Meeting Date	**30th July 2020**	**Agenda Item**	**2.2**
Report Title	**SBUHB Quarter 2 Operational Plan 2020-21**		
Report Author	Maxine Evans, Head of IMTP Development and Implementation Nicola Johnson, Interim Assistant Director of Strategy		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Siân Harrop-Griffiths, Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	This paper seeks ratification of the SBUHB's Operational Plan for Quarter 2 2020/21 which was submitted to Welsh Government on 3rd July 2020 following approval by Chair's Action.		
Key Issues	The national Operating Framework for Quarter 2 was received on 18th June 2020. The SBUHB Operational Plan for Q2 2020/21 was developed and submitted to Welsh Government on 3rd July following approval by the Senior Leadership Team, a rapid review by the agreed Independent Board Members and subsequent Chair's Action. The document builds on the Q1 Plan, reflects the national Q2 Operating Framework and the organisation's Q2 priorities which include: • Setting priorities and measuring against the 4 Harms; • Responding to the updated guidance for Essential Services; • Describing the New Ways of Working; • Resetting our functional capacity living alongside Covid-19; • Winter Planning (reflecting the Six Goals for Unscheduled Care); • Test, Trace and Protect; • Infection Prevention and Control and environmental guidance; • Social Care resilience and support for care homes; • Protecting our Workforce; • Finance and Capital implications.		

Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☐	☒

(please choose one only)				
Recommendations	Members are asked to: • **RATIFY** the SBUHB Q2 Operational Plan 2020-21 following the approval by Chair's Action to submit to Welsh Government			

SBUHB QUARTER 2 OPERATIONAL PLAN 2020-21

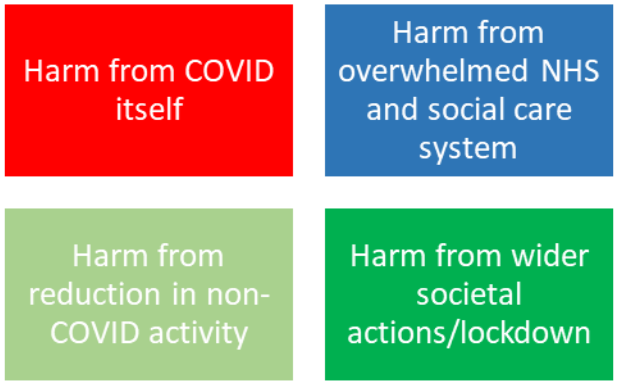
1. INTRODUCTION

This paper seeks ratification of the SBUHB's Operational Plan for Quarter 2 2020/21 which was submitted to Welsh Government on 3rd July 2020 following approval by Chair's Action.

2. BACKGROUND

On 6th May 2020 Welsh Government wrote to all Welsh NHS Organisations outlining the continued need to maintain essential services and start to scale up normal business in an environment that still needs to respond to Covid-19.

A Covid-19 Operating Framework – Quarter 1 was issued which set out a particular focus on maintaining essential services such as Cancer and Mental Health, it also reflected the need to consider 4 types of harm and how we best address them in a balanced way:



The NHS Wales Quarter 2 Operating Framework was circulated on 18th June 2020 alongside updated Essential Services Guidance and a document outlining the Six Goals for Unscheduled Care to inform winter planning.

The SBUHB Q2 Operational Plan 2020-21 which can be found as Appendix A, builds on the Q1 Plan, reflects the national Q2 Operating Framework and the organisation's Q2 priorities which include:

- Setting priorities and measuring against the 4 Harms;
- Responding to the updated guidance for Essential Services;
- Describing the New Ways of Working;
- Resetting our functional capacity living alongside Covid-19;
- Winter Planning (reflecting the Six Goals for Unscheduled Care);
- Test, Trace and Protect;
- Infection Prevention and Control and environmental guidance;
- Social Care resilience and support for care homes;
- Protecting our Workforce;
- Finance and Capital implications.

The Q2 Plan describes the priority actions for each section. An action tracker has already been developed based on the milestones and timelines identified within the Q1 Plan which will be reported under separate cover to the Board on 30th July. The actions identified within the Q2 Plan will be added to the tracker and will form the basis for our monitoring arrangements for the ongoing quarterly iterations and taken through the appropriate Board Committees for scrutiny and assurance.

Due to the deadline for submission of the Q2 Plan to Welsh Government, the Plan was considered by the Senior Leadership Team and a recommendation was agreed to submit it subject to a rapid review by the agreed Independent Board Members and approval by subsequent Chair's Action. The three Independent Members provided detailed scrutiny and responses were given to the issues raised. Following advice and feedback from the Independent Members the Plan was accompanied by an Accountable Officer letter which is included at Appendix B.

3. GOVERNANCE AND RISK ISSUES

The Reset and Recovery Co-ordination Group was established in May 2020 to bring together the seven individual work cells and advisory group managing the health board's recovery programme for essential and routine services. The Group will continue to manage a balanced approach to the reset and recovery across the health Board. Future reporting on the delivery of the Health Board's Operational Plans will be taken through the nominated Board Committee for scrutiny.

Through the Independent Member rapid review, the absence of a named doctor for safeguarding was noted, which is a statutory requirement. The operational clinical pathway to manage the needs of children presenting via safeguarding is being managed by community paediatricians to mitigate risk and ensure the safety of children. The strategic board wide statutory requirements of the named doctor is the area that is not being provided and as such remains an organisational risk. The Singleton Service Delivery Unit Director has advertised the post 4 times without success. There is a plan for a current member of the medical team to retire and return into the post by the end of Q3.

Feedback on the Plan has not been received from Welsh Government at the time of writing, although this is expected shortly. A meeting has been arranged for 31st July to discuss the Health Board's Q2 Operational Plan.

Welsh Government requirements for Qs 3 and 4 are not yet known, however, it may be that a single plan for the remaining 6 months of the year will be requested. The Health Board has established an Operational Planning Group to undertake the detailed modelling requirements to support the preparation of the Q3 and 4 Plan. Depending on the content and timing of receipt of the Welsh Government requirements for the Q3 and 4 Plan the hope is to bring the draft Plan to the full Board for approval in September prior to submission. Discussions are underway with the three Independent Members who provided comments and assurance on the Q2 Plan to secure an understanding of their expectations for the Q3 and 4 Plan.

4. FINANCIAL IMPLICATIONS

The Q2 Plan responds to the financial and capital guidance in the National Operating Framework. The financial framework for Q2 and beyond has been developed based on the planning assumptions set out.

The cost estimates within the plan will remain under detailed scrutiny through the Quarter to reflect movement in the care system across the Health Board and planning assumptions. This has been, and will be, routinely reported to Board. Both revenue and capital analyses are included in the plan.

Whilst substantial funding has been received for the COVID 19 response, there remains a gap between the costs estimates above the Health Board's baseline plan and the funds made available. This is subject to ongoing discussion with Welsh Government.

5. RECOMMENDATION

Members are asked to:

- **RATIFY** the SBUHB Q2 Operational Plan 2020-21 following approval by Chair's Action to submit to Welsh Government

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
A Quality Impact Assessment is in place for services being brought back online. An Equality Impact Assessment process will be an integral part of the recovery planning arrangements to support any services changes.		
Financial Implications		
The financial plan for Q2 is included in the document.		
Legal Implications (including equality and diversity assessment)		
A Quality Impact Assessment and Equality Impact Assessment process will be part of the broader planning arrangements to ensure that the quarterly plans are Quality and Equality impact assessed.		
Staffing Implications		
The risks and implications for our workforce forms an integral part of the recovery planning arrangements.		
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)		
The Operational Planning arrangements will aim to deliver our Strategic Objectives which were aligned to our Wellbeing Objectives through the development of the Organisational Strategy.		
Report History	This is the first report to Board on the Q2 Operational Plan 2020-21	
Appendices	Appendix A - SBUHB Operational Plan Q2 2020/21 with supporting appendices 1 to 15 Appendix B - Accountable Officer letter 3.7.20	

Swansea Bay University Health Board

Operational Plan

Quarter 2 2020/21

Contents –

1.0 Overview and Planning Assumptions for Q2

Swansea Bay University Health Board's Organisational Strategy sets out two aims for the Health Board: Supporting Better Health and Delivering Better Care. This pandemic has brought both responsibilities equally into the public eye and the Health Board's approach is focused on ensuring that resources are apportioned, with partners, to delivering against each of these aims.

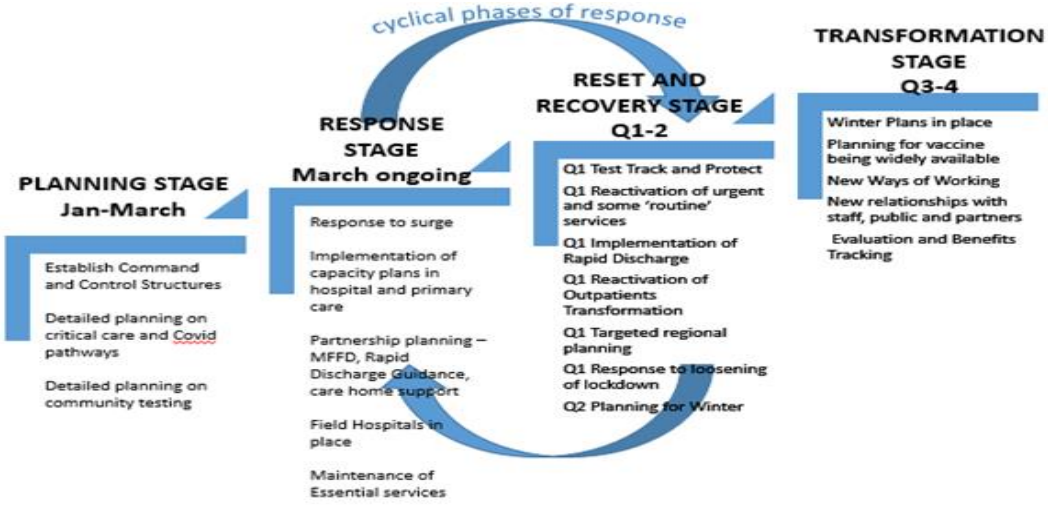
The Health Board developed an Annual Plan within a three-year context before the impact of the Covid-19 pandemic was understood which provided a baseline position at a point in time, but due to the outbreak, has not been used as the basis for operational planning for 2020/21.

The Health Board's response to the Covid-19 pandemic has been guided by the statutory requirements and guidance on Emergency Preparedness, Resilience and Response and the national guidance specific to the pandemic. A data-driven and evidence-based approach has been taken wherever possible, whilst taking into account the limitations of knowledge and research about this new disease.

The Q1 Plan was very much focused on the response to the pandemic and ensuring that the Health Board had sufficient capacity to cope with the expected demand from Covid and not be overrun, as well as ensuring essential services were maintained. The first peak of the pandemic has now passed, and whilst the Health Board's priority is to ensure that services are ready to respond to new and emerging cases or further peaks and surges as they emerge, the focus in Q2 is ensuring the full implementation of the Test, Trace and Protect plan and bringing more services back to ensure the impact of any potential harm is reduced. The Plan also provides a greater strategic focus, recognising that elements of the Clinical Services Plan are being implemented at pace.

Operational Planning Approach

The stages of the Health Board's Operational Planning Approach are shown in the diagram below.

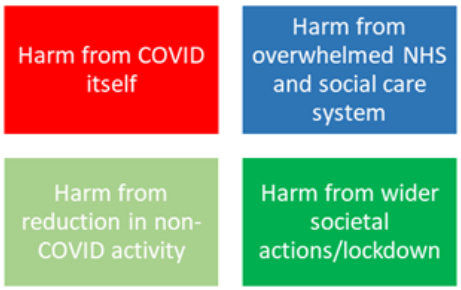


Planning Principles

The Health Board's Operational Planning for 2020/21 is based on the following planning principles:

- A Swansea Bay **system wide** service, workforce and capacity response to Covid and non-Covid,
- **Cautious and adaptive** approach to the delivery of non-Covid services through an ongoing pandemic,
- **Clinically led** risk management approaches to the reinstatement of services, operational zoning areas; clinical prioritisation, MDT approach, pre-op processes including consent,
- In line with **national policy and guidance** in respect of IPC, social distancing and minimising footfall,
- Building on the strong **partnership arrangements** with Local Authority and multi-agency partners,
- Working **regionally** on solutions where appropriate under a shared prioritisation approach,
- **Patient centred decision** making, respecting individual preference and responsibility,
- Developing **new models of care and ways of working** in context of agreed Organisational Strategy, Clinical Services Plan and KPMG action plan; and the strong Digital transformation offer that underpins all plans.

The 4 Harms



The national Q2 Operating Framework reiterates the need to proceed with caution, and to maintain a dual-track approach to managing services during the pandemic, with Track 1 defined as 'remaining ready to provide the full range of services needed to prevent, diagnose, isolate and treat Covid-19 patients', and Track 2 as 'addressing accumulated demand from services that were paused to reduce exposure to and provide care for during outbreak peaks'.

As outlined in the Health Board's Planning Principles the organisation is taking a clinically-led quality assessment approach to restarting services and to operational planning. In order to address these dual-track aims the Health Board has refined its approach to the 4 Harms in the draft diagram in Appendix 1 which shows how the priorities of this Q2 Plan address the harms and how they will be measured. This is also explored further in the Performance section.

Operational Planning Assumptions for Quarter 2

The Operational Planning Assumptions flowing from these principles for Quarter 2 are:

- Based on the reduced transmission of the virus during the summer months, the reduction in the R rate to below 1 and the cautious approach in Wales to easing lockdown, the Health Board is not expecting a surge in Q2, although will remain in readiness to respond if this changes.
- The Health Board is using the Warwick model and local short-term modelling to guide the Plan. This is being sense-checked against national modelling as it is received.
- Bed capacity modelling is based on modelling of the workforce absence, the requirements of the Nurse Staffing Act and the need to protect staff and patients by implementing the social distancing guidance for infection prevention and control guidance. The Q2 Operating Framework occupancy guidance of 85-92% has also been included to give headroom to respond to a surge.
- Operating theatre capacity will continue to be constrained in Q2 by the pattern of workforce deployment, workforce absence and the need to maintain additional infection prevention and control measures. Elective activity is being prioritised as described in the Essential Services guidance.
- SBUHB will continue to adhere to Table 4 of the PPE guidance which is a major constraining factor in operating capacity until the national guidance is changed.
- In the event of a surge the Health Board's principle from a quality standpoint is to use all substantive bed capacity first. This will require a divergence from the social distancing guidance and the Nurse Staffing Act as laid out in the escalation procedures.
- This principle along with the bed capacity modelling suggests that Field Hospitals will not be used in this quarter, as confirmed through local modelling. As guided by the Q2 Operating Framework, however, capacity will be kept in response and in readiness for any potential future super-surge.
- In Q2 the Health Board will be working through the potential to rationalise the two Field Hospitals onto a single site. The opportunity for this to be used as a regional solution, including a regional workforce model, will be part of this planning.
- The working assumption is that around 15% of the workforce will be absent (through all types of absence) at any one time, bearing in mind that the effect of Test, Trace and Protect may create specific local difficulties.
- Acknowledgement of the financial guidance in the NHS Wales Operating Framework.
- The Health Board will continue to work with partners to maintain community resilience, particularly in the care sector.

The Health Board's Operational Plan for Quarter 2 is based on these Assumptions and they have been used to undertake the capacity modelling that is described in section 2.0.

2.0 Managing Covid-19

The Board established a Pandemic Framework and Tactical Plan as part of a broader suite of local, regional and national emergency response plans and these have been

Testing Workforce Appendix 12

Current Staffing - Full Capacity	**Testers and Buddy**	**Admin**	**Transition out plan**	**Testers and Buddy**	**Admin**
			22nd June - 6 week withdrawal for all current staff		
8 Lanes	32 WTE	16 WTE	8 Lanes	32 WTE	16 WTE
4 x MTU's	16 WTE	8 WTE	4 x MTU's	16 WTE	8 WTE
	48	24		48	24
Current HB Staff	32	8	Current HB Staff	8.4	3.4
Military Staff	10	10	Military Staff - in post until end July	10	10
Total capacity currently	42	18	Total capacity after withdrawal	18.4	13.4
Deficit	**6**	**6**		**29.6**	**10.6**

This does not include replacing the military as they are not a paid workforce. We will need circa 10 WTE stewards for the testing centres.

