provision. Telehealth supports patients with heart failure and chronic obstructive pulmonary disease as well as patients pending planned care in the community in an initiative known as 'prehabilitation'. Evaluation of this care pathway has been positive in terms of patient reported outcomes and experience and we will continue to scale over time.

<u>ROLLOUT OF REAL TIME DEMAND AND CAPACITY (RTDC) METHODOLOGY</u>

RTDC is being rolled out across all acute hospital sites to support the Health Board's response to the Enhanced Monitoring Escalation expectation:

On urgent and emergency care provide a focus on timely patient flow and discharge, engage with patients (and staff) on their experience in ED and focus upon reducing trolley waits and long waits for admission from ED

RTDC is an approach to improve hospital wide patient flow. It involves implementing standard structures for ward level board rounds and hospital bed meetings as well as standard processes and reporting mechanisms for the 4 RTDC steps:

- Prediction of capacity
- Prediction of demand
- Development of a plan
- Evaluation of the plan

RTDC was introduced as a pilot at GGH in February 2022 following an offer to support the introduction of this methodology from Improvement Cymru (IC). Work has also commenced on its introduction at PPH and it is anticipated that RTDC rollout at Withybush General Hospital and Bronglais General Hospital will begin in December 2022.

The principles of RTDC form part of the Health Board wide optimal hospital flow workstream to support the implementation of TUEC Policy Goal 5. A Health board wide delivery group has been established to oversee the implementation and adoption of best practices to support optimal hospital flow across all our acute sites, which includes RTDC.

Enablers to maximise optimal hospital flow and to support implementation of RTDC include full implementation of board rounds and afternoon huddles on all inpatient areas. This work is being prioritised by the Quality Improvement & Service Transformation (QIST) team across the 4 acute sites to support the implementation of RTDC.

Other enablers that are being considered as part of the Policy Goal 5 include widespread adoption of the SAFER principles, 'Red to Green', active measures to prevent deconditioning and discharge to assess and recover pathways (D2AR)

To support this a standardised framework and policy for board rounds and afternoon huddles is being developed for HDUHB that incorporates RTDC.

Monthly meetings with IC continue in relation to RTDC implementation and support is being sought for the further roll out of the approach. The IC clinical lead and regional support lead will be meeting with the operational team at GGH and QIST team members on the 16 November 2022 to assist in taking this work forward.

Observations and lessons learned from the GGH pilot will inform a sustainable RTDC roll-out across Health Board. For example, HDUHB identified medical engagement as a key component for the widespread adoption of RTDC which now forms part of IC approach.

The Operational and Improvement Leads for RTDC at GGH will be attending a national Action Learning Set on Situational Awareness RTDC Flow Methodology, facilitated by IC in December 2022 to which identified operational and improvement leads from PPH, WGH and BGH will be requested to attend.

<u>PLANNED CARE RECOVERY</u>

Delivery plans in response to the Ministerial Measures milestones for 2022/23 (no Stage 1 patients waiting > 52 weeks by December 2022 and no patients waiting >104 weeks by March 2023) are progressing as per plan. As previously reported, whilst available capacity remains

insufficient to fully achieve both Ministerial Measures milestones, the total cohort of patients with the potential to wait in excess of these milestones is expected to reduce by over 80% by the respective target dates and the HB remains on course to achieve the delivery trajectories previously advised to WG.

Efforts to further expand outpatient and operating capacity continue, within the limits of available staffing levels. In September 2022, overall outpatient activity levels increased in 85% of pre-pandemic levels with day case surgery volumes exceeding 75% of the 2019/20 average. Inpatient surgery sessional capacity is not expected to recover to pre-pandemic levels until Q4. Recruitment to vacant Health Records staffing posts is progressively supporting the expansion of outpatient activity and the transformation of outpatient service provision continues with approximately 25% of current outpatient activity delivered via virtual platforms. Steady progress is also being achieved in the adoption of alternative delivery models to traditional clinic-based follow-up care with the combined proportion of patients being managed via 'See on Symptom' (SoS) and 'Patient Initiated Follow Up' (PIFU) pathways, along with those discharged directly following outpatient assessment, exceeding the indicative 20% threshold advised by WG. These approaches enable the release of clinic capacity to be directed to recovery priorities.

The planned handover to the Health Board of the Modular Day Surgical Unit at Prince Philip Hospital was confirmed on 11 November 2022 with the first patients to be treated on 5 December 2022. To mitigate the loss of activity through the new unit, 8 of the 10 weekly sessions planned to be delivered via the first of the two new theatres have been re-provided via the main theatre facilities at PPH. Recruitment efforts to secure necessary anaesthetic and theatre staffing resources are continuing, with further increases in activity volumes anticipated from November 2022.

CRITICAL CARE STAFF RECRUITMENT

Following Board receipt and approval of the Critical Care update in September 2022, recruitment efforts for locum and substantive recruits are continuing although no suitable applicants have yet been identified. During the 14-week period since the admissions protocols to the PPH Critical Care Unit were temporarily amended, a total of 7 patients requiring Level 3 care have been transferred away from the hospital without any adverse impact on these individuals. This remains well below the level initially anticipated and reflects the joint approach adopted by the critical care and acute medical teams in providing support to patients appropriate to their clinical needs. All patient transfers were undertaken in a safe and appropriate manner with the majority supported by the ACCTS critical care transfer service.

WINTER PREPAREDNESS UPDATE

As reflected in the Winter Plan approved by the Board in September 2022, there were a number of actions aligned to the 6 Goals Urgent & Emergency Care (UEC) which health boards were requested to accelerate over the winter period. The UEC program is established within the Health Board with an interim Senior Responsible Officer and programme support and established delivery groups focused on the 6 policy goals. The request from Welsh Government was to accelerate key pieces of work and supplement local actions that featured as part of our operational plan.

As part of Policy Goal 1, to progress coordination, planning and support for people at greater risk of needing urgent care, actions centred around optimising use of British Red Cross and Care and Repair Services to facilitate discharge and turn around at the front door. For a number of years British Red Cross have been commissioned by the Health Board and work in

partnership with community services across the 3 counties and this year the Health Board commissioned services directly from Care and Repair following a successful pilot funded directly by Welsh Government. The UEC SRO and lead recently met with the national Policy Goal 1 lead to discuss progress and ongoing developments.

The focus of policy Goal 2, signposting people with urgent care needs to the right place, first time, centres around delivery of 111 Wales MH 'press 2' pathway. The Health Board piloted this new pathway where callers to 111 services have the option to immediately obtain the support they need and this has proved very successful and the hours the pathway is available are being considered for extension.

Policy Goal 3, clinically safe alternatives to admission, focuses on Urgent Primary Care Services supported by Same Day Emergency Care (SDEC) services being provided across a 7 day period. The Health Board has established a virtual urgent primary care model (UPC), working with partners across the whole UEC pathway to clinically stream and triage people to the most appropriate pathway; this has been operational as part of a pilot in Carmarthenshire for several months and plans are ongoing to develop this model further and extend the hours of all services are in place throughout December 2022. The TUEC program is currently scoping the demand and capacity available across the 3 acute SDECs and will be undertaking a peer review to ascertain the best model moving forward to provide a 7-day service. No timescale for this has been confirmed but it will take place as soon as possible. The recently appointed Clinical Lead for Acute Medicine is leading the task and finish group developing a robust and sustainable SDEC model.

Policy Goal 4 (rapid response in crisis) is focused on expansion of remote clinical support for ambulance services alongside increased pace on ambulance handover improvement plans. An operational delivery group co-chaired by Welsh Ambulance Service Trust (WAST) and the Health Board has been established for a number of months focused on actions that can be delivered at pace to reduce the number and length of ambulance delays at our front doors. One of these actions was a joint pilot to embed Advance Paramedic Practitioners alongside health and social care staff was undertaken with WAST in Carmarthenshire and following the successful evaluation this is being rolled out to Pembrokeshire and Ceredigion. The virtual UPC model centre described above centres on clinicians working remotely across the system to pull and stream people to appropriate pathways which includes callers to ambulance services awaiting a response. Callers are contacted directly by a clinician and where appropriate, alternative pathways are advised.

Setting standards for policy Goal 5, optimal hospital care and discharge practice from the point of admission, has been undertaken at pace nationally and representatives from the Health Board have been key in influencing this work. In anticipation of the launch of this piece of work in December, the Health Board has established a delivery group which is undertaking the necessary baseline assessments and audits to ensure that any interventions can be targeted over the winter period.

Policy Goal 6 (Home first approach and reduce the risk of admission) has been developing standards nationally and the Health Board has recently piloted the new delayed pathways of care process and reporting of delayed transfers of care (DToC) prior to formal roll out by the end of the year.

MENTAL HEALTH SERVICES IN CEREDIGION

Adult Mental Health
Recruitment and retention of Adult Mental Health (MH) staff has improved in Ceredigion in recent months, with minimal staff vacancies across our MH teams. A new Senior Nurse Manager has recently taken up post, following the retirement of the previous post holder. There is also an increase in staff members who have previously left local MH services now applying to return to work in Ceredigion.

Formal links have been established with the school of Nursing in Aberystwyth University to offer placements in Gorwelion. A Mental Health Nurse training programme commenced in September which will support future recruitment of qualified nurses locally.

A Ceredigion Mental Health and Police working group has been established, which provides staff with a regular forum to meet with Dyfed Powys Police and other partner agencies including Local Authorities, A&E, Community Drug and Alcohol Teams (CDAT) and Dyfed Drug and Alcohol Service (DDAS).

An independent review has been undertaken into the changes delivered in Adult MH services in Ceredigion over the past couple of years. This is to ensure that the intended Transforming Mental Health (TMH) outcomes are being delivered and to understand the staff experience of these organisational changes. The service is currently preparing a Management Response to the review report.

Integrated Psychological Therapies
The Local Primary Mental Health Support Service (LPMHSS) is currently experiencing some long-term sickness, which is impacting on its ability to meet WG compliance. There has been some recent success in recruiting into current vacancies, however these are still going through the on boarding process, therefore the benefits will not be seen until staff have been inducted into their new roles.

Older Adult Mental Health
Older Adult Mental Health bed occupancy is currently at 100%, therefore the service is utilising the 4 ‘shared-care’ beds on Enlli Ward as surge capacity continues. This is compounded by lack of provision in the social care sector in respect of Domiciliary Care, Respite Care and Residential Care.

The service is experiencing difficulties in recruiting to existing vacancies in the Ceredigion Community Mental Health Team, particularly Care Co-ordinator posts. The Team Manager post has been appointed on an interim basis until February 2023 via an Expression of Interest while the substantive posts continue to be re-advertised.

Medical Workforce recruitment via an NHS Locum has improved psychiatry services. Memory Assessment Services (MAS) are working towards a 7% waiting list reduction target month on month, with latest returns showing a continued reduction.

Specialist Child and Adolescent Mental Health Services (S-CAMHS)
The service is currently recruiting into key vacancies including a Community Psychiatric Nurse, a Cognitive Behaviour Therapist, and a Systemic Therapist to expand the workforce in Ceredigion. A proposal is being developed to enhance the medical workforce with Advance Nurse Practitioner and Non-medical Prescriber roles.

There has been success in recruiting to all vacancies in the Specialist Eating Disorder service through sustainable SIF monies. This will increase capacity within the service and provide enhanced and timely support for Children and Young People (CYP) with severe eating disorders in Ceredigion.

The service continues to work with key partners to deliver a range of Third Sector support including MIND to deliver Individual Placement Support services for individuals seeking to re-engage in education and/or employment.

S-CAMHS has commissioned Kooth, a digital online Counselling support service to work across the 3 Local Authority (LA) areas. The service is offered to all children and young people on our waiting list and to those in receipt of mental health services to provide additional emotional support.

Following the success of the Ceredigion School In Reach Pilot the service has been awarded 3 years recurrent funding to enable further rollout across all 3 LA's. All posts across the region have been fully appointed. A multi-agency Steering Group has been established to oversee the implementation and ongoing operational development of the service.

The following Directorate wide services are now fully established in Ceredigion, with positive benefits being realised across all local MH services across the age range:

- The Alternative (Community) Place of Safety is operational 24/7, which ensures that local provision is available for individuals who require a S136 assessment. Since June the service has been utilised 5 times, with 4 individuals returning home and 1 individual requiring inpatient services. An operational policy is in development, which considers the designated Hospital Place of Safety in Bryngofal, alongside links to local community provision.

- Mental Health Liaison Services continue to be developed in Bronglais General Hospital. The Service is available 24/7 and is easily contactable, with a single referral form developed for all departments and wards within the District General Hospitals and Community Hospitals to request a mental health assessment for a patient. A new service specification setting out the services operating procedures has recently been developed. Following consultation, the document is being revised to include LD Liaison provision.

- The Mental Health Single Point of Contact operating via 111 Option 2 continues to impact positively on services in Ceredigion. The triage and brief interventions provided ensure help to those in distress to deescalate, which in turn reduces the need for statutory interventions. From 6 November 2022 111 Option 2 will be available 24/7 ensuring that help and support is available to those in crisis when needed. A data set is being agreed with WG to fully evaluate the impact the service is having on statutory MH services. In August a Professional Line was introduced via a local 01267 number for A&E, WAST, LA's, GP's and Education colleagues where a MH Practitioner will provide advice, guidance and assessment support in respect of complex mental health presentations. A process has also been established with Dyfed Powys Police whereby calls can be directly transferred from 101 into 111 Option 2, where a Police response is not required.

- The Out of Hours Clinical Co-ordinator Service has greatly benefitted MH teams in Ceredigion by providing a specialist clinical role to support and advise CRTs in

respect of complex clinical issues. The service acts as the point of contact for advice on any clinical issues and for S136 consultation by the Police. The Clinical Leads are advised of all potential admissions and provide support and advice on any in-patient discharge out of hours to the Health Board, LA, WAST and Police, liaising with Out of Hours services across all 3 local authority areas. Support is also provided to in-patient staff to manage any staffing requirements, liaising with the second on call as appropriate.

- The all-age MH conveyance scheme continues to be utilised fully by services in Ceredigion. The service is being provided by St. John Cymru, with 1 full time vehicle with a 2-person crew available from 10.00am – 10.00pm 7 days per week. Outside of these hours (10.00pm – 10.00am) there is an on-call system in place. Calls per month have steadily increased throughout the first 12 months of operation, with over 400 conveyances undertaken across MH&LD services. This service has greatly reduced demand on NHS and partnership organisations (Police & Local Authority) staff time in having to provide transport. Prior to the St John initiative Health Board staff have had to transport individuals due to several issues such as delays in waiting times for transport, unsuitability of WAST vehicles etc. In particular Ceredigion MH Services utilise the vehicle more so that than the other LA areas to support with geographic challenges, e.g. to facilitate more timely discharges home from hospital. The Service is currently supporting an individual from Ceredigion to access Electroconvulsive Therapy (ECT) treatment in Carmarthen every 3 weeks, which has freed up staff who would otherwise have had to provide the transport.

- WG have recently agreed sustainable funding for service, with a national procurement exercise expected to take place in the next 6 months for a 3-year contract. Due to the success of the service in the Health Board, WG have invited us to work with their procurement department to agree the service needs for the national commissioning of the service. This will help us to ensure that local service user feedback is incorporated including unmarked vehicles, cars rather than ambulances (unless a stretcher is required) and informal uniforms etc.

- The Sanctuary Service which is currently being piloted in Aberystwyth by Adferiad has developed close working relationships with local multi-agency services and has seen increased referrals as the service has become more established. Approval have been received from WG for sustainable funding for this service through the MH Service Improvement Fund. In the coming months the service will be procured alongside all of the Directorates Third Sector provision. This will ensure the sustainable and equitable provision of early intervention and prevention services across Ceredigion for the next 4 years.

<u>MENTAL HEALTH AND LEARNING DISABILITIES (HEALTH BOARD WIDE UPDATE)</u>

Adult Mental Health

Community Mental Health Teams across all 3 local authority areas continue to be impacted by vacancies. However, there has been some improvement with recent uptake in Practitioner vacancies that have been re-advertised. Recruits are currently going through the on boarding process and will take up post over the coming months. Key areas with ongoing issues are the Pembrokeshire CMHT's, which have been mitigated by two block booked agency staff, which have been invaluable to the team in terms of meeting ongoing patient care needs.

Staff retention continues to be problematic in some areas, with staff applying for posts within new service areas which require no care co-ordination. Long term sickness rates have

improved, however short-term sickness absences continue, both of which have been compounded by high annual leave during the summer season.

Demand on inpatient beds remains high with over 100% occupancy, with surge beds being used to ease pressures when needed. PICU ward has experienced recent staffing issues due to vacancies. The service is utilising agency staff to help to mitigate the current staffing shortages, while substantial recruitment is undertaken. Alongside this an Expression of Interest for a Band 5 post will be advertised to all Adult MH Wards, to assist with staffing deficits.

The Mental Health Single Point of Contact operating via 111 Option 2 continues to impact positively on services. With the percentage of calls requiring intervention / signposting to Third Sector agencies or self-help remaining high and the follow-on request for Mental health services remaining low as set out in the table below:

Service Area	Referral Rate
Self Help/Self Care/Advice	43%
Call Terminated	13%
Frequent Caller	11%
Call Transferred 111	8%
Other	8%
CMHT/OAMHS	5%
999/101	4%
Failed Contact	2%
Advised to attend A&E/MIU	2%
CRHT	1%
LPMHSS	1%
S-CAMHS	0.75%
Perinatal	0.75%
Edis	0.25%
Advised MHA/LA	0.25%
Veterans	0%

The service began operating 24/7 from 6 November 2022 with the Deputy Minister for Mental Health and Well-being attending on 10 November 2022 to officially launch the service.

Learning Disabilities
A review of operational management for LD has been undertaken and a decision made to appoint on an interim basis a Registered Nurse to oversee both LD and Adult Inpatient settings for 6 months. Interviews will be held in early November.

Work is progressing on the Learning Disability Service Improvement programme (LD SIP) for the community and inpatient settings change programme, with a review of the former Ty Bryn service having been completed. An SBAR has been developed to outline the future direction of travel and next steps based on recent service assessments. The SBAR will be taken to the Operational Planning and Delivery Programme Group (OPDP) in mid-November for approval to progress with the proposed change model. Following this an Organisational Change Plan

will be undertaken with all affected staffing groups within the new service structure being implemented from 1 April 2023.

Recruitment issues continue with vacancies in Community Teams, with certain posts proving difficult to recruit to. The long-term sickness within Therapy Services continues to impact waiting times.

Physiotherapy services continue to hold increasing waiting lists with subsequent breaches. Psychology and behaviour services are generally understaffed, with several staff still on maternity leave and long-term sickness. Several senior Psychology vacancies are being advertised in early November, alongside a recruitment drive for Consultant Psychiatry vacancies. Several streamlined Band 5 Nurse posts will be taking up post in November. Contingency plans remain in place.

Psychological Therapies
Performance targets against the percentage of adults waiting less than 26 weeks to start a psychological therapy is gradually improving and on an upward trajectory, however this is being impacted due to the increased referral rate. In January 2022, 29.4% of individuals were waiting fewer than 26-weeks to start a psychological therapy. This figure has increased to 43.9% (400 out of 912 individuals) in September.

Recruitment issues persist with several staff who managed group therapy sessions being successful in attaining positions with the Psychology Service. The service continues with succession planning arrangements when reviewing recruitment options.

Therapeutic intervention pilots continue across a range of modalities to achieve higher capacity for the offer of intervention appointments. The uptake of group interventions will improve the access pathway for Integrated Psychological Therapy Service (IPTS), which should result in fewer numbers requiring a more intensive intervention. As groups are still ongoing, we are awaiting the final outcomes. However, earlier group intervention pilots for Dialectical Behavioural Therapy (DBT) resulted in 20 service users out of 20 being discharged from the service, requiring no further treatment. Of these, 7 were discharges due to relocation or disengagement. External venues are being utilised to reduce the stigma attached to attending mental health services, however this may be reviewed going forward as there are financial implications. A Patient Access Policy has been drafted and approved by the Psychological Therapies Management Group. The Draft policy will be taken to the Written Control Documentation Group for wider consultation and approval. It is hoped that the impending Delivery Unit review of psychological therapies will give further clarity regarding Referral to Treatment guidance along with an understanding of the consistency and variation of services offered in Psychological Therapies across Wales. An Improving Access to Psychological Therapies SBAR was presented at the most recent Psychological Therapies Management Group and is currently awaiting approval.

A procurement exercise was undertaken to provide Cognitive Behavioural Therapy (CBT) services over 3 years from an external provider. Unfortunately, no organisations submitted a bid. Feedback from those organisations that registered an interest has highlighted those organisations are struggling to recruit staff to provide CBT services face to face, but they may be able to provide services online. However, evidence indicates that this is less effective, and the service is therefore working with procurement colleagues to review our procurement intentions.

Specialist Child and Adolescent Mental Health Service (SCAMHS)
The service has been successful in bidding for Welsh Government funding (capital and revenue) for a 12-month pilot to develop an alternative to hospital/discharge lounge provision for children and young people (CYP) based in Bro Myrddin, Carmarthen. This will be a 24/7 bespoke service which will provide an alternative to hospital admission and a discharge lounge/step down provision. This will provide a safe space for CYP who present in crisis and would otherwise end up in A&E or on a Mental Health Ward. A 24/7 Rapid Response Team will be recruited to provide therapeutic interventions and clinical assessments. This team will work closely with the existing SCAMHS Crisis Assessment Team for additional support and governance. Through dedicated therapeutic and clinical support practitioners will work with CYP to provide solution focussed interventions to de-escalate and avoid the need for referral to Secondary Mental Health services.

Further monies have been received for a 12-month pilot for two Sanctuary Services for CYP (aged 12 - 18) which will be managed by Third Sector in Haverfordwest, Pembrokeshire and in Aberystwyth, Ceredigion. The location of services is based on known areas of need. The Sanctuary will provide practical support and therapeutic interventions to CYP who present in mental distress. Therapeutic solution focused interventions will be provided in a non-clinical environment, to enable CYP to develop coping strategies for the presenting issue and deescalate. Services will be provided face to face and virtual in line with CYP needs.

Work is progressing towards meeting the services targeted trajectories in respect of Part 1A & 1B and remains on track to achieve 40% by September, with a longer-term aim to attain 80% by March 2023. September performance returns show that 43.6% has been achieved against Part 1A and 53% against Part 1B.

Bi-monthly internal waiting list management meetings have been established to monitor compliance and identify any challenges and risks early to ensure that appropriate mitigations can be put in place. The key focus will be on addressing issues and identifying areas of best practice from other Health Boards to apply any learning locally to improve the current position.

Recruitment challenges have improved with all substantive posts within Primary Mental Health and School in Reach recruited into bar one post which is out to advert. Recent recruitment includes a Clinical Psychologist and 4 x Assistant Psychologists. The on boarding process is progressing for other recent hires.

Autism Spectrum Disorder (ASD)
Demand for assessment continues to remain high with wait times of up to 3 years. The service continues to review all job plans to identify areas to increase capacity for assessments, however workforce requirements to meet the ongoing increasing demand is inadequate.

Demand within the Integrated Autism Service (IAS) service remains similarly high. Again, this is compounded by inadequate workforce numbers to meet the increasing demand. The Directorate is funding several fixed term additional posts to address some of these demand and capacity issues.

The procurement exercise to outsource assessment and treatment to address waiting lists in both Adult and Children and Young Persons ASD services closed on 21 October 2022. There were 4 applications to provide services. Following the successful evaluation of bids, a recommendation to award to two providers is being taken to Board in November 2022 for approval. As of September 2022, there are 426 CYP out of a total of 2,241 (19%) waiting less than 26-weeks to start a neurodevelopment assessment for ASD, while 1,815 CYP were waiting more than 26 weeks. There are 1,243 adults waiting less than 26 weeks to start an

assessment, with 963 adults waiting more than 26 weeks. With the potential for a minimum of 150 individual diagnostic assessments per year for each service, the outsourcing of diagnostic assessments could enable an additional 300 assessments to be completed across Child and Adult Services per year.

WG has released the Demand and Capacity Evaluation in full and national workshops have been arranged in November to undertake further consultation on the future service models required to address Neurodiversity.

Older Adult Mental Health (OAMH)
The Service is managing, albeit with occasional difficulties, to maintain an overall occupancy rate around the 85% target (years range) to maintain business continuity to enable the admission of people at high risk at any given time. Admission acuity and dependency remain high as do Delayed Transfers of Care. The wards remain short of registered nurses with two out of three wards using block-agency and one ward experiencing exceptional levels of long-term sickness. Acuity and referral rates remain high for OAMH Community Mental Health Teams (CMHT) across all four teams / 3 counties. Ceredigion CMHT is a workforce risk due to vacancies and an SBAR has been submitted to authorise agency to maintain business continuity. A significant factor of these continued pressures is the lack of adequate Domiciliary Care Packages, Day Care, Respite, Residential and Nursing Placements, especially in the higher dependency range. This is largely systemic pressure resulting in preventable admissions, delays to discharge, higher referrals to community teams with generally higher acuity throughout.

Memory Assessment Services (MAS) continue with their commitment to a 7% waiting list reduction target month on month, with the latest returns showing a continued reduction in waiting times as follows:

	> 28 days	> 12 weeks
August 2022	339	134
September 2022	232	124
October 2022	140	78

Concerns around diagnostic capacity due to the retirement of the Consultant Psychiatrist have improved due to the knock-on effect of strengthening the Medical Workforce via NHS Locum and converting an Advances Nurse Practitioner (ANP) role temporarily, due to availability, into a medical practitioner recruitment for a 12-month fixed term contract.

LEARNING DISABILITIES CHARTER

The West Wales Learning Disabilities Charter was written by people with Learning Disabilities. It is a list of things that people need, want, and expect. The Charter was launched at the 2019 Pembrokeshire County Show by Julie Morgan MS, Deputy Minister for Health & Social Care.

The Health Board signed up to the Charter at a Public Board in the Summer of 2019, where the Dream Team attended to share their experiences and explain their role and expectations from the Charter.

The Dream Team is a group of people with learning disabilities that work with the Regional Improving Lives Partnership (RILP) that is the multi-agency stakeholder group for people with a learning disability reporting to the Regional Partnership Board. The Dream Team make sure that the professionals keep people with learning disabilities fully informed, listen to them and include them in their decision-making.

Below are some of the key aspects set out within the Charter:

- **My Life My Rights** – 'having more choices and treating us with dignity and respect'
- **My Communication** – 'making everything easy read'
- **My Support** – 'give us the support we need when we need it'
- **My Community** – 'give us paid jobs'
- **My Health** – 'we need health staff to be trained by us'
- **My Independence** – 'hate crime and bullying must stop'
- **My Social Life** – 'we want to have activities in the evenings and weekends too'
- **My Relationships** – 'we want the right to have a family'

Work on the LD Charter has been difficult during the pandemic, but there is now a renewed emphasis upon a "re-launch" in 2022. The Dream Team returned to the Pembrokeshire show to highlight the important messages the Charter brings. A video developed by the team to help promote the messaging of the Charter can be accessed via the following link - https://youtu.be/99hSGLSPrA4

There is well documented evidence of the health inequalities faced by people with a learning disability and the detrimental effect this has on an individuals' health. As a result, there has been a focus on the healthcare needs of people with a learning disability by both central and Welsh Government.

In response the Learning Disabilities Service has created a Health Action Team (HAT) of nurses who provide advice and support to our acute hospital sites and to primary care. It is recognised that this Team requires additional capacity to fulfil this role and as part of the wider service improvement review of LD Services, opportunities to strengthen this response are being taken forward. The key aims of this team are as follows:

Acute Service:

- To ensure that all staff working within acute services in Hywel Dda Health Board receive training in the needs of people with a learning disability.
- To have a learning disability health champion within all wards and departments across the health board.
- To ensure that the learning disability admission pathway is followed and all individuals with a learning disability accessing secondary healthcare receive a service which recognises and acts upon the reasonable adjustments required by each individual.
- Acute health facilitation nurses will be available to provide advice and consultation on reasonable adjustments required.

Primary Care Service:

- To ensure that all people with a learning disability who are eligible for an Annual Health Check, receive one. (Increase quantity)
- To ensure that the quality of Annual Health Checks meets the standards expected by Welsh Government (Improving Lives, Improvement Cymru). (Increase quality)
- To ensure that Health Action Plans are informed by and produced following an Annual Health Check and that this information is shared with the individual and those supporting them, as necessary. (Improve outcomes)
- To work alongside the Health Check Champions (people with lived experience) and help them to promote the Annual Health Check within the learning disability population.
- To develop a network of Annual Health Check Champions within GP Practices
- To develop a network of health advocates within care providers of services to people with a learning disability. Health advocates should be in receipt of services and be supported by a named carer who will support them.

- To develop and deliver the 12 month challenge which will provide health advice on a known health condition each month, with the intention of educating people with a learning disability on common health issues and what to do about them.

Joint Roles / objectives:

- REASONABLE ADJUSTMENT CLINIC: this development has been part funded by Welsh Government and is intended to be a mock-up of a hospital bay or GP surgery where desensitisation work can take place.
- SAFE HOLDS FOR MEDICAL PROCEDURES: the HAT team will coordinate the processes required to ensure that where it is necessary to hold an individual for medical intervention it is the least restrictive process possible and is done within the law.
- VACCINATION CLINICS: the team provide support and guidance to vaccination services across the health board and provide a vaccination service to individuals who cannot be accommodated within general services. This is for both COVID and flu vaccines.
- TRAINING THE WORKFORCE: the HAT team provide training on the needs of people with a learning disability to the workforce via induction training, skills 2 care, champions training and the primary care education pack.

A new learning disability awareness training module is being rolled out to all public-facing NHS staff across Wales in memory of patient Paul Ridd who died after receiving poor care while in Morriston Hospital. Championed by the Paul Ridd Foundation and learning disability charity Mencap Cymru, the training aims to improve knowledge and awareness of the issues faced by people with a learning disability when accessing healthcare services.

It hoped to do this by enabling staff and providers to understand the specific needs of an individual with a learning disability and to make reasonable adjustments to meet those needs. The training is mandatory through ESR for all staff in Hywel Dda and compliance is 53%, this is a positive figure considering the training has only been launched in the last couple of months.

A Senior Nurses Group has been formed to ensure the physical healthcare needs of people with a learning disability are met. The purpose of this group is to improve the physical healthcare experience of people with a learning disability and to ensure the recommendations of national reports into the healthcare of people with learning disability are implemented.

INTEGRATED LOCALITIES

Connecting with Strong Communities

On 17 October 2022 the ‘Elemental CRM’ system went live for social prescribers/community connectors and on 24 October for referrers to use. This system is a piece of software that allows social prescribers, connectors and link workers to manage their referrals and casework. The system will integrate with General Medical Services information systems to enable colleagues to make and manage referrals more efficiently.

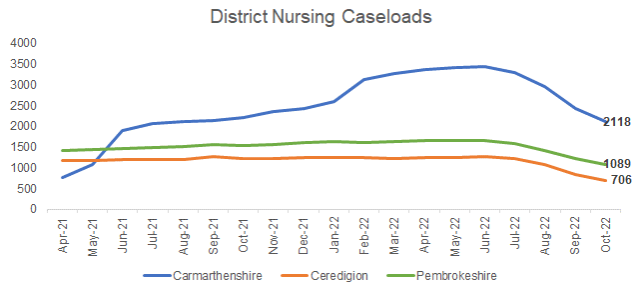
It provides a cloud-based platform that can enable individuals, families and their carers to better connect into community-based programmes, services and activities. It will also push back Social Prescribing specific codes for clinical terminology into the patient record with detailed information about the patient and track individual health journeys. As part of the data captured, we will be able to report activity within the social prescribing model, identify gaps in need and performance related outcome measures. This, for the first time, will give the Health

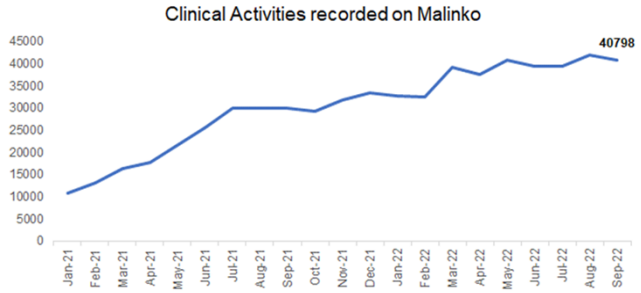
Board clear and consistent information on this element of our social model for health and wellbeing and enable us to respond to the new metrics set by Welsh Government and anticipated to be asked for in 2023.

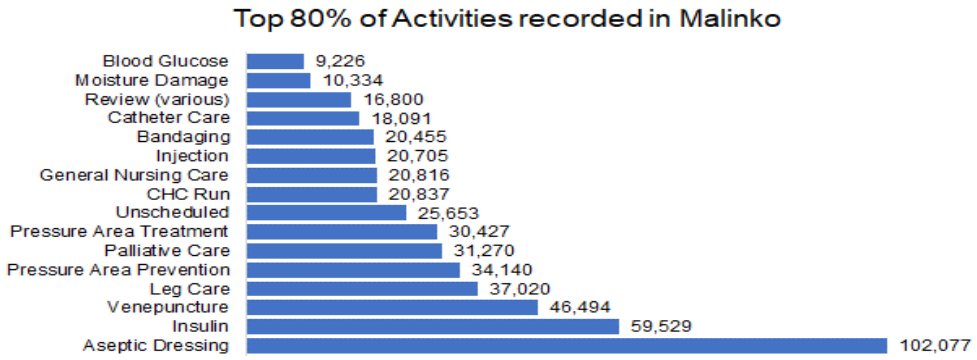
All three counties are progressing with plans to support the population this Winter. It is expected that the cost-of-living crisis will have a disproportionately larger impact on the frail and more vulnerable in our communities. Food banks, warm safe rooms, community and third sector organisations offering opportunities to reduce the impact of isolation are all stepping up plans.

Help to Help Yourself

Work has been underway to review the community nursing activity and caseloads. With no clinical patient administration system in the community the Civica Scheduling System provides some limited information. Although the caseloads have been validated over the last 2 months, there is a consistent rise in activity due to the growing complexity of patients. It is important to note that the reporting element of Malinko, the services scheduling, and caseload management system is not yet fully developed and requires further review and automation.







Work is ongoing to review the workforce required for place based integrated teams to ensure the service is better able to work more proactively.

A Discover, Design and Deliver group will be established to develop a regional set of principles and standards for proactive multi-disciplinary risk stratification and care planning. The first meeting is planned for 16 November 2022. Risk stratification is the process of assigning a risk to patients and then using this information to more effectively target resources, direct care and improve overall health outcomes. It involves the segmentation of patients into distinct groups of similar complexity and care need.

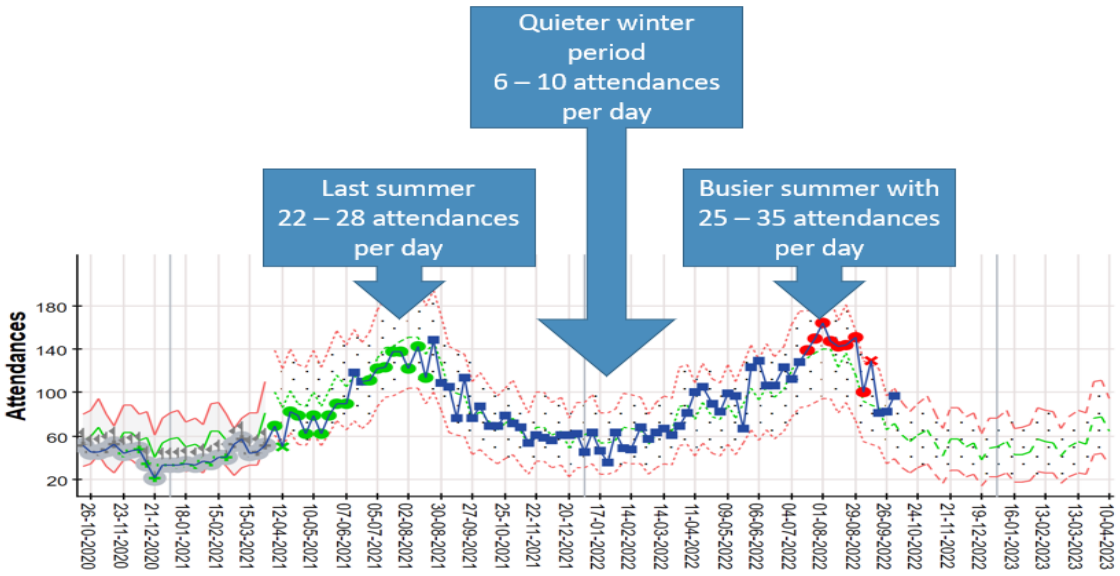
Help When You Need It

Home First intermediate care services are established in all three counties, these are mostly funded with the use of Regional Integration Funding which is time limited.

- **Carmarthenshire:** the work of the Intermediate Care Multi-Disciplinary Team (MDT) is proving beneficial in terms of reducing conveyance and conversion rates through provision of safe alternatives to hospital admission. The Teams are working at the 'front doors' of both hospitals and with WAST to 'turnaround' patients whose needs can be managed on the community virtual ward. The service is in the process of accessing support from the EQUIP programme to evaluate and measure its success. A 24/7 Home First Co-ordination point of contact is implemented for use by clinicians across hospital and community.

- **Pembrokeshire:** The Intermediate Care MDT are working with WAST to support the enhancement of the Health Board's developing Clinical Streaming Hub along with the development of the Virtual Ward. GP and Advanced Nurse Practitioners (ANP) have commenced attending board rounds at the front door to start building relationships and develop pathways in and out of the hospital. Integration of the two former hubs is complete and further pathways and teams are being developed. This Co-ordination Centre operates 8am to 6pm across 7 days, offering telephone triage, clinical advice, and signposting.