Contact Teams Appendix 13

Role	No.s of staff per USOA team	Capacity Assumption (based on 8hr working day) per USOA team	Contact Tracing Capacity (Single Team)	Contact Tracing Capacity (NPT) – 5 USOA areas	Contact Tracing Capacity (Swansea) – 8 USOA areas	Contact Tracing Capacity (Swansea Bay – 13 USOA areas)
Clinical Lead	1 per team			5	8	13
Contact Tracer	3-4 per team	Interview 4 cases / day	12-16	60-80	96-128	156-208
Contact Adviser	10-12 per team	Follow up 10-12 contacts per day	100-144	500-720	800-1152	1300-1872

Deployment Plan Appendix 15

Phase	Swansea	Neath/Port Talbot
1 (testing/shadowing)	1 team (18th to 22nd May) testing structure, shadowing EHOs and e-learning in preparation for digital solutions.	1 team (18th to 22nd May) testing structure, shadowing EHOs and e-learning in preparation for digital solutions.
2 (Preparation)	2 teams (26th to 31st May)	2 teams (26th to 31st May)
3 (Go live)	4 teams (1st June to 1st July)	4 teams (1st June to 1st July)
4 (Review)	15th to 20th June review capacity and demand.	15th to 20th June review capacity and demand.
5 (Growth)	8 teams (1st July onwards)	6 teams (1st July onwards)
	These teams will then grow further to cover additional demand.	These teams will then row further to cover additional demand.

the foundation to guide the response to Covid-19. The response command, control and coordination operate in accordance with the principles and arrangements outlined within the SBUHB Major Incident Procedure, aligned to the Civil Contingencies Act 2004. The response arrangements remain 'live' and there is an established pattern of planning, response and command arrangements in place.

Governance arrangements have remained adaptive throughout the response phase and will continue to be so. The current governance structure and Gold Programme Plan is included in Appendix 2.

The Programme Plan includes the comprehensive planning and response structure that mirrors the operational arrangements as well as having Executive leads for several areas of the work programme. Planning and response cells were established in a number of critical areas that span the Board's functions and the following cells remain live:

- Multi-Agency Test, Trace and Protect Silver (including Multi-agency workstreams for Testing (not antibody or hospital based), Workforce, Communications & Engagement, Contact Tracing & Digital and Regional Response)
- Health Board Testing Silver group focussing on Antibody and Health Board testing
- PPE
- Infrastructure & Support Services (including Equipping)
- Workforce
- Digital
- Communications (incorporated into the Covid Coordination Centre)
- Training
- Volunteering service
- Staff Health and Well Being (which now incorporates the psychological health and wellbeing and TRiM work programmes)
- Medicines Management (including Oxygen)
- Mass Fatalities
- Multi-Agency Community Silver
- (new) Social Distancing

Gold Command has continued to meet throughout Q1 and is currently meeting twice weekly. This will be reviewed throughout Q2 and the frequency adjusted dependent on the prevailing situation. All Covid and non-Covid pathways were reviewed during Q1 and will be kept under two-weekly review to reflect potential changes enacted through the reset and recovery work programme.

A new social distancing cell has been established. The scope of the cell is to ensure that risk assessments are undertaken consistently across the Health Board, and that the Board has a visible approach to ensuring both staff and patient safety and to support the reduction of nosocomial transmission. The Board began its risk assessment process ahead of the production of guidance from the national Nosocomial Transmission Group (NTG). A number of practical changes have been made and further changes will be introduced.

Ahead of anticipated further guidance on the physical layout of hospital wards, a detailed review of hospital ward layouts to understand the impact and consequences of a 1m or 2m bed separation has begun. The initial assessment is that the impact of 2m physical separation could reduce available bed capacity by 20% but this is subject to further verification. Social media platforms and internal communication mechanisms are being used to support behavioural change in ensuring that staff are mindful of social distancing guidance when not wearing PPE.

During Q1, a hot debrief was undertaken in order to:

- Capture, share and track fast time lessons, issues and notable practice whilst still fresh in the memory
- Ensure that lessons are learned given that the response phase is lengthy
- Implement learning to improve recovery
- Adopt best practice.

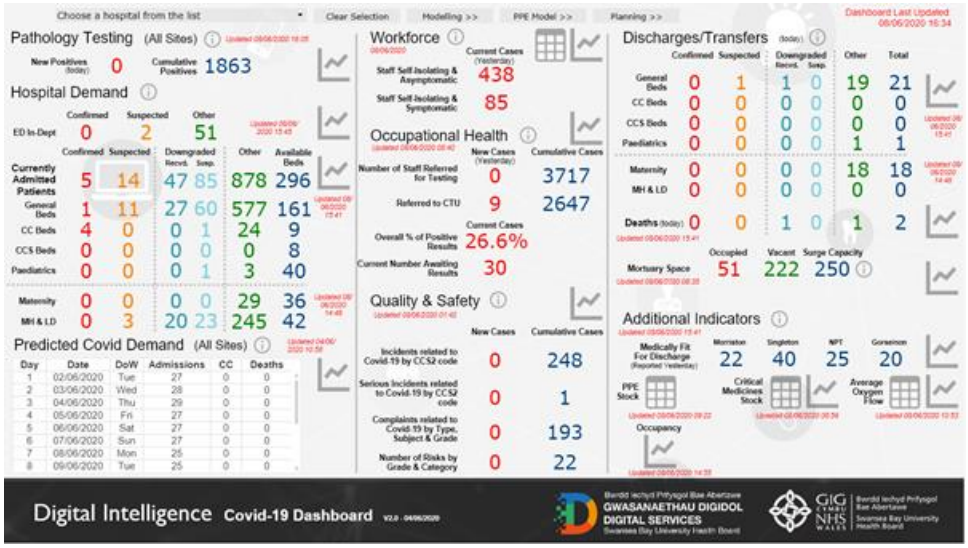
A formal report will be considered in July.

The Board has also considered how to ensure that a comprehensive record of the emergency and its response is maintained recognising that there is likely to be considerable scrutiny post pandemic. The value of an archivist to systematically preserve and retain all information gathered throughout the response and recovery phases is being explored.

The new ICU facility at Morriston Hospital remains available to support a potential surge in cases and to facilitate a separation of Covid and non-Covid flows. An integrated capacity planning tool has been developed to support flexible use of hospital estate. Capacity issues are covered in more detail in section 5.2

2.1 Swansea Bay Modelling Cell

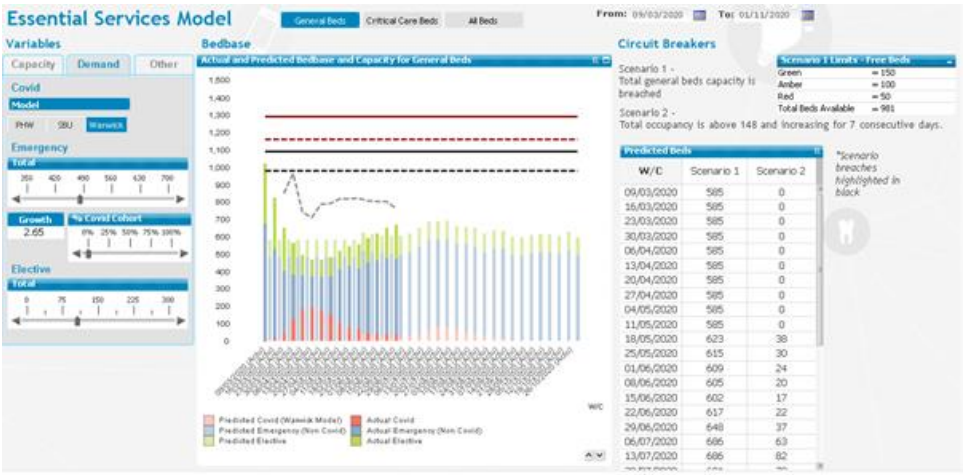
Building on the success of the Covid-19 dashboard utilised by Gold Command and service leads (see below), the SBUHB Modelling Cell has developed a dashboard to facilitate both scenario based testing as well as actual data monitoring to ensure capacity projections are rebased where appropriate.



The locally developed Essential Services Model (below) uses Qlikview technology and allows the Health Board to change the underpinning model (Warwick, PHW v2.4, SBU 14 day etc.) to display the impact. The Model includes the ability to scenario test against a range of variables that include:

- Staffing levels
- Occupancy
- Available Beds
- Emergency Demand
- Critical Care / General Beds

It also incorporates a number of circuit breakers suggested by Welsh Government. This allows the organisation to monitor, using a Red Amber Green Black (RAGB) system on a week by week basis, changes in activity including projected changes to volumes in emergency and Covid demand to facilitate timely decision-making.



Model Adopted for Quarter 2 2020/21

The model adopted for Quarter 2 outlined below is based on capacity across all three acute sites with the specialist areas excluded. The modelling is split into General and Critical Care beds and is based on weekly occupancy. The Health Board will be providing sufficient bed capacity as outlined in the Welsh Government Covid Capacity Planning letter of 24th June which set out that in order to meet a 2nd peak eventuality the Health Board would need to be able to provide an additional 46 critical care beds and 621 acute medical beds.

It is currently advised that UK Government should plan based on the RWC scenario using the Warwick model and therefore this model has been factored into Health Board assumptions which are:

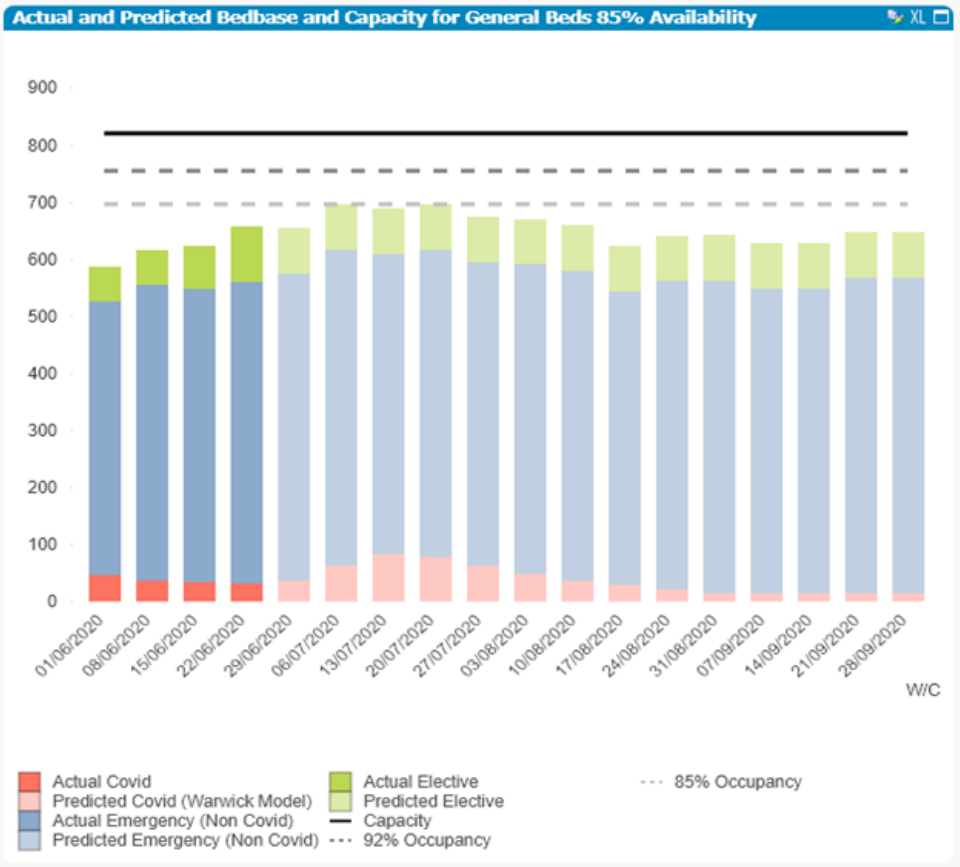
- Covid – based on the Warwick model (shown in Red)
- Emergency Admissions – based on a level of growth demonstrated in the previous rolling two weeks, to a maximum of the corresponding week in 2019/20, to account for seasonality (shown in Blue)
- Elective cases – demonstrated by the last 4 weeks average (shown in Green)

Furthermore, a predicted level of 15% staff absence has been factored into the model, along with an assumption that the inpatient 2-metre social distancing requirement is applied. There should however be significant caution acknowledged with this

assumption due to the potential case mix of staff that may available and required to reopen these areas at any one time.

Each of the models shown demonstrates occupancy levels within the Health Board's staffed beds at 100%, 92% and 85% to show the impact of each scenario.

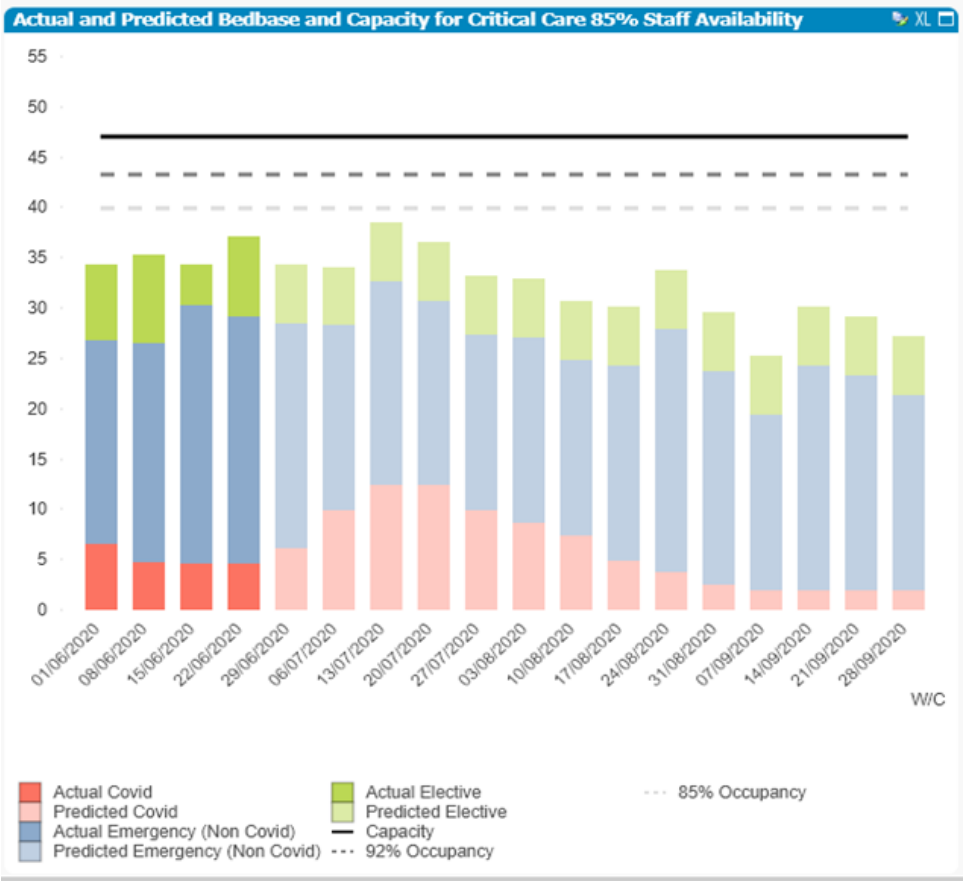
General Acute Beds for Quarter 2



Based on this modelling, the graph above displays the likely weekly occupancy from the w/c 1st June 2020 to the w/c 28th September 2020. The data from 1st June to 22nd June is actual data – the data from 29th June is the modelled data. The graph demonstrates occupancy levels at 100%, 92% and 85% of current staffed beds, and also includes an extension of the Warwick model for the remaining 4 weeks of Q2 to account for anticipated Covid patients that will still remain in hospital.

There are 3 weeks in the model where the Health board is likely to be above or close to exceeding the 85% occupancy level, and therefore it is anticipated that with further elective cases being brought back into the system, the Health Board will maintain a position closer to the higher recommended level of occupancy (92%) outlined by Welsh Government. The graph also demonstrates that based on the modelled occupancy, the Health Board will, for Q2, be able to manage the anticipated emergency demand and the elective capacity available through theatres, within its current bed base. Furthermore, the Heath Board will have the capacity to open additional substantive hospital surge capacity before initiating any requirement to surge into field hospitals.

Critical Care Beds



The graph above displays the weekly occupancy from the w/c 1st June 2020 to the w/c 28th September 2020 for critical care. The data from 1st June to 22nd June is actual data – the data from 29th June is the modelled data. The table below outlines the numbers shown in the graph, along with the remaining beds in the current open wards, against the 100%, 92% and 85% occupancy levels.

The graph demonstrates that Covid demand for Quarter 2 is likely to be lower than experienced in Q1, and as a consequence, an 85% level of occupancy is possible depending on the level of electives likely to be accommodated in Q2. The volumes of electives demonstrated are based on the average of the last four weeks and these levels could be increased in line with services coming back online. It is therefore anticipated that the current level of critical care beds will be able to accommodate demand in Q2 without the requirement to surge into additional critical care areas within the Morriston hospital.

Future modelling

This model enables the Health Board to increase elective capacity whilst monitoring the actual position with a number of circuit breakers, thereby informing timely decisions to reduce or increase elective capacity depending on any of the variables outlined previously

The Health Board will continue to monitor changes in demand on a daily basis through the internal Covid-19 dashboard and also through the modelling dashboard demonstrated. Actual data will continually be used to update the dashboard to provide

accuracy, and staff absence along with closed beds will also be monitored and factored into future iterations of the model. It is clearly understood that these are modelling scenarios, and the Health Board will review its position against the model on a daily basis, with appropriate changes to capacity being made as required.

Furthermore, the Health Board is also in discussion with Hywel Dda UHB to further enhance this model, with the opportunity to apply localised variation to the R rate.

Brexit

On the 31st January 2020, the UK left the EU and the Brexit transition period commenced which will last until 31st December 2020. Negotiations between the UK Government and the EU have continued, however, currently it appears that a comprehensive free trade agreement will not be in place by the 31st December 2020. Extensive Health Board preparations were undertaken during 2019, focussing on the potential for a no deal Brexit. During the response to the Covid-19 pandemic, there have been similarities in the preparedness requirements for the pandemic that will help to inform the EU withdrawal and subsequent recovery process to Covid-19.

In readiness and as part of the pandemic recovery, further contingency arrangements are required that need to be considered as key factors in the programme for the re-introduction of services. The specific areas of focus, which have also been areas of close monitoring during the Covid-19 response include:

- Continuity of supply and ongoing stock management arrangements of medicines, including additional stockpiling
- Continuity of supply and ongoing stock management of Medical devices and clinical consumables
- Policy regulation and the impact on local arrangements
- Re-assessment of workforce implications including the impact of future UK immigration policy
- The longer term health and well-being impact of Covid-19 is unclear, and may further exacerbate the longer term challenges for health and well-being which can be expected as a result of the EU exit which the Public Health Wales Health Impact Assessment of Brexit will need to consider for inclusion.

It is proposed therefore, that Brexit contingency planning arrangements become intrinsically linked to the Health Board recovery framework.

Pharmacy and Medicines Management

The Health Board will consider the ongoing availability of medicines and supply chain resilience as services return to routine care provision. Recognising that Chief Pharmacists and the local and national teams have a critical role in ensuring medicines are available or can be readily sourced to meet patients' needs we will ensure that we engage the Chief Pharmacist at an early stage in the planning process. We will use the recent publication from the Chief Pharmaceutical officer "A framework to support the availability of essential medicines as NHS Wales recommences routine care" to support how we balance competing demands on essential medicines for routine and COVID patient care to deliver optimised medicines related outcomes.

Key Actions:

Action	July	August	September
Social Distancing/ Nosocomial Transmission	Conclude risk assessment process in clinical and non-clinical areas & respond accordingly Implement actions from WG guidance from NTG and assessment implications Local communications campaign	Continue comms campaign Implement further guidance from NTG	Continue comms campaign Implement further guidance from NTG
Covid Response Work programmes	Each cell to review key outstanding actions & produce legacy statements	Refine Gold master plan ahead of Q3 Consolidate legacy statements Progress outstanding cell actions	
Integrated capacity plan and modelling	Review and refine integrated capacity plan on a weekly basis Work with HD UHB to further refine Essential Service Model	Review and refine integrated capacity plan on a weekly basis	Review and refine integrated capacity plan on a weekly basis
EPRR Response	Board to consider initial 'hot debrief' and lessons learned	Implement key lessons and continue to review and refine response	Undertake further review at end of Q2
Brexit	Develop contingency plans	Develop and implement contingency plans	Develop and implement contingency plans

3.0 Test, Trace and Protect Programme

A Test, Trace and Protect Programme has been established within the Western Bay region, with planning for this being taken forward on a multiagency basis in May and implementation of the service on a phased basis occurring from 1st June.

Governance

A clear governance structure has been agreed on a multiagency basis, with the Multiagency Test, Trace and Protect Silver established and meeting twice weekly, reporting to Multiagency Gold. Workstreams established under Silver include:

- Testing (lead Director of Public Health, HB)
- Workforce (Deputy Chief Executive, Swansea LA)
- Communications & Engagement (Deputy Chief Executive, NPT LA)
- Trace and Protect (Director of Place, Swansea LA)
- Regional Response (Head of Housing & Public Health, Swansea LA)

The Health Board's Executive lead is the Health Board's Director of Strategy supported by a multiagency programme manager and support.

Testing

An Interim Multiagency Testing Delivery Plan has been developed and signed off by all partners, reflecting priority groups and settings identified by Welsh Government and the latest guidance.

Capacity for testing is available at the Margam Drive-Through facility (2 lanes) which has been in place since March and the Drive-Through facility at Liberty Stadium (6 lanes) which was opened on 8th May. In addition, Community Testing Teams have also been established (2 or 3 depending on demand) to provide home tests and to carry out swabs at care homes and other priority facilities. Conservatively, each lane of the drive-through facilities can test 75 people per day (9am to 7pm) and each Community Testing Team can carry out 200 swabs per day.

At present, demand means that only 4 lanes are operational at the Liberty Stadium, although this can be increased by an additional two lanes as demand requires. Mobile Testing Units have also been deployed in Wales in May and support from an additional Mobile Testing Unit will also be available in Q2.

The Care Home testing programme was completed for all care homes and residents by 20th June and a communications and engagement plan was finalised for June regarding TTP and is being implemented. The Phase 2 plan being developed for July focusses on raising the profile of testing and its availability for the public as well as critical workers.

A Serology Testing programme has been established in the Swansea Bay region from June. Operating from the Bay Field Hospital in Swansea, the service was established quickly in order to implement the instructions set out in a letter from the Chief Medical Officer for Wales in June. As a result, the Health Board, working in partnership with City and County of Swansea and Neath Port Talbot Council, has begun the roll out of serology testing for all education staff working within 'School Hubs' during lockdown It is estimated that there are 5500 education staff eligible for testing and as at Friday 26th June, 2500 had been sampled. Given schools return on 29th June, the programme for education staff will conclude in early July.

The Chief Medical Officer letter also asked Health Boards to roll out staff testing in a phased manner. Staff testing within the Health Board went live on Tuesday 23rd June and will continue through Quarter 2 using a Standard Operating Procedure prepared by Laboratory Medicine leads and Public Health Wales colleagues.

For Quarter 2, the serology testing programme will prioritise its activities to meet the expectations of Welsh Government. After mobilising a temporary workforce to test education staff, a more robust staffing model will need to be developed during quarter 2 in order to respond flexibly to the national expectations. Early clarification of these expectations will assist in the timely delivery of the response.

Trace and Protect
On a multiagency basis the approach agreed across the Swansea Bay area for the Trace and Protect element of the programme is as follows:

- Teams will be organised by each Local Authority, linked to Upper Super Output Areas and will provide a call centre function for trace and protect activity
- Teams will initially be staffed by Health Board and Local Authority staff working to a national standard operating process and to national role descriptors supported by national e-learning
- Call centres will be virtual, utilising staff who can work from home in most cases and operate from 9am to 6pm, 7 days a week.

Regional Response
A Regional team for Swansea Bay has been established, led jointly by the Director of Public Health and Directors of Public Protection from the Local Authorities. It provides advice and support to local teams and oversees the management of outbreaks in the area. The demands on the specialist health protection staff have been significant during the initial implementation of TTP, as most cases have been identified as health and care staff. It has, however, meant that in depth investigations have been able to be undertaken of cases. A revised governance structure has been agreed with the Multi-Agency Regional Response Team Workstream reporting into the Multi-Agency Test, Trace & Protect Silver Group.

The low numbers of cases identified in Swansea Bay has meant that the tracing teams have been able to provide mutual aid to Betsi Cadwaladr UHB during June.

The All Wales Contact Tracing System (CRM) went live on 9th June. This will help to reduce reliance on workforce to undertake manual tracing, however, the reporting elements of the system to enable interrogation and an accurate understanding of activity across the region is still under development, but its introduction is vital alongside some other operational functionality for the system.

Workforce
Initially LA and Health Board staff, particularly those who are shielding, have been utilised to staff the Teams for Trace and Protect. However as more core services are prioritised by Welsh Government for reactivation the need to replace these internal workers with those recruited from outside will grow. The use of volunteers is being reviewed and built into workforce planning scenarios. The Local Authorities are currently recruiting to the tracing teams and options for the full or partial recruitment are being considered. The Health Board will continue to provide clinical leads to the tracing teams, either through internal staff redeployment or secondment, or through recruitment. Welsh Government has made a commitment to fund additional costs, although the details of this are to be finalised and confirmed.

Communications and Engagement
A multiagency webpage has been developed which hosts all information required by critical workers, members of the public and care homes, to explain how to access testing, how the tracing system works and to answer FAQs. This has been available since the end of May and links to Welsh Government and PHW information as required.

Welsh Government is establishing a new Protect Task Group to ensure this element of the TTP programme is taken forward. The governance within Swansea Bay will be

reviewed once the remit for this work is clear to ensure the Region can deliver on these requirements.

Key Actions:

Action	July	August	September
Expand testing and tracing capacity in line with agreed plan	Full testing and tracing capacity able to be brought online – depending on demand & funding	Testing & tracing requirements flexed as necessary to meet changing demands	Testing & tracing requirements flexed as necessary to meet changing demands
Recruit substantive staff to run TTP for 2020-21	HB/LA repurposed staff providing service. External recruitment of workforce	External recruitment of workforce	Full workforce in place across all organisations, with ability to flex to meet changing demands
Agree TTP Plans going forward including prioritisation of relative activities	Testing priorities revised and agreed on multiagency basis, synchronised with expansion plans for testing and tracing.	Implementation of TTP plans, based on priorities set locally and nationally.	Implementation of TTP plans, based on priorities set locally and nationally.
Establish and bed in arrangements for TTP across Region	SOPs and Flowcharts developed & regularly reviewed as TTP embeds and lessons are learnt	Processes amended / established to reflect changing priorities	Processes amended / established to reflect changing priorities
Establish serology programme	Complete antibody testing programme for Education Staff		
	Complete antibody testing programme for HB Staff		
	Roll out serology testing programme in line with WG expectations	Roll out serology testing programme in line with WG expectations	Roll out serology testing programme in line with WG expectations
	Develop workforce plan in line with WG expectations around testing rollout	Plans amended / established to reflect changing priorities	Processes amended / established to reflect changing priorities

4.0 Resetting Public Expectations and the Strategic Direction – A Healthier Wales

Society is starting to emerge from lockdown and this is likely to continue during Q2 and beyond, although the impact of lifting of social distancing measures, opening the economy and widespread implementation of TTP mean that the Health Board will need to continue to be able to adapt and respond to further changes in a flexible and agile manner.

The Health Board has continued to share the message that the NHS is “open for business” with the continued delivery of essential services. However, there is now an

opportunity to start to have further conversations with staff, the wider community and public about resetting expectations about services to be delivered in the future and the balance between the preventative and delivery focus in services, including encouraging self-care approaches. This includes how the Health Board and partners can build on the new ways of working – particularly in terms of recognising that the choices that people make (staff, patients and public) will be the biggest determining factor on what happens, and how the NHS is able to cope in the "new normal".

Many of the changes already made in Q1 reflect the strategic direction which was already being implemented from A Healthier Wales and the Health Board's Organisational Strategy and Clinical Services Plan. In Q2, the Health Board will continue to progress these – particularly the Clinical Services Plan. The opportunities to have further dialogue about resetting elements of expectations, will also help the organisation to be in a better position to address the broader responsibilities of improving health set out in the Organisational Strategy.

Some activities have already commenced, which will be built upon, for example:

- Live virtual "Meet the Executive Team" sessions to enable any member of staff from across the organisation to ask questions and provide views and ideas on how new ways of working can be embedded. It also provides an opportunity for the Executive Team to reinforce the need to change ways of working within the organisation.
- Re-establishment of system wide Clinical Redesign Groups to lead changes to service models, particularly for acute medicine, surgery, outpatients and diagnostic services. The leadership and visibility of front-line clinicians in advocating and driving these changes will enable new agenda and profile for clinically led decision making to be set.
- Engagement with the co-production group of the Regional Partnership Board to secure feedback on working during the start of the pandemic, and how this can be built upon.
- The Health Board worked as part of a group within Neath Port Talbot Public Services Board to develop an online survey to undertake a Community Impact Assessment of Covid on people who live and/or work in Neath Port Talbot. Initial findings have recently been considered and will be used to redefine and reprioritise programmes of work across the PSB and potentially RPB.

Key Actions:

Action	July	August	September
Secure views from staff, and set out expectations of new ways of working/new models of care	Live virtual Meet the Executive Team Staff engagement exercise on key learning from Covid response	Live virtual Meet the Executive Team Staff engagement exercise on key learning from Covid response	Live virtual Meet the Executive Team
Ensure clinicians lead the discussions on system wide new ways of working	Clinical Redesign Groups held, and Clinical Advisory Group used to support change	Clinical Redesign Groups held, and Clinical Advisory Group used to support change	Clinical Redesign Groups held, and Clinical Advisory Group used to support change

Work with wider community groups to build on lessons learnt	Meet the RPB Co-production group to secure feedback and opportunities for future arrangements.		Consider through RPB arrangements
Revised approach to communicating and engaging with the public on service change.		Revised communication and engagement framework agreed with CHC.	

5.0 Essential Services

The Health Board's response to the essential services agenda has been absorbed into the Reset and Recovery (R&R) Programme, which was established in May 2020 and summarised in the Q1 plan. The R&R Programme has adopted a Health Board system wide approach, which is clearly connected to the Covid-19 response structure through the Senior Leadership Team and dual supporting cells. The structure for the R&R Programme is attached in Appendix 3 and is led by the Director of Transformation.

Within Swansea Bay UHB, the approach to the reintroduction of essential services remains clinically led and quality-driven and key features of this approach include:

- Ongoing reporting through to the Performance and Finance and Quality and Safety Committees;
- Weekly touch base meetings of the clinical Executive Directors and Director of Transformation to review and discuss latest guidance and issues and caution needed;
- Appointment of an Associate Medical Director for Non-Covid services;
- Deployment of a Quality Impact Assessment (QIA) process, overseen by clinical Executive Directors and supported by a QIA panel to assess the reinstatement of activity to ensure it is structured, controlled and based on risk management;
- Mandating self-assessments against WG guidance to highlight areas of non-compliance, potential risk and to target action;
- Introduction of a Clinical Advisory Group to advise on local policies and processes that align with all Wales and UK evidence and guidance, through this group theatre SOPs, pre-operative processes, consent process and patient information leaflets have been developed and approved;
- Use of established quality processes such as incident reporting via Datix where delays due to Covid have resulted in harm;
- Updated baseline assessment against Q2 essential services framework;
- Using clinical teams to prioritise patients for treatment; and,
- Development of a Clinical Governance framework, which reflects best practice.

A baseline assessment against the revised essential services document has been undertaken and is attached in Appendix 4, This self-assessment demonstrates that there are no "essential services" that are offering no level of service (i.e. status 4). The main themes from the self-assessment are:

- Ability to create sufficient capacity to deal with demand in system taking account of workforce abstractions, IPC requirements, social distancing requirements and PPE;
- Ability to protect essential services through any future spikes;
- Interdependencies of service and capacity plans

In addition, and in line with local processes, self-assessments have been undertaken (or are in the process of being carried out) against WG issued guidance. These self-assessments are reviewed and signed off through the Reset and Recovery Coordination group. Most recently the self-assessments against the neonatal, maternity and access to medicines guidelines have demonstrated strong compliance with the guidance for the provision of essential services. Self-assessments are currently underway against the following guidance:

- Hip fracture
- Stroke
- A Framework for the Recovery of Cancer services
- Maintaining Cardiovascular treatment and cardiac services

These self-assessments will serve to identify any risks and issues with compliance with these more detailed guidelines and if so, the mitigating actions required.