Tenby Walk-In Centre: opening hours have been extended to 9am – 5pm Monday to Friday. This summer was busier than the last and consideration needs to be given to opening at weekends for the 6 weeks of the school summer holiday. There is no evidence to support extending the opening days outside of that time period. Further work is required to assess the feasibility of a possible introduction of a weekend service during the summer holiday period. This will be dependent on the availability of additional investment and prioritisation within the Integrated Medium-Term Plan (IMTP).



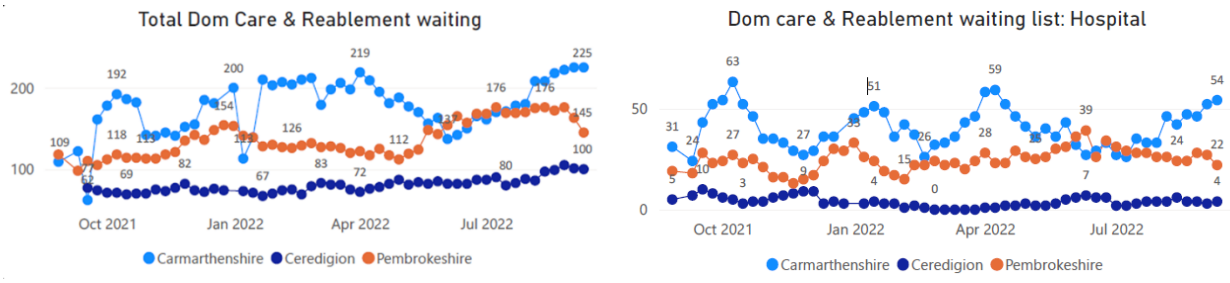
Cardigan Same Day Urgent Care (SDUC) Unit: 361 Patients used the Same Day Urgent Care Service in Cardigan in August 2022; avoiding 170 acute site attendances; with no patients being escalated to GGH SDEC.

Ongoing Help When You Need It
Care Home Capacity Challenges

- Elderly Mentally Infirm (EMI) nursing capacity in Ceredigion is further constrained following the closure of the last remaining home which offered EMI placements.

- Two homes, one in Carmarthenshire and the other in Pembrokeshire are closing resulting in a reduction of 60 beds.

The Domiciliary Care market remains constrained with 470 people currently waiting for care at home, within hospital and in interim care beds.



Building Community Care Capacity project continues its efforts to employ additional people to work in the home-based care sector, offering intermediate care services to enable people to stay at home or be discharged from hospital with support sooner. This builds upon existing staff in post. Significant capacity constraints remain however which result in long delays in discharging people from hospital.

- **Carmarthenshire** (ambition 32 WTE with supervision and administration)
  - 43 applicants – 32 overseas
  - Regarding overseas recruitment the Healthcare Support Worker (HCSW) roles have not yet been progressed – The Recruitment Department are currently reviewing the guidance in respect of this aspect of the process
  - 3 booked for interview initially (4 withdrawn, 1 rejected, 2 did not schedule)
  - A further 8 are scheduled for interview on 15 November 2022
  - Re-advertising jointly with Local Authority
  - Trajectory to complete induction and impact capacity December 2022 /January 2023

- **Pembrokeshire** (ambition 20WTE with supervision and admin)
  - 22 people interviewed (51 Expressions of interest)
  - 5.48 WTE (7 people) offered plus 5 bank staff
  - 2 are existing bank staff, 3 have commenced, 2 will begin in November 2022, 2 are awaiting start dates and 3 are awaiting employment checks to be completed
  - Band 3 administrator has been recruited although as yet the service has not recruited to the post of Band 5 Registered Nurse
  - Trajectory to complete induction and impact capacity November/ December 2022
  - DBS delays – agreed a risk management approach to on boarding

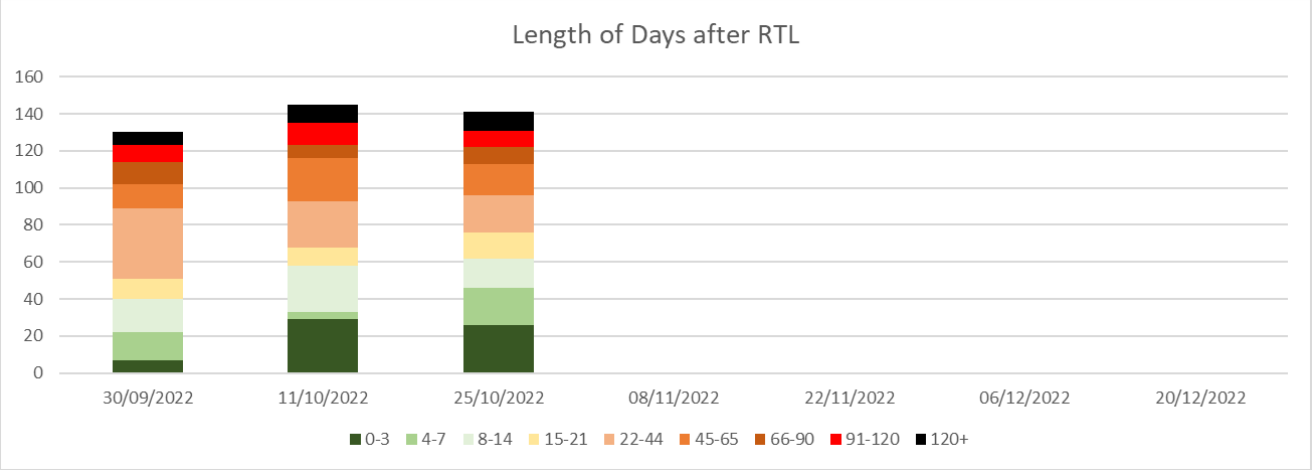
- **Pembrokeshire Joint Apprentices** (ambition 15)
  - 11 WTE, 7 awaiting pre-employment checks and 4 had completed employment checks
  - Supernumerary for most of Year 1
  - The onboarding of these posts has commenced with inductions underway.

- **Ceredigion** – actively watching and learning

Capacity is likely to be reduced considerably due to the smaller number of care workers employed when compared to the numbers required. The recruitment to HCSW roles has been challenging over the past few months due to a low level of interest. Further rounds of

recruitment are expected, and work is underway to consider registration with Care Inspectorate Wales to deliver on the packages of long-term care which are constraining the system.

Fortnightly reports are submitted to Welsh Government providing updates on the whole system, actions, and the number of delays by time band. This report includes all patients in hospital beds, acute and community, with a “Ready to Leave” (RTL) date. As of 10 November 2022, there were 422 people in a hospital bed considered complex to discharge, 291 of these were medically optimised and 140 considered ready to leave. Only 76 (18%) had been in for less than 21 days and 104 (25%) had been in for over 120 days.



Palliative Care Strategy & Implementation:

- Palliative Care consultant capacity has been challenging for the last few months due to sickness and retirement, but the Supportive Care services has enabled consistency in both Ceredigion and Pembrokeshire. There is a vacancy for a consultant in Pembrokeshire and recruitment is in the process of being finalised subject to clinical discussions on opportunities for 3 County cover arrangements.
- Ty Bryngwyn is being maintained at 4 beds, down from its original 7 for the foreseeable future with consideration regarding a fifth patient on case-by-case basis. This is due to challenges in respect of nursing and medical staffing.
- Due to the fragility within the specialist palliative care clinical nurse specialist teams across the Health Board footprint, a review is underway to consider how the service can continue over the 7-day period subject to demand for this specialist skillset. Community nursing and Acute Response Team services also offer relevant 7-day services which can provide support.
- Pembrokeshire Clinical Nurse Specialist cover is fragile with high sickness levels and delays to on-boarding new recruits. Recruitment into vacancies is progressing positively to date and both Ceredigion and Carmarthenshire are working to support where required. Referrals remain open and are being managed through the Co-ordination Centre to ensure that needs are being met by appropriate team members.

Community Bedded Facilities

High level principles have been agreed across the three Counties to support a consistent approach to community bedded facilities which can be localised dependent on the relevant pathways and existing community assets:

- Community bedded facilities unlike community hospitals do not provide 24/7 care for adults requiring rehabilitation.

- The facilities will provide bed-based care in a community setting to avoid the unnecessary admission of patients directly to an acute hospital bed either directly from the community or the front door of one of our hospitals.
- Will provide an intermediate level of bed-based community care for those patients transferring from an acute hospital within 72-hours of a Goal Plan being determined by the multidisciplinary team.
- Length of stay in the community bedded facility should ideally be no longer than 10 days before transfer for further re-ablement if required at home
  The community bedded facilities should be nurse or therapy led with medical cover as appropriate for the patient cohort.

BRONGLAIS GENERAL HOSPITAL STRATEGY

A clinical strategy for future services at Bronglais General Hospital was drafted as part of the delivery phase of Health Board strategic vision, "A Healthier Mid and West Wales: Our Future Generations Living Well". Following a clinically led development process, the clinical strategy entitled 'Bronglais General Hospital: Delivering Excellent Rural Acute Care', was approved by The Health Board on 28 November 2019. An Implementation plan for 2021-24 has been developed and agreed. Implementation of the strategy is one of the Health Board's Planning Objectives as follows - 'Planning Objective 5F: Fully implement the Bronglais Hospital Strategy over the coming three years as agreed at Board in November 2019, considering learning from the COVID pandemic.'

Supporting implementation of the Bronglais strategy is the Bronglais General Hospital Strategy Implementation Steering Group. This group leads on the development and implementation of a phased approach to delivering the strategy. Work to implement the strategy has slipped during COVID-19 due to operational pressures and capacity. Although progress has been made against numerous areas, some of which are outlined below:

- Reduction in the number of single-handed consultants (Colorectal and Cardiology)
- Development of a frailty model for the site (Appointment of a Frailty Consultant and team)
- Expansion of Advanced Nurse Practitioner (ANP) and Clinical Nurse Specialist (CNS) roles to cover more specialties
- Pathology Dashboard implementation to provide data that can be used to assess service efficiency and identify areas for improvement
- Discussions ongoing regarding Urology Pathways with GPs and Consultants across the Mid Wales area
- Agreement of funding for additional Laboratory staff to allow weekend mornings to be part of contracted hours
- Replacement of Pharmacy Robot due to be complete in January 2023

The Bronglais General Hospital Strategy Implementation Group met on 15 September 2022 with a focus on undertaking a stocktake of the current position. A review of the strategy is currently in progress to examine what has been learned from the changes made during the pandemic that will influence and enhance the actions set out in the plan. This review is being supported by the Mid Wales Joint Committee team. Once the review is complete the strategy will be brought back as a reviewed strategy to ensure it aligns with other plans. Project management resource is required to support implementation of the strategy going forward, which will form part of the review to be completed by the end of November 2022.

ALTERNATIVE CARE UNIT – GLANGWILI GENERAL HOSPITAL (GGH)

There are currently high numbers of medically fit patients being cared for on acute wards at GGH due to a lack of domiciliary care available in the community setting as well as challenges accessing care home placements within the county. As of 10 November 2022, there were a total of 21 patients falling within this category. This lack of domiciliary care provision and care home capacity is presenting significant challenges to discharge and patient flow at the site. To address the issue an Alternative Care Unit, 'Y Lolfa Unit' is being established. The purpose of the unit is to provide suitable alternative provision to care for patients waiting home care or placement but unable to do so due to the lack of community domiciliary support or care home beds. The Unit will consist of 15 beds and is anticipated to start accepting patients from 31 October 2022.

A standard Operating Procedure is being finalised for the Unit with the key selection criteria for patients to include the following:

- Patients requiring x4 calls per day (Personal care, dressing/undressing, monitor skin integrity, assist with transfers, meal prep, medication, assist with toileting)
- Patients Requiring x3 calls per day (personal care, meal prep, fluid intake, medication and reminiscence therapy)
- Patients requiring x2 Calls per day (personal care and meal prep)
- Patients requiring Permanent Placement (Residential/Nursing placement dependent on NNA)
- Patients requiring Temporary Placement
- Patients requiring Reablement
- Patients requiring Rehousing
- Patients requiring Low Level Support

The patient cohort will require the 24/7 oversight of a Registered Nurse. Care plans for the patients will mirror those care and support plans agreed by the lead commissioner. Frailty focus will be adopted by Band 2 and 3 Health Care Support Workers at ward level. All patients transferred to Y Lolfa will have had a comprehensive medication review, a confirmed CPR status or DNARCPR in place.

A daily review by the Home First service (Intermediate Care MDT) will be conducted and a programme of therapy agreed to be delivered by Frailty Support Workers supported by Band 2 Health Care Support Workers.

UPDATE ON MANAGED PRACTICES DECISION

Following the decision of the Board at its September 2022 meeting, work has been progressing to transfer the provision of general medical services managed at Neyland and Johnston GP Practice to the Health Board from 1 November 2022.

Whilst several locum GPs have come forward to participate in the rota in November 2022, there has been limited ongoing commitment which leaves the clinical rota in a challenging position going into December 2022. The clinical rota in other Managed Practices is also a challenge with some days seeing only one GP on shift. This results in limited flexibility within the system to offset any impact of a no doctor day at Neyland and Johnston. There is a risk associated with only one GP being available for consecutive days and the impact that this will have on service efficiency. Adverts have been placed for salaried GPs and for a Clinical Lead to join the team at Neyland and Johnston. Work continues to secure an ongoing commitment to locum cover and a process of escalation has been developed to signal any early concerns where there are gaps in the clinical rota. A risk register has also been developed for the

Practice. The TUPE transfer of staff is in progress, and practice systems and processes will be reviewed as part of the move into new management arrangements.

Arrangements are being made for the Health Board to lease the Johnston building from the former partnership for 12 months, however due to space and rota constraints, the Health Board cannot commit to running GP services from there at present. Work is ongoing to review the accommodation available for administrative staff.

TEMPORARY OUT OF HOURS (OOH) SERVICE CHANGES

GP availability has been a growing concern for several years in the OOHs service. It has become challenging to fill rotas to meaningful levels at all bases resulting in the need to develop a mechanism to stabilise rotas and promote access to doctors during the out of hours period across the three counties of Hywel Dda. In March 2020 a temporary service change was agreed which closed two bases for the overnight periods throughout the week. This affected the Prince Philip Hospital and Llynyfran Surgery treatment centres.
The overriding intention was to encourage the concentration of available
GP resource across three bases instead of five, however this has not been seen.

The number of available GPs has continued to decline through a combination of retirement, a reduced appetite to undertake out of hours work and the draw of other employment opportunities. Since February 2021 there has been a reduction of approximately 12% of regular GP support. Over the last three months there has been an increase in the applications and recruitment of both salaried and sessional OOH GPs. Due to the COVID-19 pandemic and the recent Adastra outage there has been little opportunity to progress the work around which, has at its centre the development of a multidisciplinary team (MDT). The WAST Advanced Paramedic Practitioner (APP) pilot does however provide some additional resilience in the meantime. The situation has resulted in little scope to safely re-open any bases. This measure was a key feature in the feedback from the recent Peer Review process which in the case was undertaken in conjunction with WG, the National Programme and Cwm Taff University Health Board.

The current position sees Llynyfran predominantly closed during weekday evenings and only offering morning services during weekends. The base at Prince
Philip Hospital frequently only has one GP during weekday evenings and a service typically until 6pm on weekends. There is a significant variance in the shift fill rate ranging from a base closure to full rota, although this is infrequent.

It is recognised that Prince Philip Hospital also has a GP led Minor Injury Unit which affords some resilience when the Out of Hours service is not available. The population in South Ceredigion does not have any alternative and so the loss of the Out of Hours service in this area creates a greater level of impact.

Work is underway to identify opportunities to develop the service. COVID-19 has held the progress of any planning opportunities in abeyance. A series of reviews and evaluations have taken place during recent months. These have resulted in a clear series
of recommendations upon which to set a direction of travel for the Out of Hours service including:

- Development of the MDT
- Streamlined process of recruiting locum GPs
- Relaunched salaried GP advert
- Discussion with Primary Care directorate to offer portfolio opportunities to benefit daytime and out of hours services e.g.

    - Implementation of Advanced Practitioner roles, including the use of ANPs and APPs
    - Managed practice GPs to work on a rotation between daytime and OOH shifts
- Strengthening the link between Urgent Primary Care and Out of Hours which will include opportunities to work collaboratively with SDEC as part of the national Six Goals strategy.
- Promoting Out of Hours opportunities with GP trainees to encourage an uptake of this work once qualified

The service changes affecting Prince Philip Hospital and Llynyfran Surgery remain temporary in status. The temporary arrangement currently in place remains the subject of constant and ongoing review particularly when the underlying intention it to restore 5 treatment bases once resources allow. This situation is unlikely to change until after the current winter pressures period.

ADASTRA SYSTEM OUTAGE UPDATE

The Board was informed in the September 2022 Operational Update paper of a compromise to the Adastra clinical tracking and reporting system that resulted from a cyber-attack which occurred on 4 August 2022. The Adastra system is the nationally adopted patient treatment platform that enables OOH services to integrate with the WAST Clinical Assessment Service system and provides an interface with daytime practices. The failure of this system significantly impacted the GP out of hours service. The system remained unavailable until 11 October 2022 when it was largely but not entirely restored.

The initial processes for managing the outage followed the usual Business Continuity mechanisms in place for the service which involved passing calls by fax and using manual sheets to record consultations. These sheets were subsequently faxed or scanned and emailed to surgeries. An interim solution was developed as a national contingency using SharePoint and allowed a Case Tracking to take place but was never able to match the broader more comprehensive functions provided by Adastra. The GP out of hours service locally mitigated the loss of Adastra and any potential increased clinical risk with interim measures allowing access to other systems which provided past medical history. The interim measures resulted in a reduced efficiency with consultations and a significant increase in administrative requirements which continues today.

A consequence of the contingency measures implemented was that consultation times increased, although it has not been possible to accurately audit the full impact and provide an evidence base as would normally be the case when Adastra is fully functional. There have been cases of delayed contact with patients, however these have been brought into focus through additional bespoke audits and managed appropriately once identified. This may have negatively affected patient satisfaction due to delayed contacts but there have been no clinical incidents or complaints recorded to date.

Adastra has been available again with limited functionality since 11 October 2022. A software component referred to as the concentrator remains outstanding and is a barrier to full functionality. The concentrator allows the communication between WAST/111 and Adastra. In its absence there remains additional administrative functions over and above that which is normally required. As a result, calls are sent to each Health Board through the interim Case Tracking Solution and must then be added to Adastra manually. From this point Adastra works as intended except for A-Remote which is the laptop device route used for Home Visit Consultations. In mitigation these must be documented manually on Adastra once back at a Health Board Treatment Centre which causes a degree of

inefficiency where the administration of these cases is concerned. However, these consultations make up less than 10% of overall activity. The reinstatement of the concentrator is anticipated to take five weeks following the commencement of work, which is expected in the last week of October 2022. In this scenario where there is no firm start date available, planning to continue with manual intervention is being mobilised until after the Christmas/ New Year holiday.

EMERGENCY DEPARTMENT RISK OVERSIGHT GROUP

An Emergency Department Risk Oversight Group has been established that will meet bi-weekly. This will be chaired by the Director of Operations to lead on a programme of work covering 5 workstream areas:

- **Workforce** - to include pay, rotas, establishment, and staff wellbeing.
- **Communications** - to agree messaging with the location population, ED waiting room, primary care / community, and external stakeholders
- **Patient Experience** - covering environment, nutrition, quality measures and quality improvement
- **Escalation Plan Review** - to consider escalation risk levels and propose alternative reporting system with required actions
- **Patient Flow** – including the review of SDEC models, balancing of risk across the system, and the clinical agreement of escalation levels and actions

The group will report to the Quality, Safety and Experience Committee (QSEC). The key operational responsibility of the group will include:

- Providing oversight and strategic direction to the working groups to ensure risks are addressed and quality improvement is being achieved.
- Providing assurance to the Board through the Quality, Safety and Experience Committee (QSEC) that risks are being mitigated and quality and patient experience concerns are being addressed.
- Providing a forum to discuss important related topics, as they arise, and other meaningful measures.
- Receiving feedback from triumvirate and clinical leads regarding the implementation of the actions agreed and providing a forum where concerns can be discussed
- Agree actions which require escalation to the Quality, Safety and Experience Committee is required.

WAGESTREAM

The Health Board has engaged in conversations with an organisation called Wagestream who work with Allocate our rostering system providers. Wagestream offer an alternative payment system to staff which allows individuals to draw down part of their salary at any time in the month without creating difficulties which are normally encountered when weekly and monthly payrolls are run for the same individual. Their app ‘Instant Pay’ would be utilised to facilitate this function. Additional functions that are made available to staff via the app are as follows:

- A calendar to view shifts an individual has already booked themselves so that they can see upcoming shifts.
- A savings account which can be activated by an individual. This can either be by setting a regular monthly deposit, ad hoc savings actioned at any time, or pennies from shifts worked can be moved into the savings account. At present the interest earned on this savings account is 5%.

- A financial education platform to provide advice to individuals who are struggling financially - this can include mental health support, financial calculators and tools and support track spending or savings options.
- A facility where individuals can enter their personal circumstances and the app will check any household benefits an individual may be able to claim. It is reported that 76% of Wagestream users were entitled to £568 per month.
- Access to financial coaches to further support financial wellbeing.

The anticipated benefits that HDdUHB will gain from implementing this system are as follows:

- Support employee wellbeing.
- Can be used as part of our attraction strategy as part of staff benefits.
- Support workforce retention.
- Increase bank work if staff are paid sooner which could also be linked to an improved shift scheduling as individuals can see what they are booked to work and how this fits with their financial position and if money is a concern it could support additional work.
- Reduce absenteeism linked with individuals unable to put fuel in their car or are worried about their finances.
- Reduced agency spend if flexible pay is the main attraction for some staff to join an agency.

The system is due to be implemented on 1 December 2022.

GWILI RAILWAY CAR PARK DEVELOPMENT - GGH

The Gwili Railway Company (GRC) approached the Health Board in November 2020 seeking interest in the development of a shared use agreement for the new car park they are planning to build on their site adjacent to the GGH site.

Following initial agreement in principle from the Executive Team further discussion and negotiation has been taking place in respect of how this could be arranged and implemented. The GRC also agreed to provide further clarity on the proposed development of the site and potential format of the shared use arrangement.

Further engagement with the GRC has allowed finalisation of a firm proposal for this scheme. Key elements of the proposal include the following:

- Initial provision of 130 parking spaces for the use of Health Board staff on completion of the main car parking area planned for 1 April 2023
- An increase to 144 parking spaces for staff following completion of the remainder of the works on the site in June 2023
- Provision of these dedicated spaces on a 24-hour basis on weekdays (Monday to Friday).

Given the long-standing and current car parking challenges present on the GGH site the Use of Resource Group approved the provision of recurrent funding to enable implementation of this proposal at their meeting on 4 October 2022. A working group is currently being established to define how site access will be managed and to formalise the agreement between the Health Board and the GRC.

There remains a modest risk to the delivery of this scheme which relates to the requirement for a change of planning consent currently in place for the GRC development to allow shared use of their land. The GRC is in the process of liaising with planning consultants to consider

their approach to addressing this requirement. The Health Board has offered to provide support if required.
Argymhelliad / Recommendation The Board is asked to **RECEIVE** the operational update and progress report.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	572 - Inappropriate use of hospital beds due to a lack of availability for timely assessments and delivery of packages of care in Ceredigion 576 - Fragile EMI and General Nursing Home availability due to deregistration into residential homes affecting Ceredigion County 853 - Risk that Hywel Dda's response to COVID-19 will be insufficient to manage demand (Score 5) 854 - Risk that Hywel Dda's Response to COVID-19 will be larger than required for actual demand (Score 6) 855 - Risk that UHB's non-COVID-19 related services and support will not be given sufficient focus (Score 8)
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	As presented
Rhestr Termau: Glossary of Terms:	ACCTS – Adult Critical Care Transfer Service ANP – Assistant Nurse Practitioner APP – Advanced Paramedic Practitioner ASD – Autism Spectrum Disorder CBT – Cognitive Behavioural Therapy CDAT – Community Drug and Alcohol Teams

	CMHT – Community Mental Health Team CNS – Clinical Nurse Specialist CPR- Cardiopulmonary resuscitation CYP – Children and Young People DBS – Disclosure and Barring Service DBT – Dialectical Behavioural Therapy DDAS – Dyfed Drug and Alcohol Service DNARCPR - Do not attempt cardiopulmonary resuscitation DToC – Delayed Transfers of Care ECT – Electroconvulsive Therapy ED – Emergency Department EMI – Elderly Mentally Infirmed ESR – Electronic Staff Record GGH – Glangwili General Hospital HAT – Health Action Team HCSW – Healthcare Support Worker HDdUHB – Hywel Dda University Health Board IAS – Integrated Autism Service IC – Improvement Cymru IEG – Integrated Executive Group IPAR – Integrated Performance Assurance Report IPTS – Intensive Psychological Therapies Service LA – Local Authority LD SIP – Learning Disabilities Service Improvement Plan LoS – Length of Stay LPMHSS – Local Primary Mental Health Support Services MAS – Memory Assessment Service MDT – Multi Disciplinary Team MH – Mental Health OAMH – Older Adult Mental Health OPDP – Operational Planning and Delivery Programme (Group) PPH – Prince Philip Hospital QIST – Quality Improvement and Service Transformation QSEC – Quality Safety and Experience Committee RILP – Regional Improving Lives Partnership RPB – Regional Partnership Board SCAMHS – Specialist Child and Adolescent Mental Health Service SDEC – Same Day Emergency Care SOS – See on Symptoms SPOC – Single Point of Contact SRO - Senior Responsible Officer TUEC – Transforming Urgent and Emergency Care TMH – Transforming Mental Health UEC – Urgent and Emergency Care UPC – Urgent Primary Care WAST – Welsh Ambulance Service Trust WG – Welsh Government

	WGH – Withybush General Hospital WTE – Whole Time Equivalent
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Operational Planning and Delivery Programme Group

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

Enhanced Monitoring

Enhanced Monitoring Action Plan

Area	Description	Comments
Planned Care	Agreed trajectories towards the planned care ambitions	Trajectories updated and latest version seen in the pack
	Progress made month on month against agreed trajectories	Trajectories monitored within the directorate, Enhanced Monitoring Group, Executive Team, Committees, Board & IQPD. Reflected in the 'Planned Care' section.
	Activity back at 19/20 levels particularly surgical specialities	
UEC	Ensure adoption of the six goals programme	Six goals programme has been set up with a Programme Director, Clinical Leadership and Project Team
	Continuous improvement in 4 hour ambulance patient handover performance delays in transfer of patients from crews to hospital staff by end of 2022/23 eradicating	The ED Risk oversight control group has been established. This group will lead on a programme of works, to provide quality assurance and improvement for patients and staff. The programme of works integrates with the TUEC objectives and has been divided into 5 overarching themes
	Plan to implement SDEC at each site plus a community SDEC by March 2023	Roll out of SDEC – achieved in Glangwili, Withybush and Prince Philip with a nurse led SDUC established in Cardigan. Currently Bronglais does not have capacity to introduce this but we will review going forward. We will monitor the true demand and design provision to target the best outcomes for our population and resources. SDEC will be targeted to need, varying provision accordingly and delivered across acute and community.
		RTDC rollout plan and timeline developed. RTDC Plan. RTDC Timeline.
Cancer	Clear trajectory to achieve sustainable backlog reduction and maintain balance	Trajectories monitored within the directorate, Enhanced Monitoring Group, Executive Team, Committees, Board & IQPD. Reflected in the 'Cancer' section.
	Improved performance for all tumour sites	
	Focused improvement on lower and upper GI, skin, lung, urology and gynae	
	Cancer workforce plan	
Mental Health	Part 1a and 1b LPMHSS CAHMS backlog trajectory achieved each month	Trajectories monitored within the directorate, Enhanced Monitoring Group, Executive Team, Committees, Board & IQPD. Reflected in the 'Mental Health' section.
	Monthly meetings to progress activity and mitigate risks	
	Neurodevelopmental backlog trajectory agreed and delivered	Trajectories monitored within the directorate, Enhanced Monitoring Group, Executive Team, Committees, Board & IQPD. Reflected in the 'Mental Health' section.
	Finalised demand and capacity model	
Infection control	Focus on C-Diff	A HCAI improvement plan has been developed which includes a suite of actions aimed at the prevention of HCAI's and Infection Prevention & Control.
Critical Care	Critical Care workforce plan	A paper was taken to Board in September 2022 to outline our position and key actions. Link here.
	Plans developed and agreed with CHC and the public for a safe, sustainable service	
	Effective surge planning in case increase of capacity was required	

Planned care recovery

As at 7th November 2022

Planned Care

Enhanced monitoring

- Agreed trajectories towards the planned care ambitions
- Progress made month on month against agreed trajectories
- Activity back at 19/20 levels particularly surgical specialities

Context

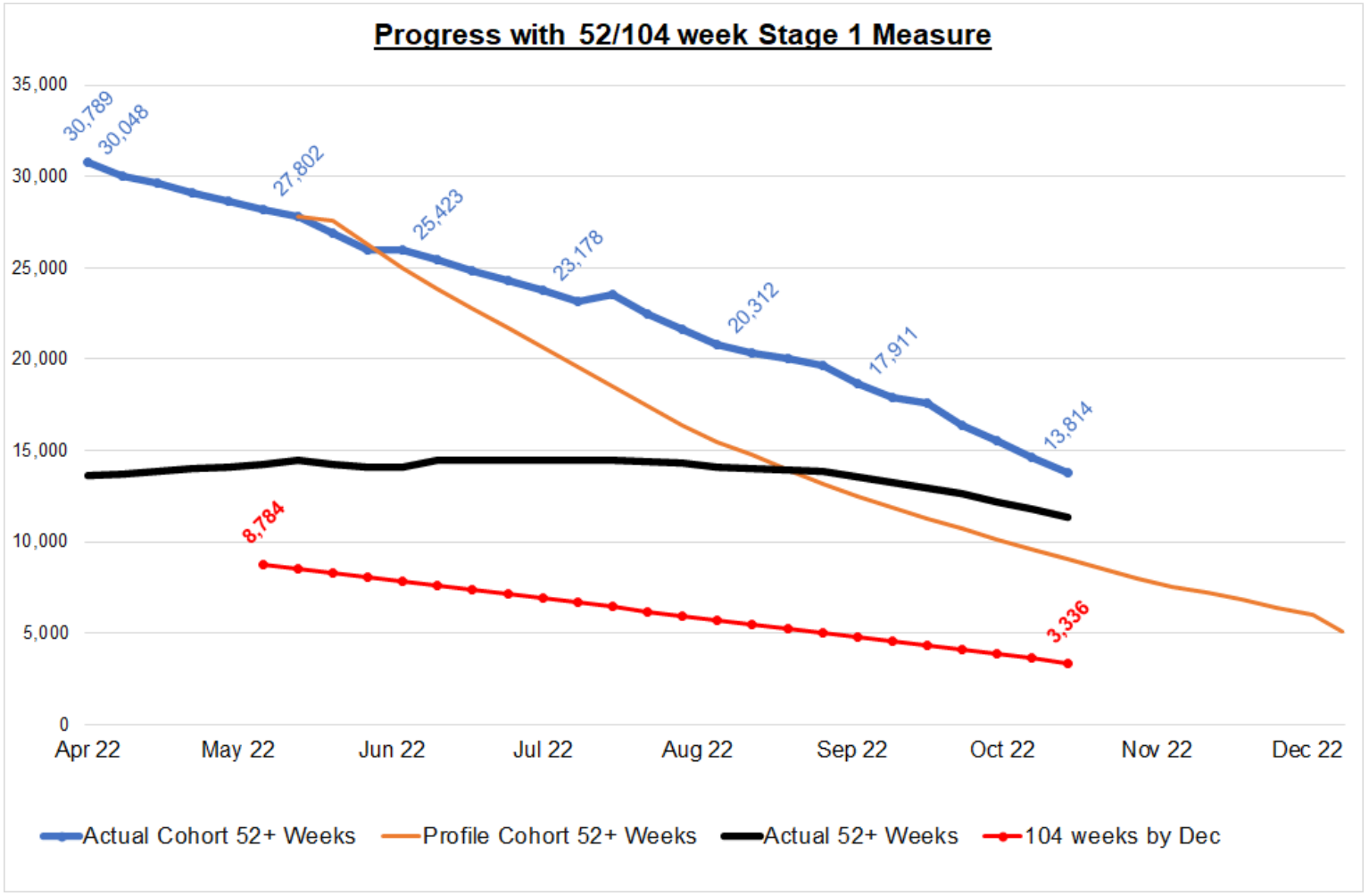
Our delivery plan includes trajectories to:

- reduce the volume of patients waiting in excess of 52 weeks for a Stage 1 outpatient appointment to a range between 5,061 and 7,778 patients by end December 2022
- reduce the volume of patients waiting in excess of 104 weeks for a Stage 1 outpatient appointment to less than 200 patients by end December 2022
- reduce the volume of patients waiting in excess of 104 weeks for total pathway waits to a range between 1,900 and 3,358 patients by end March 2022

Key features of our delivery plan include:

- Dedicated wards areas for elective inpatients
- Further improvements in the volume of patients booked / treated from cohort numbers
- Incremental improvements in outpatient, day case and inpatient activity as determined by workforce development and recruitment plans
- Clinical leadership and adoption best practice guidance to support improved productivity and efficiency to support outpatient and surgical treatment activity
- The advent of a dual theatre modular day surgical unit at Prince Philip Hospital from December 2022
- A new dedicated Ophthalmology day surgical facility at Amman Valley Hospital
- Continues progress with our outpatient transformation priorities including utilisation of digital delivery platforms and increasing application of SoS/PIFU approaches to follow-up care
- Focused and targeted continuing validation of waiting lists, utilising local resources and external support
- Active support to long waiting patients awaiting access to care via our locally developed Waiting Lists Support Service (WLSS)
- Close scrutiny and monitoring of delivery plans by specialty to support these ambitions

Progress with 52/104 week stage 1 measure (7th Nov)



Trajectory 52

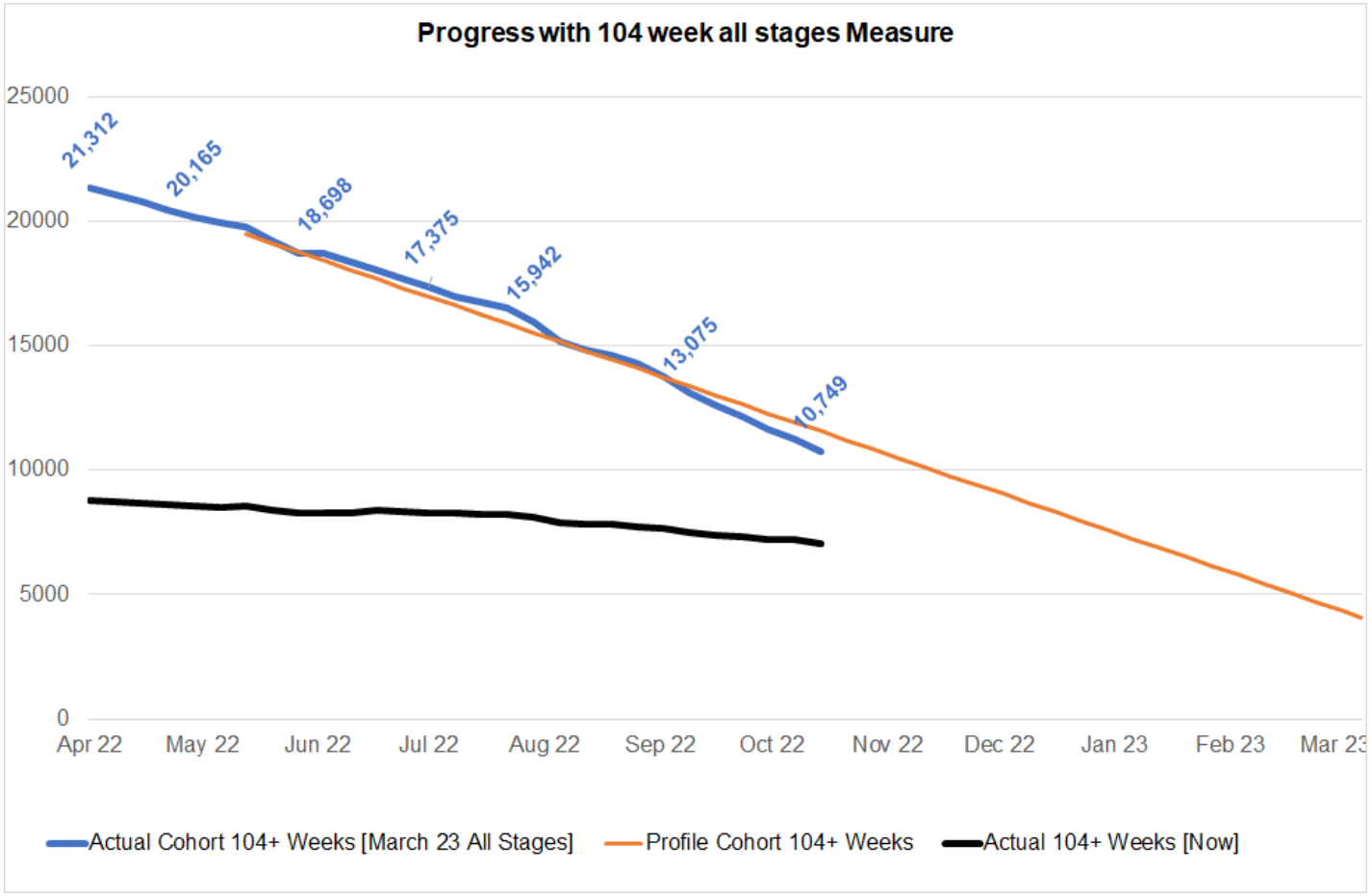
Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