This plan therefore focuses on areas where further work is required and does not repeat the status updates provided in Q1 plan. Based on the baseline assessment and self-assessments to date, priority areas of focus in Q2 are:

- Unscheduled Care and Winter Planning
- Surgical services
- Critical Care
- Diagnostic services
- Cancer Services

These are the essential service areas where capacity and demand are most significantly affected as a result of reducing activity in order to prepare for Covid in line with Welsh Government guidance. In addition to these priorities, a number of other key workstreams are taking forward the essential and routine services agenda:

- Primary and Community Care
- Mental Health and LD
- Children's services
- Outpatients Transformation
- Rehabilitation
- Field Hospitals.

In line with the Quarter 2 Operating Framework this plan outlines the Health Board's Operational Planning at a point in time and work is ongoing in many of the following areas to improve service provision whilst balancing risk and maintaining a cautious approach.

5.1 Unscheduled Care and Winter Planning

Whilst unscheduled care pressures have remained relatively low during Quarter 1 the charts below show that Emergency Department attendances and emergency medical

admissions are gradually returning to the pre-Covid levels. However the performance against the national USC indicators is significantly better than last year and it is anticipated that, based on our Planning Assumptions during Quarter 2 this will remain steady. It is also anticipated that attendances and admissions will continue to increase and therefore the Health Board's priority is to prepare for that demand leading up to winter 2020.

Number of A&E attendances													
Month	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20 (1st-29th)
Total	10,344	11,686	10,787	10,918	10,833	10,182	9,806	9,968	9,137	7,442	5,280	7,761	8,268

% patients seen within 4 hours in Emergency Department													
Month	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20 (1st-29th)
Total	75.0%	74.5%	74.3%	71.4%	71.0%	73.2%	70.9%	71.6%	74.1%	72.8%	78.4%	83.5%	83.0%

Number of patients waiting over 12 hours in Emergency Department													
Month	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20 (1st-29th)
Total	644	642	740	939	889	926	1,017	1,038	783	557	130	97	63

Number of emergency admissions													
Month	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20 (1st-29th)
Total	4,325	4,470	4,265	4,290	4,670	4,508	4,515	4,333	3,917	3,256	2,072	2,821	3,031

The Health Board's approach is to ensure measures are in place to optimise patient flow across the health and social care system by reducing unnecessary delays. The internal winter plan will take account of lessons learnt from previous winters and incorporate elements of the Health Board's Clinical Service Strategy, including the development of a new acute medical model, particularly where there is an opportunity to accelerate the change.

The lessons learned through the period of Covid-19 will also be incorporated into the plan:

- the benefits of using 'virtual consultant' for the management of primary care demand will continue to be built upon
- the transfer of the minor injuries service to Neath Port Talbot has made a positive impact on managing the demand in the Emergency Department at Morriston and therefore will be maintained during Q2
- processes which added potential delay to the transfer of patients from Morriston to the other sites have been removed and an internal transfer policy is in progress. This flow model will be maintained and will be a key function of the central management of patient flow
- the new ways of working with the Local Authorities including virtual meetings with patients and "discharge to recover and assess" will be maintained and will be key to the implementation of the Rapid Discharge Policy from 1st July.
- there will be continued focus on the number of medically fit for discharge patients which have been reduced from approximately 300 to less than 100 across the Health Board. Whilst the Rapid Discharge Policy will be a key enabler the need for focus on each of the sites from a senior member of the Unit will also be retained.

In addition to the key actions listed below the Health Board will also identify in Quarter 2 the options for surge capacity for times of highest escalation. Whilst this will be primarily focused on developing capacity on the current hospital sites consideration will also be taken to the role that the existing Field Hospitals both within in the Health Board and where appropriate and cost effective with neighbouring health boards. In addition, a revised health system escalation policy will be launched pre-Winter.

The Health Board has undertaken an initial assessment against the six goals for urgent and emergency care published by Welsh Government June 2020. The six goals span the health and social care system and are focussed on the following themes:

- **Co-ordination, planning and support for high risk groups**, aimed at primary care, in particular support for shielding patients, implementation of the flu vaccination programme and management of care home residents. An initial assessment is that there are systems and processes in place to ensure that these key priorities are achieved.
- **Signposting, information and assistance for all** – promote the use of a 'phone first' model to manage Emergency Department demand and the use of referral pathways from '111' and urgent primary care services; the focus being on respiratory and mental health pathways for Q2. There is the opportunity to build on the enhanced telephone triage services that the Health Board have employed including the use of the AGPU GP to triage ambulance calls and to undertake a review of the waiting ambulance stack. In addition, there is opportunity to explore expanding the remit of '111' and revising the referral pathways in view of recent changes in minor injuries service provision and the pending changes to the acute medicine model with improved ambulatory care services.
- **Preventing admission of high-risk groups** – describes the use of technology to provide virtual consultation to care home residents and reduce ambulance conveyance. The Health Board undertook a previous pilot based on this model, managed by primary care, re-establishing this model or the role of the

paramedic in the service will be considered. The use of community services for respiratory patients and promote home with support from front door services is consistent with the local 'keep me at home' rapid discharge pathway.

- **Rapid response in crisis** - refers to direct admission pathways for specific patient groups, #NOF, stroke, STEMI, palliative care and respiratory. The assessment is that the pathways for STEMI and stroke are well established in the Health Board however, further work is required to establish the rapid access pathways for the other patient groups.
- **Great hospital care** – promotes ambulatory care models and same day emergency care, the measure being 30% of the acute medical intake being discharged via these pathways. Phase 1 of the acute medical service redesign work programme will serve to support this action. There is also a requirement to ensure access to rehabilitation and re-ablement services, for those patients that can receive their rehabilitation at home, again the rapid discharge pathway and the rehabilitation framework will deliver against this. However, there is a need to review the capacity to support the small numbers of patients requiring in-patient rehabilitation. The focus on maintaining reduced medically fit numbers is also a key aim of the Health Board's rapid discharge policy and the internal transfer policy.
- **Home first when ready** – dovetails with the actions described above, the focus being on use of voluntary sector support, discharge to recover and assess models and the rapid discharge policy. The Health Board will review the need to extend the triage hub function during the winter to fully cover weekend periods, this mirrors the surge model advocated in the rapid discharge policy.

The response to the pandemic has given the Health Board the opportunity to energise the work on the Acute Medical Model and this is proceeding at pace. Notably a single vision for acute medicine has been agreed across the Swansea catchment as shown below based on the following principles:

- Quality of the first 48h of acute medical care determines outcome
- Acute medicine needs to be an actively managed process
- Getting it right first time
- The right person in the right clinical setting
- Senior leadership 12h /day 7 day per week
- Equality of access
- Patient safety

It is planned that the detailed clinical model will be worked up over the summer. In order to ensure that some benefits are in place for the winter, whilst meeting the engagement and consultation requirements (for both staff and public) a phased implementation has been agreed as follows:

Phase 1 - Establish prehospital triage pathways and Ambulatory Emergency Care services for Singleton and Neath Port Talbot hospitals for autumn/winter 2020/21 and make preparations for the Acute Medical Unit at Morriston by end March 2020/21.

Phase 2 - Centralise the acute medical take for Swansea – Quarter 1 2021/22.

In addition, the Board has successfully deployed Health Care Systems Engineering (HCSE) as a methodology with evidence of benefits in a number of service areas. As part of the reset and recovery programme, our internal HCSE capacity is being used to support modelling and flow to support the delivery of essential services. Our

planned work on unscheduled care and patient flow was initially suspended due to the outbreak but this has now re-started and will run through Quarters 2 and 3 in preparation for winter. The initial focus of the programme is on the Emergency Department Ambulatory stream which accounts for circa 70% of flow.

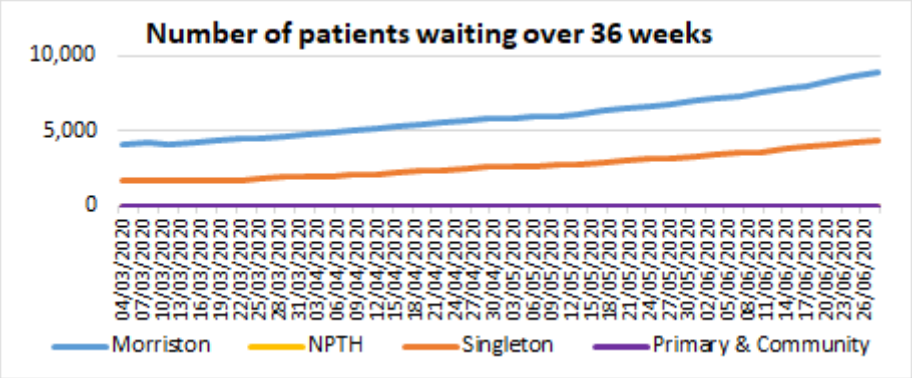
Performance levels for unscheduled care are expected to be maintained during Q2, and Phase 1 of the changes to the Acute Medical Model will provide greater resilience during Q3. More detail on the impact of the improvement in Ambulatory Emergency Care will be provided in the Quarter 3 plan.

Key Actions:

Action	July	August	September
Implementation of Rapid Discharge Process to improve flow and maintain lower numbers of medically fit for discharge (MMFD) patient numbers across all the hospital sites (see section 6.0)	Launch of the Rapid Discharge Policy on July 1st develop in conjunction with local authority partners and agreed by the West Glamorgan Partnership Board	Monitor the initial implementation and review effectiveness	Monitor and review effectiveness
Mobile unit to allowing cohorting of patients at entrance of Morriston ED to release ambulance crews	Site visit with Estates Department for company supplying Unit to establish location and connection to services	Delivery of mobile unit on Morriston site and work with WAST to agree staffing model	Implement cohorting at Morriston in mobile unit, monitor and review effectiveness ahead of winter
Central management of patient flow across the health board to maintain effective patient movement across all sites	Present and secure agreement with Executive Team for the establishment of a centralised patient flow team for Health Board	Commence Organisation Change Process to facilitate development of centralised patient flow team	Establish centralised patients flow team
Phased implementation of the Acute Medical Services Redesign	Development of implementation plan Agreement of priority pre-hospital pathways as part of AEC model	Secure agreement (including clinical “buy in”) for plan Commence implementation of priority pre-hospital pathways Establish AEC model in Singleton	Commence implementation of phased plan
National Unscheduled Care Programme - six goals for urgent and emergency care which will help winter preparedness.	Develop an agreed action plan to address the 17 proposed key deliverables in conjunction with GP clusters and other key stakeholders	Implement and monitor and action plan	Implement and monitor and action plan

5.2 Surgery

Due to the response to the outbreak the number of patients waiting over 36 weeks for treatment has increased as shown below. The Health Board is managing surgical services based on the Essential Service guidance.



All surgical procedures are currently being graded using the Royal College of Surgeons guidance, published on 10th June 2020. It states that patients requiring surgery during the Covid-19 crisis are classified in the following groups:

- Priority level 1a Emergency - operation needed within 24 hours
- Priority level 1b Urgent - operation needed with 72 hours
- Priority level 2 Surgery that can be deferred for up to 4 weeks
- Priority level 3 Surgery that can be delayed for up to 3 months

Capacity constraints as a result of the impact of Covid-19 are such that only levels 1-2 procedures are prioritised at the current time. As such, consolidating capacity for all emergency and level 2 planned surgery is a key priority for the continued recovery of essential services through Q2. Whilst emergency surgery has continued for the Level 1a and 1b cases throughout the pandemic, the focus in the latter part of Q1 has been the recovery of theatre capacity to deliver essential services alongside the impact and constraints on facilities and staffing as a result of the Covid-19 response.

The current zoning of theatres into a Red/Amber/Green system was developed at pace during the height of the pandemic in March. The key driver for which was for infection control and prevention and includes:

- Prevention of infection of staff, from patients – the zoning of theatres helped facilitate clarity for staff on the level of PPE required in the different areas.
- Prevention of cross infection of patients - isolating the patient's pathway through the theatre pathway.

The Health Board acknowledges that in reducing the risk of cross infection of patients within theatres, there is the need to balance this risk with the reduction in flow and productivity and the need for more staff to support the current Theatre SOP, which means that harm is also being introduced to other patients who are experiencing significant delay in accessing time sensitive, priority surgery or treatment, because of limited theatre capacity.

An increasing body of knowledge, information and evidence at a local, national and international level now allows the health board to review the current arrangements in the context of this new information in an ever-changing clinical arena. The key principle which has underpinned the proposed changes to zoning is the need to protect and maintain the safety of Health Board staff and to reduce risk for patients on an individual as well as total patient population basis on hospital sites.

Following a review of evidence an updated list of Aerosol Generating Procedures (AGP) has been issued by NERVTAG / Health Protection Scotland. It is proposed to utilise this list (left hand side column in the table below) to underpin revised arrangements. There continues to be some procedures included as AGP, where it's accepted that the evidence is weak. NB: The list of AGPs produced and published by NERVTAG / Health Protection Scotland is a live document that is constantly updated. It can be accessed here-

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe

Evidence of AGP	**No evidence of AGP**
Respiratory • Intubation, extubation and related procedures, e.g. mask ventilation and open suctioning of any part of the respiratory tract. • Tracheostomy-related procedures: insertion, open suctioning or removal. • Non-invasive ventilation (NIV) including CPAP. • High-flow nasal oxygen (HFNO)*. • Bronchoscopy • ENT airway procedures that involve suctioning. • Upper gastro-intestinal endoscopy involving open suctioning of the upper respiratory tract. • Some dental procedures, e.g. high-speed drilling. • Induction of sputum*. *Surgical* • Surgery involving high-speed devices*.	*Respiratory* • Supraglottic airway insertion**. • Nasogastric tube insertion. • Chest drains. • Sedation with inhalational agents. • Heavy exhalation during labour. *Other* • Diathermy. • Irrigation during surgery. • Use of a manual saw during surgery. • Pulsed lavage. • Abdominal suctioning. • Amputation with open arterial surgery. • Bone drilling (there is weak evidence for high-speed cutting). • Dental procedures not involving high-speed devices.

A new standard operating procedure has been developed and was implemented from Monday 29th June 2020. This maintains the stance that any room where an AGP is performed is deemed a red zone until the room has received five air changes (ACT5). The Health Board has reviewed all theatres to calculate the ACT5 which range between 8 – 17 minutes. Following the time lapse the theatre environment, including anaesthetic room will be considered an amber zone. In addition, cohorting of patient recovery across both screened and unscreened adult pathways with a separate bay for paediatrics will be introduced. These will be classed as amber zone areas unless an AGP is performed. In that case the area becomes a red zone for 17 minutes (ACT5 for Recovery).

It is envisaged that these changes, as well as facilitating a more efficient patient pathway through theatres, will reduce the number of staff required to support each theatre by at least 1 member of staff. The efficiencies gained will enable the Health Board to consolidate and support the Q2 priorities to maintain a third trauma list designated for Plastic Surgery and a dedicated Cardiothoracic list to deal with the growing emergency and urgent demand. It will also close the gap that has emerged at the loss of Sancta Maria capacity. Unfortunately, agreement reached in Q1 that saw Sancta Maria theatre staff utilised at Singleton Hospital are not transferring into Q2 at

the ceasing of the All Wales agreement with Private Healthcare Providers. Options are being explored around potential capacity at Werndale BMI Hospital.

The Health Board has a prioritised waiting list of Level 2 patients requiring surgery within 4 weeks. An analysis of the Priority 2 list can be found in Appendix 5. At present there are around 70 additions (exc. Ophthalmology) to the list each week against a capacity of 45, this will increase to a capacity of 55 when the second elective list at Singleton comes online at the end of June/beginning of July. The list is therefore growing by around 15 cases per week based on current demand. The theatre complement split by emergency and elective is set out in the table below and the associated capacity plan can be found in Appendix 6.

Hospital Site	Theatre Designation	Sessions/Hours	Days per Week
Morriston	CEPOD 1	24 hrs	7
	CEPOD 2	2 sessions	5
	Cardiac	24 hrs	7
	Trauma 1	13 hrs	7
	Trauma 2	2 sessions	5
	Elective 1	2 sessions	5
	Elective 2	2 sessions	5
Singleton	Obstetrics	24 hrs	7
	CEPOD	2 sessions	5
	Elective 1	2 sessions	5
	Elective 2	2 sessions	5

As part of Covid recovery a specific work stream focussing on orthopaedic and spinal services has been established, looking at the immediate and long-term strategic capacity issues and the potential for developing NPTH as a cold elective centre for Musculoskeletal services. Currently NPTH also provides theatre facilities for Cwm Taf Morgannwg residents as part of the Boundary change processes. The implications of this will have to be considered as part of any changes to provision across Swansea Bay and discussions are therefore ongoing.