Trajectory 104

	52 Weeks by end of Dec	52 compared to "reasonable worse case"	104 Weeks by end of Dec
Vascular	486	192	80
Dermatology	40	27	30
Rheumatology	464	0	0*
Total	**6,578**	985	**110**

* assumes transfer of circa 300 patients to SBUHB

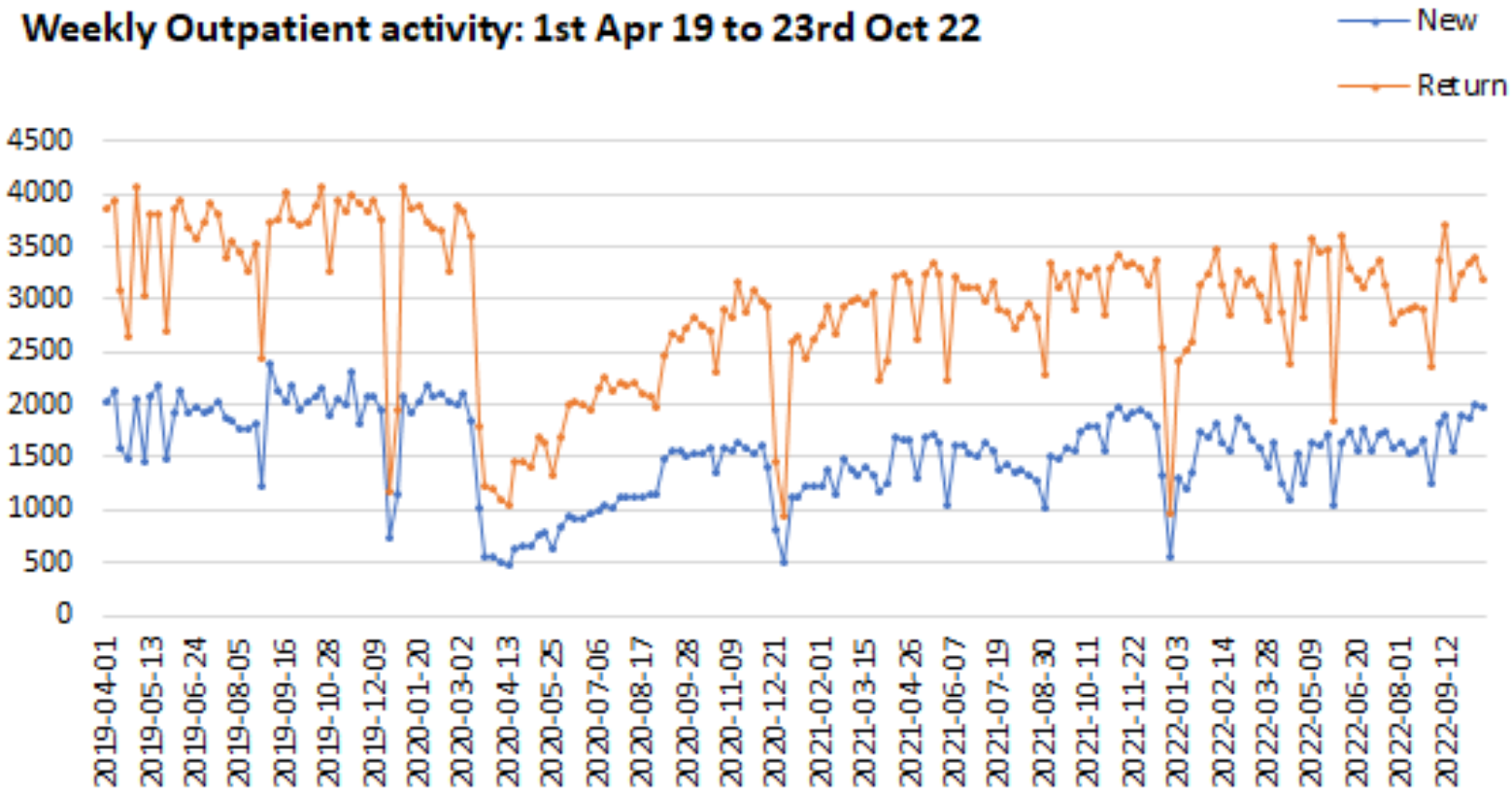
Progress with 104 week all stages measure (7th Nov)



Revised Trajectory

Specialty	Current Total	Best Case	Reasonable Worse Case
100 - General Surgery	1,709	0	372
101 - Urology	1,595	1,000	1,204
110 - Orthopaedics	2,267	700	1,086
120 - ENT	1,961	200	303
191 - Pain Management	453	0	150
330 - Dermatology	159	0	67
430 - Geriatric Medicine	267	0	176
Grand Total	**13,075**	**1,900**	**3,358**

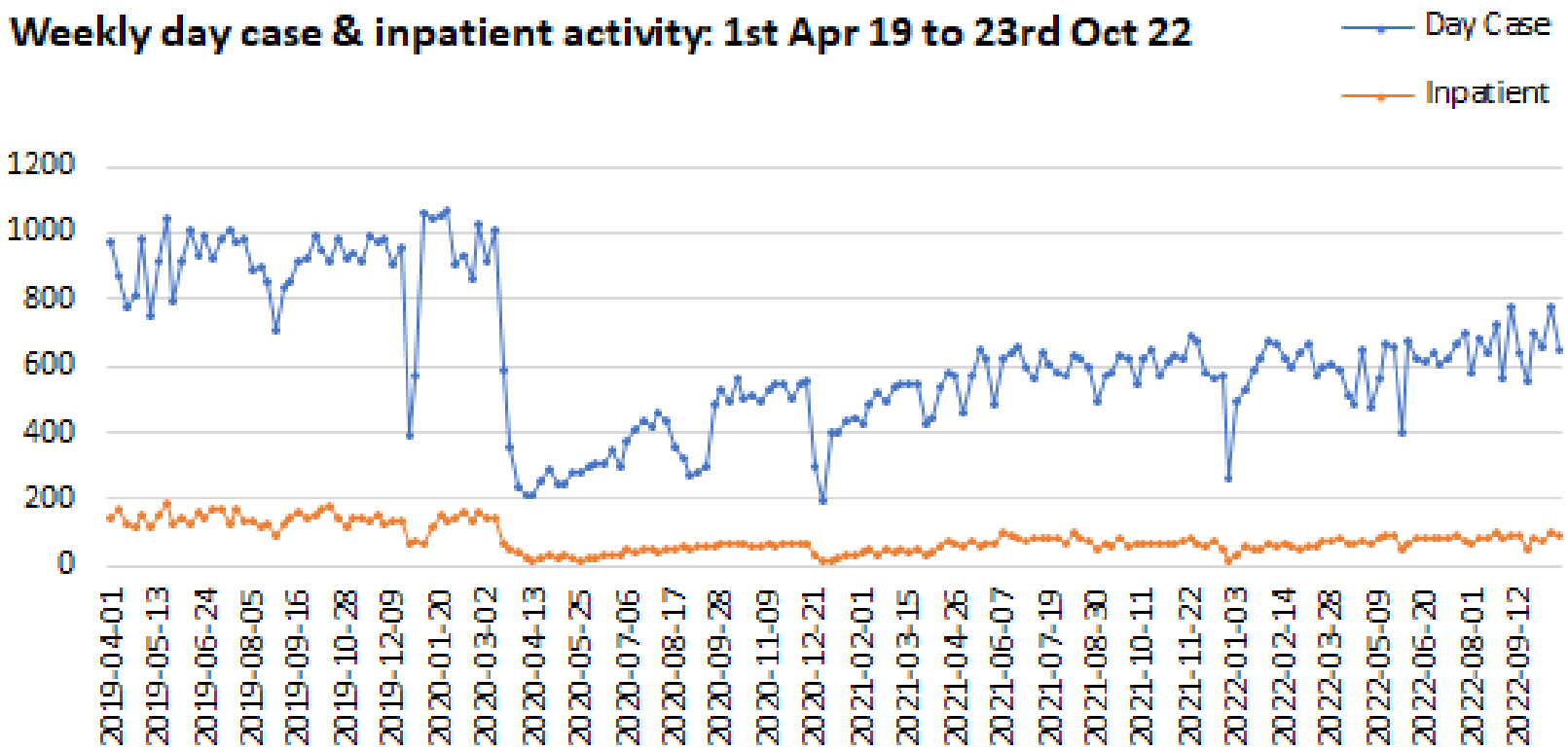
Weekly Outpatient activity: 1st Apr 19 to 23rd Oct 22



Outpatient activity: Comparison October 2019 and October 2022

Surgical Specialty	New			Return		
	Oct-19	Oct-22	% change	Oct-19	Oct-22	% change
Breast	344	458	**133%**	551	462	**84%**
Colorectal	292	388	**133%**	159	264	**166%**
ENT	647	424	**66%**	750	563	**75%**
General Surgery	414	195	**47%**	510	126	**25%**
Gynaecology	702	842	**120%**	845	542	**64%**
Ophthalmology	729	615	**84%**	2086	963	**46%**
Trauma & Orthopaedics	767	575	**75%**	1870	930	**50%**
Urology	305	695	**228%**	1386	839	**61%**
Surgical specialties total	**4200**	**4192**	**100%**	**8157**	**4689**	**57%**

Weekly day case & inpatient activity: 1st Apr 19 to 23rd Oct 22

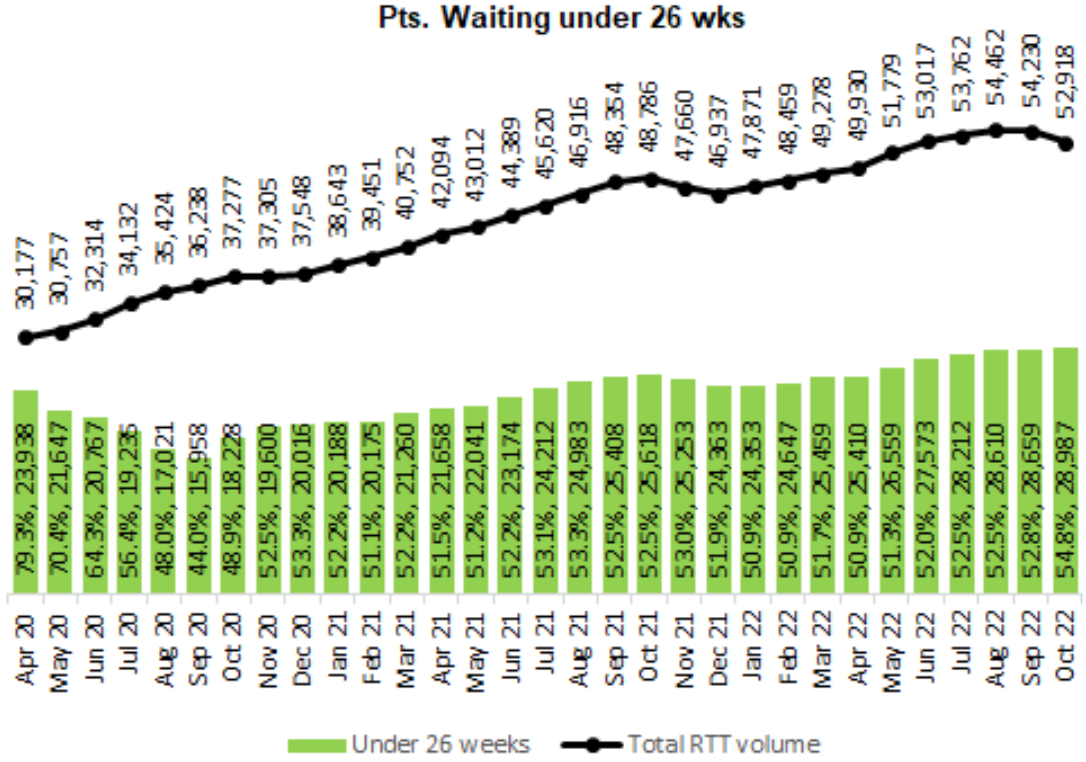


Inpatient and day case activity: Comparison October 2019 and October 2022

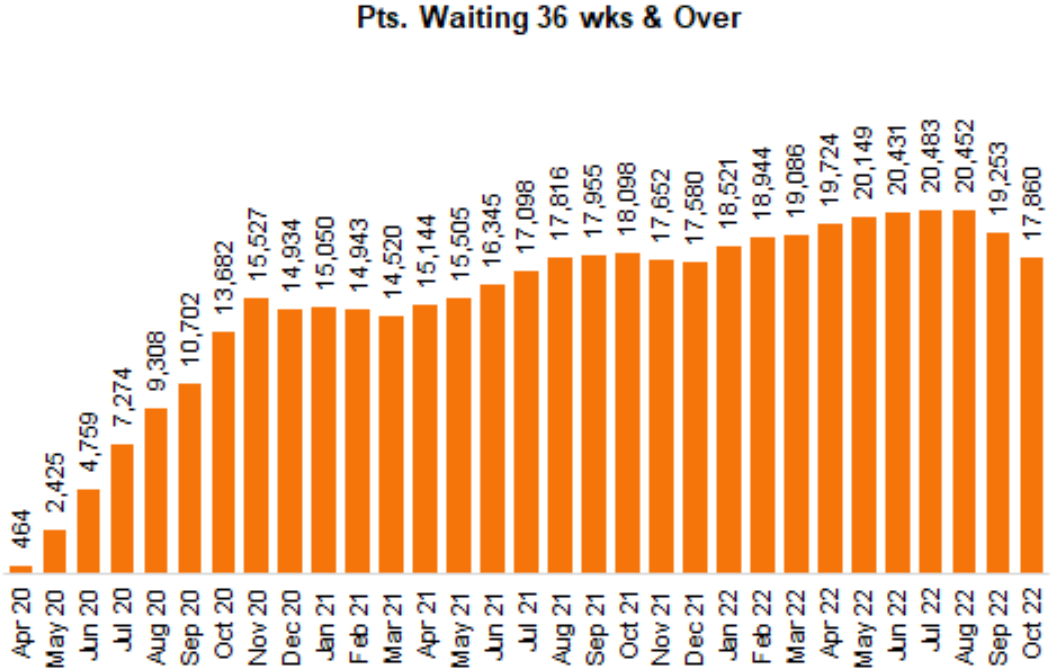
Surgical Specialty	Inpatients			Day cases		
	Oct-19	Oct-22	% change	Oct-19	Oct-22	% change
Breast	24	21	**88%**	8	6	**75%**
Colorectal	12	19	**158%**	13	18	**138%**
ENT	25	19	**76%**	20	18	**90%**
General Surgery	27	21	**78%**	89	66	**74%**
Gynaecology	25	28	**112%**	48	45	**94%**
Ophthalmology	3	4	**133%**	52	38	**73%**
Trauma & Orthopaedics	40	28	**70%**	28	22	**79%**
Urology	48	45	**94%**	85	72	**85%**
Surgical specialties total	**204**	**185**	**91%**	**343**	**285**	**83%**

Specialty: (Multiple Items) - Pathway Stage - 1

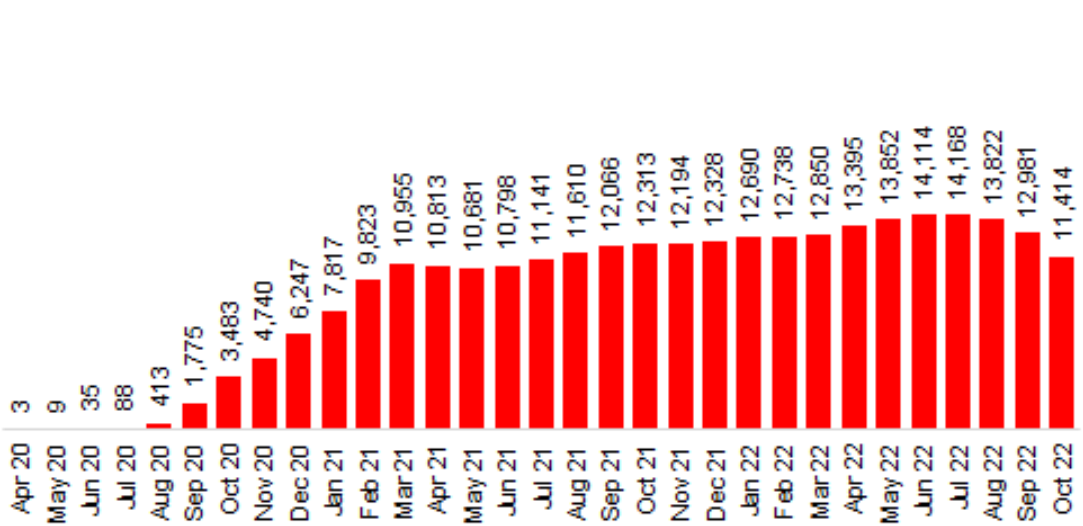
Pts. Waiting under 26 wks



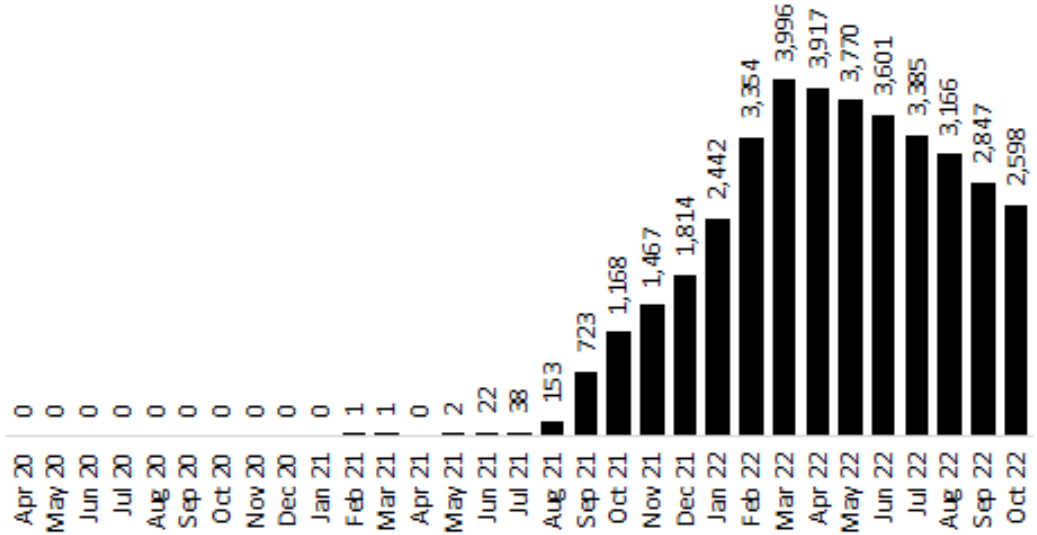
Pts. Waiting 36 wks & Over



Pts. Waiting over 52 wks

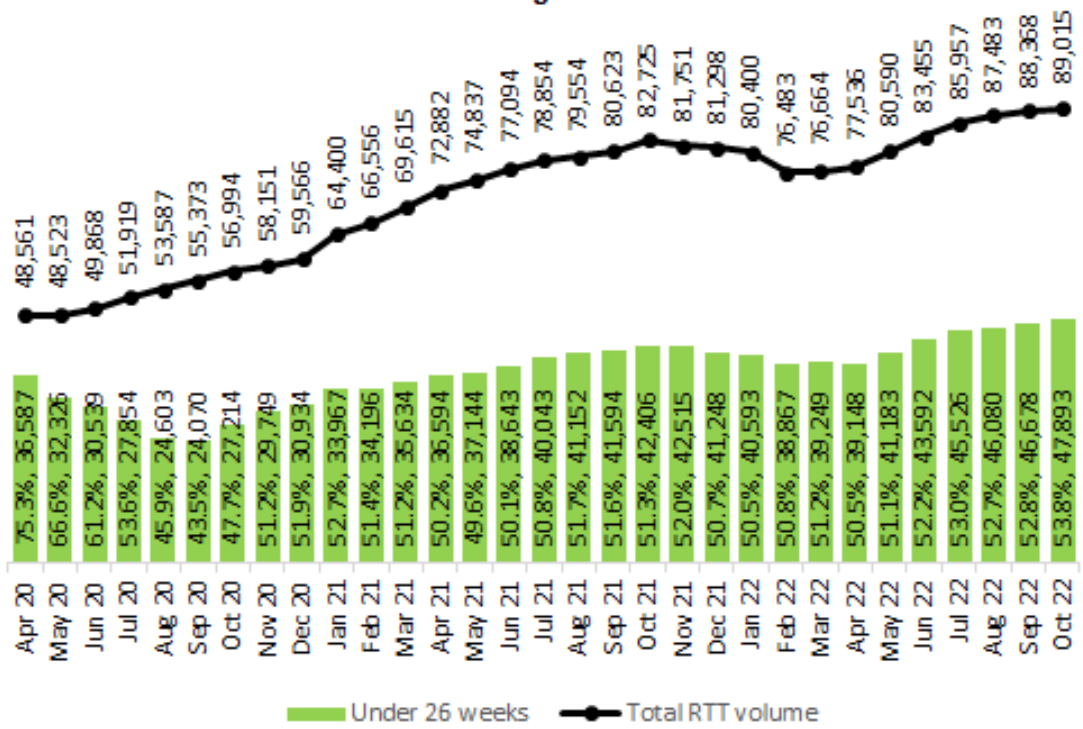


Pts. Waiting over 104 wks

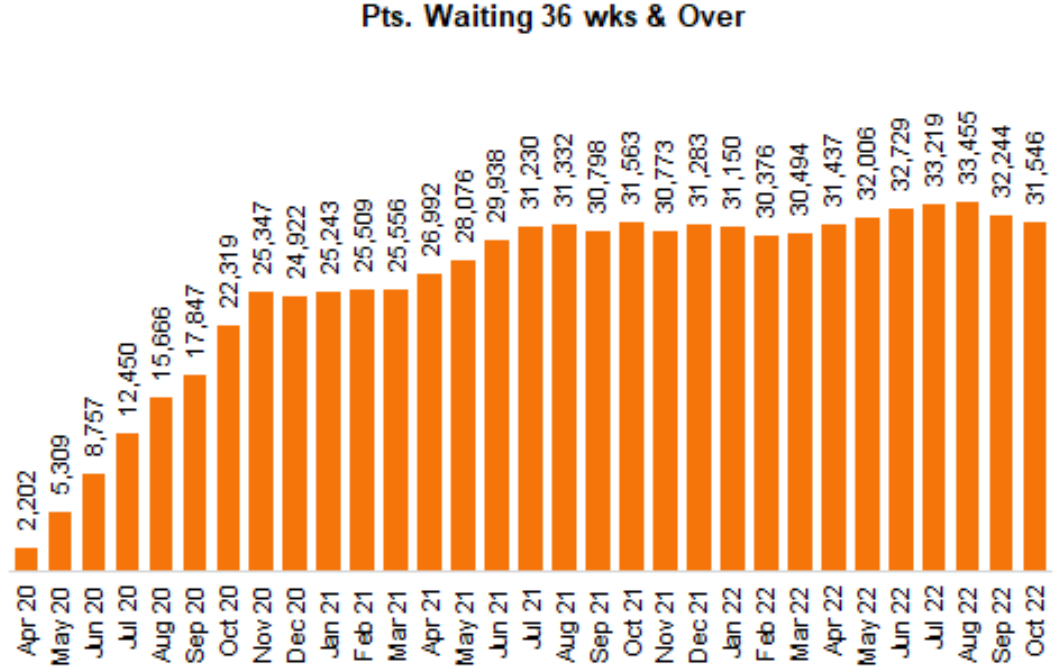


Specialty: (Multiple Items) - Pathway Stage - (All)

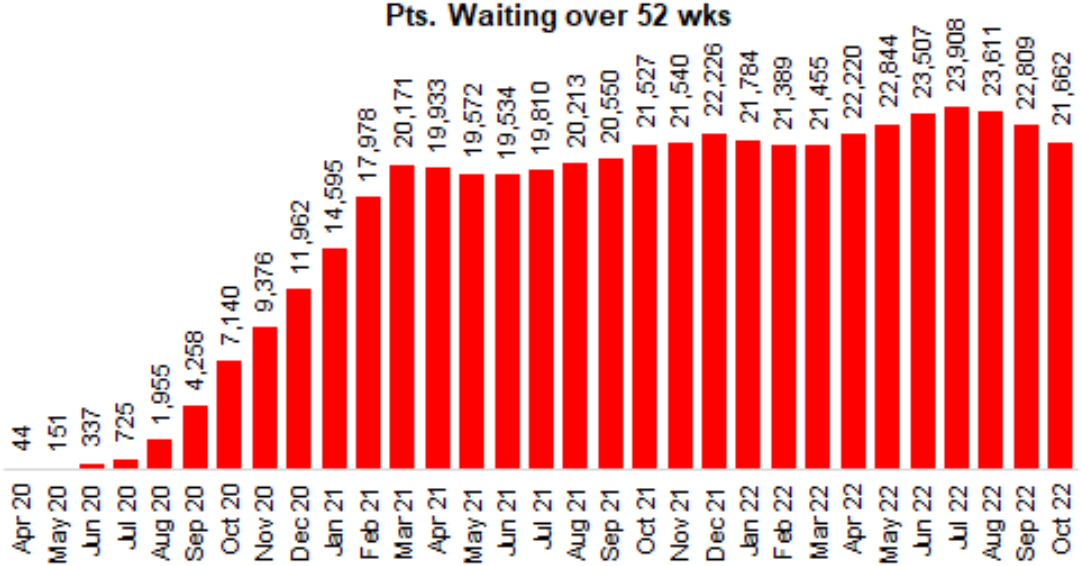
Pts. Waiting under 26 wks



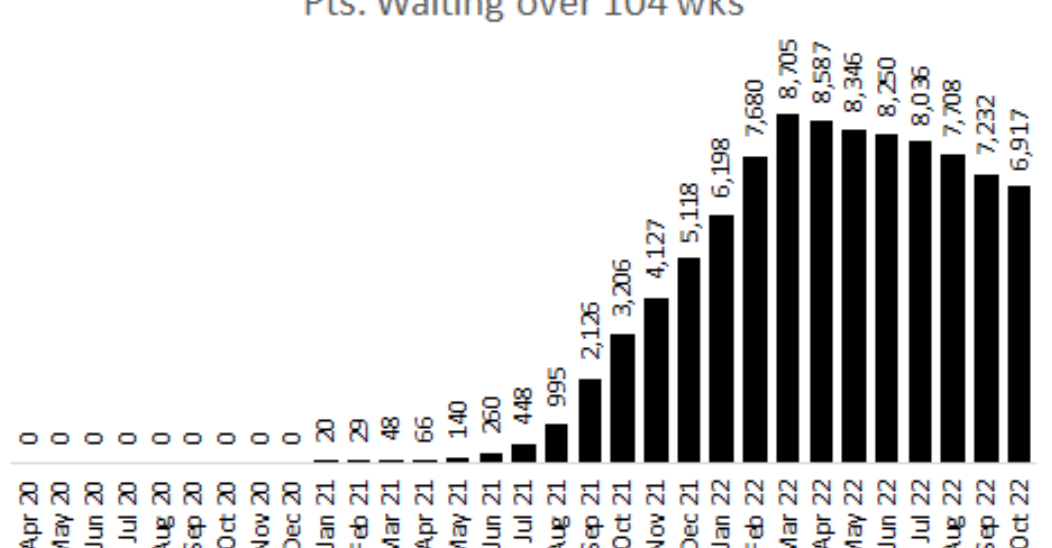
Pts. Waiting 36 wks & Over



Pts. Waiting over 52 wks



Pts. Waiting over 104 wks

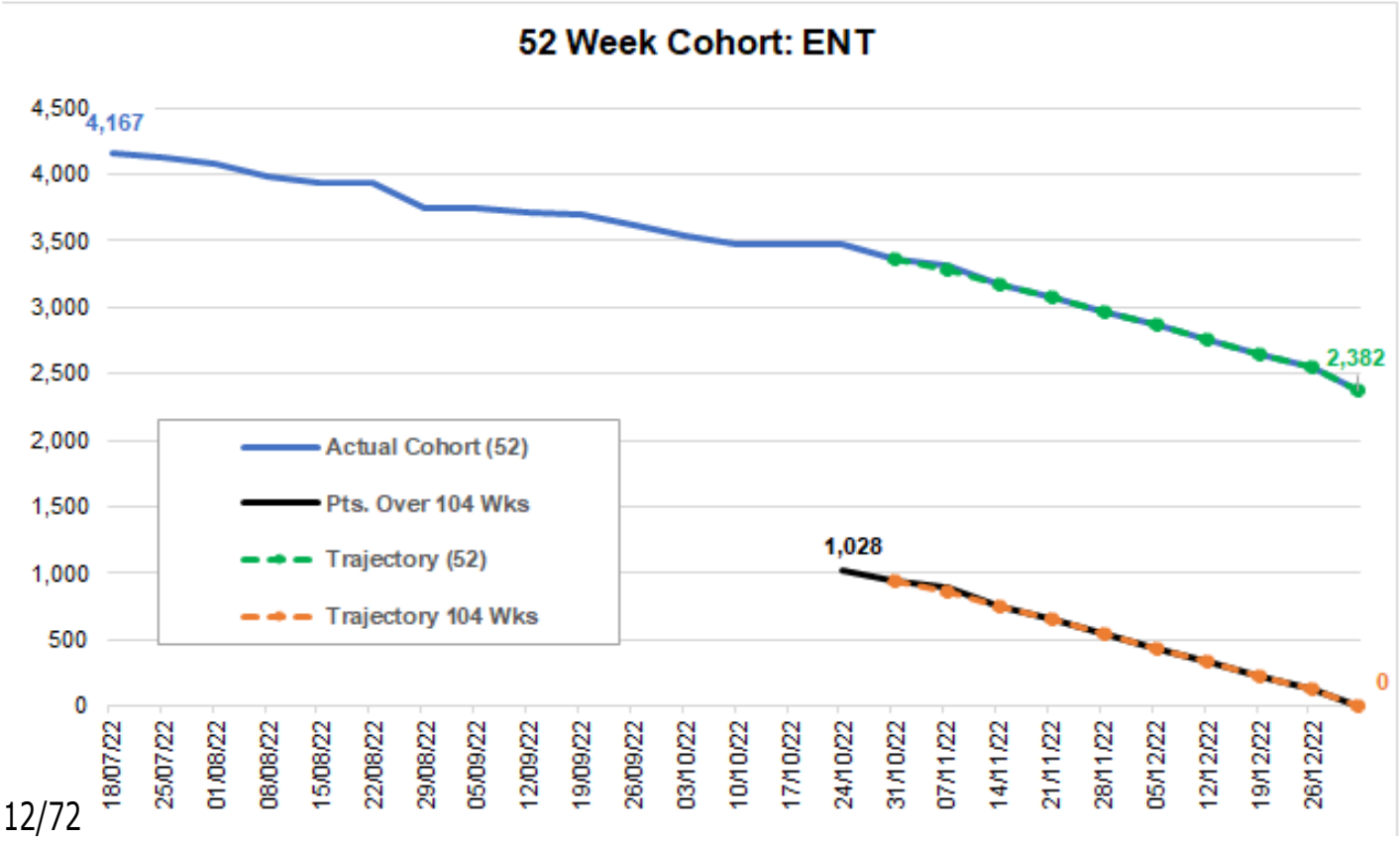


Current Forecast Stage 1 52/104 Weeks by end Dec 22

	52	52 compared to "reasonable worse case"	104
52 Week Cohort: ENT	2,382	18	0
52 Week Cohort: General Surgery	1,032	3	0
52 Week Cohort: Urology	304	571	0
52 Week Cohort: Breast	0	0	0
52 Week Cohort: Colorectal	592	0	0
52 Week Cohort: Ophthalmology	598	9	0
52 Week Cohort: Vascular	486	192	80
52 Week Cohort: Orthopaedics	0	0	0
52 Week Cohort: Pain	155	0	0
52 Week Cohort: Gastro	525	165	0
52 Week Cohort: Derm	40	27	30
52 Week Cohort: Neuro	0	0	0
52 Week Cohort: Rheumatology	464	0	0
52 Week Cohort: Paeds	0	0	0
52 Week Cohort: Geriatric Medicine	0	0	0
52 Week Cohort: Gynae	0	0	0
Total	**6,578**	985	**110**

ENT

New Outpatients	52 Week Cohort: ENT	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
	Activity each week																	85	105	105	105	105	105	105	105	165
	Actual Cohort (52)	4,167	4,129	4,074	3,984	3,939	3,939	3,750	3,750	3,718	3,693	3,619	3,545	3,470	3,469	3,467	3,368	3,308	3,178	3,073	2,968	2,863	2,758	2,652	2,547	2,382
	Pts. Over 104 Wks															1,028	943	895	753	648	543	438	333	227	122	0
	Trajectory (52)																3,368	3,283	3,178	3,073	2,968	2,863	2,758	2,652	2,547	2,382
	Trajectory 104 Wks																943	858	753	648	543	438	333	227	122	0

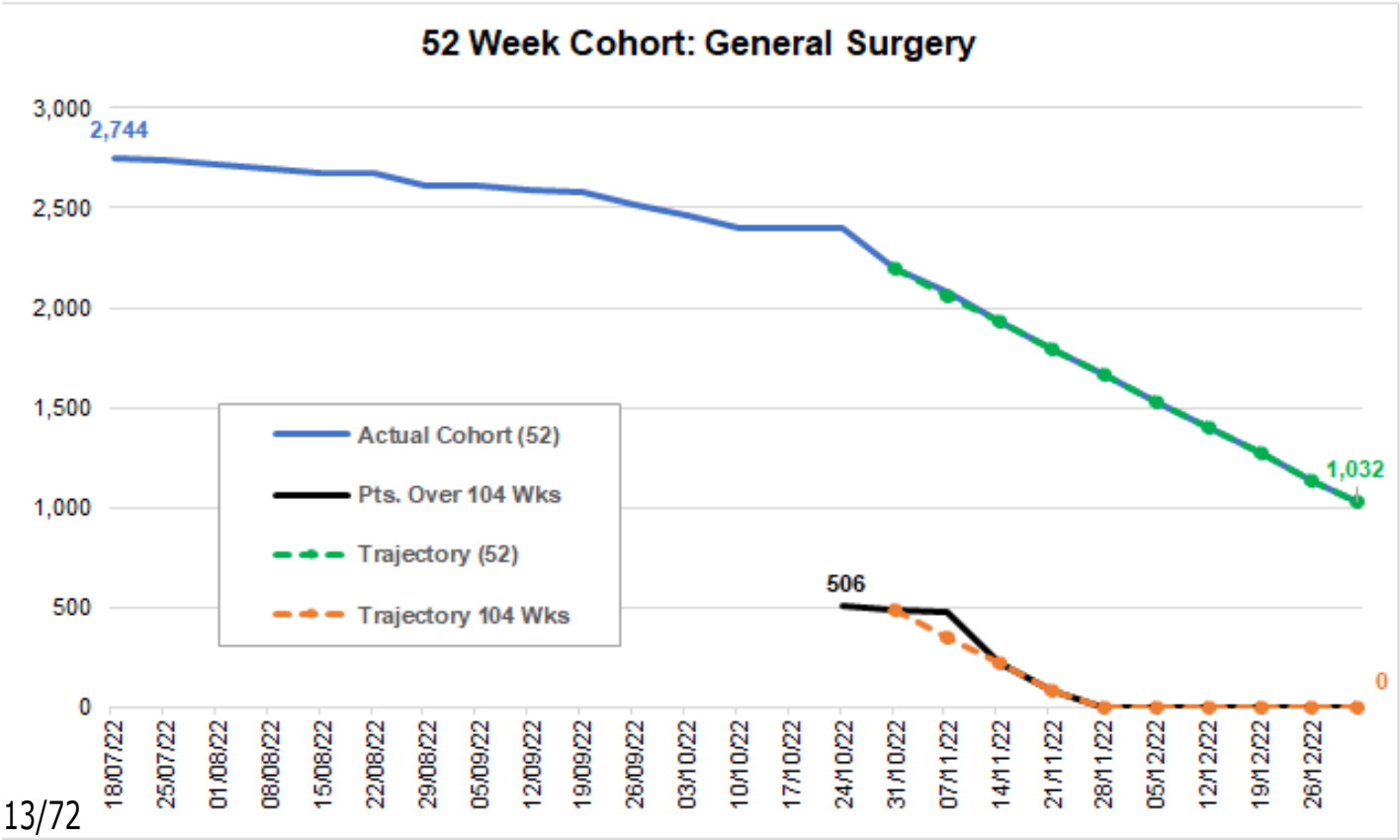


Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

General Surgery

New Outpatients

52 Week Cohort: General Surgery	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
Activity each week																	132	132	132	132	132	132	132	132	104
Actual Cohort (52)	2,744	2,737	2,717	2,691	2,671	2,671	2,611	2,611	2,587	2,581	2,520	2,459	2,398	2,398	2,397	2,194	2,077	1,929	1,797	1,665	1,532	1,400	1,268	1,136	1,032
Pts. Over 104 Wks															506	484	476	219	87	0	0	0	0	0	0
Trajectory (52)																2,194	2,062	1,929	1,797	1,665	1,532	1,400	1,268	1,136	1,032
Trajectory 104 Wks																484	352	219	87	0	0	0	0	0	0