Key Actions:

Action	July	August	September
Patient Prioritisation and Management	Prioritisation of Levels 3 & 4 to be completed	HB wide approach for the systematic review and documentation of potential harm to patients as a result of treatment delayed beyond their expected timeframe	
Theatre Capacity and Utilisation	Second elective list at Singleton to come online utilising staff released as a result of the revised Theatre SOP.	Develop monitoring tool for theatre utilisation, specialty activity and patient outcomes with support from IM&T around TOMS data	Development of a whole system model for NPTH as a centre for Orthopaedic and Spinal services, to include the scoping of ambulant trauma options and capital requirements
	Sustain Plastic surgery trauma and Cardiothoracic list(s)	Ongoing development of 'live vitals' dashboard to quantify	

		and monitor level 2 & 3 demand	
	Principles agreed and signed off for re-zoning of theatres to gain efficiency in turnaround times and release of supplementary support staff	Commence recruitment process for PACU development at Morriston (Phase 1)	Scope and undertake an option appraisal process for a PACU model at Singleton and NPTH to support enhanced care complexity
Regional / Partnership Working	Seek regional agreement in principle around the equitable distribution of patients across the geographical boundaries. Progress with agreed priority areas of urology and gynae oncology and spinal. Testing regional solutions for thyroid and vascular services	Agree a framework for the utilisation of staff / capacity within the independent sector, including potential for regional solutions	Agree a model for the emergency surgical requirement for the HB to encompass emergency services provided regionally

The South Wales Trauma Network (SWTN)

There has been a delay to the go-live date of the SWTN due to the Covid-19 pandemic. The Operating Delivery Network however is in place with core staff recruited. Work has been ongoing during the pandemic to ensure that the SWTN remains as close to a state of readiness as possible and an updated state of readiness report was submitted to the Implementation Board on June 15th. A surge plan has also been developed to support the network should a further pandemic peak occur. A further Implementation Board is planned for July 1st where a decision regarding a go-live date will be made. Due to the risks of not going live and the mitigation put in place to manage further peaks in demand the aim is likely to be September 2020. Welsh Government has confirmed that major trauma is an essential service in Wales and therefore needs to be maintained now as well as when the formal network is in place.

Key Actions:

Action	July	August	September
Agree Go Live date for MTN and implement	Work with the MTC, TUs and pre-hospital providers to ensure all critical to go live issues are resolved or mitigated against. This includes ensuring benefit from investment agreed by the HB (i.e. IMTP agreements - major trauma practitioners, rehab coordinators, rehab medicine consultant sessions and TARN coordinators)	Develop online e-learning platform to support education and training going forward	Develop and instigate a comprehensive communication plan
			Develop formal network governance structure including M&M meetings across network. This incorporates ensuring data quality through the TARN database
			Go Live as a Major Trauma Network

5.3 Critical Care

In response to the Covid pandemic, the Health Board put capacity in place for 112 functioning critical care beds within Morriston Hospital, clearly designated and segregated from the Covid-lite Cardiac ITU being utilised for the screened pathway patients in line with the Red/Amber/Green zoning. This is working well and will continue as the plan through Q2.

The section above on modelling confirmed the planning assumptions that critical care Covid demand for Q2 is likely to be lower than experienced in Q1. It is therefore anticipated that the current level of critical care beds will be able to accommodate demand in Q2 without the requirement to surge into additional critical care areas within the Morriston hospital. The focus of work for critical care in Q2 therefore is to continue to improve the operational working of the Covid–lite and Covid streams and attempt to safeguard Covid-lite/green ITU capacity from any future surges.

Key Actions:

Action	July	August	September
Critical Care	Finalise the revised 2nd wave surge bed plan in line with new capacity options		
	Review the critical care workforce plan for 2nd wave, assuming a % of additional staff would not return to support critical care in 2nd wave and continue with development programme for additional support staff (this will be ongoing during August and September)	Ongoing	Ongoing
	Map out timeline and risks of capital works in General ITU ahead of potential 2nd Wave		

5.4 Diagnostics

Increasing capacity in diagnostic procedures is a priority of the Reset and Recovery Programme. Whilst diagnostic procedures for emergency cases have continued to be delivered throughout the pandemic, the focus is to increase capacity in the priority areas of endoscopy, radiology and cardiology diagnostics. Pathology services have continued to be delivered through the pandemic and planning is predominantly happening in the testing cell and TTP work programme.

Endoscopy Recovery Plan

Activity levels are continuing to increase as staff from redeployed areas return to endoscopy and consultants are released to undertake their usual roles. However, as a consequence of the PPE, increased infection control and cleaning procedures the number of patients on endoscopy lists has reduced, therefore capacity is constrained.

To support the increased activity as more sessions are implemented, an Endoscopy Covid Standard Operating Procedure has been developed, setting out the pre-assessment and Covid screening process.

Activity has continued to increase through the later part of Quarter 1, with a planned step change to 33 sessions in the first month of Quarter 2, with subsequent increases throughout the remaining months of the quarter.

The key actions are detailed in section 5.3 Cancer Services

Radiology
Prior to the pandemic, radiology capacity and demand were relatively well balanced and the Health Board typically achieved the 8-week standard. However, due to the outbreak a waiting list has developed. The plan is to match demand and capacity during the initial part of Q2 to limit the increase in the waiting list size, with the second phase focusing on waiting list size reduction. Over 90% of the current waiting list is for routine diagnostic procedures in all three of the modalities.

Modality	USC	Urgent	Routine	Total Waiting
CT	94	124	2300 (91%)	**2518**
Non Obs - US	25	95	3507 (96%)	**3627**
MRI	15	54	2629 (97%)	**2698**

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Key Actions:

Action	July	August	September
Extend the working day across all three acute sites	Morriston 8-7:30 pm Singleton 8-8pm Neath Port Talbot 9-5pm	Assess options for weekend working	
Continue discussions with ILS for additional capacity 2 days / wk = 32 pts	Develop service specification for screened non Covid 19 cases and establish cost implications	Implementation if viable solution	
Use mobile CT	Develop business case	Implementation if viable solution	
Deploy agency staff for additional capacity	Review potential CT gantry capacity using Bay hospital to provide non-Covid pathway	Implementation if viable solution	

MRI

Key Actions:

Action	July	August	September
Utilise mobile MRI van	Complete QIA and business case to establish financial impact and risks associated with increased routine activity	Implement if viable	

Further develop MRI plan to reduce waiting list	Ongoing assessments to be completed with additional alternative solutions		
Review rotas to increase capacity	Complete review of rota's & implement additional capacity	Ongoing implementation	
Workforce review for MR services	Complete workforce review & develop business case	Implementation if viable	
Continue discussions with ILS for additional capacity	Develop service specification for screened non Covid 19 cases and establish cost implications	Implementation if viable solution	

Ultrasound

Key Actions:

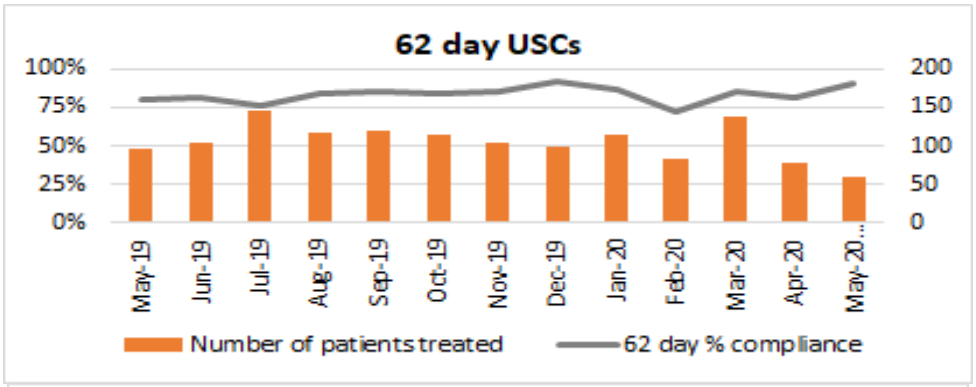
Action	July	August	September
Assess opportunity to utilise vascular lab to increased capacity	Complete assessment – potential 2 days / week – increasing capacity by 20 pts per week	Implementation if viable solution	
Assess radiologist support for scanning	Complete assessment– increasing capacity by 20 pts per week	Implementation if viable solution	
Deploy Head & Neck locum increasing capacity	Implement – adding 5 further pts per week	Maintain capacity	Maintain capacity
Review opportunities to extend the working day plus 7 day working	Complete review and commence implementation if viable	Further implementation if viable	Embed changes
Further develop Ultrasound plan to reduce waiting list	Ongoing assessments to be completed with additional alternative solutions		

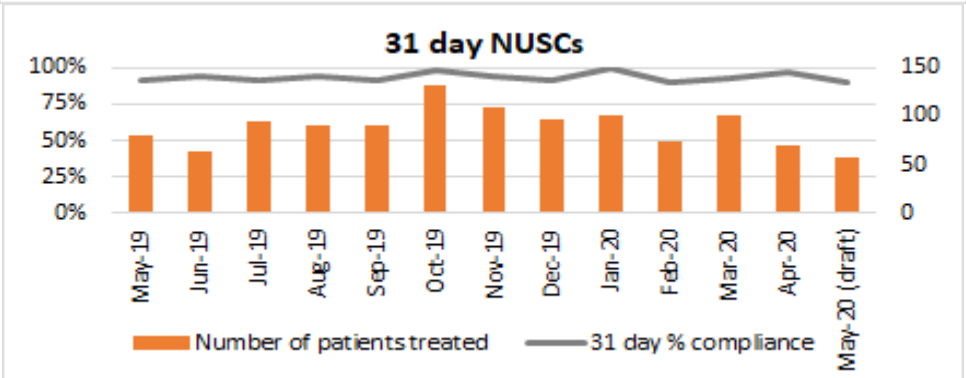
5.5 Cancer Services

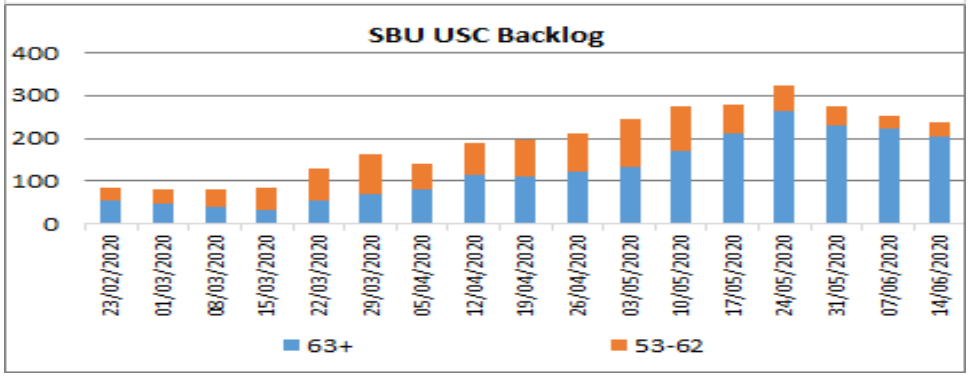
On June 17th the NHS Wales Health Collaborative issued 'A Framework for the Reinstatement of Cancer Services in Wales during Covid-19'. The framework recognises that whilst it is very clear that there may well be further Covid-19 surges, the harm to patients with cancer as a result of delayed presentation and reduced access to diagnostic tests and treatment must be minimised.

As a Health Board, a progressively cautious approach has deliberately been taken to bringing further services back into operation to ensure that patient and staff safety is the top priority. Theatre capacity at both Morriston and Singleton hospitals has been reintroduced and there is now surgical activity for all tumour sites. Teams are working together to produce a prioritised list of cancer patients to ensure optimal use of theatre capacity. These plans resulted in greater post-operative ITU capacity for cancer patients at the end of May.

As shown below the increase in theatre capacity has improved the performance for USC and non-USC cancer patients and the cancer backlog is starting to reduce. Based on our Planning Assumptions, this improvement is expected to be sustained in Q2.







A number of actions have been planned and implemented within SBUHB to re-commence endoscopy services as a matter of priority; these actions are also aligned to the SBUHB guidance and protocols regarding Covid risk management and infection control.

For Oncology Services a risk versus benefit assessment of all systemic therapy was undertaken in line with National guidance at the start of the pandemic. Steps to reduce the risks of admission such as less emetogenic regimens and the addition of Granulocyte Colony Stimulating Factors were introduced and all patients were considered, and consented for, treatment in light of the potential Covid risks. Some treatments have also been deferred when deemed safe to do so which led to a small reduction in number of patients undergoing treatment.

Radiotherapy treatment has proceeded as normal, but changes were made in light of the emerging evidence to reduce the number of treatments as far as possible. Evidence is emerging that the risk is likely to be less significant than initially feared and so the oncology department are increasing the patient numbers receiving treatments and are catching up with the backlog.

There is clear guidance and processes in place for these vulnerable patients attending hospital for their SACT and radiotherapy treatments.

Virtual clinics and phone consultations have replaced face to face consultations when possible and pathways for remote consent have been developed for radiotherapy and chemotherapy.

Key Actions:

Action	July	August	September
Phased and sustainable solution for the required uplift in endoscopy capacity that will be key to supporting both the Urgent Suspected Cancer backlog and future cancer diagnostic demand on Endoscopy Services.	Restoration of endoscopy rooms and redeployment of specialist staff to their endoscopy units. Plan for 33 Endoscopy sessions during July onwards to include Upper/ Lower GI, EBUS, Bronchoscopy and Thoracoscopy sessions. Weekly Clinical Leads Recovery planning meetings to provide leadership and assurance in terms or delivery. Clear decision making and tracking of USC deferred and new referrals to continue. Maintain use of the National Endoscopy Programme (NEP) for deferred patient tracking. Continue planned implementation of FIT in USC groups of deferred patients. Capacity and Demand costed plan for 2020/21 to be approved and recruitment into eight additional Endoscopy	Plan for additional 6 Endoscopy sessions from August onwards for Upper and Lower GI sessions. Advance discussions re: logistics for implementing FIT in low risk groups (as per NICE DG30 guidance) and Business Case developed. Recruitment into additional Endoscopy Nurses as outlined in C+D Plan. Commence insourcing sessions as outlined in C+D plan Maintain training lists for additional Endoscopists. Continued prioritisation of new referrals and review of alternative diagnostics as appropriate Re-start Bowel screening colonoscopy for all new participants waiting following a positive screening FIT test	Plan for further 4 additional Endoscopy sessions with appointment of new gastroenterologist. Implement FIT in low risk groups as per Business case triaged within primary care. Undertake analysis of lessons learnt and new ways of working in line with NEP.

	sessions agreed and enacted.		
To explore the possibility of offering SBAR RT for high risk lung cancer patients in SWWCC	To undertake an assessment within RT Dept and Oncology to scope out the ability to be able to delivery SBAR RT for high risk lung patient. Work with VCC and WHSSC around the role out and availability of SBAR RT within SWWCC	Business case detailing the risks and benefits of delivery SBAR RT for high risk Lung Cancer patients in SWWCC	
Establishment of mobile unit to carry out PET/CT scans for Swansea and South West Wales patients.	First PET/CT scanning day: 2nd July 2020. Commence mobile PET/CT diagnostic service on Thursdays and Fridays; 12 patients per day.		
Introduce Covid testing for Oncology and Haematology patients and staff involved in service delivery in line with national guidelines.	Continue work stream to roll out testing in order of clinical priority until the total of @250/300 patients is met. Staff would be in addition to this number.	Maintain testing in line with any change in national guidance.	Maintain testing in line with any change in national guidance.
Continue to expand Surgery capacity to allow complex cancer surgeries to deal with any backlog of patients	Weekly Theatre capacity workstream reviewing demand and capacity in order to increase theatre capacity across all site but particularly Morriston. Reviewed theatres staffing establishment per Covid process to allow release of theatre teams to deliver additional theatre sessions	Incremental increase of theatre sessions to address priority 2 elective surgery demand	Incremental increase of theatre sessions to address priority 2 elective surgery demand
Convert interim PACU arrangements at Morriston to sustainable solution	WG funding already agreed PACU workstream established to agree actions required to deliver this development. Agree location	Recruitment of staff, formulation of SOP's, agree date for delivery depending on staff appointments	Aim to move to sustainable location late September at latest.

5.6 Primary Care

The Covid-19 pandemic has required primary care to respond rapidly in order to minimise the spread of infection and allow services to cope during a surge of cases.

This has resulted in transformation and the service models across primary care look very different now compared to four months ago.