Specialty	Current	Best Case	Reasonable Worse Case
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410 - Rheumatology	974	300	464
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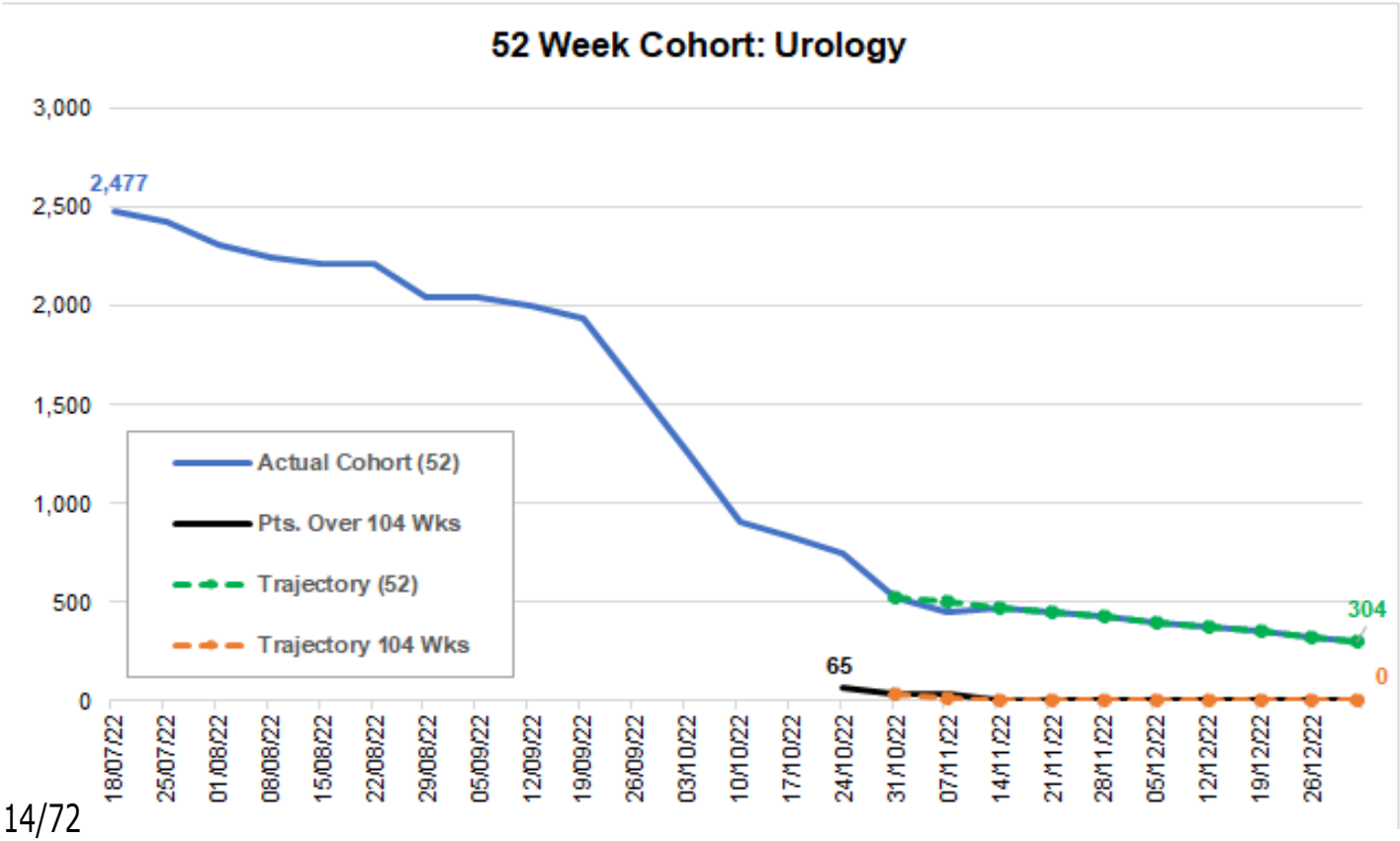
Total	17,911	5,061	7,788

Urology

New Outpatients	52 Week Cohort: Urology	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
	Activity each week																	25	25	25	25	25	25	25	25	23
	Actual Cohort (52)	2,477	2,424	2,307	2,249	2,216	2,216	2,047	2,047	2,004	1,937	1,596	1,254	913	829	746	525	450	475	451	426	401	376	352	327	304
	Pts. Over 104 Wks															65	40	36	0	0	0	0	0	0	0	0
	Trajectory (52)																525	500	475	451	426	401	376	352	327	304
	Trajectory 104 Wks																40	15	0	0	0	0	0	0	0	0



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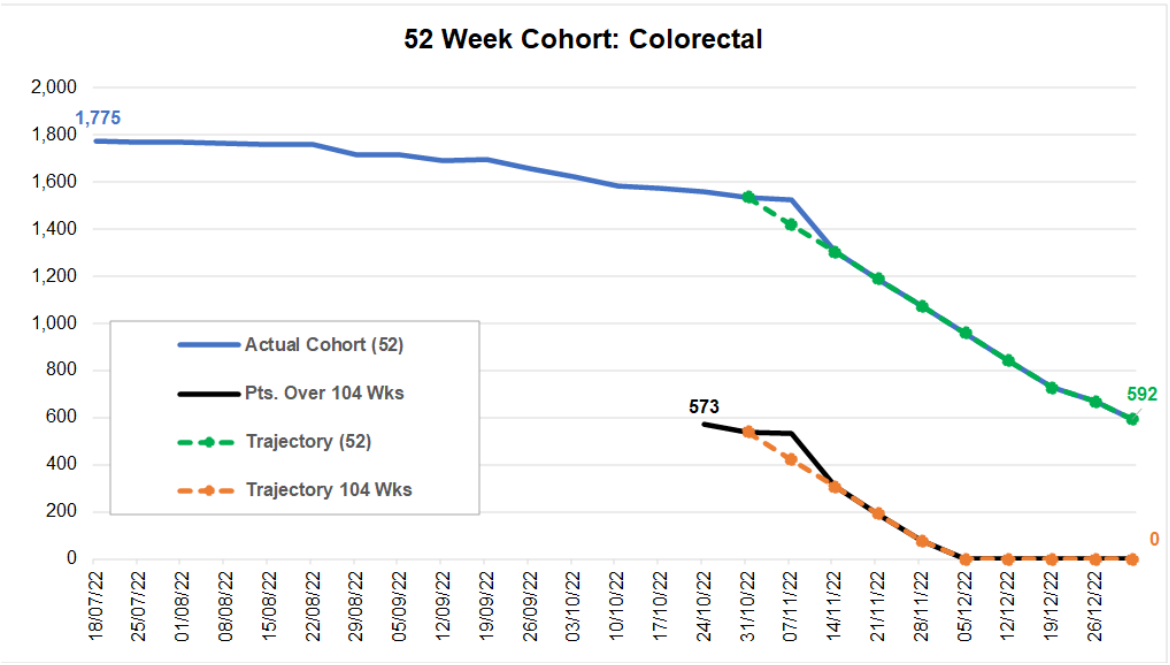
Total	17,911	5,061	7,788

Colorectal

New Outpatients	52 Week Cohort: Colorectal	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
	Activity each week																	115	115	115	115	115	115	115	59	76
	Actual Cohort (52)	1,775	1,771	1,768	1,763	1,758	1,758	1,715	1,715	1,690	1,694	1,658	1,622	1,585	1,572	1,559	1,535	1,527	1,304	1,189	1,074	958	843	728	668	592
	Pts. Over 104 Wks															573	538	535	307	192	77	0	0	0	0	0
	Trajectory (52)																1,535	1,420	1,304	1,189	1,074	958	843	728	668	592
	Trajectory 104 Wks																538	423	307	192	77	0	0	0	0	0

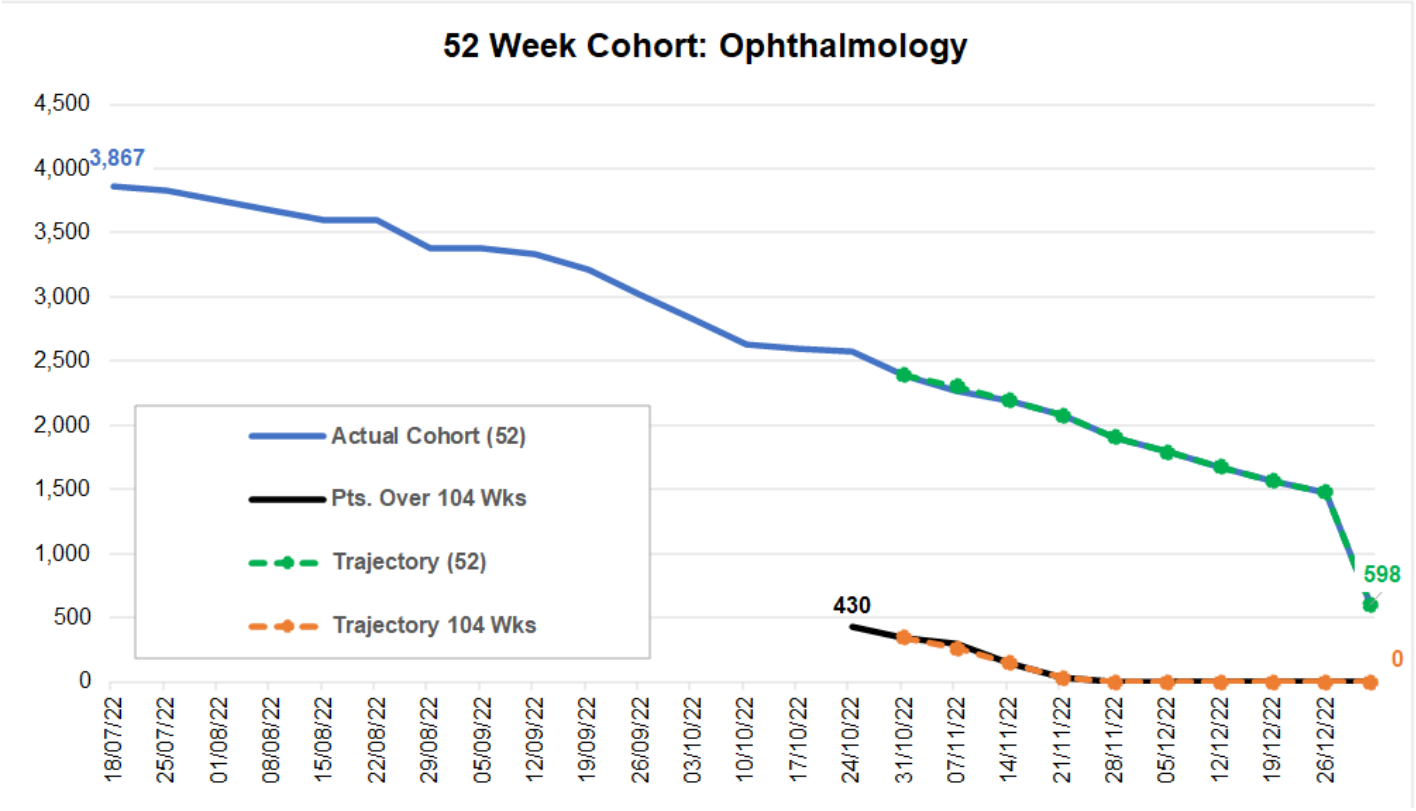


Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

Ophthalmology

New Outpatients

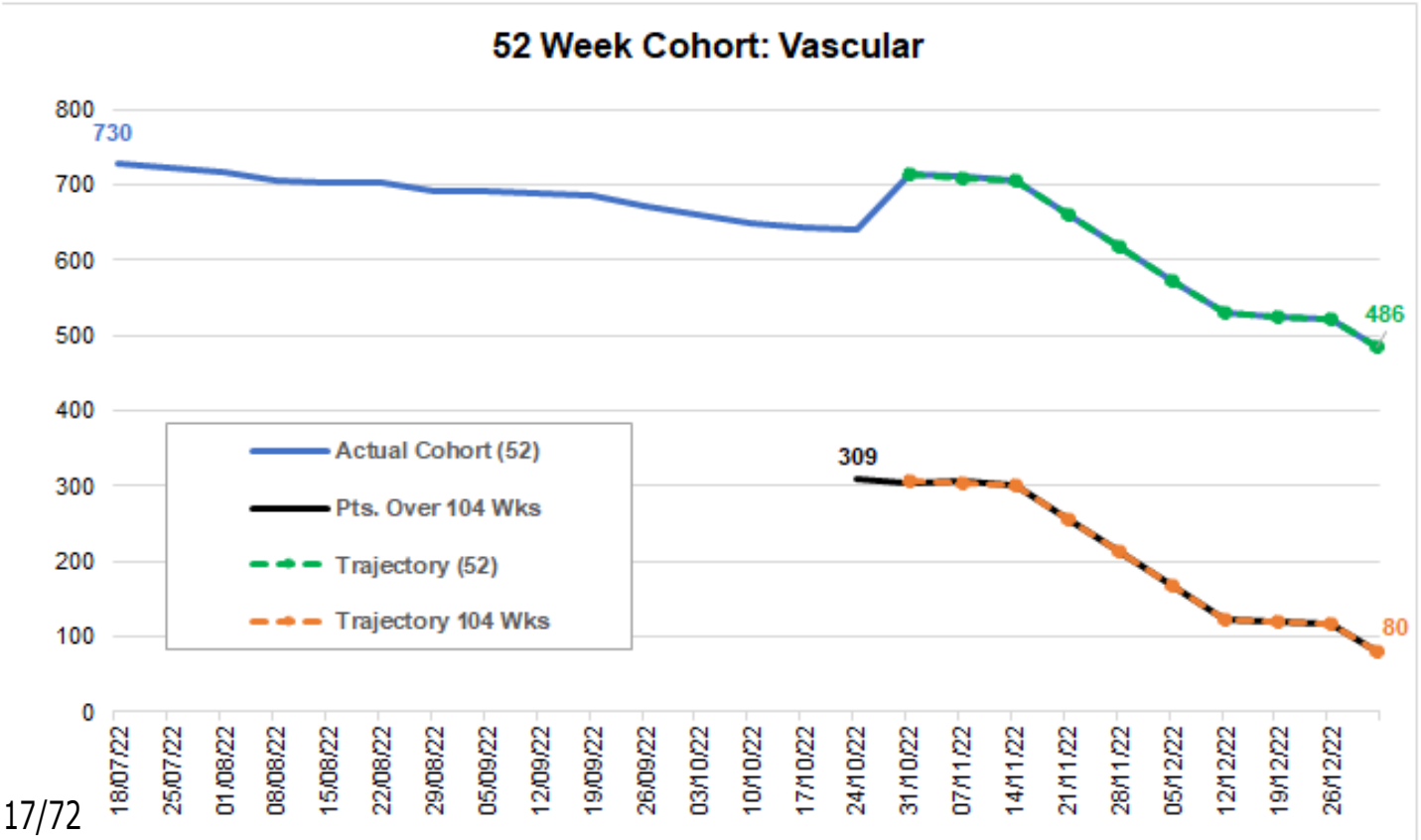
52 Week Cohort: Ophthalmology	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation etc
Activity each week																	84	114	114	174	114	114	114	84	884
Actual Cohort (52)	3,867	3,833	3,758	3,671	3,595	3,595	3,382	3,382	3,333	3,213	3,019	2,824	2,630	2,600	2,571	2,390	2,273	2,193	2,080	1,906	1,793	1,679	1,566	1,482	598
Pts. Over 104 Wks															430	346	302	149	36	0	0	0	0	0	0
Trajectory (52)																2,390	2,307	2,193	2,080	1,906	1,793	1,679	1,566	1,482	598
Trajectory 104 Wks																346	263	149	36	0	0	0	0	0	0



Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

Vascular

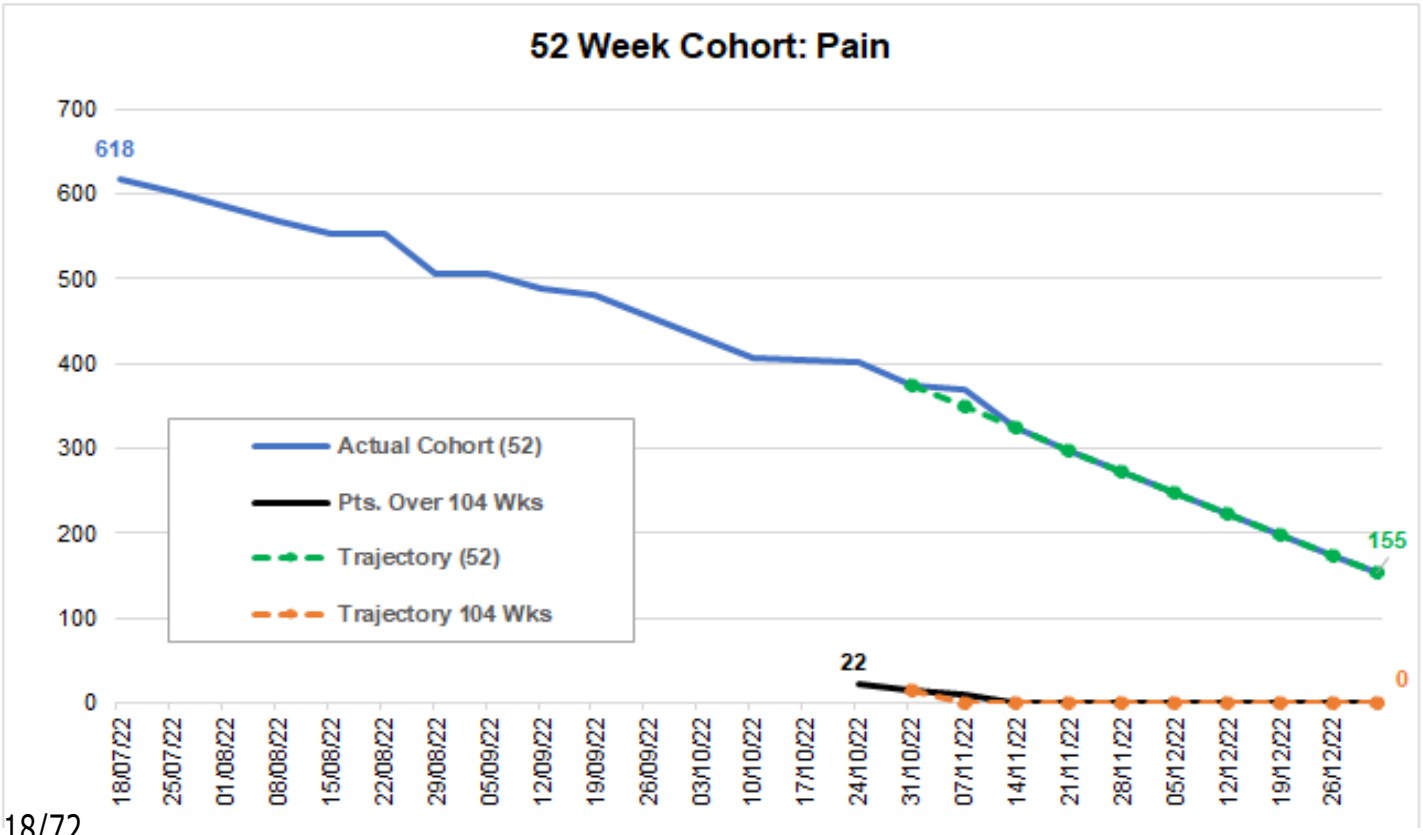
New Outpatients	52 Week Cohort: Vascular	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
	Activity each week																	4	4	44	44	44	44	4	4	36
	Actual Cohort (52)	730	723	717	706	703	703	691	691	690	686	674	661	649	645	641	714	713	706	662	618	574	530	526	522	486
	Pts. Over 104 Wks															309	305	307	300	256	212	168	124	120	116	80
	Trajectory (52)																714	710	706	662	618	574	530	526	522	486
	Trajectory 104 Wks																308	304	300	256	212	168	124	120	116	80



Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

Pain

New Outpatients	52 Week Cohort: Pain	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
	Activity each week																	25	25	25	25	25	25	25	25	18
	Actual Cohort (52)	618	603	586	569	553	553	505	505	489	480	456	432	408	405	401	374	369	324	299	274	249	224	198	173	155
	Pts. Over 104 Wks															22	14	11	0	0	0	0	0	0	0	0
	Trajectory (52)																374	349	324	299	274	249	224	198	173	155
	Trajectory 104 Wks																14	0	0	0	0	0	0	0	0	0

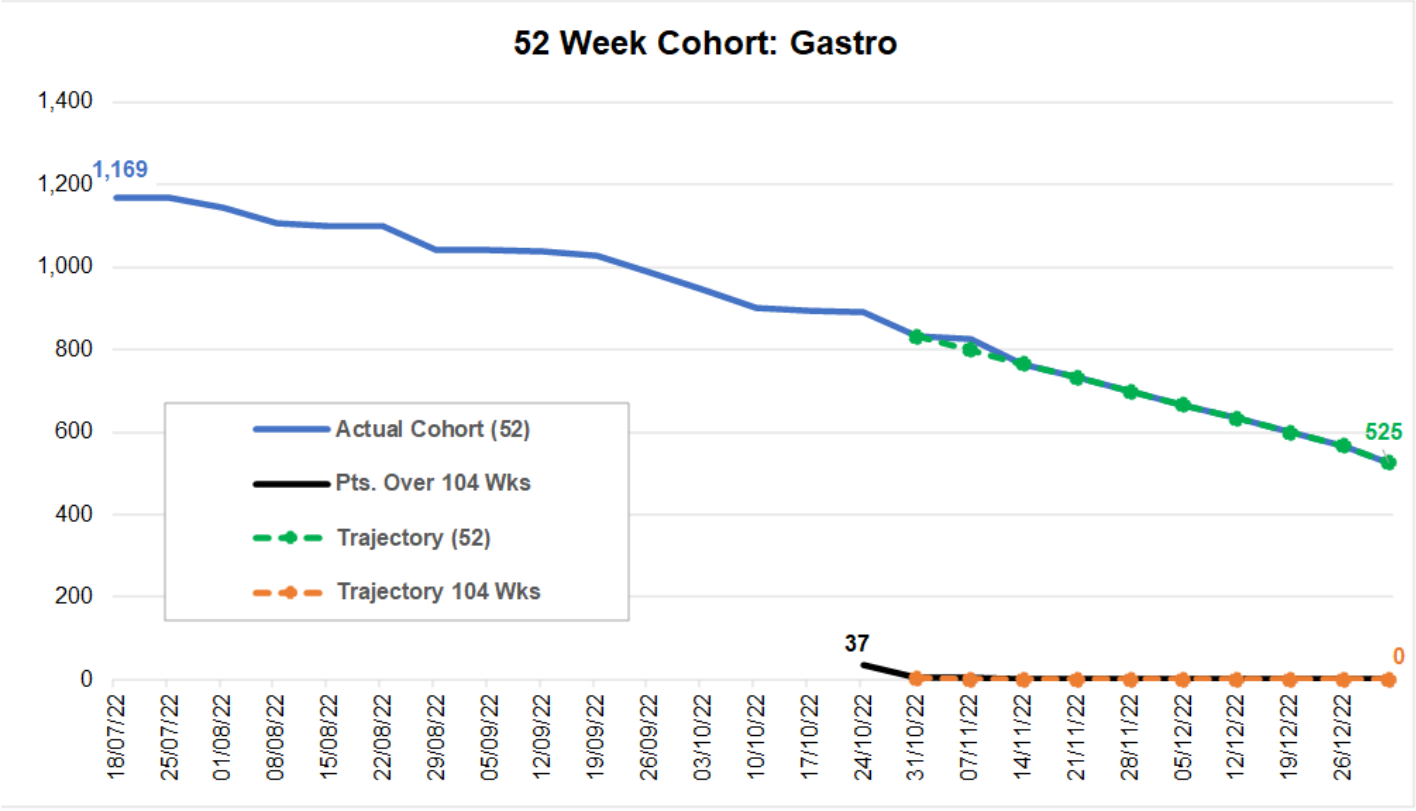


Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

Gastro

New Outpatients

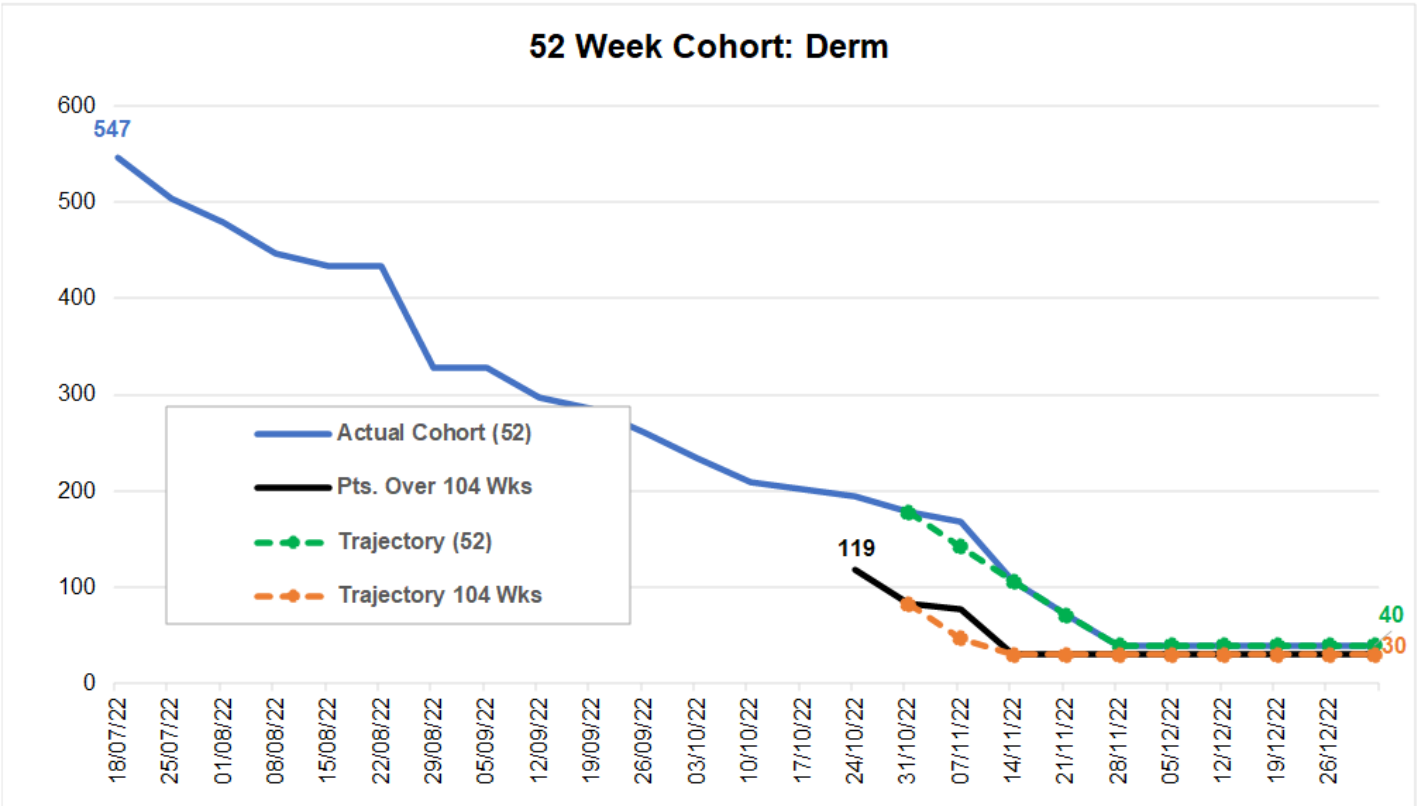
52 Week Cohort: Gastro	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
Activity each week																	33	33	33	33	33	33	33	33	41
Actual Cohort (52)	1,169	1,167	1,143	1,107	1,099	1,099	1,041	1,041	1,038	1,029	987	945	902	896	890	832	827	766	733	699	666	633	600	567	525
Pts. Over 104 Wks															37	4	4	0	0	0	0	0	0	0	0
Trajectory (52)																832	799	766	733	699	666	633	600	567	525
Trajectory 104 Wks																4	0	0	0	0	0	0	0	0	0



Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

Dermatology

New Outpatients	52 Week Cohort: Derm	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
	Activity each week																	36	36	36	36	36	0	0	0	8
	Actual Cohort (52)	547	504	479	447	434	434	328	328	297	286	260	235	209	202	195	178	168	107	71	40	40	40	40	40	40
	Pts. Over 104 Wks															119	83	77	30	30	30	30	30	30	30	30
	Trajectory (52)																178	142	107	71	40	40	40	40	40	40
	Trajectory 104 Wks																83	47	30	30	30	30	30	30	30	30

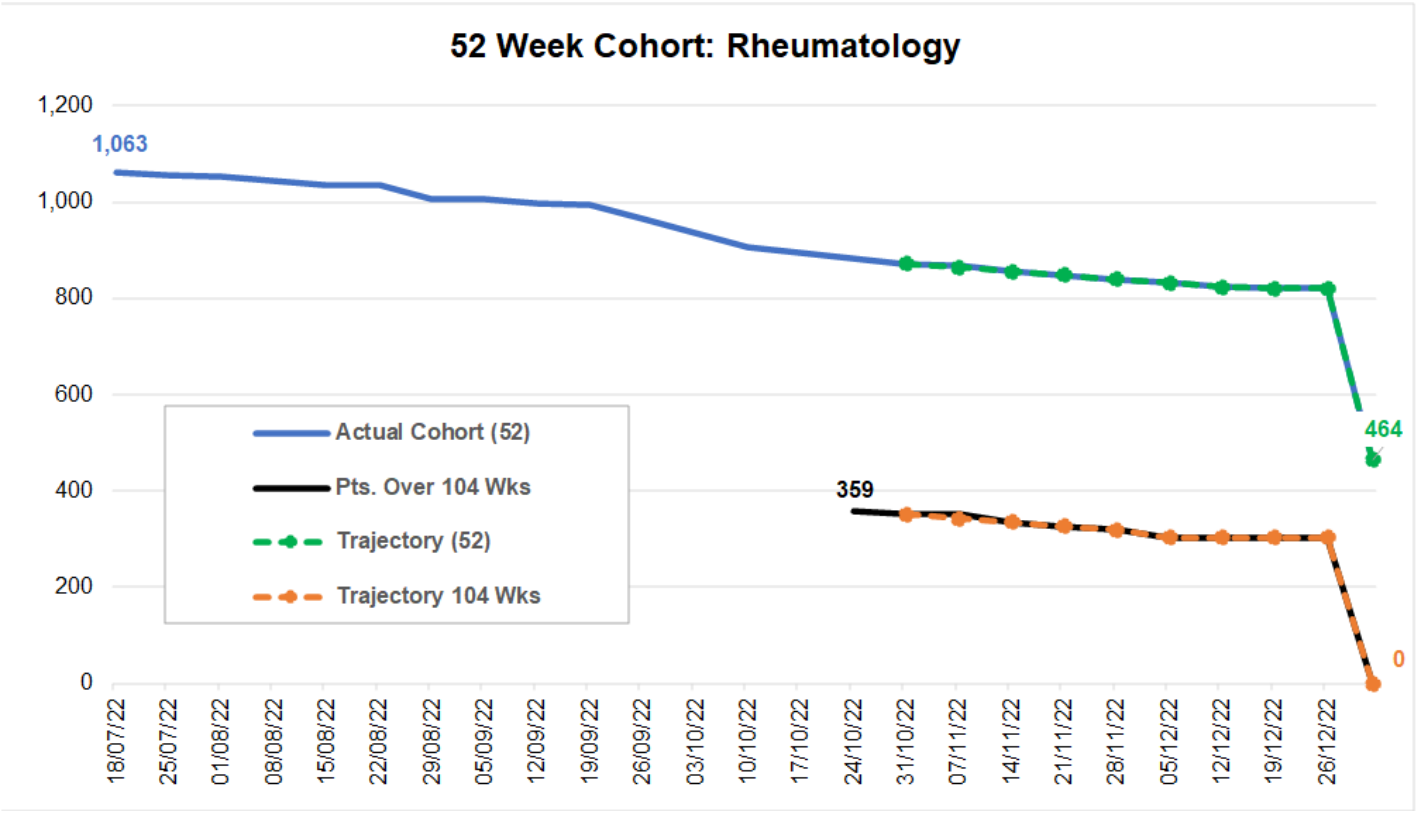


Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

Rheumatology

New Outpatients

52 Week Cohort: Rheumatology	18/07/22	25/07/22	01/08/22	08/08/22	15/08/22	22/08/22	29/08/22	05/09/22	12/09/22	19/09/22	26/09/22	03/10/22	10/10/22	17/10/22	24/10/22	31/10/22	07/11/22	14/11/22	21/11/22	28/11/22	05/12/22	12/12/22	19/12/22	26/12/22	Validation
Activity each week																	8	8	8	8	8	8	4	0	356
Actual Cohort (52)	1,063	1,055	1,053	1,045	1,036	1,036	1,007	1,007	997	994	965	936	906	895	883	872	868	856	848	840	832	824	820	820	464
Pts. Over 104 Wks															359	351	351	335	327	319	303	303	303	303	0
Trajectory (52)																872	864	856	848	840	832	824	820	820	464
Trajectory 104 Wks																351	343	335	327	319	303	303	303	303	0



Specialty	Current	Best Case	Reasonable Worse Case
100 - General Surgery	2535	635	1035
101 - Urology	1365	500	875
104 - Colorectal	1684	300	592
107 - Vascular	670	544	678
120 - ENT	3600	2100	2,400
130 - Ophthalmology	2972	0	607
191 - Pain Management	448	100	155
301 - Gastroenterology	992	582	690
330 - Dermatology	231	0	67
410 - Rheumatology	974	300	464
430 - Geriatric Medicine	354	0	225
Total	17,911	5,061	7,788

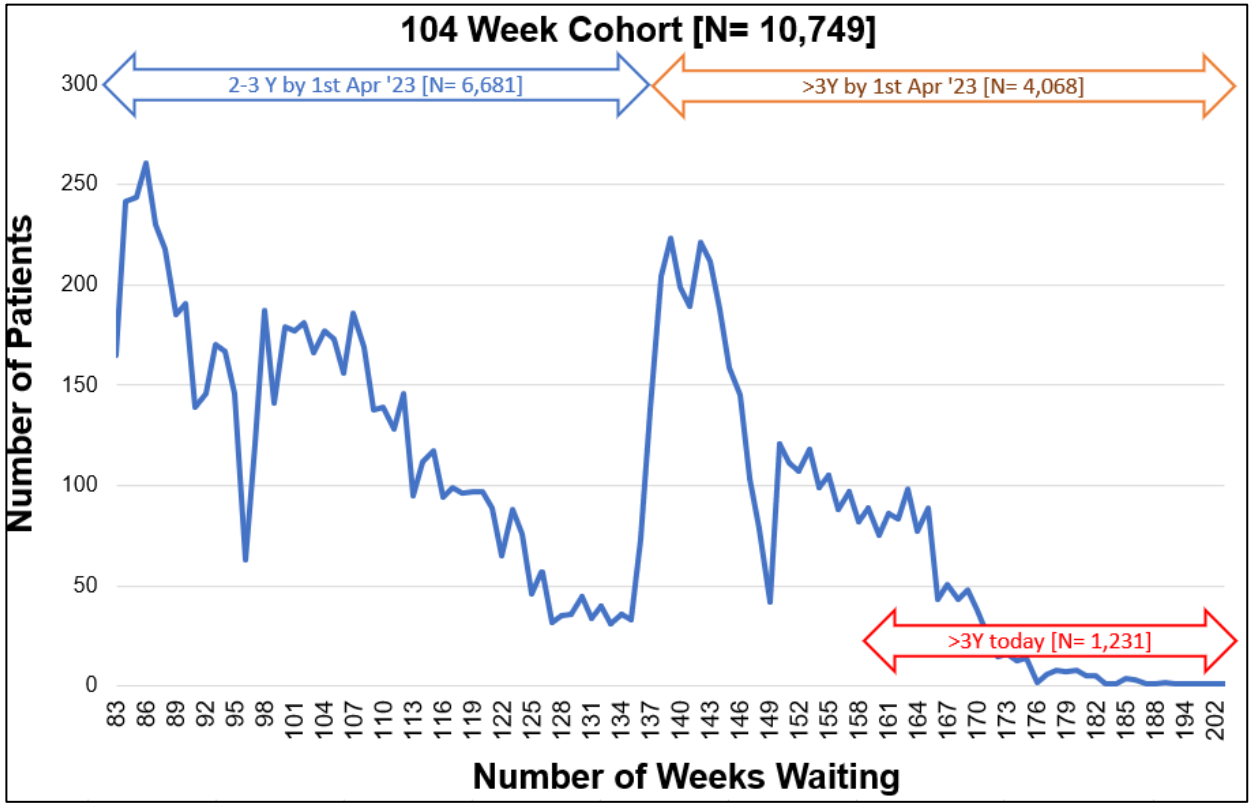
52 Weeks – booked from cohort (7th Nov)

	NON COHORT		52 Wk COHORT	
Row Labels	No.	%	No.	%
100 - General Surgery	97	16%	504	84%
120 - ENT	286	38%	458	62%
101 - Urology	441	52%	414	48%
130 - Ophthalmology	329	50%	329	50%
502 - Gynaecology	766	73%	283	27%
301 - Gastroenterology	344	58%	253	42%
110 - Trauma & Orthopaedics	642	72%	246	28%
191 - Pain Management	19	10%	169	90%
330 - Dermatology	523	80%	128	20%
430 - Geriatric Medicine	94	59%	65	41%
400 - Neurology	184	76%	59	24%
410 - Rheumatology	91	71%	38	29%
104 - Colorectal	209	89%	27	11%
300 - General Medicine	76	79%	20	21%
103 - Breast	169	91%	16	9%
420 - Paediatrics	304	97%	9	3%
401 - Clinical Neurophysiology	31	86%	5	14%
107 - Vascular	46	92%	4	8%
822 - Chemical Pathology	34	97%	1	3%
320 - Cardiology	289	100%	1	0%
Grand Total	**5,058**	**63%**	**3,030**	**37%**

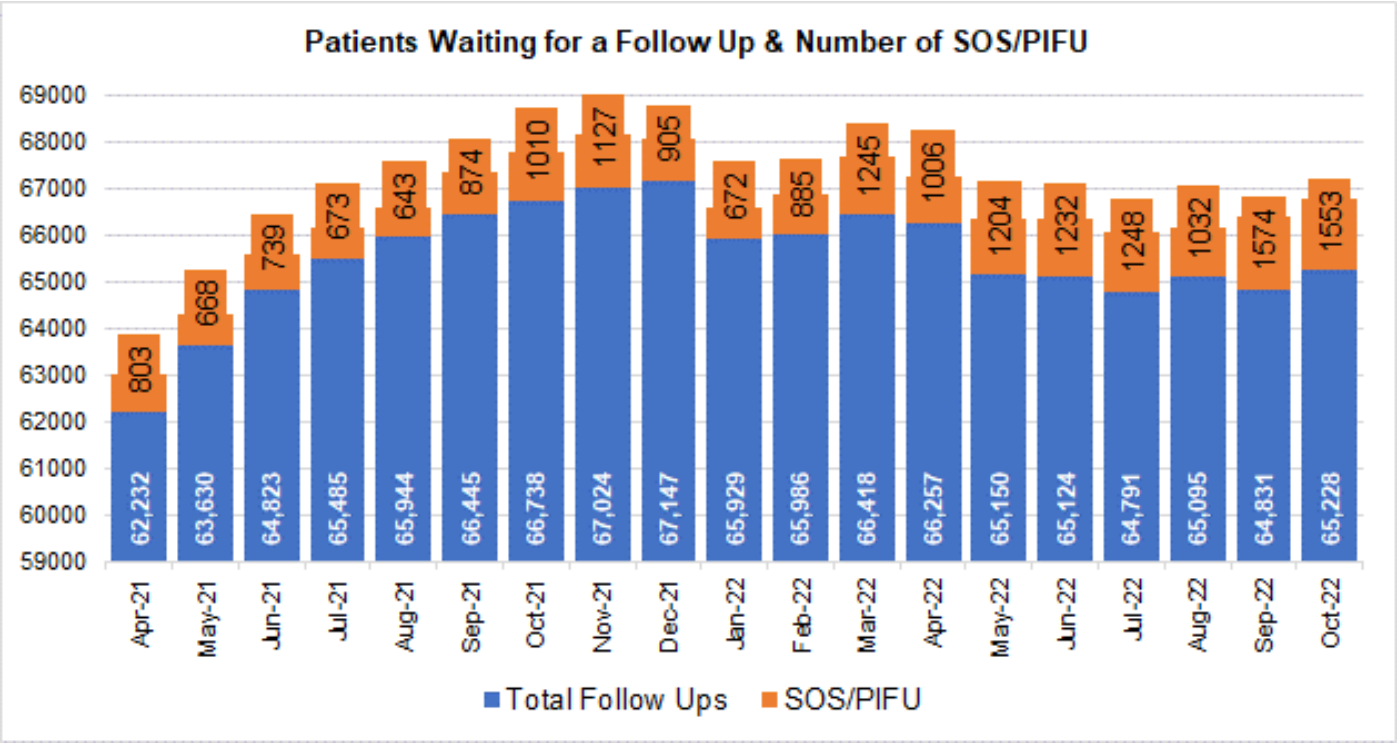
Neurology, Gynaecology and Urology have booked 100%, 97% and 92% of their cohort respectively

3 year waits & total waiting list

	Stage 1	Stage 2/3	Stage 4	Grand
110 - Trauma & Orthopaedics		20	517	537
101 - Urology	2	5	188	195
100 - General Surgery	13	3	108	124
130 - Ophthalmology	43	5	52	100
502 - Gynaecology		11	74	85
120 - ENT		11	43	54
104 - Colorectal	27	8	15	50
107 - Vascular	24	5	12	41
191 - Pain Management			24	24
330 - Dermatology	11			11
410 - Rheumatology	1	2		3
430 - Geriatric Medicine		2	1	3
300 - General Medicine	3			3
103 - Breast			1	1
Grand Total	**124**	**72**	**1,035**	**1,231**



SOS/PIFU



- **26,258** pathways to date
- Sep/Oct 2022 – **highest so far**
- **26** Specialities using pathways
- **167** clinical conditions
- **155** clinicians

Benefits

- Also used for New attendances
- Improves capacity for S1 & FU
- Facilitates self care for patients

New patients in October 22	Future Appointment (%)		SOS/PIFU (%)		Discharged (%)		SOS/PIFU + Discharge (%)	
103 - Breast	105	23%	12	3%	345	75%	357	77%
300 - General Medicine	19	35%	0	0%	36	65%	36	65%
328 - Stroke Medicine	25	46%	0	0%	29	54%	29	54%
410 - Rheumatology	38	50%	15	20%	23	30%	38	50%
107 - Vascular	25	57%	3	7%	16	36%	19	43%
502 - Gynaecology	525	58%	93	10%	295	32%	388	42%
120 - ENT	255	60%	19	4%	150	35%	169	40%
110 - Trauma & Orthopaedics	842	60%	364	26%	193	14%	557	40%
100 - General Surgery	121	63%	19	10%	51	27%	70	37%
320 - Cardiology	151	65%	14	6%	68	29%	82	35%
301 - Gastroenterology	208	67%	14	4%	90	29%	104	33%
302 - Endocrinology	53	67%	0	0%	26	33%	26	33%
420 - Paediatrics	270	68%	20	5%	107	27%	127	32%
400 - Neurology	101	72%	16	11%	23	16%	39	28%
101 - Urology	504	72%	23	3%	170	24%	193	28%
330 - Dermatology	482	74%	43	7%	125	19%	168	26%
340 - Respiratory Medicine	197	75%	4	2%	62	24%	66	25%
430 - Geriatric Medicine	70	75%	2	2%	21	23%	23	25%
130 - Ophthalmology	745	77%	51	5%	176	18%	227	23%
303 - Clinical Haematology	53	85%	0	0%	9	15%	9	15%
361 - Nephrology	37	88%	0	0%	5	12%	5	12%
307 - Diabetic Medicine	31	89%	0	0%	4	11%	4	11%
104 - Colorectal	335	92%	6	2%	24	7%	30	8%
191 - Pain Management	38	95%	2	5%	0	0%	2	5%
Grand Total	**5,230**	**65%**	**720**	**6%**	**2,048**	**12%**	**2,768**	**35%**

SOS PIFU use for Stage 1 OPD patients = 6%

Some specialties utilise SOS/PIFU **before** OPD appointment- Figures not reflected

Overall discharge + SOS/PIFU rate = 35%

Return patients in October 22	Future Appointment (%)		SOS/PIFU (%)		Discharged (%)		SOS/PIFU + Discharge (%)	
328 - Stroke Medicine	5	20%	0	0%	20	80%	20	80%
107 - Vascular	55	60%	3	3%	33	36%	36	40%
400 - Neurology	77	64%	30	25%	14	12%	44	36%
110 - Trauma & Orthopaedics	1,408	67%	295	14%	394	19%	689	33%
320 - Cardiology	158	68%	26	11%	48	21%	74	32%
100 - General Surgery	112	70%	8	5%	40	25%	48	30%
330 - Dermatology	332	73%	64	14%	58	13%	122	27%
104 - Colorectal	163	74%	11	5%	47	21%	58	26%
340 - Respiratory Medicine	275	77%	13	4%	68	19%	81	23%
430 - Geriatric Medicine	146	78%	3	2%	38	20%	41	22%
191 - Pain Management	52	79%	3	5%	11	17%	14	21%
301 - Gastroenterology	506	79%	71	11%	64	10%	135	21%
410 - Rheumatology	322	79%	67	16%	18	4%	85	21%
420 - Paediatrics	548	79%	34	5%	109	16%	143	21%
502 - Gynaecology	509	80%	33	5%	96	15%	129	20%
120 - ENT	471	82%	31	5%	75	13%	106	18%
302 - Endocrinology	192	84%	1	0%	36	16%	37	16%
103 - Breast	426	87%	10	2%	54	11%	64	13%
300 - General Medicine	28	88%	0	0%	4	13%	4	13%
101 - Urology	728	88%	36	4%	66	8%	102	12%
130 - Ophthalmology	1,784	88%	53	3%	181	9%	234	12%
307 - Diabetic Medicine	176	94%	0	0%	12	6%	12	6%
361 - Nephrology	163	96%	2	1%	5	3%	7	4%
303 - Clinical Haematology	848	97%	0	0%	23	3%	23	3%
Grand Total	**9,484**	**80%**	**794**	**6%**	**1,514**	**12%**	**2,308**	**20%**

Follow Up SOS & PIFU Challenge:

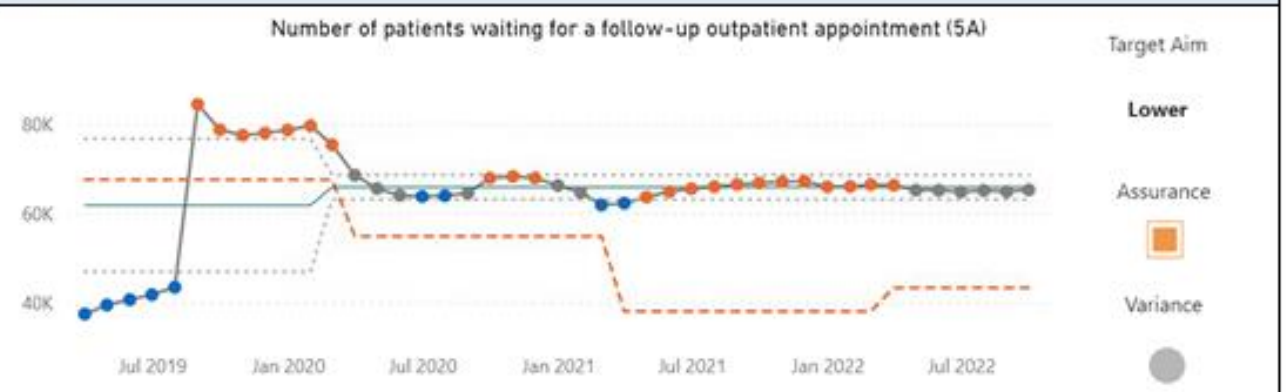
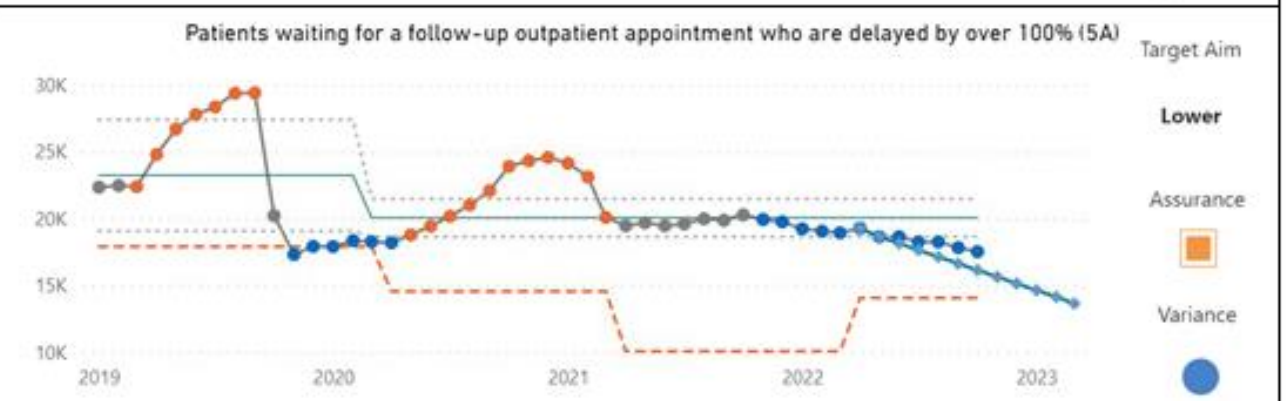
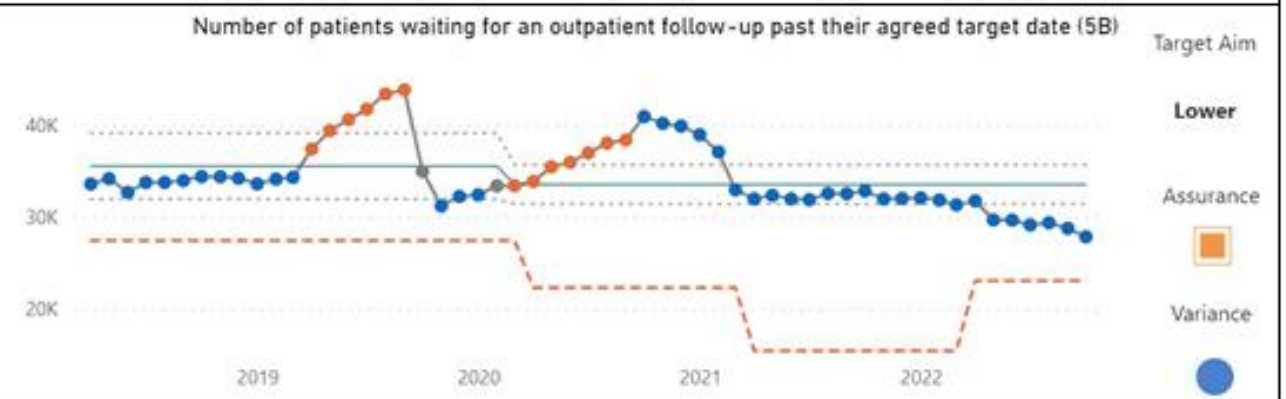
T&O have a high SOS/PIFU rate (14%) and even higher discharge rate (19%)

Stroke have highest discharge rate (80%) but no patients put on SOS/PIFU

Some specialties utilise SOS/PIFU **before** OPD appointment- Figures not reflected

Overall discharge + SOS/PIFU rate = 20%

Follow Ups October 2022

Metric	Data	Chart
The number of patients waiting for a follow-up outpatient appointment	Sep 22: 64,831 **Oct 22: 65,228**	
Delayed Follow-ups - by over 100%	Sep 22: 17,833 **Oct 22: 17,527**	
Delayed follow-ups: (booked and not booked) who are delayed past their agreed target date	Sep 22: 28,774 **Oct 22: 27,862**	

Sustained improvement in all 3 performance measures

[16.6% of our population on a FU pathway]

HB Transformation Measures: SOS/PIFU Challenge

- Currently 16.6% (64,831) of HD population on a Follow up pathway
- Compared to up to 34% in other HB's including SB (March 2022 data)

Health Board	Population	Total March 22	% of Population
Cardiff & Vale	504,497	**172,902**	34%
Swansea Bay	390,949	**133,772**	34%
Betsi Cadwaldr	703,361	**185,293**	26%
Cwm Taff	449,836	**112,698**	25%
Aneurin Bevan	598,194	**113,107**	19%
Hywel Dda	389,719	**66,416**	17%
Powys	133,030	**6,440**	5%
Wales	**3,169,586**	**790,628**	25%

52 Week Cohort Validation Plan

Ministerial targets and beyond, Internal and external validation plan.

Cohort	Current volumes	Trajectory	Week Beginning. 07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023	09/01/2023	16/01/2023	23/01/2023	30/01/2023	06/02/2023	13/02/2023	Already validated under 3 months.
Stage 1 -52 weeks unbooked....	5670	5670																
100 - General Surgery	1112	1112	200	912														487
101 - Urology	2	2	2															70
103 - Breast	0	0	0															69
104 - Colorectal	5	5	5															1504
107 - Vascular	13	13	13															697
110 - Trauma & Orthopaedics	0	0	0															65
120 - ENT	2088	2088	1200	888														786
130 - Ophthalmology	1851	1851		1851														150
191 - Pain Management	0	0																203
300 - General Medicine	1	1	1															150
301 - Gastroenterology	558	558	558															16
303 - Clinical Haematology	0	0	0															12
330 - Dermatology	9	9	9															41
410 - Rheumatology	25	25	25															825
420 - Paediatrics	0	0	0															1
430 - Geriatric Medicine	0	0	0															249
502 - Gynaecology	6	6	6															1
Internal planned numbers			819	912														
External planned numbers			1200	2739														

52 week cohort validation completed by week ending 14th November 2022

Key: Yellow = Internal Validation Red = External Valuation

104 Week Cohort Validation Plan

Ministerial targets and beyond, Internal and external validation plan.

Cohort	Current volumes	Trajectory	Week Beginning. 07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023	09/01/2023	16/01/2023	23/01/2023	30/01/2023	06/02/2023	13/02/2023	Already validated under 3 months.
Stage 4 -104 weeks stage 4 - unbooked, including ringing all patients. Largest specialties first, longest waits first	26	4831																
100 - General Surgery	488	488				488												67
101 - Urology	972	972				972												195
103 - Breast	6	6				6												2
104 - Colorectal	135	135				135												19
107 - Vascular	22	22				22												0
110 - Trauma & Orthopaedics	1907	1907			1907													166
120 - ENT	198	198				198												74
130 - Ophthalmology	359	359				359												65
191 - Pain Management	318	318				318												89
300 - General Medicine	3	3				3												0
301 - Gastroenterology	69	69				69												21
303 - Clinical Haematology	1	1				1												0
430 - Geriatric Medicine	2	2				2												1
502 - Gynaecology	351	351				351												267
Stage 3 Revisit 104 weeks ministerial (clean as at 30/09/2022)	700	700				700												0
Stage 3 further down list not validated within 3 months, non 104	16783	9400				0	700	700	1000	1000	1000	1000	1000	1000	1000	1000	1000	
Stage 1 non ministerial longest waits first (or folow ups tbd)		19343	0		1907	2436	1500	1500	1500	1500	1500	1500	1500	1500	1500	1500	0	
Stage 4 non ministerial longest waits first (or follow ups tbd)		17000					1500	1500	1500	1500	1500	1500	1500	1500	1500	1500	2000	

Key: Yellow = Internal Validation Red = External Valuation

External validation are telephoning patients to see if they've been treated elsewhere

Patient Support and Communication

Objective: A designated service (Waiting List Support Service) to support patients on waiting lists for elective procedures (stage 4) with the aim to:

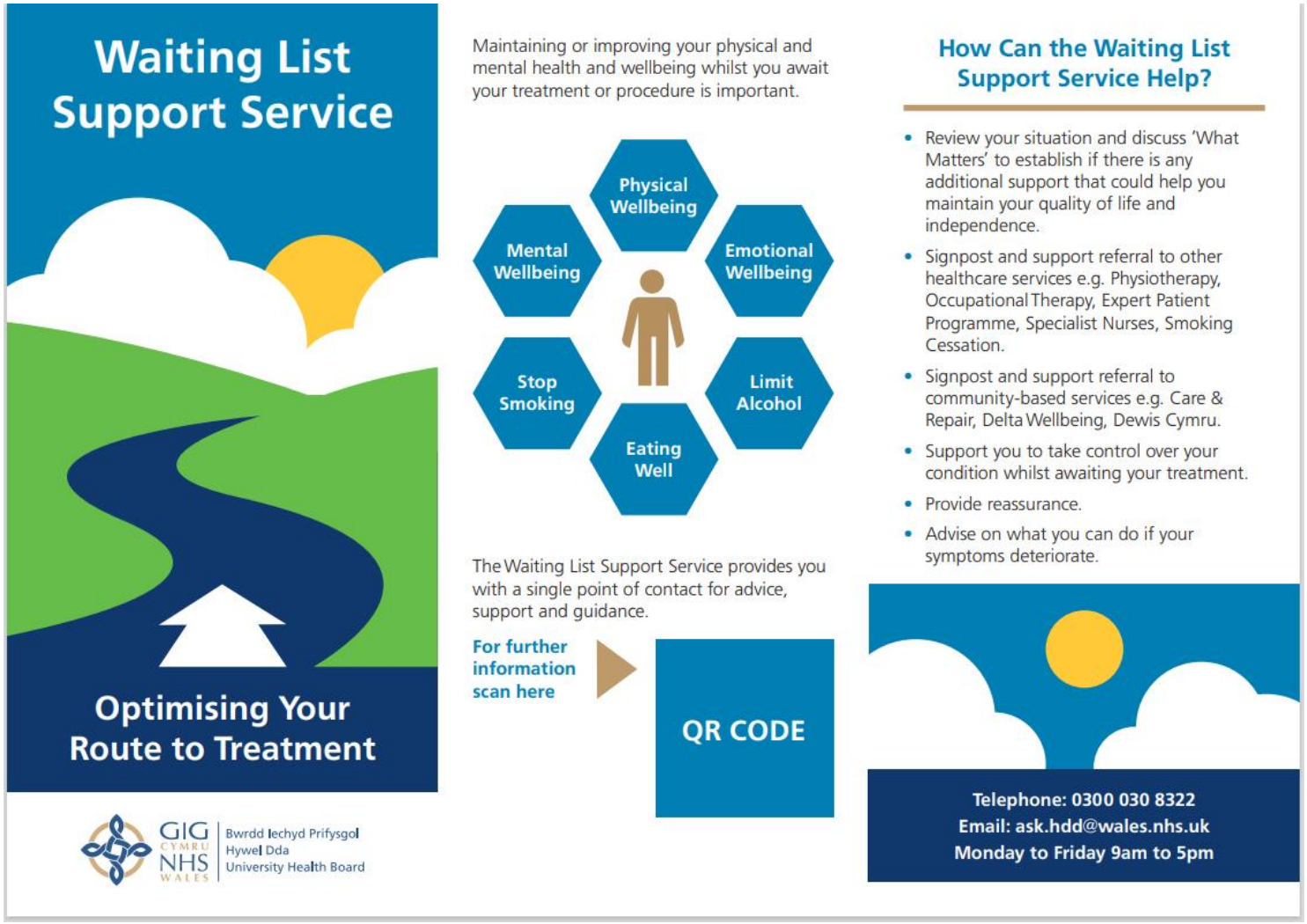
- Establish a process to maintain personalised contact with all patients on waiting lists
- Keep them regularly informed of their current expected wait
- Offer a single point of contact should they need to contact us
- Provide advice on self-management options whilst waiting
- Offer advice on what to do if their symptoms deteriorate
- Establish a systematic approach to measuring harm- bringing together the clinically assessed harm and harm self-assessed by the patient and use this to inform waiting list prioritization.
- Offer alternative treatment options if appropriate

Outcomes (Dec 2021- Oct 2022):

- 10,800 Stage 4 patients contacted (ENT, T&O, Dermatology, Urology, Ophthalmology, Gynae)
- 1445 calls received
- 4511 hits online on "Preparing for Treatment" resources

- Plan to contact a further 3425 patients in October and November (General surgery, Gastro and colorectal)
- Aim to contact all stage 4 patients who have waited over 36 weeks by end of November 2022
- Services linked to Prehabilitation programmes

Draft leaflet to be provided on listing:



Urgent and emergency care

Urgent and Emergency Care (UEC)

Enhanced monitoring

- Ensure adoption of the six goals programme
- Continuous improvement in 4 hour ambulance patient handover performance delays in transfer of patients from crews to hospital staff by end of 2022/23 eradicating
- Plan to implement SDEC at each site plus a community SDEC by March 2023

Data analysis has indicated that our older population (specifically those who are frail) and our high risk complex patients significantly contribute to our UEC pressures. The data indicates that we convey and admit proportionately greater numbers of our older people population than our counterparts across Wales. The data also indicates that if this population is admitted and stays > 72 hours they are likely to have an Average LOS of 21 days or more. Management of our complex inpatients is therefore critical.
Consequently, our UEC improvement Programme is built around a 3C's model: **C**onveyance reduction and Reducing Self Presentation to ED ; **C**onversion reduction; **C**omplexity management in hospital and community :

- Reducing conveyance to hospital for the frail and elderly and self presentations of our population to the Emergency Department
- Reducing conversion rates proportionately where appropriate to do so for our frail and elderly population
- Enhancing our inpatient management of complexity (frailty) and management of high risk / vulnerable patients in the community to reduce risk of unplanned admission to hospital

We deliver the 3 Cs UEC programme utilising the 6 Goals UEC Framework.
Six goals programme has been set up and a Director for our 6 Goals Transforming Urgent and Emergency Care (TUEC) has recently been appointed. Clinical leadership across urgent primary care and acute hospital care has also been secured as part of the Triumvirate and a Programme Management Office is in place.
Our **priority areas f**or this year include:
- Im**plementation of a Clinical Streaming Hub** that will take referrals from APP Navigator and undertake PTAS to reduce avoidable conveyance. We are also progressing alternative pathways to conveyance from Clinical Streaming Hub for Care Homes and those presenting on the stack with Chest Pain (part of WG initiative).
- E**nhancing or Urgent Primary Care service** response to decompensated frail adults in the community through the provision of intermediate care and wrap around support with GP practice sign up to provide oversight as part of virtual ward model. The latter includes Telehealth where possible

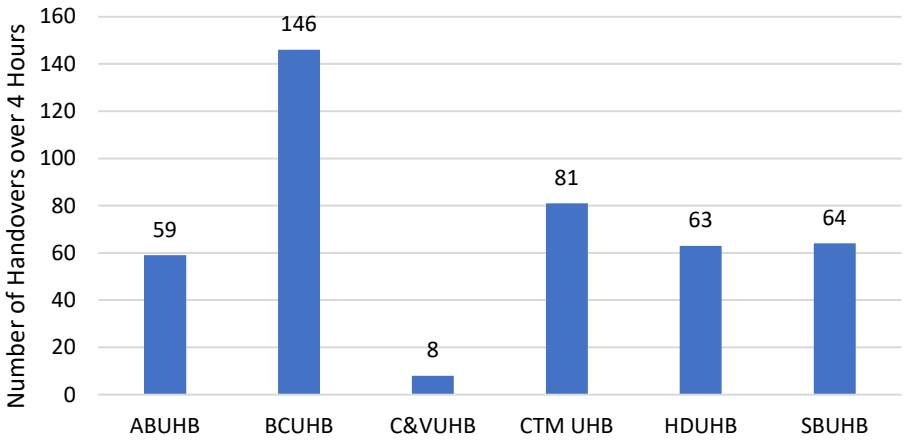
UEC 6 goals funding has allowed the additional resourcing to the Urgent primary care service, specifically this includes 'wrap around care' and GP time.
- **Enhancing use of SDEC** – implementation of streaming GP referrals through Clinical Streaming Hub and scheduling SDEC appointments to optimise its use to reduce conversion rates / utilise our Clinical Decision Units to provide short term stays for those identified in SDEC and ensure rapid turnaround. UEC 6 Goals funding has allowed the enhancement of SDEC in PPH, GGH and WGH and SDUC in Ceredigion. These currently run during core hours with the exception of WGH which operates between 0900 – 2100. An analysis of the true demand of SDEC has been undertaken as well as consideration of how we deliver value for money in terms of impact and affordability across the 4 sites.
- **Improve management of complexity** – early identification of the complex, establishing clinical criteria, EDD and discahrge pathway within day 1.

Our **Winter Plan for 2022/23** is also built around the 6 Goals UEC framework and our 3Cs priorities
A joint ODG has been established between WAST and the Health Board to oversee any implementation of actions which require partnership working across the organisations.
Current activity includes:
Direct referral to SDEC by Paramedics.

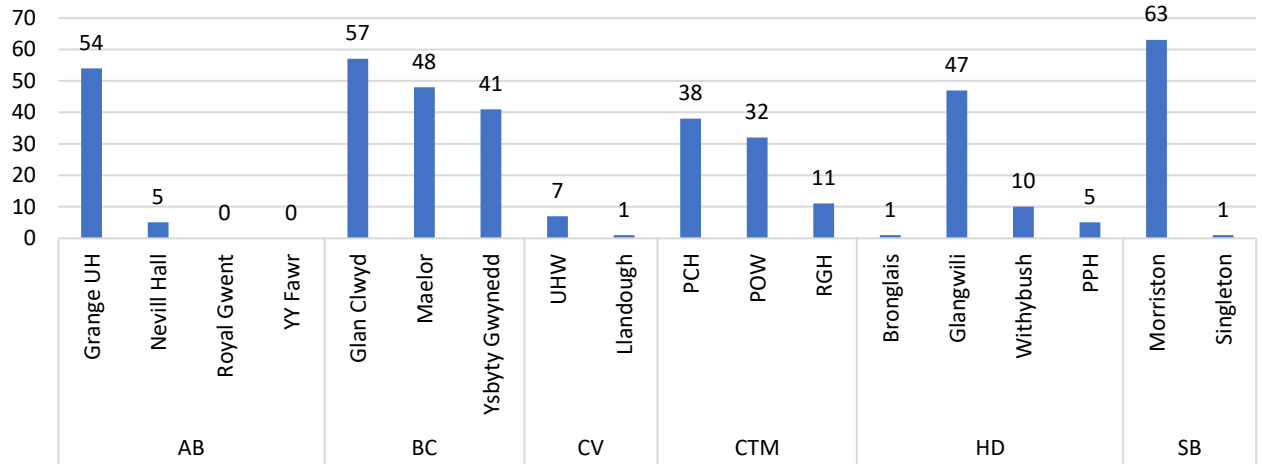
- Direct referral to social care / GPs (via private access numbers in Consultant Connect) to provide paramedics with further info that may support decision making for conveyance avoidance
- PIlot APP Navigator in Carmarthenshire with the Home First Hub.
- Alternative transportation - WAST provide additional 3 private (NEPTS) vehicles at three sites (Prince Phillip, Glangwili & Withybush), for the period Monday-Sunday, for a period of six months, the aim to support improved flow across these three key sites in HDdUHB.

UEC – ambulance delays >4 hours

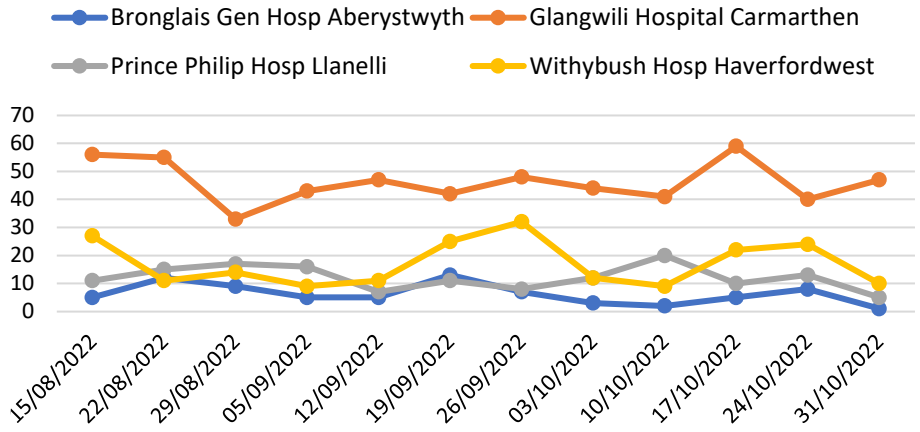
Ambulance delays > 4 hours by Health Board - w/b 31st October 2022



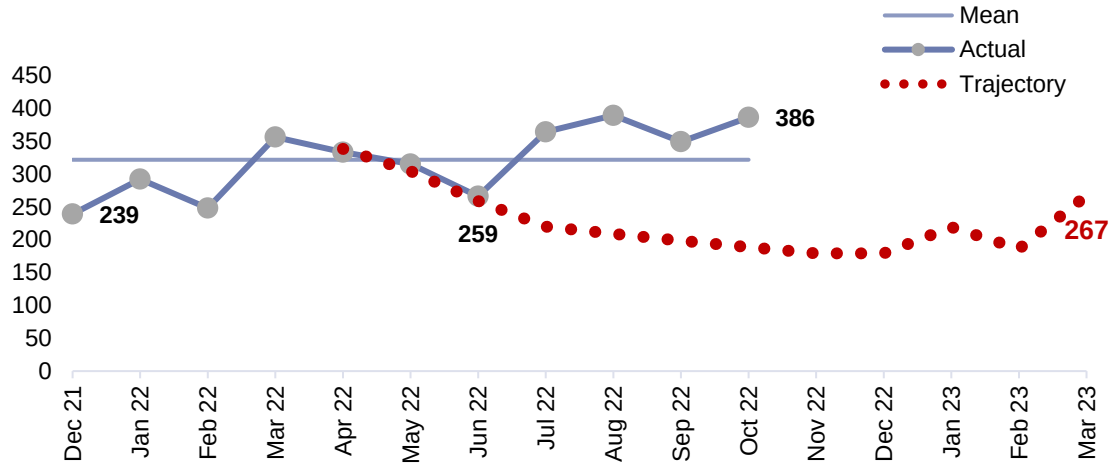
Ambulance delays > 4 hours by hospital - w/b 31st October



Ambulance delays > 4 hours trend by hospital



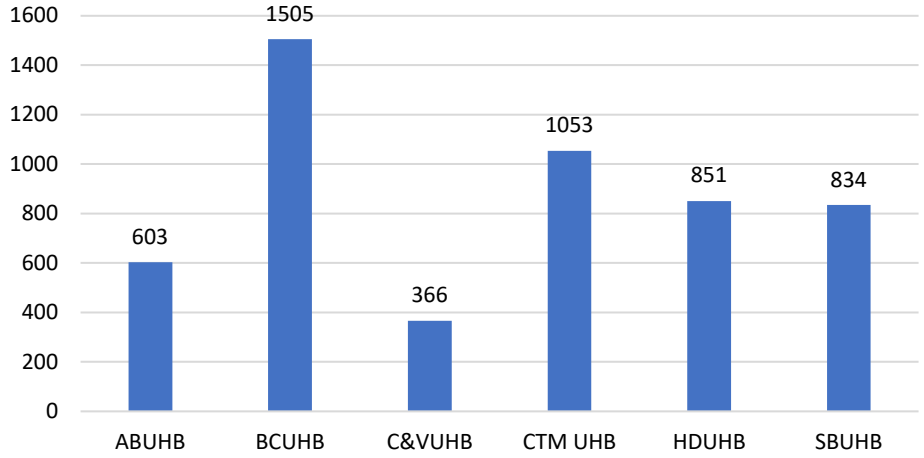
Ambulance handovers > 4 hours - monthly trajectory



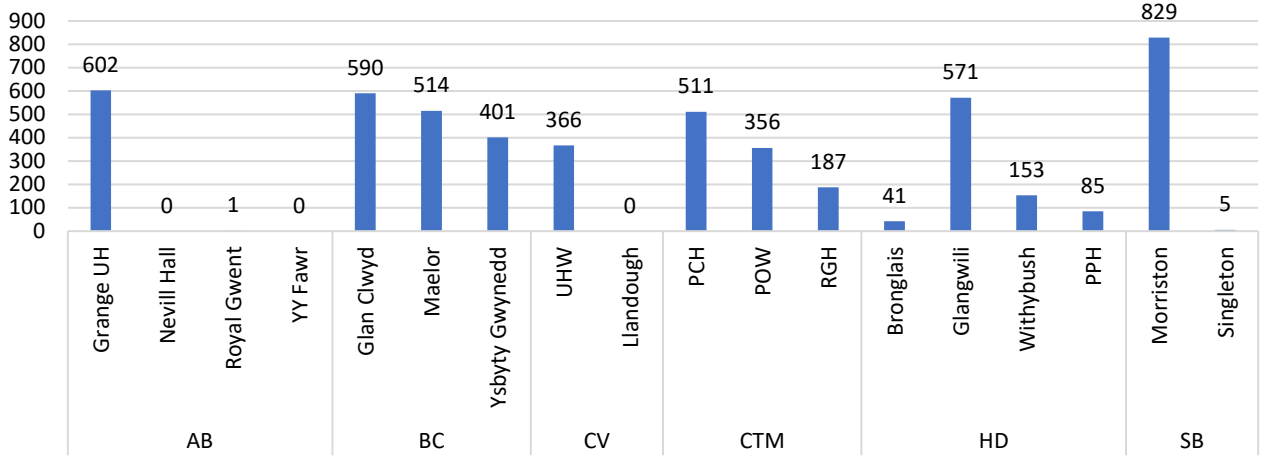
Data source: EASC and WAST handover notifictions

UEC – ambulance lost hours

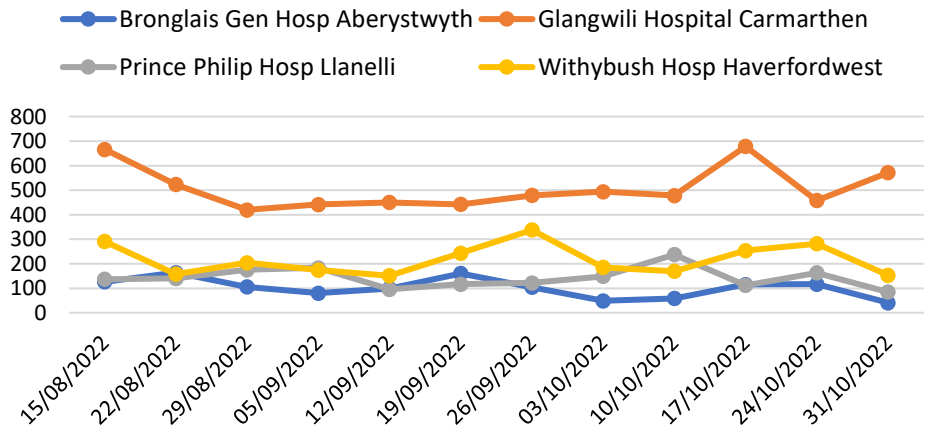
Ambulance lost hours by Health Board - w/b 31st October 2022