Throughout Wales, change has occurred in primary care at pace and through the application of both workforce and digital enablers. Swansea Bay University Health Board provided primary care services and contractor services have put in place measures to support business continuity, leading to new service models being implemented swiftly. Some examples of transformative changes implemented in Q1 include:

- Separation of Covid and non-Covid patient flows, e.g. establishment of Primary Care Assessment Hubs based around existing cluster areas, these provided Support practices and clusters to provide robust assessment, review and management of patients who are self-isolated and require medical attention that cannot be managed over the telephone by their own GP practice.
- Establishment of hubs for urgent and emergency care, i.e. Urgent Care Dental Centre established in Port Talbot Resource Centre for an urgent dental problem that cannot be delayed but requires an Aerosol Generated Procedures (AGP) or is Covid positive.

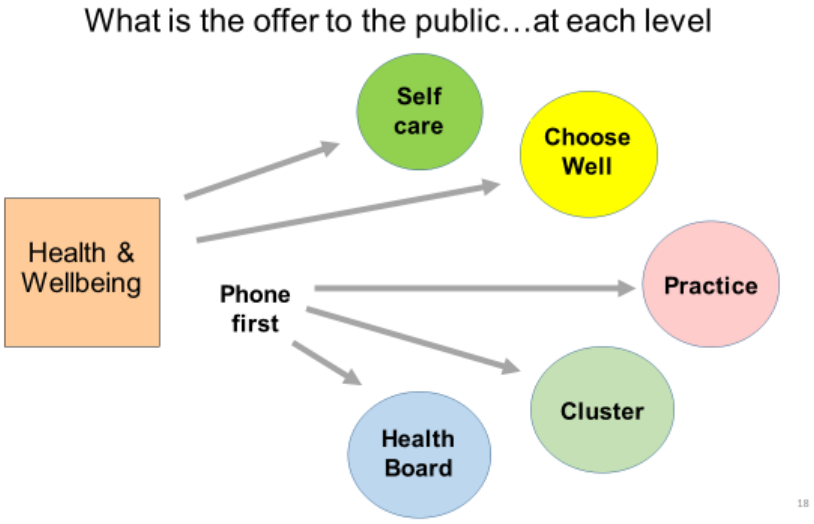
These have adhered to social distancing and infection control (PPE) requirements through both physical measures but, significantly, rapid roll-out of remote consultation working, supported by digital and telephony infrastructure.

The National Strategic Programme for Primary Care lead has also been working closely with the Chief Allied Health Professional Advisor as the lead for rehabilitation. It is expected that there will be significant increase in rehabilitation requirements with coordinated support from across health and social care services required, and the Health Board is committed to implementing changes to services within primary care in order to facilitate the increased demand for rehabilitation.

Swansea Bay UHB has been adopting the principles as set out in *A Healthier Wales* of care closer to home across the whole health system (and with partners) and will now use the experience gained throughout the pandemic to accelerate progress in this area. The following factors influence the context for delivery of primary care services:

- Public and workforce may be cautious about accessing healthcare because of Covid-19
- Infection control procedures necessitate a change in access arrangements
- Suitability of premises to adapt to social distancing requirements
- Increase in digital access for consultation is both an opportunity and a threat (noting digital inequities in access and literacy)
- Lack of availability of relevant interdependent services (where services have temporarily ceased, or service pressure has led to reduced service capacity)
- Diversion of community staff to support field hospitals, community testing and contact tracing
- Adequate supply of, and agreement for, appropriate PPE for specific settings
- Workforce capacity due to clinical and non-clinical staff needing to self-isolate or shield, noting impact of test, trace and protect.

From a Strategic Programme perspective and using the design principles of *A Healthier Wales* to reset the operating model, the work to map out the primary and community care infrastructure is a national priority in Quarter 2. Starting with the principle of care closer to home, it is proposed to set out service delivery at five levels:



In Swansea Bay, one of the key Q2 priorities is to restart the existing programme of Whole System Cluster Transformation, the delivery of which was stepped down in Q1 to focus on providing support from primary care and community services environment to the pandemic. To maximise opportunities in this area to provide seamless care closer to home for the population, in Q2 the Health Board will embark on a programme of refreshing the Transformation Plan in order to support learning, remodelling or transformation of services for the future, in addition to recognising the additional challenge of working with Covid and ensuring that the safety of staff, patients and carers are of utmost importance. The Health Board will ensure that the excellent work already undertaken is recognised and will continue to strengthen the Health Board approach to engagement and leadership of the Cluster transformation leads. Key priority areas for embedding into the programme have already been identified, including:

- Initial start-up of cluster based virtual wards
- Remodelling of community phlebotomy services
- Further promotion of digital platforms including addressing the needs of those who may need support to access digital platforms.

The recovery and restart of primary care contractor services and Swansea Bay Health Board primary care & community services also remains a priority for Q2. Phased plans for reactivation of services will be implemented in Q2 and have been informed by a number of key factors, including:

- National Direction/Policy/Operating Guidance (health and non-health) in particular national direction on primary care contracts and Royal College guidance.
- The decisions on the re-activation of services across the Health Board e.g. outpatients and elective surgery that will impact on primary and community services, as directed by the Health Board Reset & Recovery Group
- The impact assessments undertaken on each service identifying the risk of continued operation on a business critical basis.

- The need to address Covid, deliver essential services and cautiously reintroduce services that are assessed as a priority for re-activation.
- Social distancing requirements
- Use of new technology /availability of digital platforms eg web-text consultation and video consultation, and suitable location/ facilities
- Workforce capacity to undertake Covid and non-Covid services.
- Patient and partnership expectations
- Learning and retaining pathway change that is beneficial
- Systematic triage before further assessment as the norm
- availability, sharing and integration of operational data
- Communication to the public about new models, access and self-care.
- Enhancing Cluster collaboration and innovation to strengthen and further embed integration between contracted services and between these services and the wider health and care system, including the third sector.

General Medical Services (GMS) Recovery

Q2 plans for GMS recovery encompass the phased approach to recovery set out by national guidance, this will include in discussion with the Local Medical Committee monitoring levels of additional service provision, supporting the re-activation of the cervical screening programme, and a phased re-introduction of the wide range of Enhanced Services planned from 1st July 2020. The Health Board will encourage a focus on the most vulnerable people in the populations. This includes the implementation of the revised Care Homes Directed Enhanced Service, which will be rolled out to general medical practices who have elected to adopt this, from 1st July 2020.

Planning for flu vaccination campaign over the autumn and winter period will be a key priority for both General Medical Practice and Community Pharmacy.

Out of Hours/ Urgent Primary Care will continue to be based out of the relocated site, the Beacons Centre, throughout the Q2 period. The priority for these services will be continuing and increasing the provision of remote access for patient assessment, in line with patient feedback that this is the right thing to do to enable improved accessibility to services for people in times of urgent need.

There is a continued focus on building on opportunities relating to the use of digital platforms to support telephone or video consultation as the default position, for example, in Q2 the roll out of Ask My GP (currently uptake is at 53%) will be extended across the cluster footprint and continue to encourage general medical practices to take up Consultant Connect.

Dental Recovery

Following the announcement made by the Minister for Health and Social Services to lift the Red alert in dentistry in Wales and move to the Amber phase of de-escalation, and in line with national guidance issued by the CDO, in Q2 the Health Board will support dental contractors to open General Dental practices where they feel ready to do so, in order to provide more care and treatment for patients. In this phase, dental practices will be able to enhance delivery of dental care services, prioritising so that those patients who need care more urgently are seen first, address definitive care and offering routine procedures to patients who need essential dental care. This phased

process will be supported throughout Q2 by offering dental practices the opportunity to become designated Health Board Urgent Care Dental Centres (UCDC) for AGP dental procedures. This model will build on the existing UCDC in Port Talbot Resource Centre established during Covid which it is intended will continue to operate as a Hub with agreed dental practices acting as UCDC Spokes.

In addition, dental services will be supported to establish effective infection control and safe practice; including social distancing, spacing of appointments to facilitate empty waiting areas and use of PPE to prevent future spread of virus; linking with wider work on virus transmission, through the development of IPC issuing a comprehensive checklist for contactors, including GMS, Dental, Optometry and Community Pharmacy services, for their local implementation.

Reactivation of Health Board provided dental services, including the Restorative Dental and Community Dental Service, is included within the phased reset and recovery approach for Q2. In terms of secondary care dental services, activity at Parkway Clinic which provides the Paediatric General Anaesthetic pathway will be resumed.

Optometry Recovery

In line with national guidance that Optometry Services move to Amber phase from 1st July 2020, all optometry practices in the Swansea Bay region will be encouraged to open if they are able to safely observe social distancing and infection control protocols. Services to be provided in Q2 include General Ophthalmic services, Eye Health Examination services and Low Vision service (with careful consideration for this vulnerable group of patients).

As Optometrists traditionally spend a considerable amount of time in close contact with patients, in order to deliver urgent and essential eye care many areas of practice have adapted to ensure the face-to-face consultation time with patients is reduced. In Q2 practices will be supported to continue to operate using such different models of care, including:

- Triage of patients to ensure only asymptomatic patients are seen in practice.
- History and symptoms and other relevant clinical areas such as dispensing considerations to be conducted by telephone/video.

Community Pharmacy Recovery

Community Pharmacy has maintained most services through the Covid pandemic. Pharmacies have experienced unprecedented demand and have responded flexibly in putting in social distancing measures and increasing capacity for deliveries as-well as working with volunteers. Most pharmacies have now returned to normal opening hours with the exception of a lunchtime closed hour for well-being purposes. The Health Board will be planning for Quarter 2 in line with the community pharmacy recovery plan and the four strategic objectives. As part of the Health Board pharmacy re-activation plan activity levels for common ailments, emergency contraception and emergency medicine supplies will be monitored. Weekly meetings are held with Community Pharmacy Wales (CPW) to discuss ongoing issues with workforce or sustainability or service delivery issues, there are currently 8 pharmacies at level 3 or 4 and a reduction in this number would be supported

During Q2 work will be undertaken with Community Pharmacies to embed the national escalation tool to enable improved intelligence on services. Opportunities to increase the digital platform 'offer' within community pharmacies to assist in service delivery will be reviewed and there are discussions with pharmacies about the maximisation of texting patients to help with demand management. As stated above the annual flu vaccination programme will also be an area of priority to support population health and wellbeing. In addition, the viability of restarting the 'Sore throat, treat and test service' in line with national guidance on infection, prevention and control will be assessed.

Reset and Recovery of Health Board Primary Care and Community Services

In Q1 the Health Board Reset and Recovery approach to reactivating services was adopted, which includes a key focus on the provision of primary care and community services. The Primary Care and Community Services (PCCS) Recovery work cell has been established to develop plans for the reinstatement of services within scope of work cells, to reflect:

- Risk based approach
- Workforce considerations
- Interdependencies with other workstreams
- Key enablers
- Critical path

To date and continuing into Q2, the PCCS recovery work cell has focused on developing proposals to reactivate priority services in view of national issued guidance as well as reflecting the need to continue many of the significant service changes that have taken place throughout Covid that have demonstrated improved patient experience and that are strategically aligned with the organisational priorities. For example:

- Audiology paediatric hearing services, a priority service for restart as a significant proportion of paediatric audiology cases can only be managed on a face to face basis
- Adult speech & language therapy services delivering Fibreoptic Endoscopic Evaluation of Swallowing (FEES - an instrumental swallowing assessment allows rapid and direct assessment of swallowing in order to: minimise risk of aspiration pneumonia, maintain/commence oral intake safely, guide rehabilitation and support the tracheostomy/ventilation weaning process on ITU)
- Reinstatement of the School Nursing Service which provides a statutory safeguarding role responsible for delivery of the national annual school aged immunisation programmes of; Fluenz vaccine to all primary school pupils, the HPV programme to all year 8 & year 9 pupils and the double immunisation programme of Teen Booster [Diphtheria, Tetanus & Polio] and Meningitis ACWY programme to all year 9 pupils. Delivery of the Fluenz programme has a specific focus by WG & PHW as uptake has been evidenced to decrease the level of circulating flu in communities which is considered to be a high priority going into the winter.

In addition, as part of the re-establishing of essential services, children and young people who are either being considered for a statement of special educational need

or those who already with have a statement of special educational need are being prioritised in order to ensure that the Health Board meets its statutory duties under the Special Educational Needs regulations. The preparations for the implementation of the ALNET Act on the 1st September 2021 requires prioritisation by all services/departments which provide care to children and young people between the ages of 0 to 25, and PCS continues to support the DECLO in progressing plans to meet the requirements of the ALN Act by September 2021.

Preparation for Phase 3 Green moving into Q3

Welsh Government set out a phased approach for the recovery of Primary Care. There has been a change in escalation levels from red to amber and during Q2 detailed planning to plan and prepare for a further de-escalation to phase 3 (Green) will be undertaken.

Moving forward the benefits of remote and digital working will be embedded to ensure that access to primary care services is made more accessible. This will also include learning from the response to the pandemic to energise work to tackle health inequalities in partnership and a reinvigorated approach to public health. This will include targeting the support to vulnerable population groups such as those within Care Homes. Care Home staff and services may require further training and support to continue to provide compassionate and quality care to residents and this will be planning and delivered through the excellent partnership arrangements with the local authorities.

The full range of services within Primary Care Services will also require support to plan and return to providing routine services. This will not be a simple return to previous practises but will be based on the learning that has been gathered throughout the Covid-19 pandemic. Contract reform with contractor services will require attention and support to ensure this is undertaken in genuine partnership, and we will need to plan for the decommissioning of Covid-specific services.

Key Actions:

Action	July	August	September
Support reset and restart of primary care contractor services – GMS, Dental, Optometry and Pharmacy in line with National direction. Of note: - dental and optometry services level of escalation will reduce from red to amber as of 1st July 2020.	Plan and implement (in line with national guidance) to deliver support to patients to ensure optimum service provision for face to face assessment and safety netting. Optometry Practices to commence opening in line with national guidance to include General Ophthalmic services provided. Eye Health Examination services provided. Low Vision service provided (with careful consideration for this vulnerable group of patients)	Review – reactivation and monitor pressure levels Initiate planning for future implementation of digital platforms, e.g. Attend Anywhere in dental practices Pharmacy - Implement national escalation tool and encourage uptake Pharmacy - Prioritise Flu Planning in line with national discussions	Review of independent pharmacy based prescribing programme Pharmacy - Review Sore Throat Test and Treat programme for feasibility of re-activation in conjunction with WG

	Optometry - Acute domiciliary commissioned service to continue. Routine domiciliary service to remain suspended Optometry - All practices to complete the National Wales Shared Services Partnership self-certification process for opening, including the Covid-19 training available through the WOPEC website GDS Dental practices to be supported to offer wider range of services Dental – establish urgent care dental centre hub and spoke model for delivery of AGP procedures Pharmacy - Prioritise Flu Planning in line with national discussions Develop and issue IPC checklists for contactor services implementation		
Phased re-activation of GMS additional and Directed, National and Local enhanced services in line with national guidance by 1st October 2020	Phased 3-month programme -working within national programme of restarting Additional and Enhanced services across contractor services – e.g. cervical screening is a priority for restart Initiate planning for flu vaccination programme delivery in winter Implement Revised Care Home Directed Enhanced Service Extended roll out of Ask My GP Increase usage of Consultant Connect and review uptake Increase access to urgent /out of hours primary care services	Phased 3-month programme -working within national programme of restarting Enhanced services across contractor services. Review uptake of revised Care Home DES	Phased 3-month programme -working within national programme of restarting Enhanced services across contractor services.