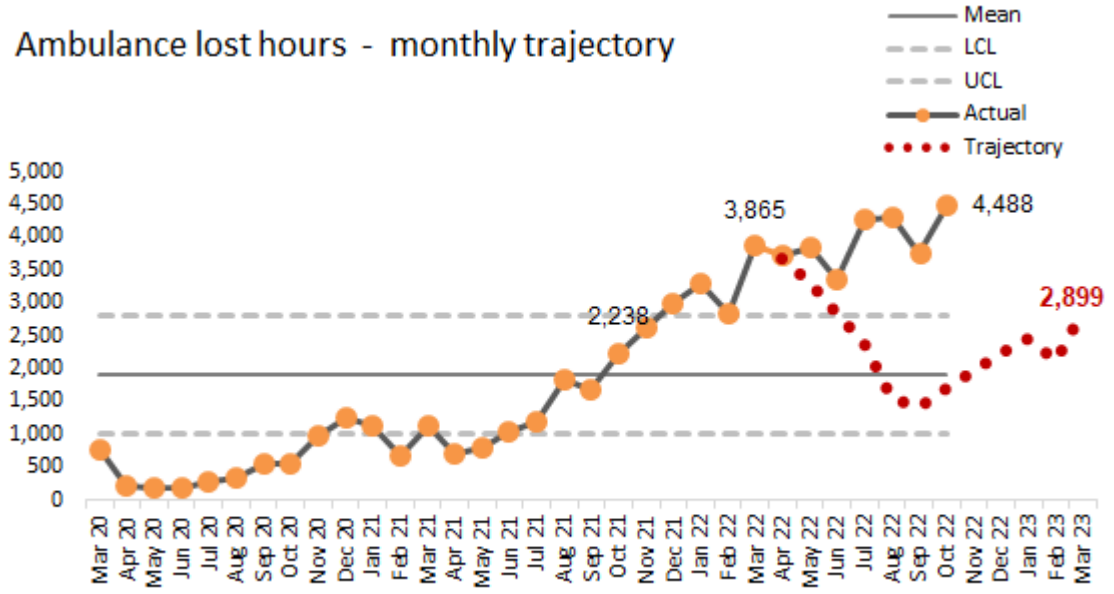
Ambulance lost hours by hospital - w/b 31st October



Ambulance lost hours trend by hospital



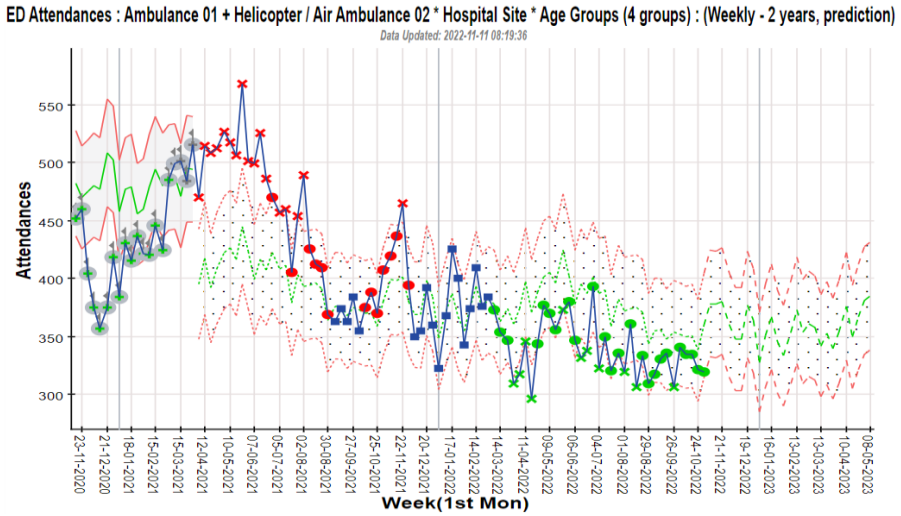
Ambulance lost hours - monthly trajectory



Data source: EASC and WAST lost hours notifications

Ambulance arrivals at an Emergency Department (Conveyance)

HDUHB



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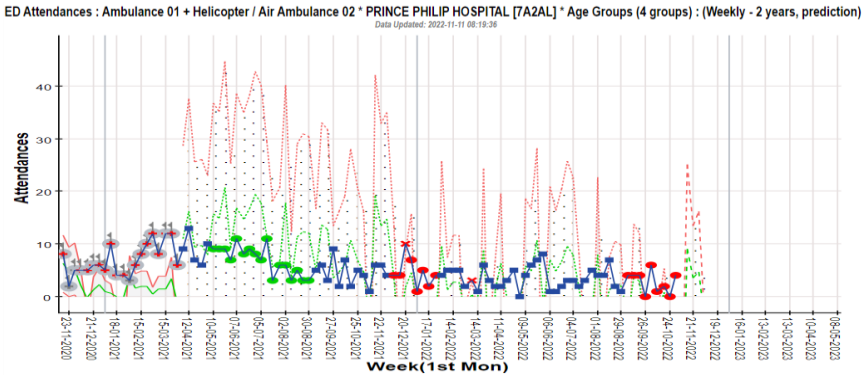

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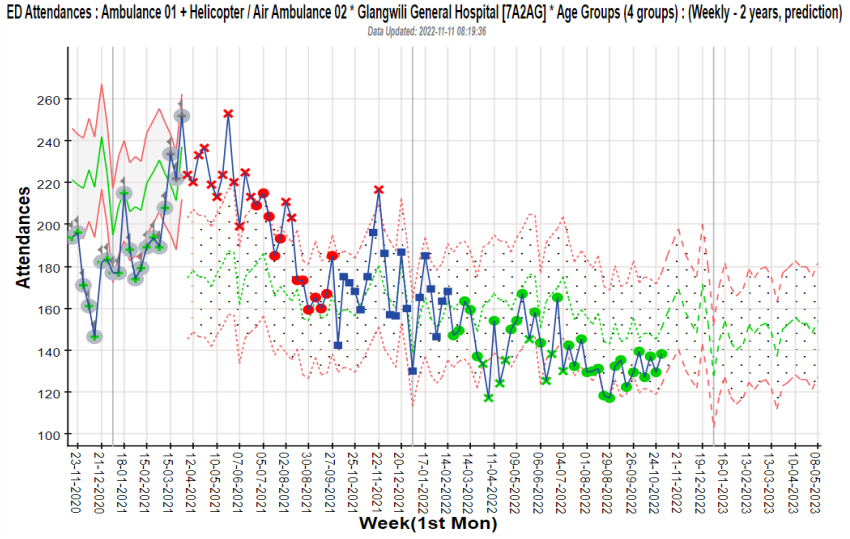

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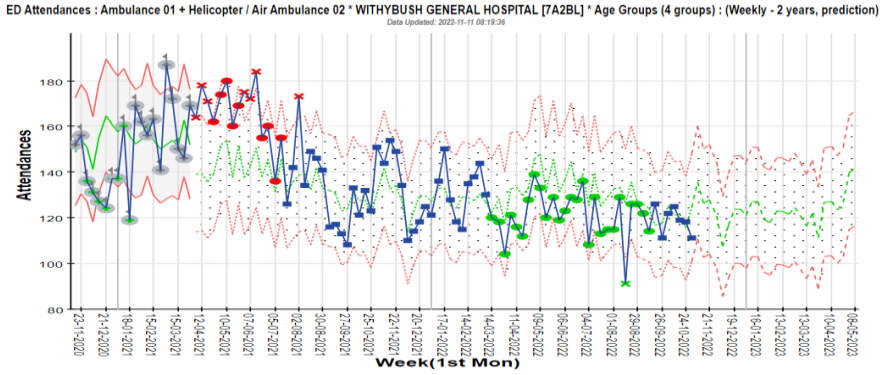

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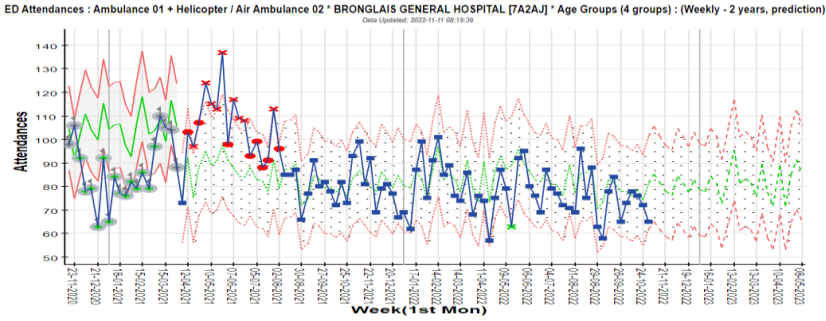

Data source: Lightfoot SDEC Viewer

SDEC attendances (Conversion avoidance)

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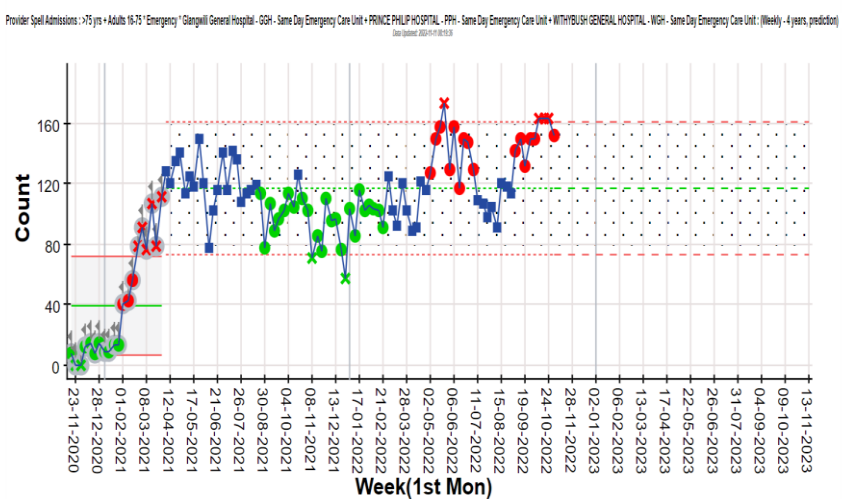
HDUHB



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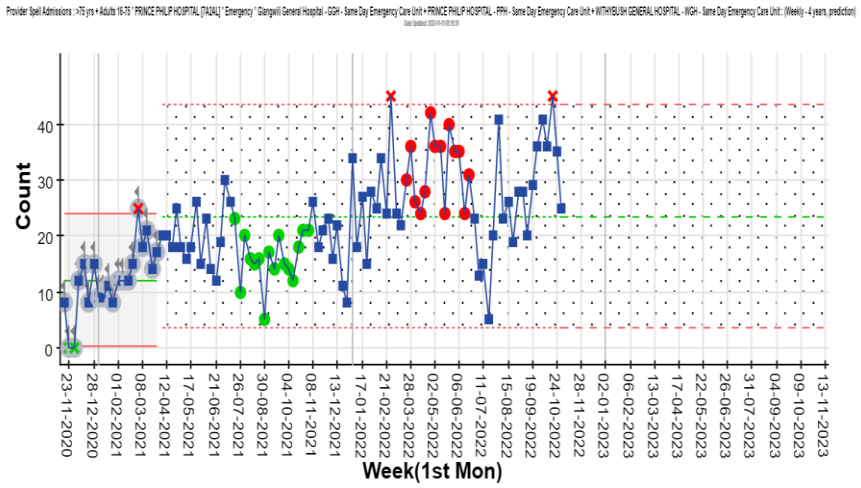

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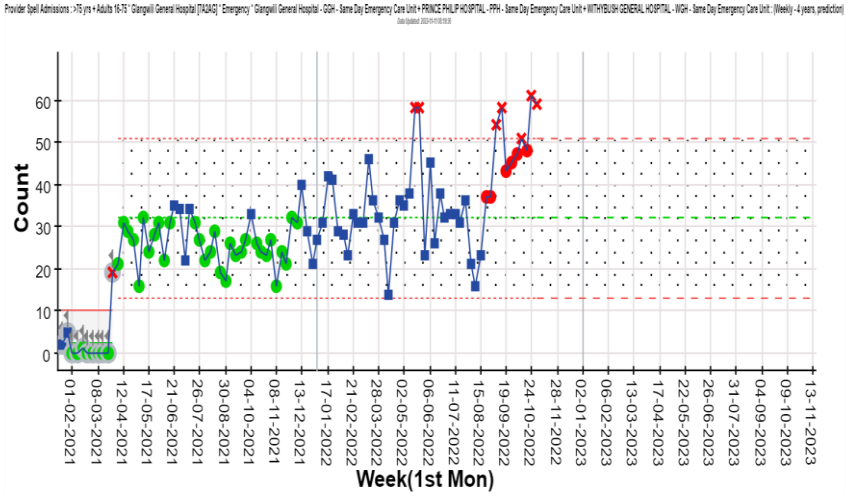

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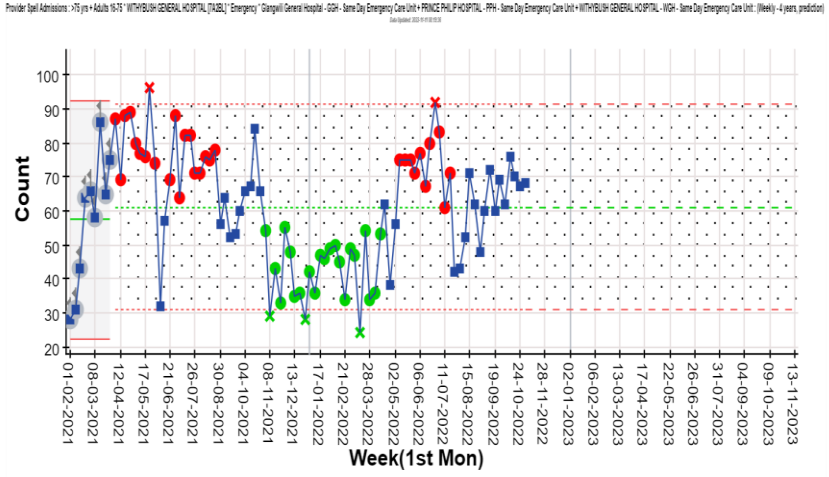
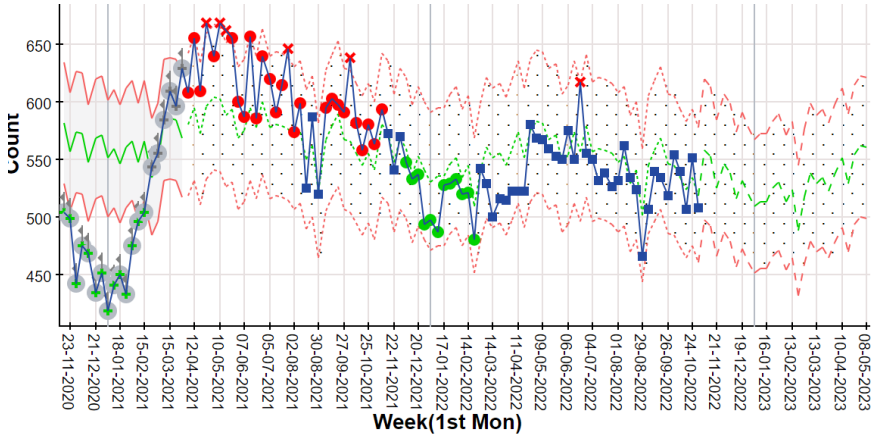


Data source: Lightfoot SDEC Viewer

Emergency Admission via an Emergency Department (Conversion avoidance)

HDUHB



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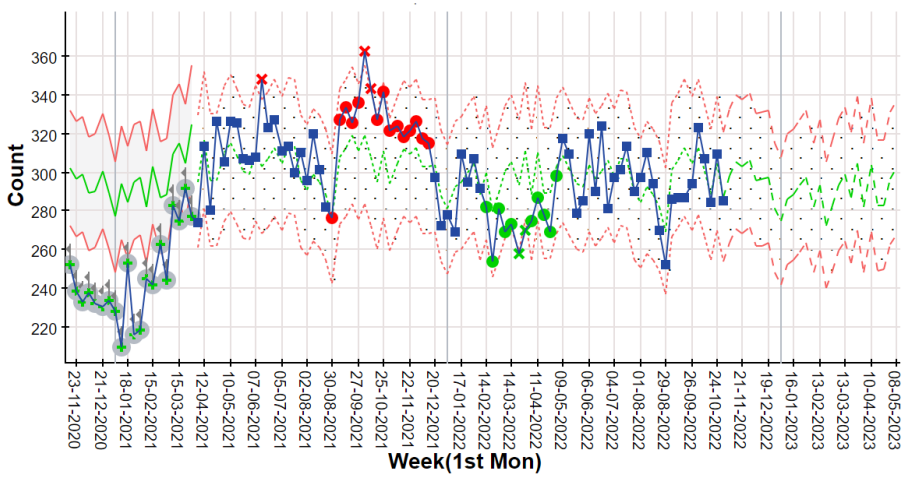

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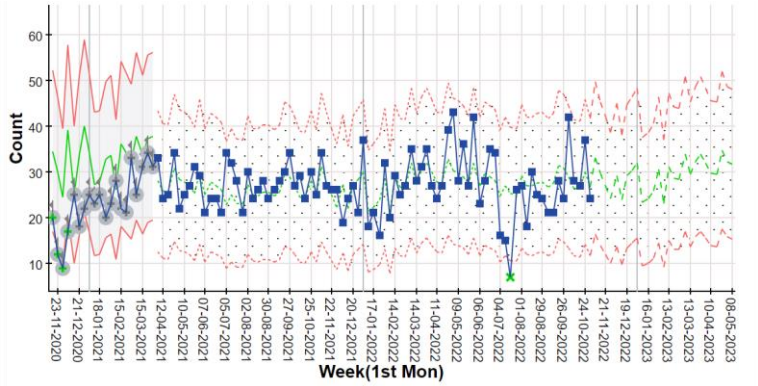

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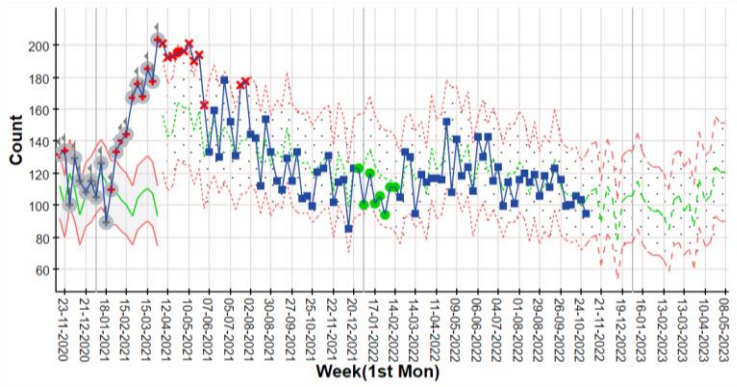

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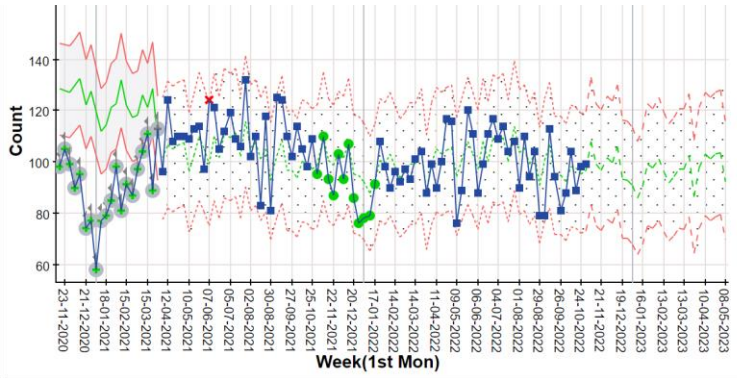
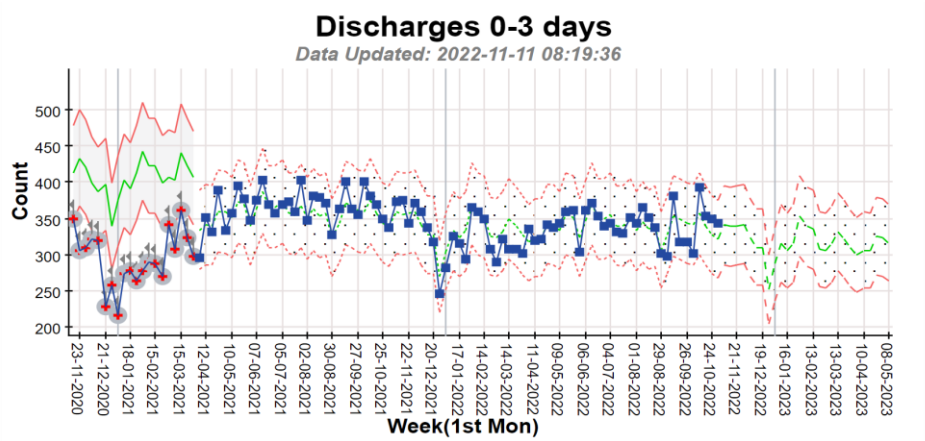


Discharges within 72 Hours (Complexity)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HDUHB



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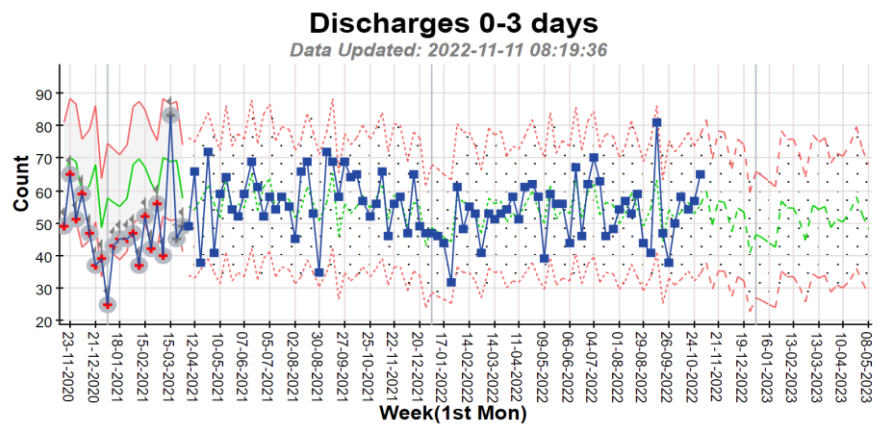

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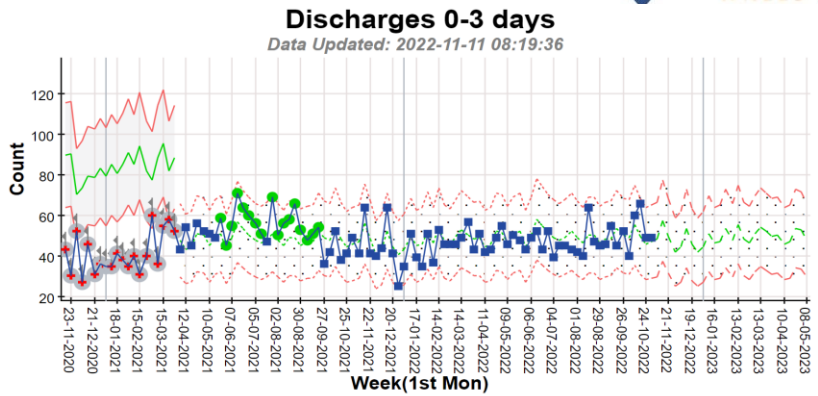

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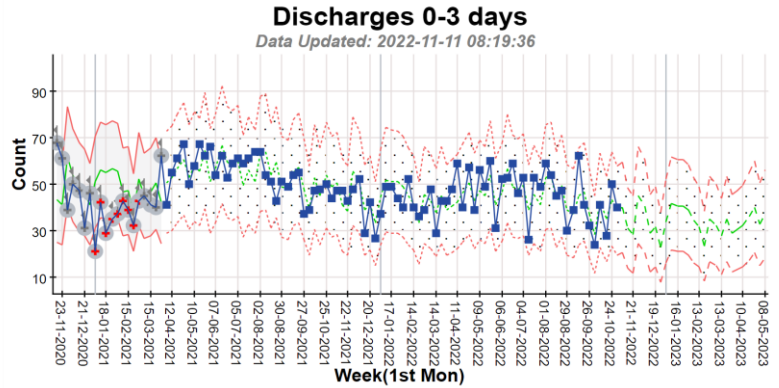

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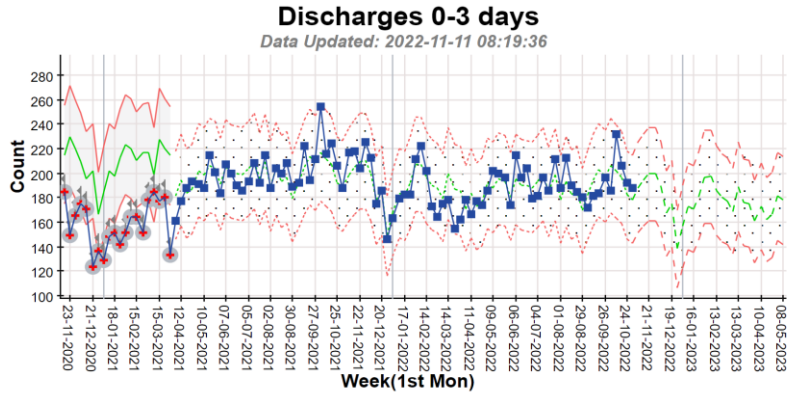
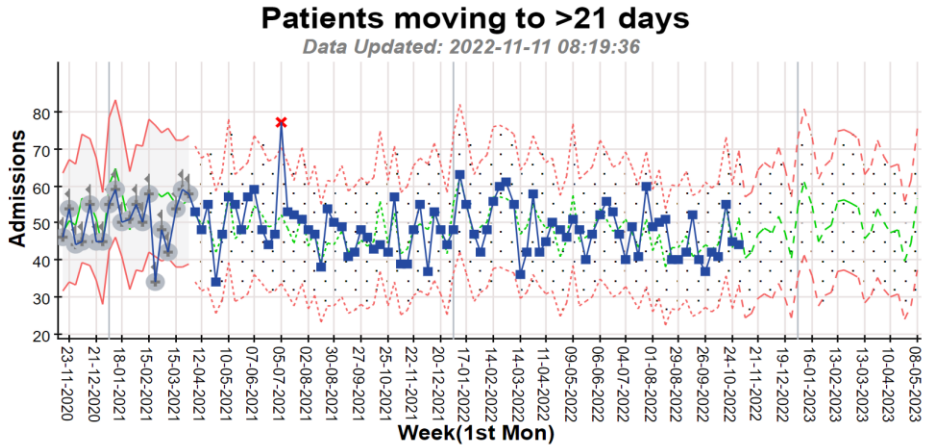


Data source: Lightfoot Baseline Analysis Viewer – Admit Pathway Analysis

Patients 75+ years with a length of stay > 21 days (Complexity)

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

HDUHB



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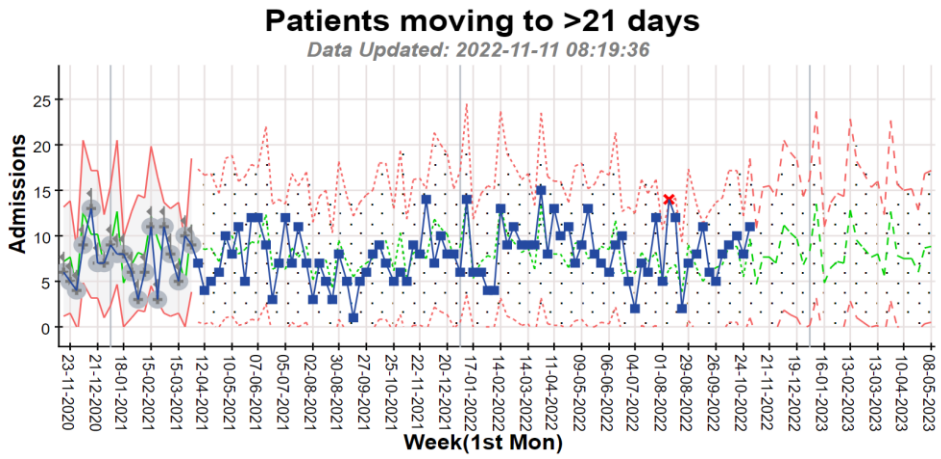

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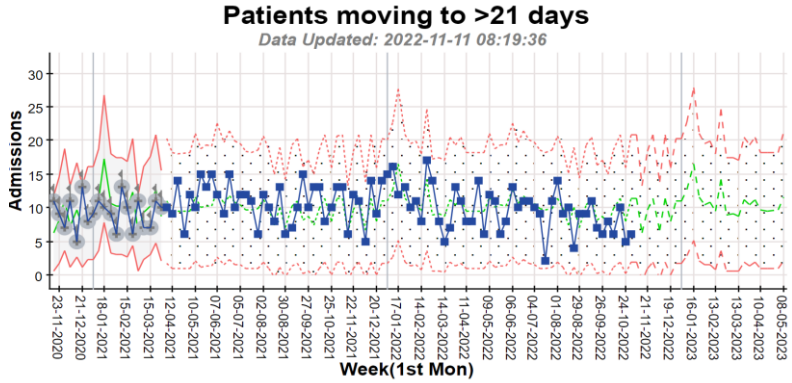

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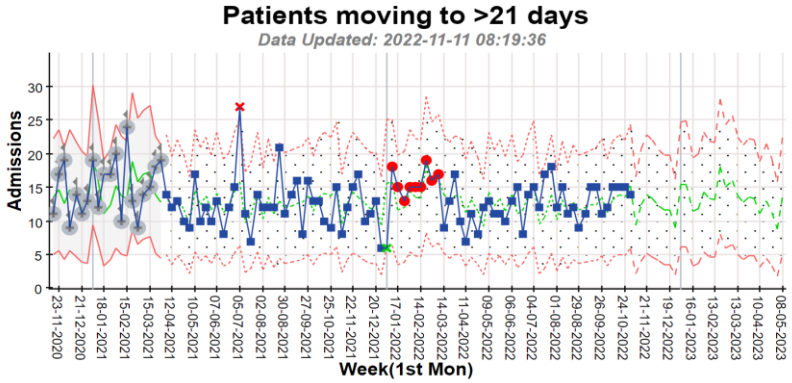

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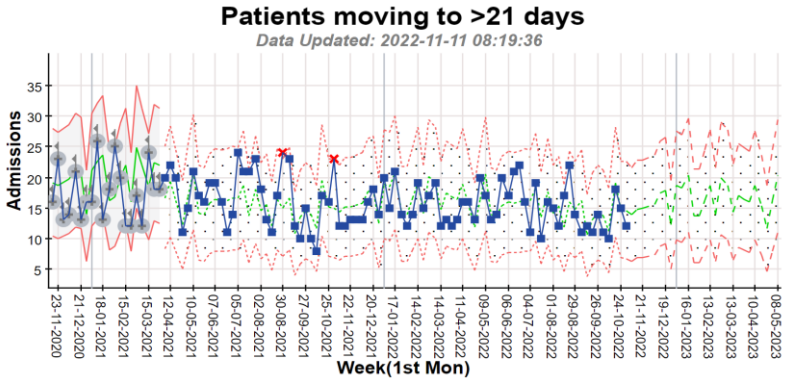


Data source: Lightfoot Baseline Analysis Viewer – Admit Pathway Analysis

3Cs Priority High Level Actions to improve flow and reduce ambulance delays

Action	Targeted outcome	By whom	By when
Complexity Management Establishing a clinical criteria for discharge on day 1 with implications for clinical staff being considered. Improved clinical decision-making and lowering threshold for clinical decision making for those patients who are very / severely frail based on 'what matters' and the level of risk hospital admission presents this vulnerable patient group. This includes early identiication of patients with existing packages of care and focusing on discharge before they lose that care package. **Conveyance Avoidance** ➢ Roll out of Phase 1 of clinical streaming hub enhancement by December, followed by rollout of GP referrals, SDEC scheduling and ED redirection by end of December. Review of patients with a crew at the scene in Carmarthenshire and will assess the situation by end of October with a view to extending to Pembrokeshire by end of November and Ceredigion by end of December. ➢ GP referrals streamed to the clinical streaming hub – pending confirmation of targeted practice based on data analysis ➢ A business case for telephony and scheduling enhancement to support management of GP referrals / SDEC scheduling via Clinical Streaming Hub. ➢ Procurement of 24/7 Telemedicine pathway for care home enquiries to avoid conveyance	Reduced AvLOS and lost packages of Care *(high level metric = no patients with LOS > 21 days)* Reduced number of GP Direct referrals to ED Improved ED waiting times and reduction in unplaced activity Increased SDEC attendance (reduced Improved quality markers. Reduced ambulance conveyancing and offload delays.	TUEC Director / County Director	14/12/22

3Cs Priority Actions to improve flow and reduce ambulance delays

Action	Targeted outcome	By whom	By when
Conversion Reduction Implementation of frailty pathway to all SDECs and best practice for very / severely frail 'Reclaim CDU / AMAU functioning' - Reviewing of current accommodation to facilitate across all sites. Undertake peer review of SDECs and benchmark against best practice to ensure optimal performance and value for money and equity of outcomes for whole population As per Conveyance action – aim to increase the proportion of SDEC attendances that are scheduled	Increase proportion of older people being reviewed in SDEC and 90% discharged home Max LoS in these areas of 72 hours	TUEC Director / County Director	14/12/22
Ambulance delays • Introduction of a Mobile Ambulance Unit at GGH to safely care for 6 patients, whilst potentially releasing up to 5 crews back to the community. • Working closely with the site team, Clinical body, estates and WAST to agree the right location, scope of practice/assessment and terms of use.	Reduced ambulance offload delays Improved diagnostic and assessments times for patients.	JE	30/11/22

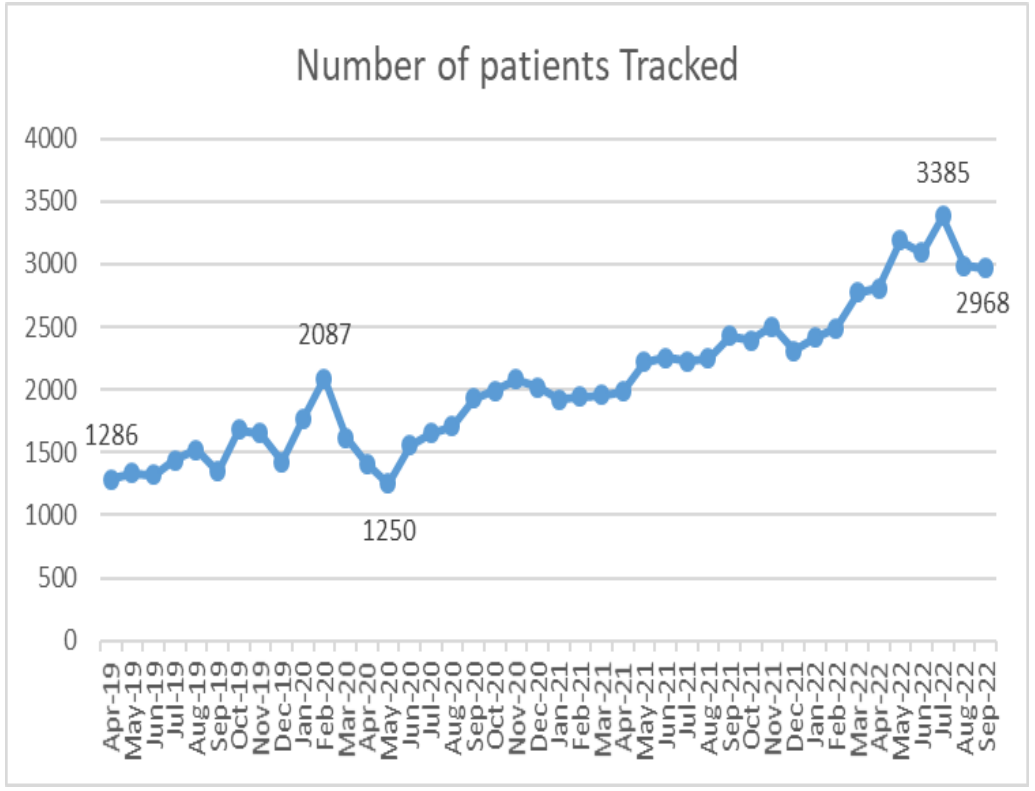
Cancer

Overview

Enhanced monitoring
- Clear trajectory to achieve sustainable backlog reduction and maintain balance
- Improved performance for all tumour sites
- Focused improvement on lower and upper GI, skin, lung, urology and gynae
- Cancer workforce plan

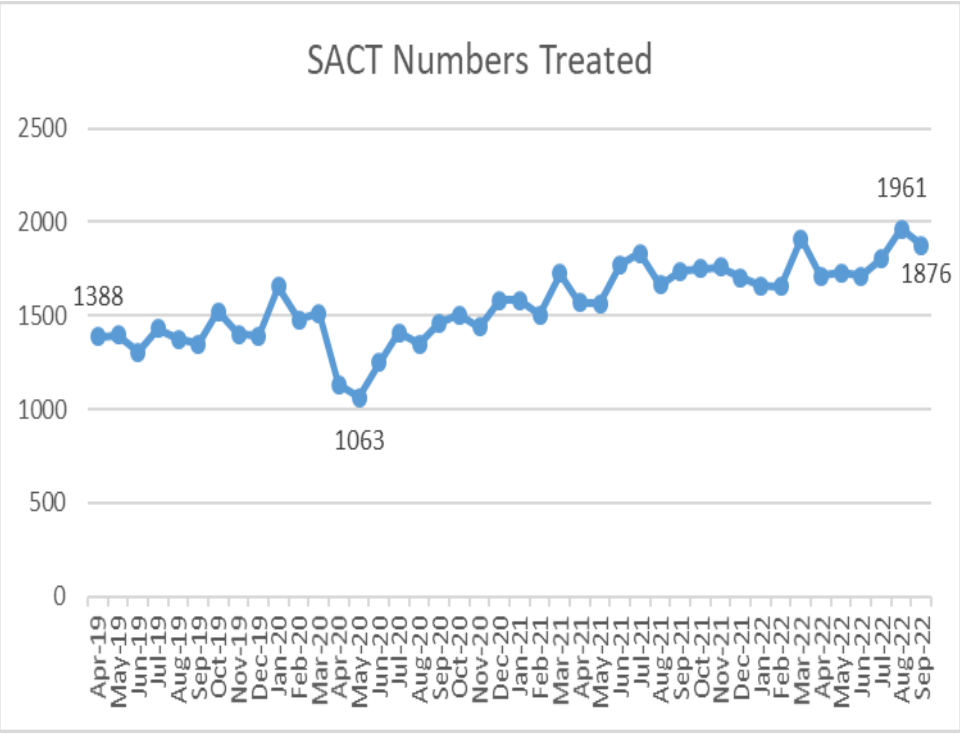
- Key challenges with the **front end** of the pathways in Urology, LGI, UGI and Gynaecology.
- The key focus is on the **backlog** reduction- live tracking of backlog patients, both 62 days plus and 52-62.
- Improvement and trajectory plans in place for **every** tumour site.
- Working towards **sustainability** within key tumour sites, utilising the 85th percentile of demand.
- Key **risks** remain in Endoscopy and Radiology.
- Treatments provided within HDUHB are **above** pre COVID levels for both surgery and SACT.