Reset and restart of the Cluster Whole System Transformation Programme	Reactivate Cluster meetings on virtual basis Restart Transformation / Primary Care Forum Lessons learnt exercise with cluster leads undertaken and reset of cluster to increase integration and as set out in the new primary care model. Complete stocktake of whole system cluster transformation programme and development of priority re-activation proposals, including promoting digital platforms/ facilitating digital inclusion and review of HB community phlebotomy model.	Implement Whole System Cluster Transformation projects informed by stocktake and development of transformation project proposals	Continue to implement Whole System Cluster Transformation projects aligned to refreshed programme of work
Reset and Recovery of Primary Care and Community Services via the Health Board Reset and Recovery Programme.	Consider the restart of the following services through the Restart and Recovery Group: Restart School Nursing Service to supporting the delivery of childhood imms vaccination (including influenza). Restart Paediatric audiology and urgent hearing aid reviews – clinics to take place on reduced basis using non-acute sites only Reactivation of services subject to approval: Delivery of Cardiac rehab programme on face to face basis supplemented by virtual programme Extend provision of community Wound clinics – reinstatement of more venues MCAS, Podiatry and Orthotics face to face clinics for priority cases Adult SLT services; face to face outpatient clinics and	Restart services in line with Reset and Recovery Group and review service delivery	Restart services in line with Reset and Recovery Group and review service delivery

	dysphagia service, FEES and services Dental Services - Restorative Dentistry/ Community Dental Service and Dental Training Unit – treatment for urgent / essential dental care in line with national guidance – Amber phase		

5.7 Mental Health, Learning Disabilities and CAMHS

Adult Mental Health & Learning Disabilities

Mental health and learning disability services are essential non-Covid areas of work which have continued during the pandemic in an adapted form to ensure that people remain supported and the likelihood of their conditions worsening is minimised. Urgent assessments including crisis assessments and statutory work under the Mental Health Act 1983 have been prioritised with face to face assessments where required to ensure people are safeguarded and that home treatment has remained an alternative to hospital admission. It has been important to the overall flow within acute hospitals during the pandemic that psychiatric liaison services have continued to function effectively, particularly in Emergency departments and to support rapid discharge planning and along with other service provision this has been regularly monitored with a weekly assurance update on service status provided to the all Wales Mental Health Coordinating Centre.

During the early stages of the pandemic there was a reduction in referrals for primary and secondary mental health services but also a reduction in the available workforce due to illness, self-isolation and shielding which meant it was critical to utilise clinical risk assessments to prioritise activities and to enable adaptability. Community staff are regularly risk assessing their caseloads for contact and welfare checks and are maintaining contact with patients that are care coordinated based on the need and levels of risk. This has included considering the needs of patients particularly vulnerable to the consequences of Covid-19 due to co-morbid physical health problems and eating disorder services. There were issues with clients receiving eating disorder services accessing priority supermarket slots as but the guidance for this is being reviewed nationally.

Service users and carers have shown significant resilience in the face of extraordinary circumstances and staff have demonstrated great flexibility and fortitude in making rapid changes to the way services are delivered.

As with other areas of service provision the Mental Health and Learning Disability community teams have made increased use of digital technology. Assessments have been undertaken and the effect of treatments monitored remotely as well as providing supportive calls and welfare checks by phone in place of domiciliary visits. This has been particularly important in learning disability and older people's mental health

services where carers have required support due to temporary decreases in availability of day services.

Unscheduled care services, specialist inpatient rehabilitation and recovery services, forensic services, specialist extended assessment services for older people and specialist residential services for people with learning disability have all continued as normal with staff redeployed as necessary to maintain safe staffing levels. All inpatient services adapted their approach to isolating patients with Covid-19 symptoms as effective quarantine procedures could be provided, with patients who were understanding of the need to reduce contact between people to limit the infection spread. Based on this experience, revised acute pathways to older people and adult mental health through a single admission ward approach to limit the risk of infection outbreaks in multiple sites are being introduced.

The Health Board has expanded its Opioid Substitute Therapy (OST) services within Community Drugs and Alcohol Team (CDAT) to try and assist the Area Planning Board to reduce the waiting times for OST within its area. There has been increased costs to the Health Board, which resulted in the Health Board submitting a bid to the APB to continue to expand the services for OST. This was against the additional SMAF funding the APB received from Welsh Government for key priorities. The APB allocated funding to the Health Board for Q1 of 2020/21 but no reoccurring funding following that period and as a result the enhanced service will not continue. The Health Board will continue to work with the APB in the planning on the future model including key priorities during Q2.

All referrals for Primary Mental Health assessments under Part 1 of the Measure have been received and processed as per the 28 day target via a telephone assessment/triage model during the pandemic. Group work was suspended at an early stage but alternatives continued to be offered such as 1:1 telephone or video call interventions and a range of Tier 0 resources are available on-line with people advised as to what is appropriate to meet their needs.

Evidence from previous pandemics and research on wellbeing during the current social restrictions indicates that an increase in the prevalence of mental health conditions is likely during, and immediately after, the Covid-19 outbreak. The pandemic is increasing psychosocial distress and people are fearful and anxious with anxieties relating not only to coronavirus itself but also the loss of employment, reduced finances and to uncertainties over the future.

Some of this will lead to a short-term increase in demand or requests for support and addressing some psychological impacts may require longer term adjustments to service provision. Increasing demand has already been reported by existing well-being services provided by the Third Sector and as social restrictions are relaxed referrals to statutory services are predicted to rise above previous levels as the system returns to normal.

During Q2 demand and capacity planning for primary mental health support is therefore being prioritised, to inform the opportunities to secure potential investment taking account of new remote ways of working as the year progresses. It will be essential to ensure that primary mental health assessments, in particular, are timely

so that people's experiences are not over-medicalised, and that people get the level of support they need whether through community services or the third sector.

The Health Board will also ensure that the backlog of high intensity therapies that has inevitably built up is addressed, bringing the service back into compliance with the 26-week access target. In Q2 action to address the backlog whilst refreshing plans for delivering a stepped care model of psychological therapies for longer term sustainability will be addressed.

It is important that whilst services continue to be delivered during the challenging circumstances of a pandemic that the opportunity is now taken to restart some of the modernisation plans that were previously developed with partners using the learning from rapidly introduced new ways of working. Plans for Community Learning Disability Teams as part of the Improving Lives Programme will be reviewed. In Q2 progress will also be made on the development of the Mother and Bay unit in conjunction with WHSSC so that this important south Wales service is not unduly delayed due to the pandemic.

Key Actions:

Action	July	August	September
Demand & Capacity analysis for Primary Mental Health to meet anticipated growth due to pandemic	Finalise demand analysis. Confirm current telephone triage assessment as standard practice across all areas.	Review Tier 0 provision.	Review additional resource requirement
Address backlog for High Intensity Psychological Therapies	Waiting list review. Trial Group Work with Microsoft Teams.	Introduce Low intensity workers.	Completed recruitment to outstanding additional Band 5 & 6 posts.
Progress development of interim Mother and Baby unit	Option appraisal of permanent solution for Mother and Bay Unit	Advanced recruitment commences for Key staff.	Building work commences on Site
Implement single point of admission for adult mental health	Medical staffing agreement. Pathway commences		
Implementing the findings of the CLDT Review	Refresh specialist pathways development plan to set revised implementation dates.	Participation in Health Equality Framework project to assess COVID 19 impact for people with LD	Development of implementation plan for use of Health Equality Framework within inpatient services.

Child and Adolescent Mental Health Services (CAMHS)

Whilst CAMHS is restricted to how it can deliver its service during the pandemic, the Team have made changes to ensure that children & young people and professionals get the advice and support they need including the implementation of a Single Point of Referral Team (SPORT). CAMHS is a small specialist Service that is delivered by two teams P-CAMHS, and S-CAMHS and efforts are being made to integrate these teams to simplify the referral pathway. The development of the Single Point of Referral Team (SPORT) is the first step to achieving this integration, and features in the Swansea Bay Strategic Vision. The implementation of the SPORT has been fast

tracked due to Covid, and is a significant achievement, which and has the potential to deliver significant benefits.

SPORT activity has been gradually increasing and SPORT interventions (consultation, advice, self-help support / resources, signposting, etc.) may be contributing to the ongoing pattern of reduced referrals into P & S-CAMHS. Systems not currently in place to fully capture and analyse this new service / pathway – work on this in progress.

Performance has much improved across the service, and the numbers of children & young people waiting has much improved. Clearly, there is a risk that this position changes significantly as lockdown restrictions ease, however the Team are confident that the implementation of SPORT will support the mitigation of this

Key Actions:

Action	July	August	September
Covid response for CAMHS	Monitoring and adjusting of current working practices in line with Covid restrictions / guidance	Monitoring and adjusting of current working practices in line with Covid restrictions / guidance	Monitoring and adjusting of current working practices in line with Covid restrictions / guidance
Single base for CAMHS Staff	Finalise staff meetings/ consultation	Finalise staff meetings/ consultation	Swansea Team vacate Cefn Coed and move to NPT

5.8 Children's Services

In line with the Clinical Services Plan the Health Board implemented a Children's' Emergency Unit (CEU) at Morriston in response to Covid in Q1. However, this was an urgent response to the pandemic and there is now a need to develop a sustainable workforce plan. To deliver the CEU the Paediatric rota was split to create a separate ward/non-resident on-call rota, and a shift rota system for the emergency unit. Due to the numbers of staff no longer able to work on the medical rota, the CEU will return to its previous incarnation from the end of June i.e. reviewing paediatric emergencies only, with GP referrals and open access returning to the paediatric ward template. A sustainable medical rota and investment in nursing resource is required to maintain the CEU in the longer term. A joint proposal is being developed by the Singleton Children's Services and Morriston Emergency Department.

In neonatal services the proposal to increase the out of hours neonatal transport service to 24 hours has been progressed, with a draft service specification due to be reviewed at a joint meeting in July. The neonatal Transitional Care Unit is also due to be commissioned to provide crucial additional capacity. Following water testing issues, it is envisaged these will be resolved during the early part of Quarter 2.

From the onset of Covid and as part of the Outpatients response and recovery programme, Children's Services set up an Outpatients Planning Group to oversee the reintroduction of paediatric clinics, either virtually or face to face in the paediatric outpatient departments and children's centres across the three hospital sites. Guiding principles were developed at the outset, so that face to face consultations were limited only to when deemed clinically necessary and that measures are put in place to ensure that the footfall is restricted to minimum numbers and social distancing is in place.

There are representatives from all sectors of the service on the Group including surgical disciplines.

Nearly all consultants are holding regular virtual clinics which are coordinated by management and administrative staff. There are standard letters to be sent out beforehand with the required information for parents. Consultants are reviewing their waiting lists directly in order to decide which patients need a face to face appointment or virtual, and who needs to be seen most urgently. This has been a very time-consuming process for consultants but has brought the benefit of many being discharged or removed from the Follow Up Not Booked (FUNB) list, as well as giving clinicians some degree of control over who they see.

Concern has increased about the limitations of virtual clinics, including the ability to perform a clinical examination, keep consultations confidential, the lack of ability to "read" reactions from families, and the inability to monitor growth parameters, urinalysis, blood pressure etc. With this in mind Phase 2 planning has begun, to ensure these risks are addressed and minimised.

Children's services have supported the surgery recovery programme, with redesign of the ward template to ensure safe introduction of urgent paediatric surgery alongside medical and Covid pathways. Access to sufficient theatre capacity has been challenging and this will be a focus in the next quarter. To support the safe introduction of this work, all children and young people are pre-assessed, with shielding guidance prior to surgery.

The Named Doctor for Safeguarding will retire at the end of June, and it has not been possible to recruit despite multiple advertising. A plan is urgently being developed to ensure statutory requirements are met.

The Neurodevelopmental Team were the first to pilot "Attend Anywhere" which has allowed appointments to continue for children and young people with suspected Autistic Spectrum Disorder. Unfortunately, for ADHD this has not been possible, however a recent Lancet article has identified these as an essential service, and there is potentially more harm if not seen. Plans will be progressed in the early part of Quarter 2 to address this. In addition, vacant posts will be advertised to increase capacity and further reduce waiting times for assessment.

Children and young people who are either being considered for a statement of special educational needs or already have a statement of special educational needs require to be prioritised in order to ensure that the Health Board meets its statutory duties under the Special Educational Needs regulations. Due consideration needs to be given that the provision identified within the statement of special education needs is met in a practical and flexible manner. In view of the announcement of the opening of schools from 29th June 2020, the Health Board has developed its recovery plan for the re-instatement of school-based service delivery and the meeting of its statutory duties.

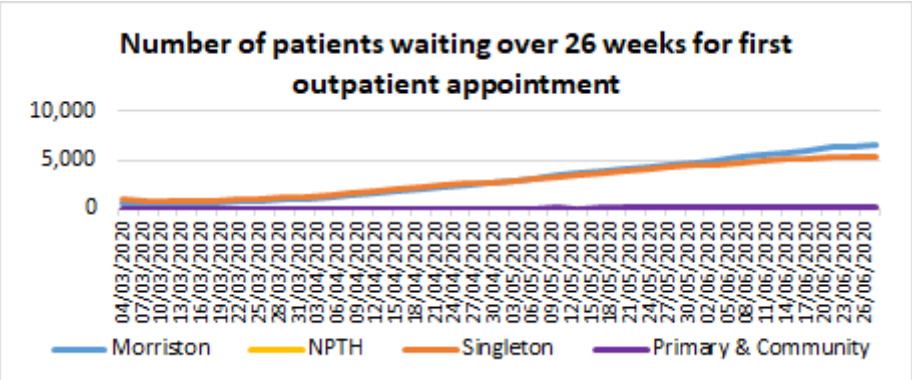
The preparations for the implementation of the Additional Learning Needs (ALN) Act on the 1st September 2021 will be prioritised by all services/departments which provide care to children and young people between the ages of 0 to 25, as well as a number of the corporate offices, such as Information, Welsh Language, Putting Things Right,

Communication, etc. Children's Services continue to support the DECLO in progressing plans to meet the requirements of the ALN Act by September 2021.

Key Actions:

Action	July	August	September
Sustainable workforce plan to maintain CEU in Morriston	Agree sustainable rota model for paediatric wards and OOH	Develop staffing model for CEU with ED and Morriston DU	
Progress Neonatal 24-hour transport proposal	Meeting to review proposal scheduled 15 July 2020		
Transitional Care unit	Resolve water testing issues and commission unit		
Outpatient recovery	Finalise requirements for Phase 2 and complete risk assessments, including roll out of Attend Anywhere		
Progress paediatric surgical recovery plan	Work to increase number of paediatric theatre sessions available		
Named Doctor Safeguarding	Agree alternative options following failure to recruit		
Neurodevelopmental service	Finalise capacity plan and recruit to vacant posts		
Meet the statutory duties of the SEN regulations in a flexible and practical manner	Respond to requests for information as well as complete medical statutory assessments within the timeframe.		
As part of re-establishing essential services, re-introduce school-based service delivery	Develop organisational recovery plan to include crosscutting paediatric therapy services		
Support the DECLO in progressing the preparations for the requirements of the ALNET Act		Establish children' Services response to the Organisational ALN Implementation Action Plan	

5.9 Outpatient Transformation



Due to the response to the outbreak there has been a growth in the number of patients waiting over 26 weeks for a first outpatient appointment. The Health Board is complying with the Essential Services guidance and as part of its Reset and Recovery Plans the Health Board is seeking to transform its outpatient services in line with the national outpatient strategy. In doing this, it is expected that demand from primary to secondary care will be minimised and that follow up appointments will reduce. The Health Board will develop and implement systems and procedures such as virtual appointments, See on Symptoms (SOS), Patient Initiated Follow Up (PIFU), self-management and group consultations. A combination of these initiatives will help transform the way the outpatient service is delivered.

In additional there will be a particular focus on recommencing those initiatives developed to reduce the number of follow-up not booked (FUNB) patients in ophthalmology. This will be achieved through an expansion of ophthalmic diagnostic treatment centres, increased virtual review and community-based services.

Full implementation of all of the plans is however is dependent on securing the £780,000 Health Board's Outpatients Transformation allocation and the bid was submitted in June.

Key Actions:

Action	July	August	September
Reset and recovery plans for essential outpatients for each Unit required	Commence phased introduction of the reset and recovery plan	Monitor implementation plan with a view to increasing number of face to face consultations where deemed essential	Monitor implementation plan with a view to increasing number of face to face consultations where deemed essential
Continuation of eye health initiatives focused on reducing follow up not booked (FUNB) numbers in ophthalmology	Re-introduction of face to face appointments in ODTC, additional Virtual Clinics and Community based Clinics of medical retina	Monitor and report impact of re-introduction of schemes on FUNBs	Monitor and report impact of re-introduction of schemes on FUNBs

Expand self-management /patient knows best (PKB)	Start to register patients for the Diabetes team.	Continue to work with all teams on implementations	Continue to work with NWIS on integration with WPAS
Facilitate and support the implementation, adoption and mainstreaming of SOS and PIFU pathways	Appoint project and clinical lead together with associated staff	Develop implementation plan for adoption of SOS and PIFU pathways	Commence the mainstreaming of SOS and PIFU with clinical staff.
Expand the use of virtual activity (inc PROMS)	Appoint product specialist for Attend Anywhere	Procure text reminder solution (to include PROM functionality)	Implement triage & prioritisation tool for heart failure + 1 other speciality

5.10 Rehabilitation

The Health Board has established an Allied Health Professionals Task and Finish Group to advise on the rehabilitation response to the pandemic to enable patients to return to their optimal level of independence and well-being. This Group has published a therapy advice pack for post-Covid patients which includes:

- Collation of work across the professional groups
- Development of a website, information packs and videos.