Number of Patients on Pathway April 19 – September22



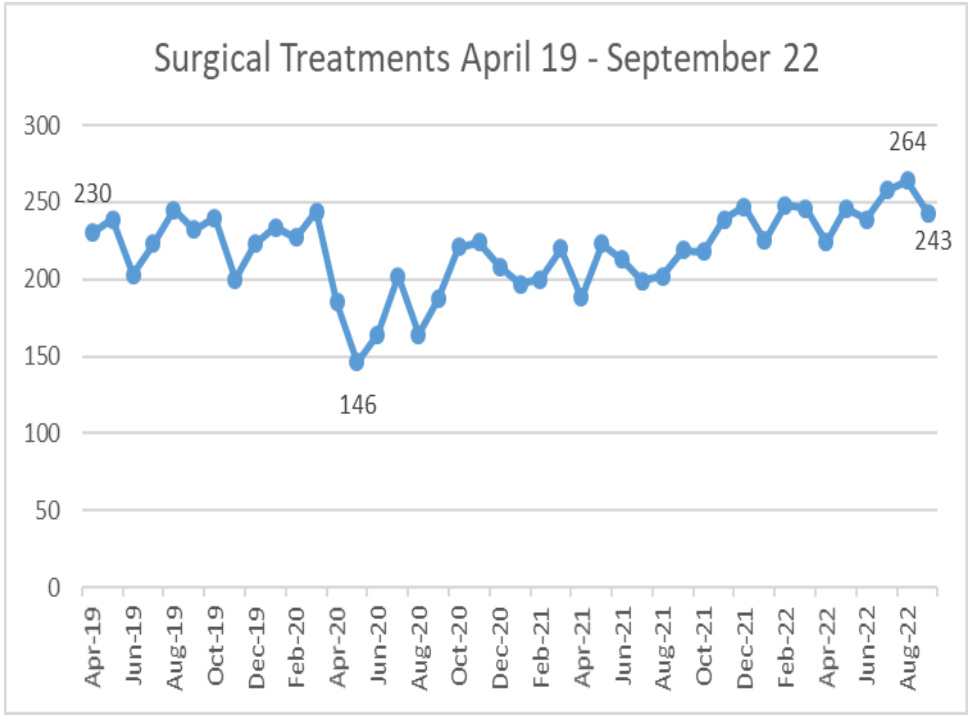
- The changes from USC/NUSC to SCP in Feb 2020 saw an increase in the number of patients being tracked on the pathway.
- There are now 1298 more patients entering the pathway then in February 2020
- Increased demand Vs re-categorisation?

SACT Treatments
April 19 – September 22



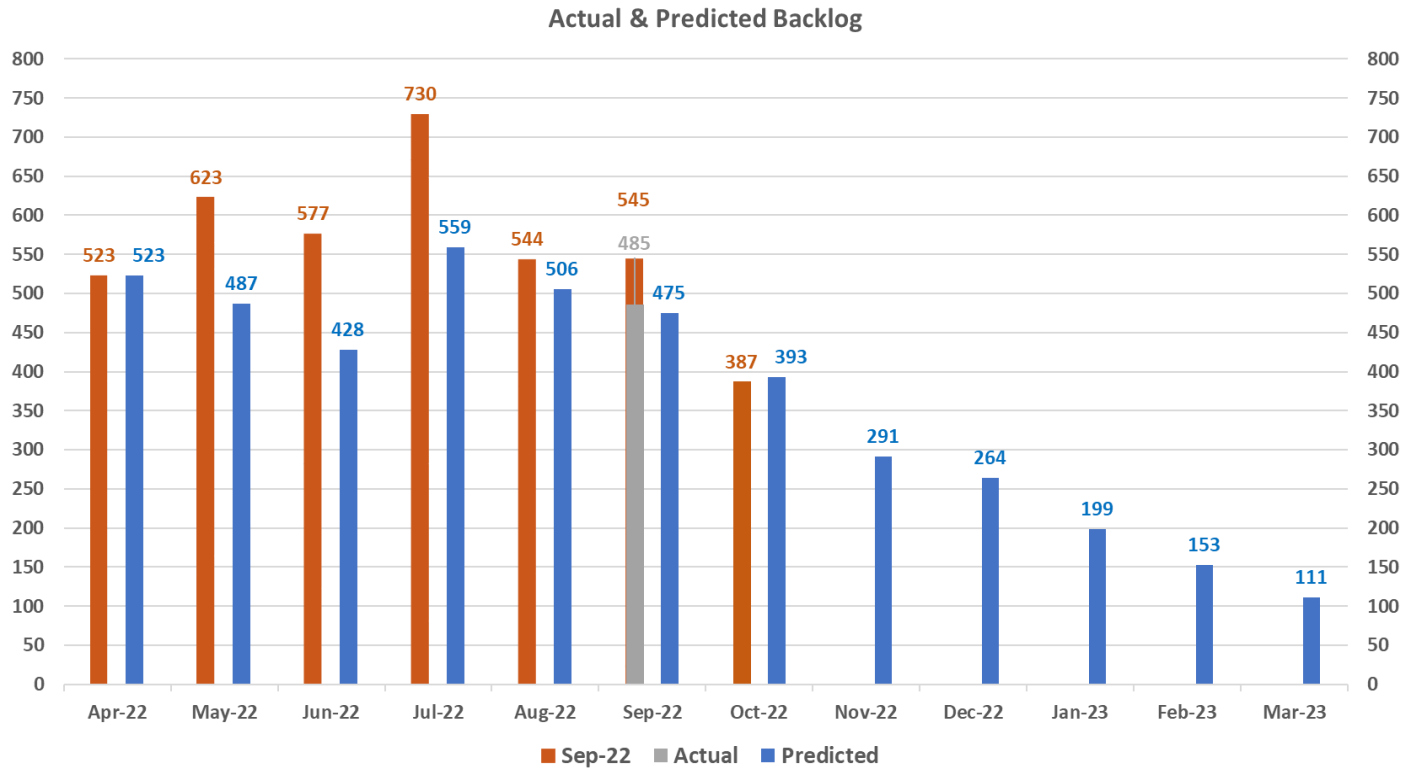
- SACT treatment demand exceeds the pre COVID period

Surgical Treatments April 19 – September 22



- Surgical treatments are back in line and slightly above pre COVID levels

Predicted & Actual Backlog Improvement Overall

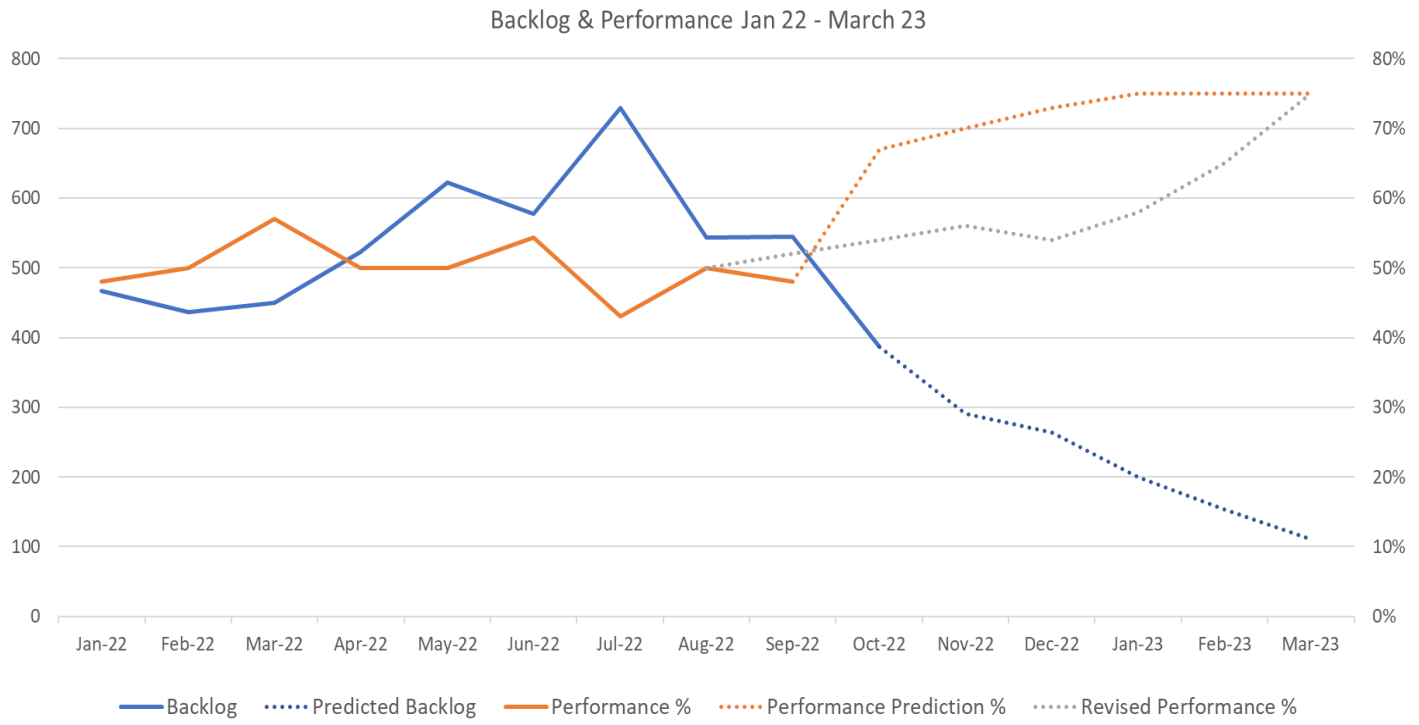


- July backlog growth - delay in Radiology reporting.
- August backlog significantly improved.
- September core backlog improved with (exception small cohort of skin patients).
- October core backlog reduced by 158 patients
- Diagnostic capacity presents challenge to 100% backlog eradication 2022/23
- NB not all backlog patients will become breaches on the SCP.

Predicted 63 & 104+ Days
November 22 – March 23

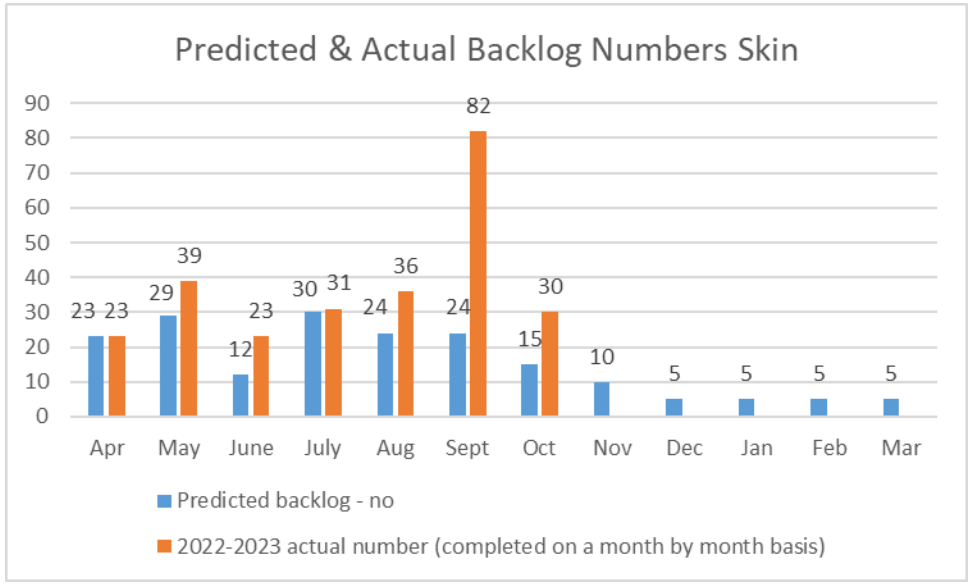
	Nov 22 Predicted		Dec 22 Predicted		Jan 23 Predicted		Feb 23 Predicted		Mar 23 Predicted	
	63-103	104+	63-103	104+	63-103	104+	63-103	104+	63-103	104+
Head and neck	4	1	5	0	5	0	5	0	5	0
Upper GI	24	4	23	3	18	2	16	2	13	2
Lower GI	90	20	75	15	50	10	35	10	20	10
Lung	15	3	16	2	13	2	11	1	9	1
Skin (exc BCC)	7	3	4	1	5	0	5	0	5	0
Breast	5	0	5	0	5	0	4	0	3	0
Gynaecological	18	2	17	3	15	0	10	0	9	1
Urological	65	25	60	30	45	25	30	20	20	10
Haematological (exc acute leukaemia)	4	1	4	1	4	0	4	0	3	0
Total Numbers	**232**	**59**	**209**	**55**	**160**	**39**	**120**	**33**	**87**	**24**
Overall Backlog	**291**		**264**		**199**		**153**		**111**	

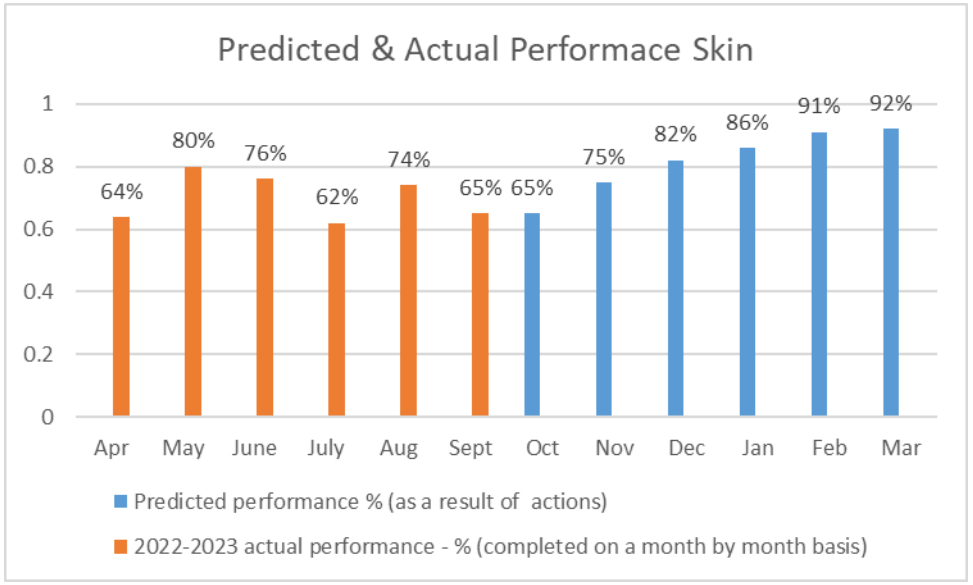
Backlog & Performance January 22 – March 23



- Revised performance profile
- Accounts for backlog reduction and impact on performance.

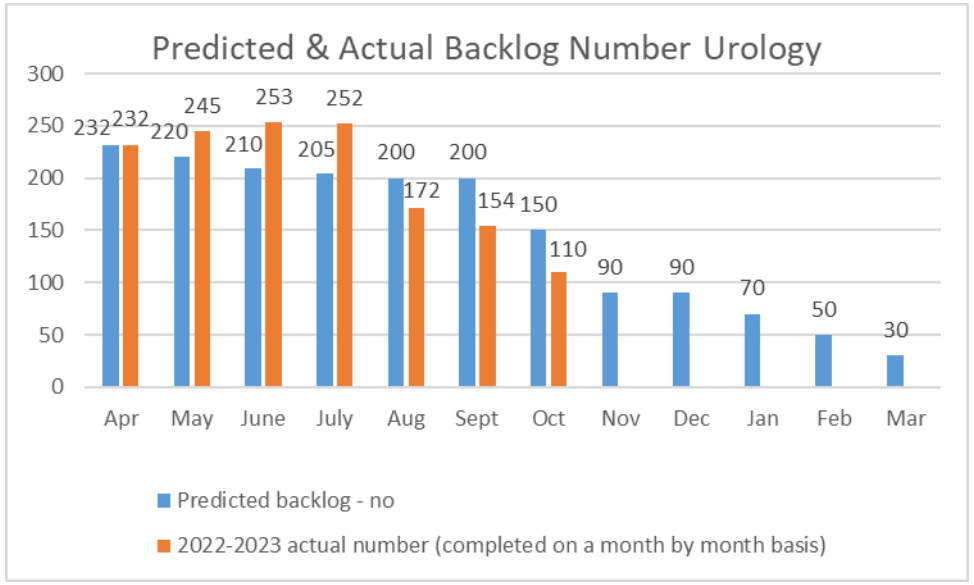
Predicted & Actual Performance & Backlog Skin

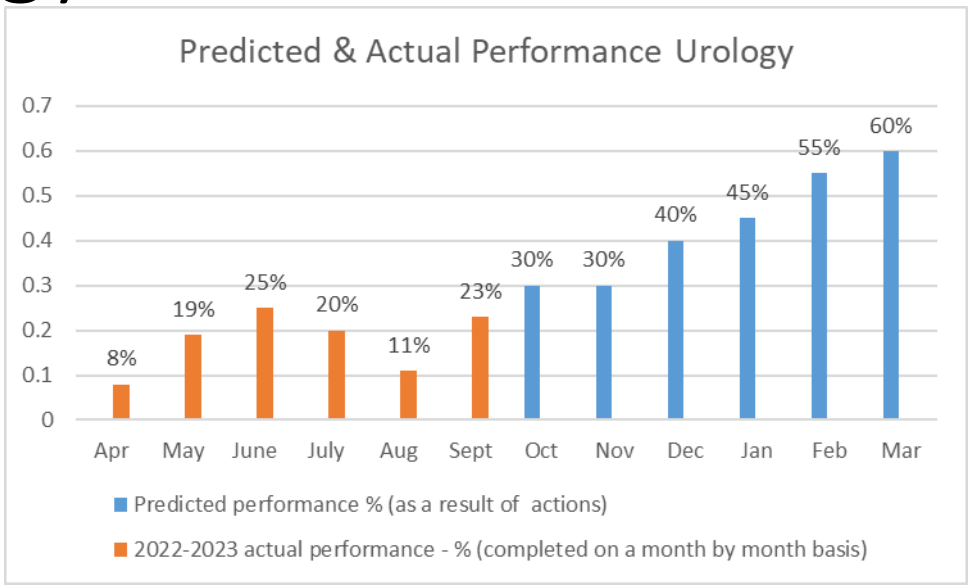




- Average breaches per month YTD 11
- Insourcing to continue . Minimum of 30 MOP additional slots per week.
- Teledermatology introduced in the HB. This will create more OPA capacity during Q4 & Q1
- Future sustainability plan: Exploring GP MOP scheme for Non USC lesions, which would create more capacity for USC MOPs.
- Sustainability: required 31 removals per week, current assessment 40 per week with extra capacity.
- Residual backlog account for complexity

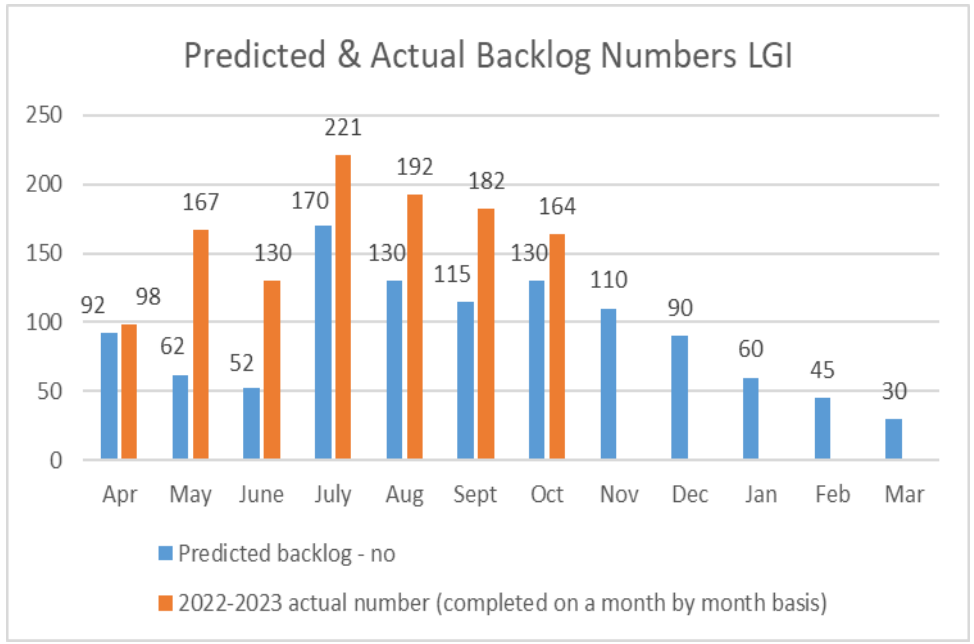
Predicted & Actual Performance & Backlog Urology

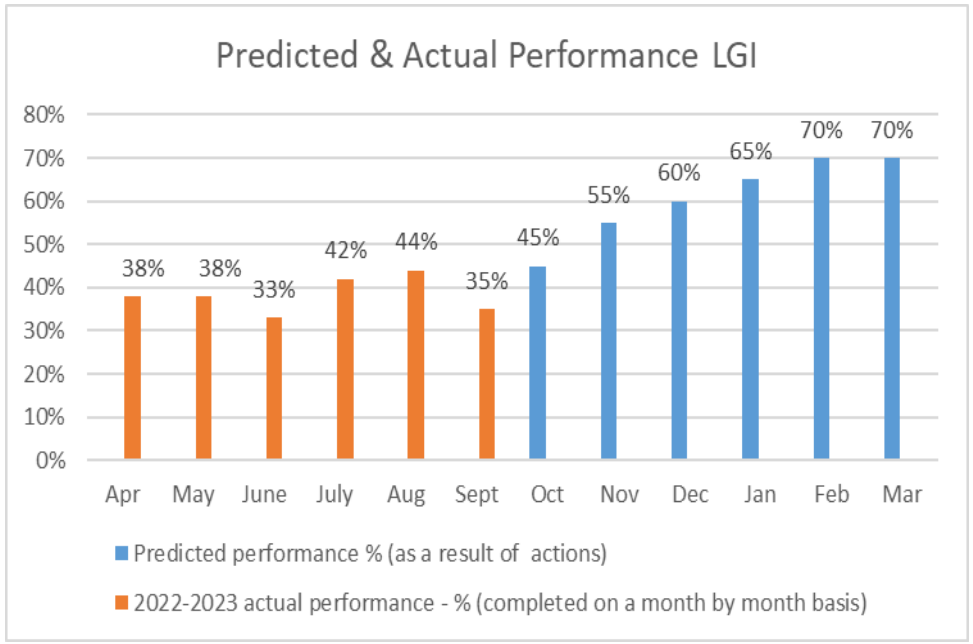




- Average breaches per month YTD 43
- Loss of key Consultant October & November will temporarily limit backlog improvement.
- Planned extra capacity for GA diagnostic throughout November and December for 50 patients.
- Extra TRUSS capacity throughout November and December
- Utilising modular unit for LATP from January 2023.
- 6 month pilot for a 2 step RDC style clinic for suspected Prostate Cancer. Start date TBC.
- Sustainability required 82 removals per week, current assessment 75 per week with extra capacity.
- Residual backlog account for diagnostic capacity challenges

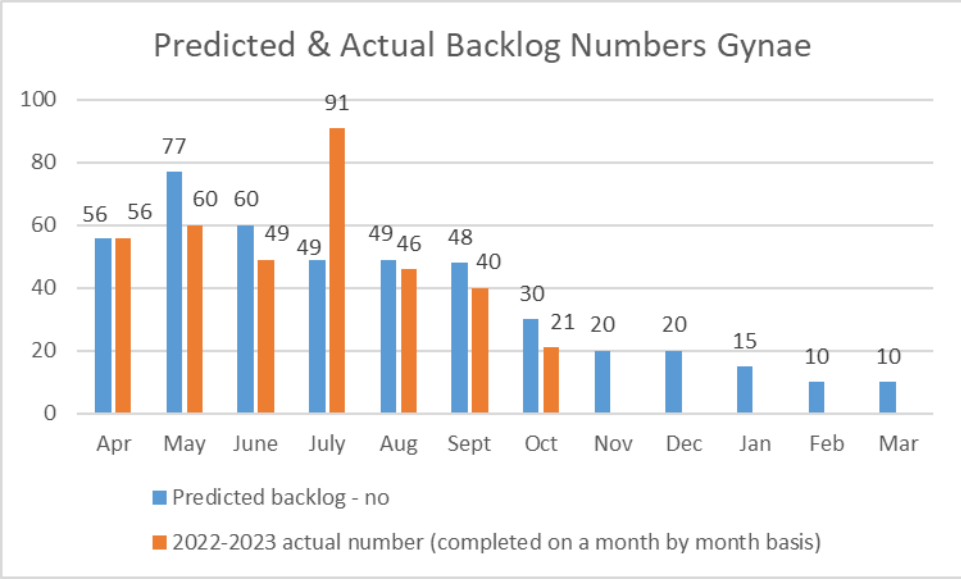
Predicted & Actual Performance & Backlog LGI

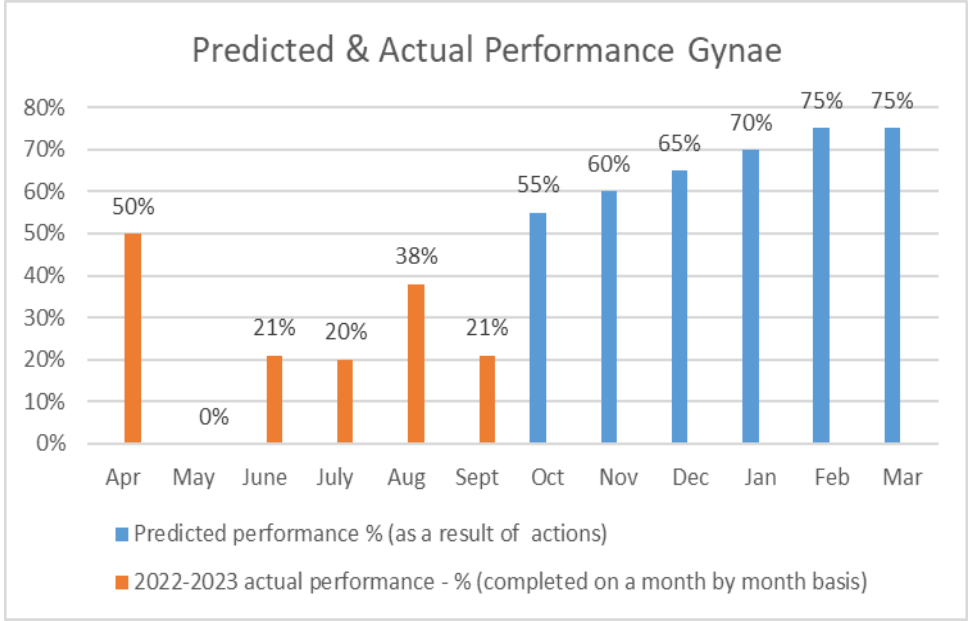




- Average breaches per month YTD 19
- Significant loss of Consultant capacity Q1 & Q2 has impacted performance.
- 3 additional clinics planned in November for USC patients awaiting 1st OPA. Total of 34 clinic slots.
- Straight to FIT Vs straight to test. Pilot all OPA to have FIT. Initial Outcome
- FIT role out to primary care in April 2023.
- New Colorectal consultant due to start at BGH in November 2022 additional 12 OPD slots + 1 theatre session
- Sustainability required OPA 80 removals per week, with additional activity 82.
- Residual backlog account for diagnostic capacity challenges

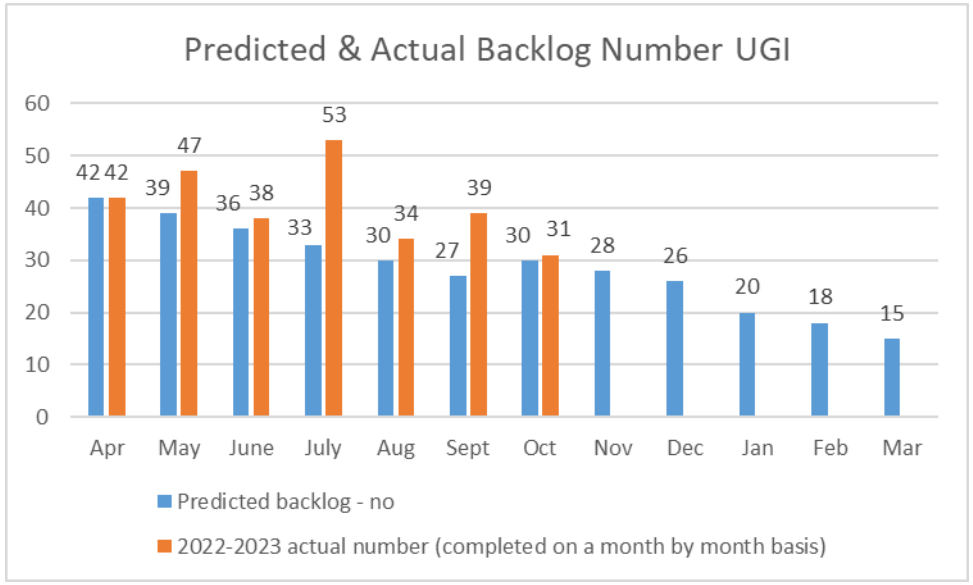
Predicted & Actual Performance & Backlog Gynaecology

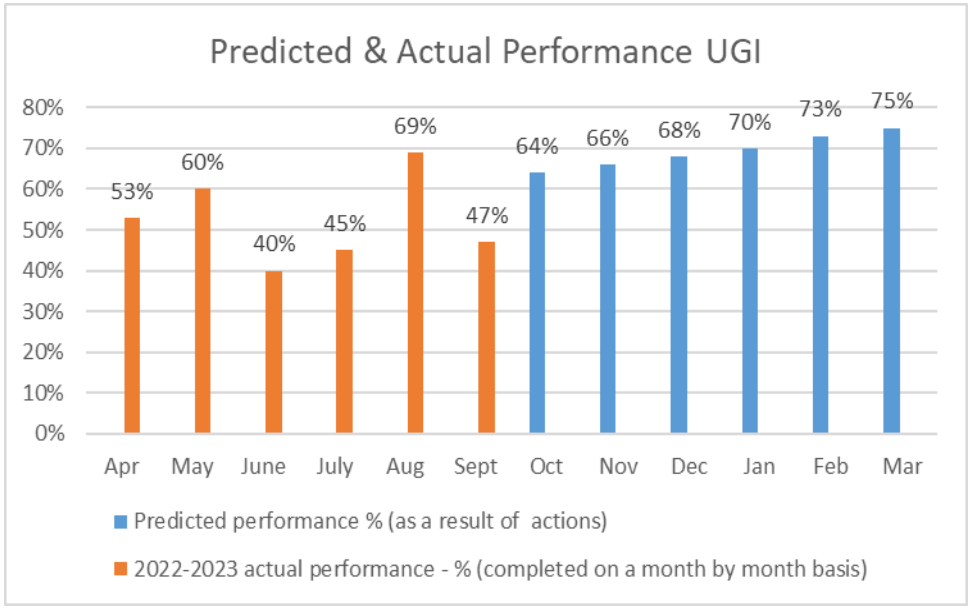




- Average breaches per month YTD 9
- The backlog is improving
- Additional/increase in Hysteroscopy & Theatre Capacity from August
- Establish an additional outpatient Hysteroscopy suite end of Q4
- Establishing regional working with SBUHB. Regional RAC to commence within HDUHB from December 22, to facilitate increased capacity and care closer to home.
- Sustainability required OPA 57 removals per week & 46 Diagnostics. With additional activity OPA currently at 60 and Diagnostics 42
- Residual backlog reflects tertiary capacity pressures

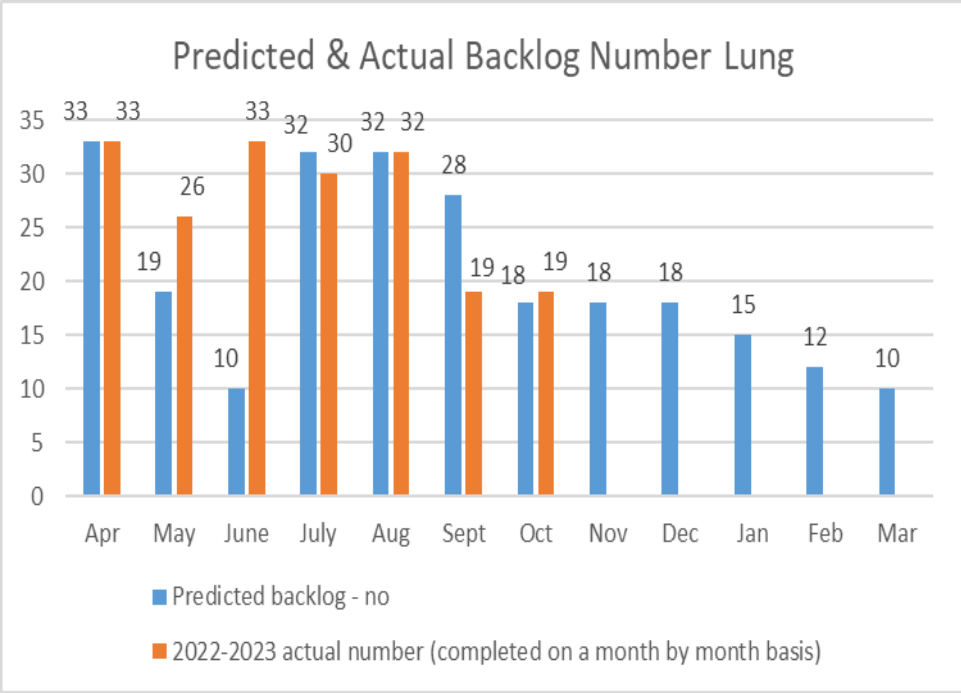
Predicted & Actual Performance & Backlog UGI

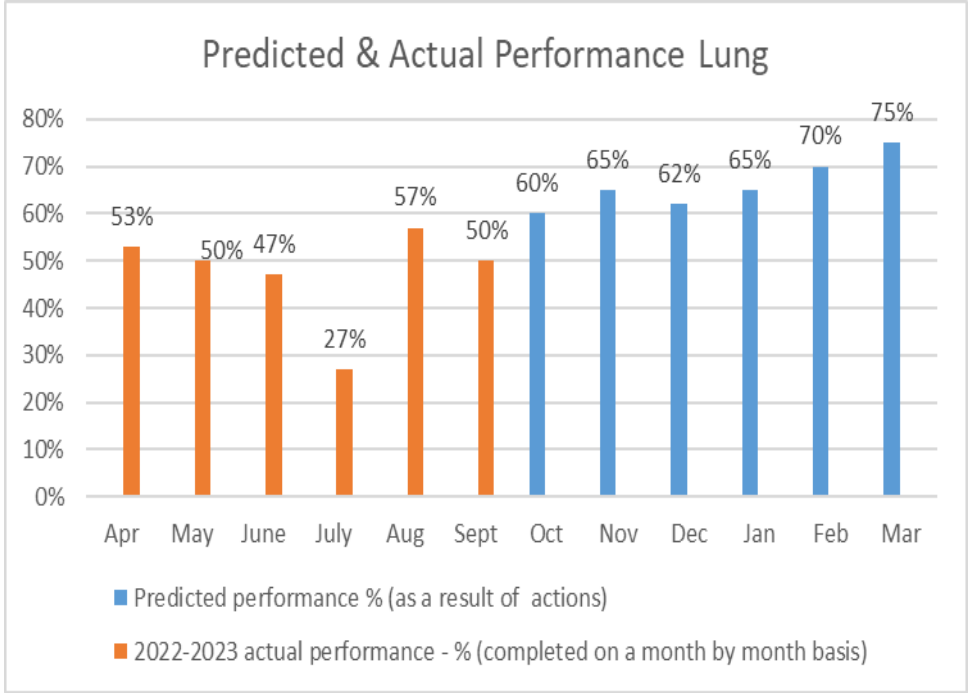




- Average breaches per month YTD 9
- Additional 1st OPA capacity of 6 patients per week has been identified from October 22. Plans are being developed to increase capacity by an additional 6 patient per week to meet the 85 percentile of additions to list.
- Reviewing all OPA referrals weekly to see what can be converted straight to FIT test and Endoscopy. This will reduce the first OPA pathway
- Work continues on FIT test in primary care. Implementation planned for April 2023
- Sustainability required 60 OPA & 57 Diagnostics removals per week, current assessment 54 OPA per week with extra capacity & plans to increase capacity in Diagnostics are being developed
- Residual backlog account for diagnostic capacity challenges

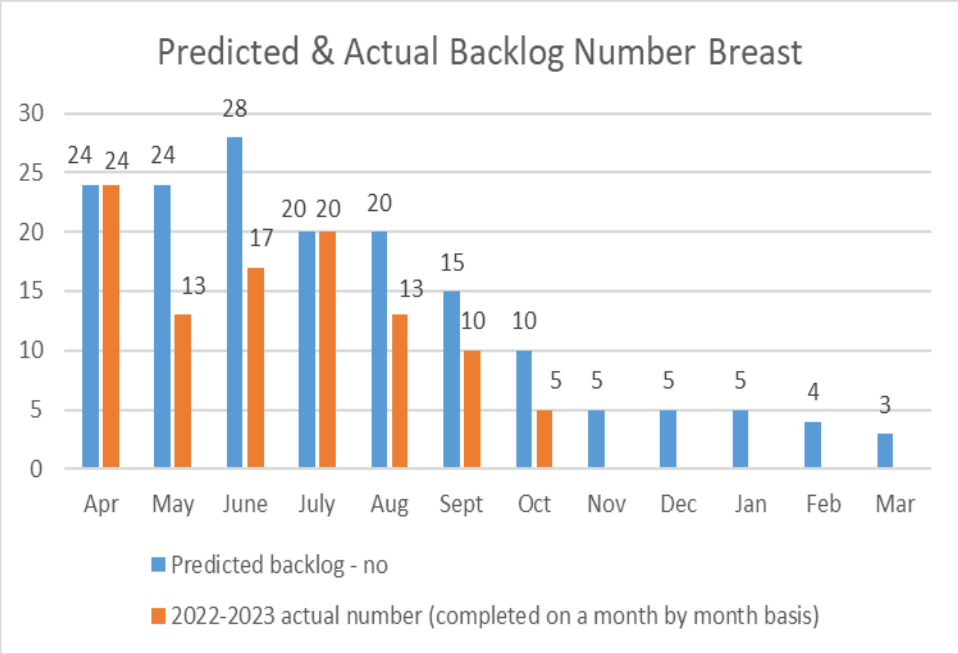
Predicted & Actual Performance & Backlog Lung

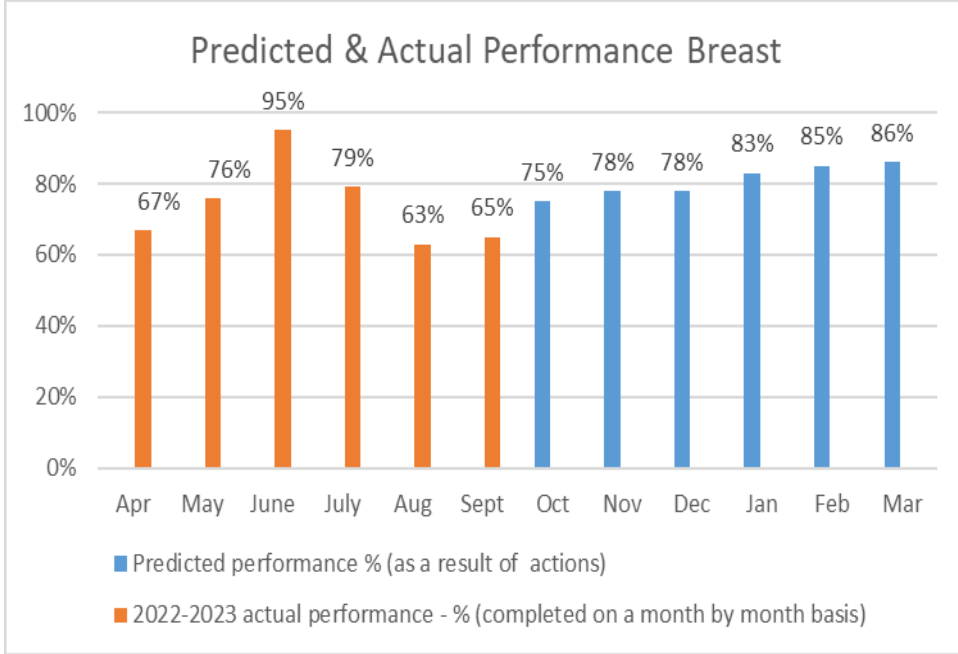




- OPA capacity meets demand
- Plans to increase internal capacity for CT guided biopsy from November/December to 8 per week, currently 12 patients waiting.
- Plans to outsourcing CT guided biopsy being developed.
- Treatments provided within HDUHB in balance.
- Residual backlog accounts for tertiary capacity risks (surgery & radiotherapy).

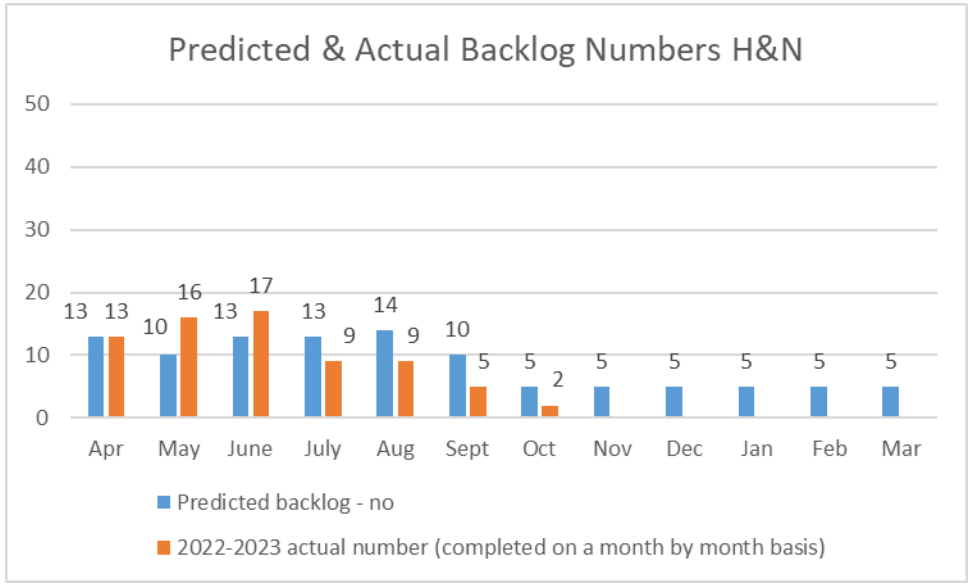
Predicted & Actual Performance & Backlog Breast

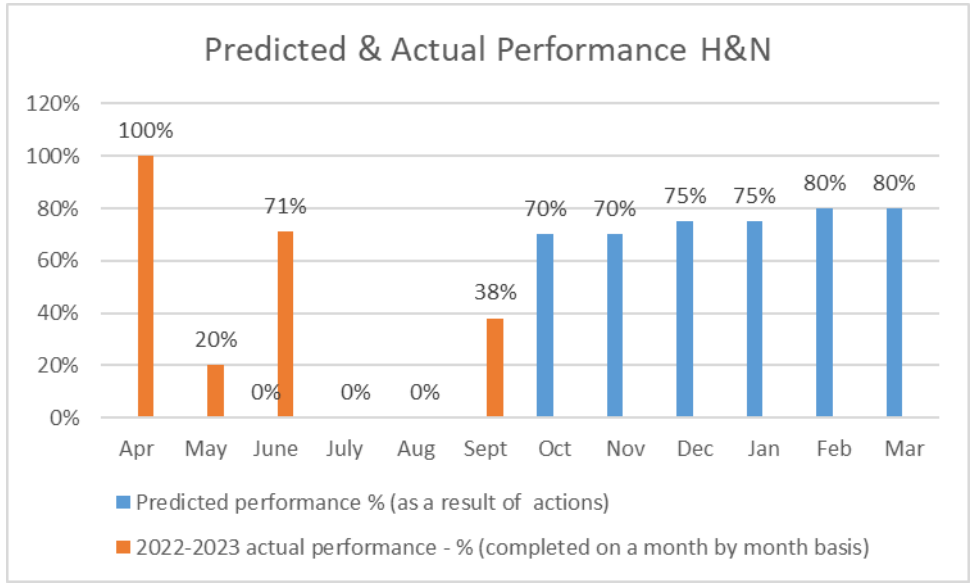




- Average breaches per month YTD 12
- 1 Stop Breast pathway working well
- Annual leave impacted on August performance which will recover in September.
- Residual backlog due to Complexity

Predicted & Actual Performance & Backlog H&N





- Average breaches per month YTD 3
- Small treatment numbers which influence large swings in performance between months
- Planned pathway enhancement - endoscopic laryngeal biopsy via Outpatients
- Residual backlog due to complexity

Optimal Pathways

- **Breast** currently in place. 1 stop clinics
- Head & Neck currently in place. NB CT neck lump capacity challenges
- 6 month pilot for a 2 step RDC style clinic for suspected **Prostate** Cancer. Start date TBC
- **Lung** in place. NB CT Guided Biopsy challenges.
- **Gynaecology** – partially implemented for PMB. Plans to establish an additional outpatient Hysteroscopy suite end of Q4
- **LGI/ UGI** - exploring straight to FIT Vs straight to test. Primary Care FIT April 23

Further Enablers

- Radiology In-sourcing solution for ultrasound expanded to multiple sites
- Cancer dashboard developed with funding from the Wales Cancer Network.
- Single Cancer Pathway (SCP) Project Manager is mapping optimal pathway opportunities
- Key challenge is 7 Day turnaround for diagnostics for all tumour sites

Support for Patients on Pathway

- Cancer Helpline housed within the Cancer Information and Support service for concerned patients, relatives, members of the public or healthcare professionals (Mon-Friday 10-12am and 2-4pm)
- Cancer Information and Support Service also provides email access support, call back, outreach and onsite hubs in acute hospital sites
- A Key Worker policy ensures that the expectations of the Key Worker role are clear and consistent for all patients on a cancer pathway across the health board
- Support Worker roles in all main tumour site teams enhance patient key contact support and Person-Centred care
- Welfare benefits advice and support
- 24/7 Triage line for patients on treatment

Cancer Workforce

- Clinical and Medical Oncologists, medical physics and therapeutic radiographers are all employed by the South West Wales Cancer Centre and provide services to Hywel Dda University Health Board.
- Hywel Dda UHB have developed a strong non-medical team of Oncology Clinical Nurse Specialists, and Cancer Pharmacists to provide local, consistent support to the Oncology Service and to the Hywel Dda population.
- Hywel Dda UHB has a Cancer Key Worker Policy that supports consistency in the roles of the Clinical Nurse Specialist across tumour sites.
- Strong leadership for the cancer nursing teams is provided by a Lead Cancer Nurse and several Seniors Nurse Managers.
- Hywel Dda UHB cancer nurses are represented at an all Wales level.
- Hywel Dda UHB has a Therapies Lead for Cancer and this is a substantive post.

Mental health

Mental health

Enhanced monitoring

- Part 1a and 1b LPMHSS CAHMS backlog trajectory achieved each month
- Monthly meetings to progress activity and mitigate risks
- Neurodevelopmental backlog trajectory agreed and delivered
- Finalised demand and capacity model

CAMHS

S-CAMHS will focus on the development of the workforce through increasing skills and competencies in order to improve emotional resilience in children and young people. Objectives for 2022/23 include:

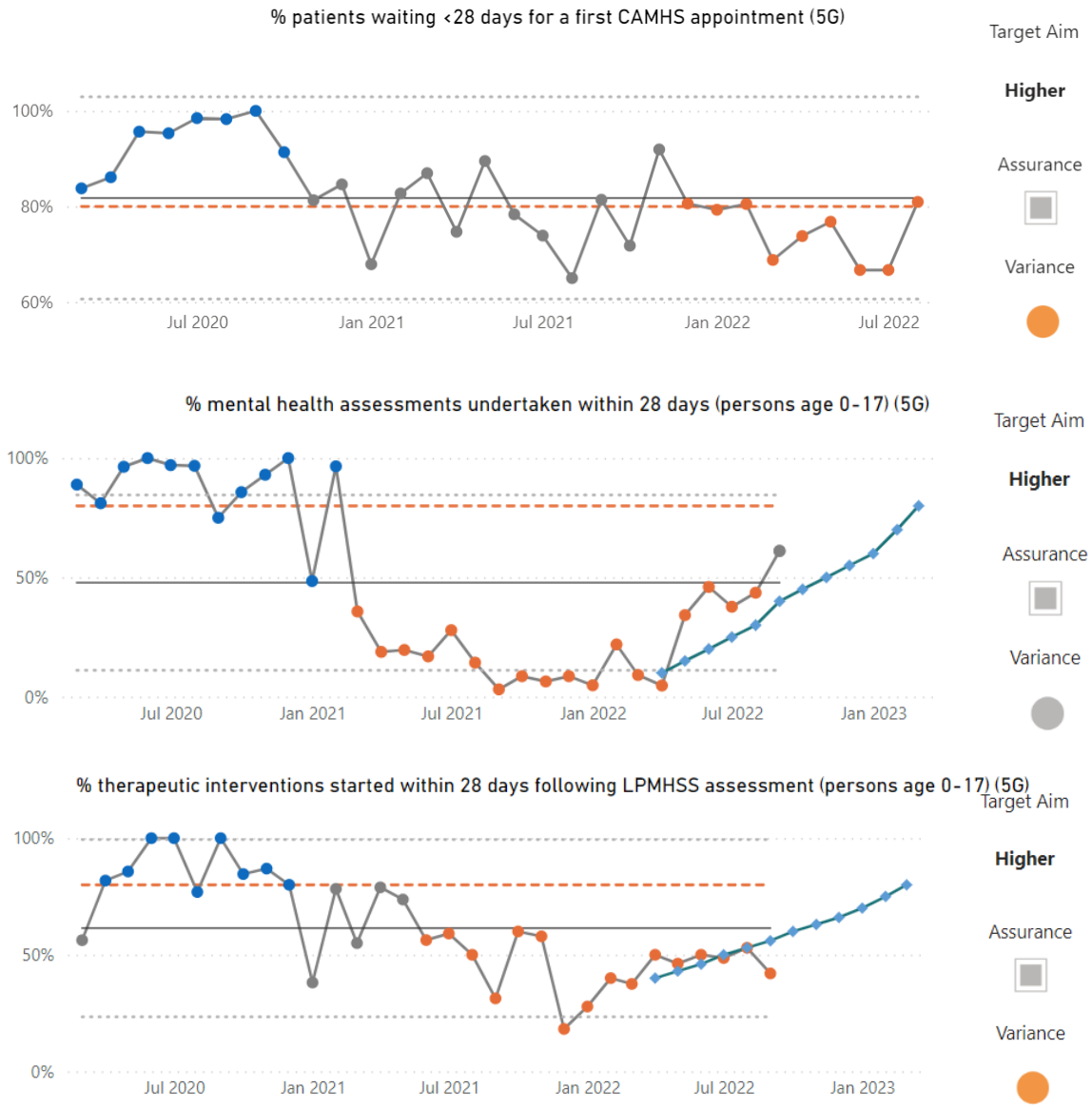
- Continue to develop an integrated service model for children with mental health and learning disabilities.
- Further develop the established multi-disciplinary Perinatal Mental Health including the development of infant mental health services.
- Continue our commitment to achieving and implementing the RCP Standards for Perinatal Mental Health.
- To work collaboratively with Welsh Government in the implementation of the recommendations from the Neurodevelopmental Service evaluation (2022/23) all ages.
- In line with the anticipated recommendations of the review develop ways to deliver timely multi-disciplinary assessments and interventions in Autistic Spectrum Disorder services (all ages).
- Undertake a restructure of primary care mental health services in line with the implementation of the School In-reach Service .
- To continue strengthening our pathways with adult services in line with the Transforming Mental Health agenda and to continue improving transition pathways.
- To progress the recruitment of the CAMHS Eating Disorder Service, which will align closely to the adult service to increase access to timely assessment, treatment and transition.
- In order increase capacity to expand the age range across EIP services additional resources will be secured via Welsh Government funding (2022/23).
- To continue working in partnership with Local Authorities and other stakeholders to develop Trauma Informed services to enable care closer to home.

The Directorate commissions a range of Third Sector organisations that provide essential early intervention and prevention well-being and mental health services, including undertaking a full commissioning exercise of all Third Sector services in line with OJEU procurement regulations including:, Service reviews; Market engagement; Service user and carer engagement; Development of new service specifications and Tender exercise

As part of our ACD offering:

- MDT Working / Recruitment of other Roles (16 projects) – Reducing pressures on Secondary Care and improving community access by enhancing cluster services e.g. recruitment of Occupational Therapist; physiotherapists; Cluster Pharmacists; Care Co-ordinators; Respiratory Specialist Nurses and providing better Psychological support to patients.

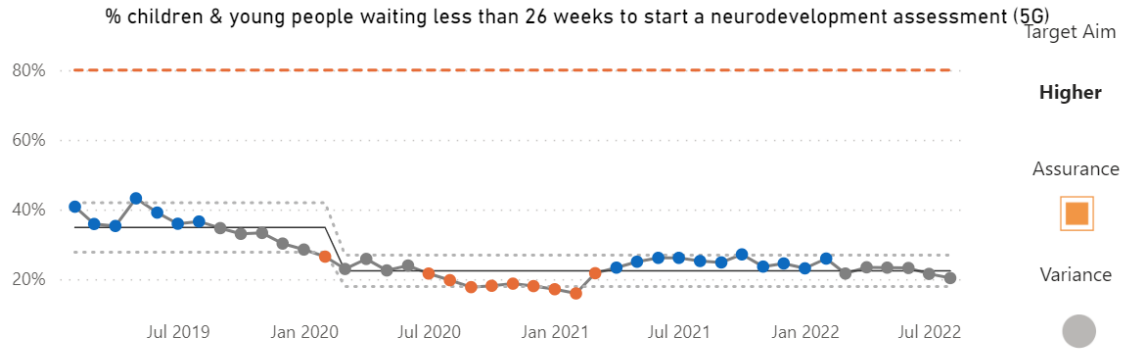
Mental Health - CAMHS

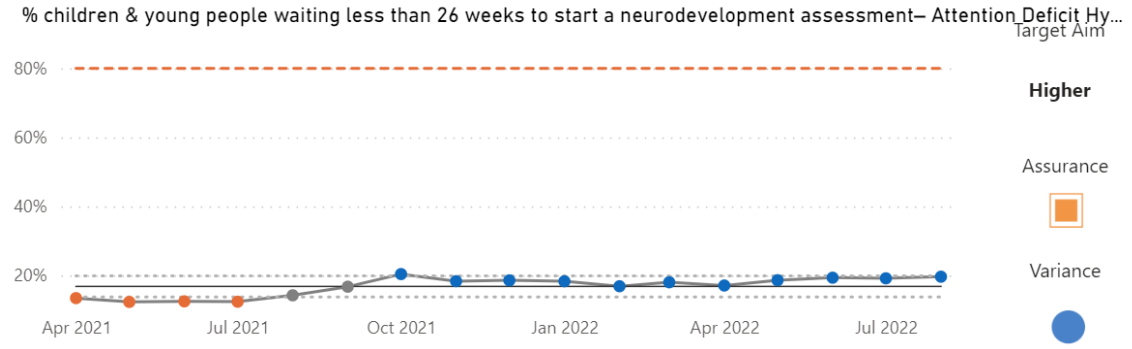


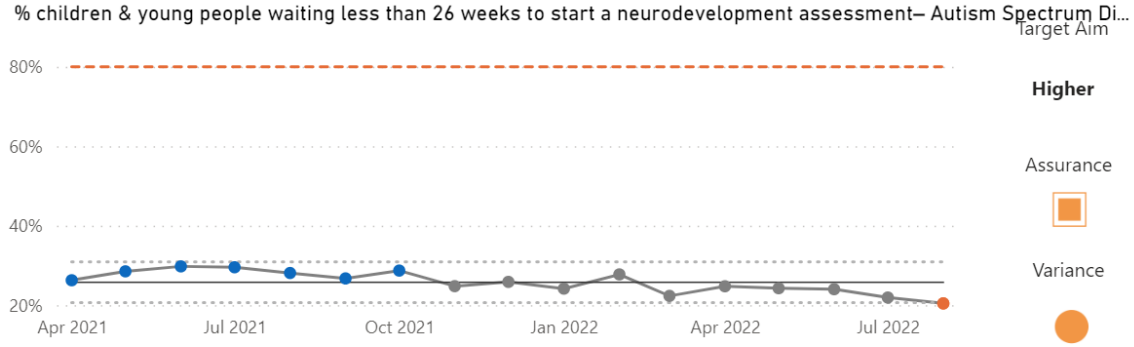
Action plan (Identify possible solutions and prioritise based on value and ease of implementation, actions, owners, deadlines and review dates)	**Owner**	**By When**	**Complete Y/N**
Risk stratification on all referrals	Alastair Wakely	Ongoing	Ongoing
A recruitment campaign is currently underway within the Health Board to complete full recruitment inline with allocated budget. This will help mitigate the risks around staffing issues.	Alastair Wakely	September 2022	Complete
Training to ensure all new staff have the requisite skills to undertake the assessments and interventions to meet the Mental Health Measure.	Alastair Wakely	December 2022	Ongoing
Deliver the targeted recovery plan	Angela Lodwick	March 2023	Ongoing
Consider alternative accommodation and secure additional estate to increase capacity, enable client appointments and increase number of assessment opportunities	Angela Lodwick & Estates	March 2023	Ongoing
Increase the number of therapeutic groups to increase capacity to meet 28 day target.	Alastair Wakely	September 2022	Y
Review the number of Did Not Attend (DNA) and explore use of text messaging service to remind and reduce DNAs	Alastair Wakely	September 2022	Y
Continue use of Digital platforms to increase capacity e.g. Use of digital online counselling support service Kooth offered to all referrals who do not meet threshold criteria and those on the waiting lists	Angela Lodwick	March 2023	Ongoing
Undertake individual job planning for all staff, to improve capacity and efficiency across the service	Alastair Wakely	December 2022	Ongoing
Use SiR pathway to divert referrals from the service where school based MH consultation can meet the need	Alastair Wakely	March 2023	N
Clinical psychologist to support more efficient and targeted use of intervention time to address greater acuity and complexity and utilise robust outcome measures	Alastair Wakely	March 2023	N
Undertake demand and capacity training and embed learning – the Delivery Unit have agreed to facilitate this training when we are ready	Alastair Wakely	December 2022	N
Improve service understanding of performance standards and need for robust data	Alastair Wakely	October 2022	Y

Mental Health - Neurodevelopmental Services

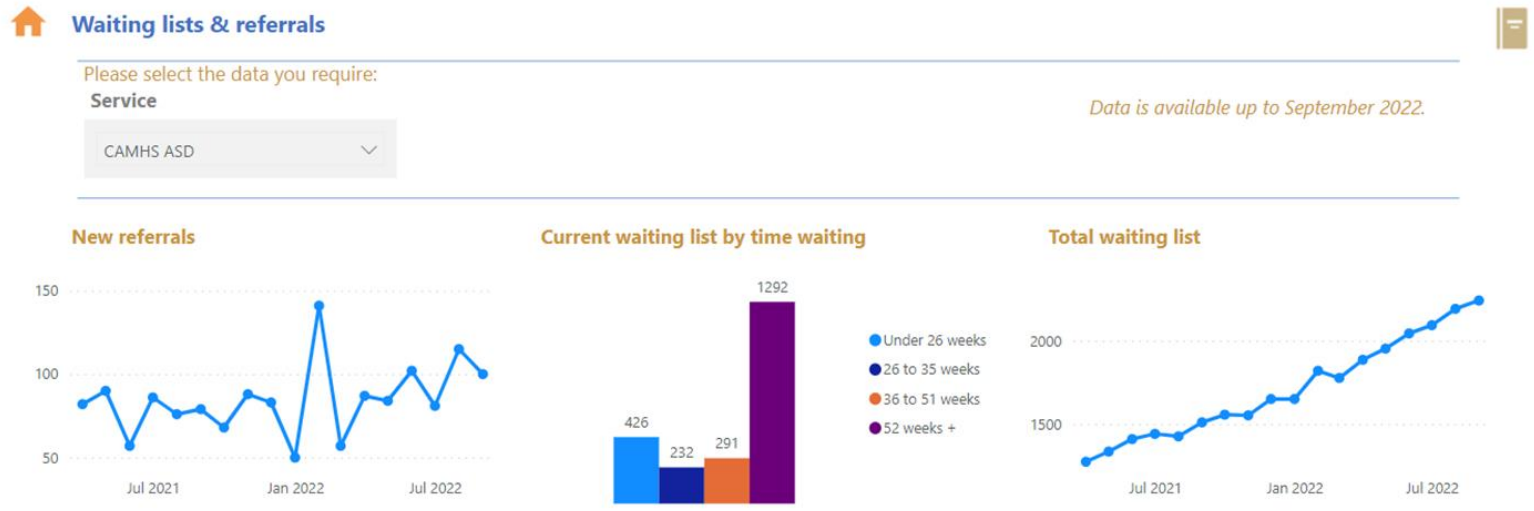
- The WG target for the percentage of children and young people and Adults waiting less than 26 weeks to start a neurodevelopmental assessment is 80%. Demand for assessment continues to remain high, with wait times of up to 3 years. Demand for assessment is increasing year on year, ranging from an average of 26 referrals per month in 2016 to 87 referrals per month in March 2022.
- Due to the significant waiting lists, for Adult and SCAMHS ASD services, we are unable to agree a realistic trajectory at this time. However, we are providing regular data to the National Delivery Unit on activity (completed assessments) to assist with the national demand and capacity exercise. We are reviewing all the processes involved in diagnostic assessment to identify efficiencies and identify ways to reduce the length of time that to takes to complete an assessment.
- All current posts within the service have been successfully recruited to, which will provide additional capacity for diagnostic assessments once staff have been inducted and onboarded. However, workforce requirements to meet the ongoing increasing demand is inadequate. We continue to review all job plans to identify areas where we can increase capacity for assessments.
- Demand within our IAS service remains similarly high. Again, this is compounded by inadequate workforce numbers to meet the increasing demand. The directorate is funding a number of fixed term additional posts to address some of these demand and capacity issues. Work continues on the procurement exercise to outsource assessment and treatment to address our waiting lists in both Adult and CYP ASD services. Due to the cumulative value of the tender proposal (over 1 million over 3 years) we had to send the procurement proposal to Welsh Government for sign off in August 2022. With approval granted on 26th September. The anticipated go live date for the tender is 3rd October. Dependent on provider uptake, services will be procured until 31st March 2025, with a minimum of 150 individual diagnostic assessments per year being undertaken.
- While we await the WG review of Neuro-developmental Services across Wales we met with WG colleagues in July to identify possible non recurrent funding to assist in waiting list initiatives, which we are awaiting a response to. Senior Managers are currently working with other health boards to identify areas of best practice to improve waiting lists.
- At this point we will develop a plan which monitors progress against the backlog reduction

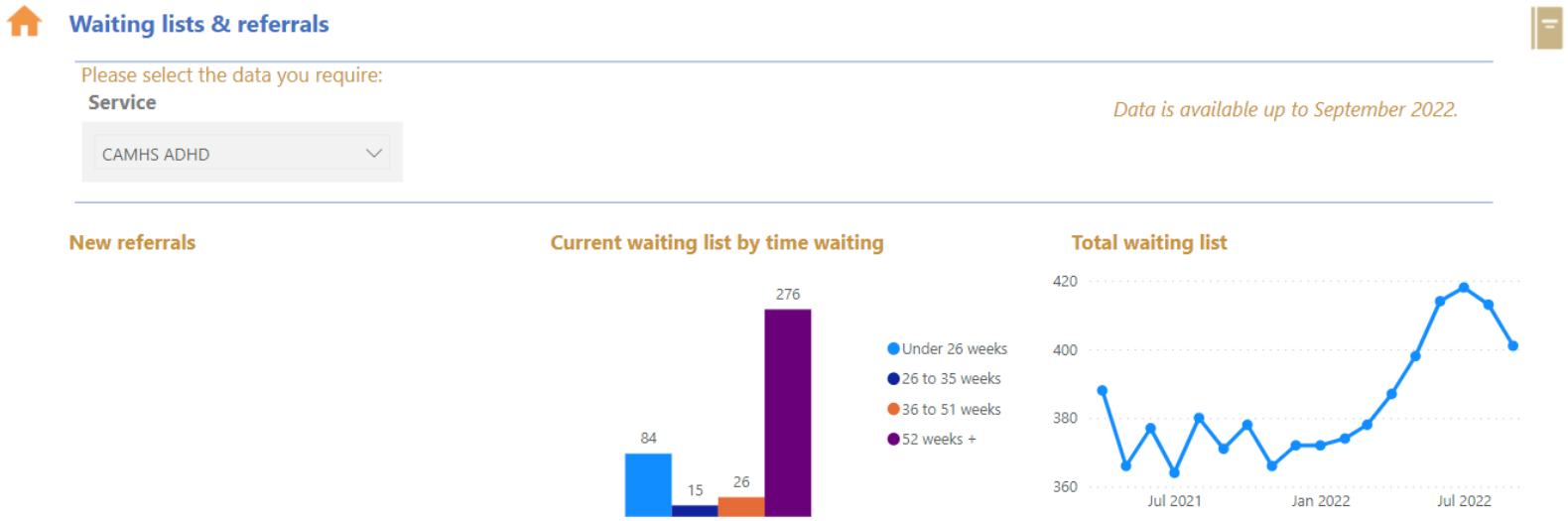




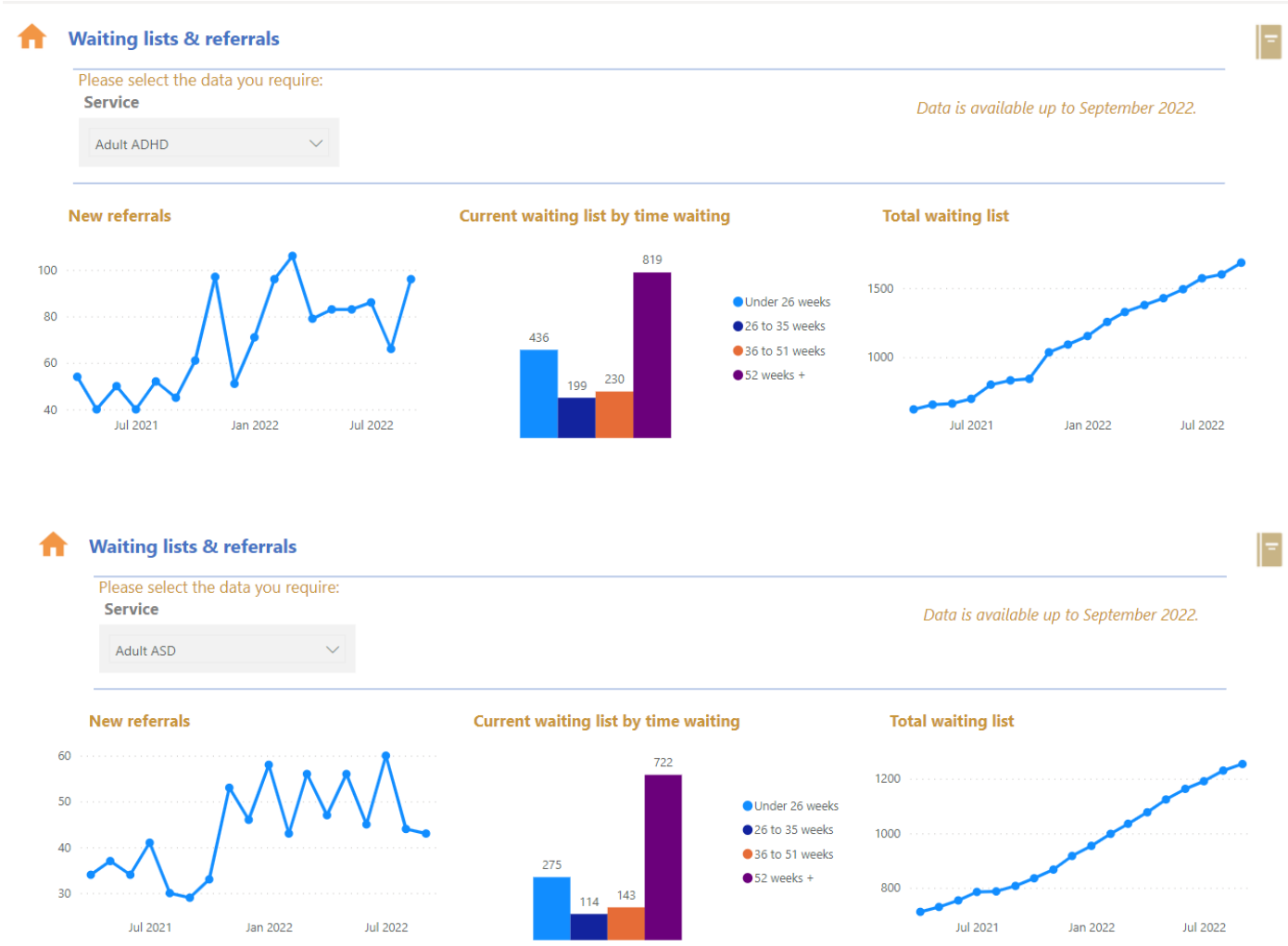


Mental Health - Neurodevelopmental Services





Mental Health - Neurodevelopmental Services



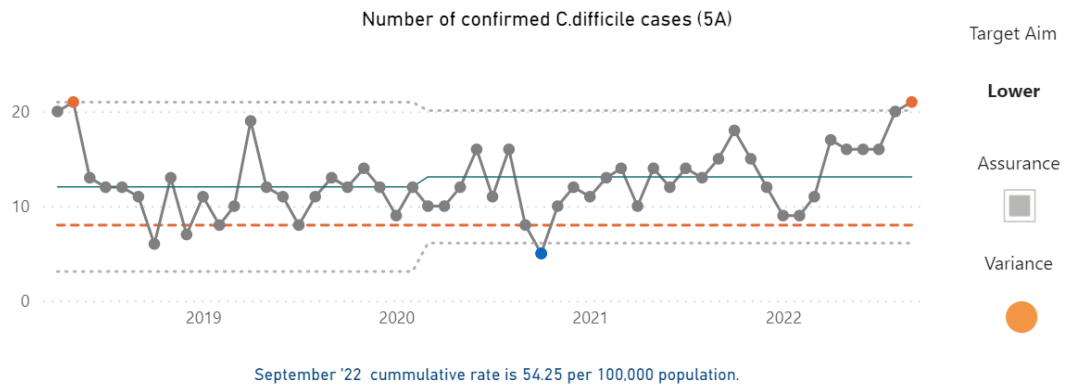
Infection control

C-difficile

Enhanced monitoring
- Focus on C-diff

- HDUHB have the highest incidence of Clostridioides *difficile* infection (CDI) within Wales. Within the period April to September 2022 45% of these are attributed to non-inpatient specimens meaning that they have been either sent from a GP surgery or taken within the admission departments on the acute sites. This is not exclusive to CDI and other infections must be considered.
- Prevention of HCAI's and subsequent hospital admissions must be a priority across the Health Economy, inclusive of Community, Primary & Secondary care. For these reasons this Improvement Plan has a focus on both Infection **Prevention & Control** and is wider than Nosocomial Infection.
- In order to understand this fully the Health Board has already invested in its Community IPC resource this year. Improvement work has already started. What is not clear without an in-depth deep dive is whether these cases were admitted following confirmation of the infection or indeed how many of the in-patient cases are a result of community transmission or primary care prescribing. The community infection prevention team is imperative to enable this detail to be sourced and improvement action plans to be developed.
- An Improvement Plan has been developed aligned to the Strategic Framework set out in Commitment To Purpose - Eliminating Preventable Health Care Associated Infections as many of these strategic goals are still relevant today. In operationalising the Plan has been written, as far as possible; with the nine standards as set out int the Code of Practice for Healthcare Associated Infections
- Progress against the Improvement Plan will be monitored monthly and reported back in line with the enhanced monitoring arrangements as applied under Targeted Interventions.

- Copy of Copy of 2022 11 10 Delivery Table for CDI Improvement v7



Critical care

Critical Care

Enhanced monitoring

- Critical Care workforce plan
- Plans developed and agreed with CHC and the public for a safe, sustainable service
- Effective surge planning in case increase of capacity was required

On 25th July 2022, an operational decision was implemented to amend the admission protocols to the Critical Care Unit at Prince Philip Hospital as a consequence of a further deterioration in the availability of Critical Care consultant staff to provide appropriate and sustainable levels of on-site support to the unit. This decision was affirmed on 28th July 2022 by the Operational Planning & Delivery Group, chaired by the Director of Operations, following discussion at the In-Committee Board session earlier that day.

From this date, admission protocols to the unit were amended to patients requiring Level 1 and 2 Critical Care, with patients requiring Level 3 care to be admitted/transferred to neighbouring Critical Care units, appropriate to their clinical needs. This adjustment to the admission protocol was intended as a temporary measure, with restoration of the previous arrangements dependent upon an improvement in consultant level Critical Care staffing resources.

A paper taken to Board in September 2022 provided an overview of the latest position and to agree to receive a further assessment and update in January 2023, in the event that Critical Care consultant staffing levels do not improve to a sufficient level in the intervening period to enable restoration of the admission protocols in place prior to 25th July 2022.

A full copy of the Board paper can be found via the link here.