The resource will be developed further to improve accessibility and functionality for patients. The Group has also agreed a set of rehabilitation principles to ensure that a system is created that combines agility and discipline to ensure:

- A focus on two-way sharing of information between individuals and teams to build a ‘common operating picture’, a collective endeavour for the development of knowledge base and action.
- Consulting and sharing information with a broad range of partners including those outside the organisation so constraints and opportunities for collaboration are understood.
- Avoiding creating processes that become bottlenecks with people unable to get on with sensible actions because they are waiting for someone else to make a decision.
- Permission is given to frontline teams to test and apply changes providing they can do so safely and effectively and that their actions are consistent with system-wide priorities.

It is likely that there will be an increased demand in rehabilitation in all settings due to the Covid-19 pandemic and so this Health Board’s rehabilitation response is focussed on the four populations defined by the national Rehabilitation guidance in the diagram below:

POPULATION 1	People post-COVID-19: those recovering from extended time in critical care and hospital and those with prolonged symptoms of COVID-19 recovering in the community
POPULATION 2	People awaiting paused urgent and routine planned care who have further deterioration in their function
POPULATION 3	People avoiding accessing services during the pandemic who are now at risk of harm e.g. disability and ill-health
POPULATION 4	Socially isolated/shielded groups where the lockdown is leading to decreased levels of activity and social connectivity, altered consumption of food, substance misuse, the loss of physical and mental wellbeing and thus increased health risk

A Care Aims approach has been developed for use by all Health Board workstreams as shown below and will be supported by national work on a modelling resource. The framework and resources produced will support the planning of services to identify and meet the rehabilitation needs of our population.

The framework and resources produced will support the planning of services to identify and meet the rehabilitation needs of our population.

5.11 Future of Field Hospitals

The Health Board is keen to explore the possibility of decommissioning Llandarcy Field Hospital and developing Bay Field Hospital (FH) to become a single mixed acuity Field Hospital for the duration of the Covid pandemic and beyond.

The operational team was asked to scope all pathways/systems/equipment to give a 'go/no go' response as to whether it is possible to relocate to the Bay FH. If the decision is made the plan of action to merge the clinical pathways and consolidate on Bay site is as follows:

- **Medical pathway**: Go. Implementation possible within Bay FH. Immediate transfer possible

- **Palliative Care pod**. Go. Appropriate area sourced at Bay FH. Immediate transfer possible
- **Body storage/temporary mortuary.** Go. Cost associated – awaiting detail.
- **Equipment.** Go. To be transferred from Llandarcy. Immediate transfer possible
- **Oxygen.** No go. Confirmation received that oxygen could be placed at Bay via vacuum insulated evaporator (VIE) but the Health Board is awaiting fire and a Health and Safety steer regarding the level of risk that would need to be accepted, building adaptations needed, timeframes and cost. Oxygen is vital on site if the level of acuity associated with Llandarcy is to be established. It would also be essential if Bay Field Hospital were to become a supra regional Field Hospital.
- **Ambulance decontamination.** Go. Discussion ongoing regarding what kit/set up can be moved from Llandarcy ambulance bays. 1 decontamination lane already in situ at Bay. Further scoping needed to maximise the number of lanes on site for potential super surge scenario.

Workforce

In the event of a second surge, adequately staffing the extra beds required would present a significant challenge, which would affect all areas of the Health Board.
In line with the Heath Board Field Hospital Operational Plan, a focussed group are currently exploring a number of initiatives to mitigate this risk including stratifying the COVID-19 Emergency Levels of care and identifying staffing levels, including volunteers, based on clinical need.

Challenges do remain however, and while there is a level of confidence in respect of the availability of the non-registrant workforce, which has been facilitated through significant recruitment, the supply of Registrants creates a key risk for the Health Board.

The workforce model is attached at Appendix 7

It is important to note that even with the deployment of flexible and creative workforce solutions being able to safely staff the field hospitals cannot be guaranteed. A regional workforce solution would be required to staff the Field Hospital if it were to be established as a regional facility.

Key Actions:

Action	July	August	September
Ensure all elements of the patient journey have been tested to ensure robustness of clinical and non-clinical model	Undertake 'patch' tests to walk through key elements of a patient's journey at Llandarcy Field Hospital. Undertake 8 hr walk through at Llandarcy.		
Develop option transferring operational model at Llandarcy Field Hospital to Bay Field Hospital	Undertake table-top exercise with all key players to test the potential new model.		

	Undertake 12 hr walk through at Bay Field Hospital		
Based on new modelling consolidate services into one Field Hospital to service SBUHB footprint and possible a supra regional footprint	Develop and finalise plans based on table-top and walk through exercises	Implement plans to consolidate into one Field Hospital then enter dormancy phase until/if Field Hospital is required in a super surge scenario	Return Llandarcy Field Hospital to Ospreys following transfer of all equipment/services to Bay Field Hospital.
Consider alternative use for Bay Field Hospital during dormancy phase	Develop and agree a proforma for completion and submission to Operational and Exec leads to include ability to exit the building within 24 hrs to accommodate reactivation as needed.	Implement plans for alternative usage or enter dormancy phase.	Implement plans for alternative usage or enter dormancy phase
Transfer of site management from PCS Project leads when sites become used for alternative services or become dormant	Identify Site management role and appoint. Project Leads to return to substantive roles to reactivate PCS services	Identify Site management role and appoint. Project Leads to return to substantive roles to reactivate PCS services	

6.0 Partnership Working

6.1 West Glamorgan Regional Partnership Board

Revised structures for partnership working with Local Authority and Third Sector colleagues were described in Quarter 1 Operational Plan and have remained strongly fit for purpose. The priorities for Q2 are set out below.

Rapid Discharge Process

During the Covid-19 pandemic the Health Board has worked closely with both Local Authorities and Third Sector partners to develop rapid discharge pathways for all adult patients being discharged from general hospitals. This work has been based upon national guidance as well as previous work to develop a Hospital2Home service across health and social care services. Detailed planning of the Rapid Discharge Process (RDP) took place in Q1 and it will be fully launched on 1st July. The RDP consists of 3 new fast-track pathways jointly agreed on a regional basis (across the HB and both LAs) through the Multi-Agency Community Silver group. It is supported by a new Community Wellbeing Support Service provided by the Third Sector which started on 17th June for patients being discharged from Morriston Hospital using e-referral and will be rolled out in early Quarter 2 to the other hospital sites.

The new rapid discharge process involves the use of streamlined assessments, a full Discharge to Assess and Recover model and a joint discharge approach for those requiring care, including CHC and LA-funded patients. The pathways aim to facilitate

discharge of all adult patients from general hospitals on the same day (maximum of 24 hours) depending on the ongoing care needs.

Demand and capacity planning has been undertaken and this change could improve the care pathway for up to 90 patients per day. This is a major action within the Winter Plan and is therefore also included in section 5.11.

Care Home Support

The Health Board has worked through the West Glamorgan Regional partnership with both Local Authorities, the Third Sector and Care Home contractors to ensure coordinated support to Care Homes. The West Glamorgan Regional Care Home Protocol (version 8.0) is attached in Appendix 8 and outlines how partners will be working together to provide continued support to the Care Homes and ensure that Care Home populations receive the extended support required as a result of Covid-19. The Protocol has regular review and oversight from the multiagency cell and so will be updated to reflect the needs of the sector and the population that it cares for. This has also been supported by Care Inspectorate Wales who have been in weekly contact with Care Homes and have provided feedback regarding any issues to the Health Board.

To further enhance the Protocol in Q2, the partnership will undertake a survey of the Care Homes to gain direct feedback regarding the support that has been provided and will use information gathered to develop and implement further improvements.
The protocol ensures that areas of support such as Infection prevention and control, training needs, support to access Covid-19 testing and delivered in a coordinated manner. It outlines the regular contact arrangements for Care Homes and how the utilisation of care home escalation data will be used to guide actions.

A regional review of how the Health Board and two Local Authorities have worked to support the care home sector and understand learning has been undertaken and will be available early in Q2.

6.2 Safeguarding

The Safeguarding Team continues to work with respective partner agencies to manage and respond to Safeguarding concerns.

To ensure Safeguarding remains “everybody’s business” and to ensure Safeguarding statutory duty is maintained the Corporate Safeguarding Team will continue to operate and be the conduit for all Safeguarding Referrals/Reports to Local Authority and partner agencies including:

- Adult at Risk/Child at Risk Reports/Referrals to Local Authority
- Safeguarding Allegations/Concerns about Practitioners and those in Positions of Trust
- Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)
- Identification and Referral to Improve Safety Interventions (IRISi)
- Female Genital Mutilation
- Adult/Child Practice Reviews
- Domestic Homicide Reviews
- Procedural Response to Unexpected Death in Childhood (PRUDiC)
- Safeguarding Supervision

- Safeguarding Training
- Suicide
- Deprivation of Liberty Safeguards (DoLS)

The Team are operating an Extended “Duty Desk” Line, Monday-Friday 8am-8pm to provide staff with Safeguarding advice and support.

6.3 Hywel Dda UHB

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

- **Field Hospitals -** in Q2 the two Health Boards will be exploring options for a regional solution for the Bay Hospital, including a regional workforce model
- **Eye Care**
  - the importance of developing regional solutions is recognised and work will be finalised in July to establish a Service Level Agreement (SLA) for paediatric ophthalmology and a similar approach is being used to support Glaucoma services
  - a workshop is planned for end July to establish plans for a regional eye care service that will be considered by both Health Boards by end of Q2
- **Dermatology**
  - A regional work plan is already in place and proposals to recruit an additional plastic surgeon will be reactivated as a priority in Q2
- **Tertiary services**
  - Agreed principle that patient prioritisation will be based on clinical need and on the funding streams available, recognising that WG funding support is finishing and there will be associated costs from Q2 onwards
  - Spinal – priority is to understand the range and volume of patients that can be undertaken by Werndale and develop joint funded plans
  - Urology and gynaecology – continue to review what activity can be undertaken in Hywel Dda
- **Vascular** – clinical group continuing to ‘work up’ patients for diagnostics
- **Thyroid services** – scoping of regional opportunities.

6.4 Cwm Taf Morgannwg UHB

The formal meetings between the two Health Boards have restarted in order to explore the regional opportunities to manage the dual track aims set out in the Quarter 2 Operating Framework. A light-touch commissioning review meeting will also be undertaken at the end of Quarter 1 due to the complex legacy of the Bridgend boundary transfer.

The two Health Boards are exploring the short-term opportunities to restart surgery at Neath Port Talbot Hospital, in the light of the Essential Services guidance and the revised independent sector commissioning model. Discussions are also ongoing about the medium-term service model and the alignment with the Acute Medical Redesign in SBUHB and the overall surgical model for CTM UHB.

The two Health Boards are also undertaking work to review the regional opportunities regarding the Field Hospital capacity which will conclude early in Q2.

6.5 Cardiff and Vale UHB

The Regional and Specialised Services Provider Planning Partnership continues to meet in order to take forward the planning of specialised services delivered on a regional basis. Over the next quarter work is ongoing in the following areas:

- Oesophageal and Gastric Cancer Surgery – following a significant reduction in surgical activity during the Covid-19 response, both organisations have identified the development of a supraregional MDT as a priority. The aim is to improve resilience across South Wales, and to ensure that there is a consistent approach to managing and prioritising patients for treatment. The supraregional MDT is expected to launch in early summer and will be reviewed in six months.
- Spinal Surgery – discussions are scheduled with Hywel Dda to discuss the future service model at Swansea, with the aim of developing a comprehensive 24-hour service for South West Wales. Pending the outcome of these discussions, a provider service specification will be developed in partnership with the Cardiff and Vale service, which will be used to inform discussions with Chief Executives about the most appropriate commissioning arrangements for these services.
- Liver and Pancreas Surgery – the Wales Cancer Network has been asked to lead the development of a service specification for a comprehensive Hepatopancreatobiliary service for South Wales.
- Tertiary Services Strategy – the baseline risk assessment exercise will be updated to include the impact of Covid-19 against the following domains:
    - Impact on patient care (patient selection, care, and outcomes, etc.)
    - Impact on service (service model, efficiency, workforce, etc.)
    - Implications for future delivery (opportunities to change service delivery)

6.6 WHSSC

The Health Board remains engaged with WHSSC and the light-touch commissioning processes that have been in place since March. This includes scrutiny and assurance of decisions on a small number of services through the Management Group and the Joint Committee, as well as the organisation's assurance work on WHSSC-commissioned services as part of the pandemic. The main issues of note are:

- The UHB supported the work undertaken to do a high-level assessment of WHSSC-commissioned services and the configuration of service delivery, although WHSSC recommended to the Joint Committee that this did not provide full assurance on commissioned services.
- Swansea UHB has a robust process in place to respond to Essential Services guidance and an overall self-assessment is being refreshed as part of the work led by the NHS Wales Delivery Unit. This includes some services which are WHSSC-commissioned, e.g. cardiac and neonatal services.
- The new PET-CT Mobile Unit will be operational at Singleton Hospital in July.
- The plans to deliver a perinatal mental health Mother and Baby Unit are progressing.
- The Health Board's work on Major Trauma is included in section 5.1

- There will be significant underspend against the WHSSC ICP due to the slippage on developments.

6.7 EASC

The work of the ambulance services to support the whole NHS in its response to the pandemic was noted by the Emergency Ambulance Services Committee in May and the Health Board continues to work closely with EASC and WAST colleagues to plan, commission and deliver the response to Covid and the reactivation of Essential and routine services. This includes consideration of the review of the EASC and WAST IMTPs and the Demand and Capacity review through the EASC Management Group.

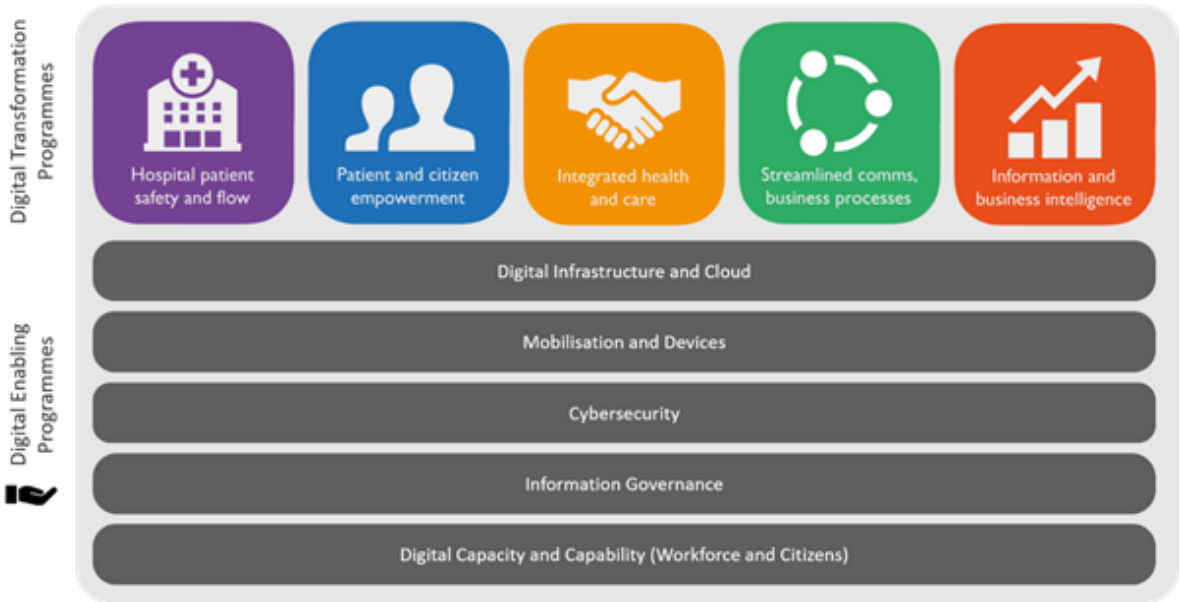
Key Actions:

Action	July	August	September
To continue robust West Glamorgan RPB response arrangements	Implement Rapid Discharge process Survey Care Homes regarding support received Undertake regional review of response	Monitor Revise Care Home protocol	Monitor Monitor
To ensure Safeguarding remains "everybody's business" and to ensure Safeguarding statutory duty is maintained	Operate extended Duty Desk Mon-Fri 8am-8pm Support staff to make referrals/Reports to Local Authority for Children/Adults at Risk Monitor Health Board Safeguarding activity including Professional Concerns Introduction of virtual Safeguarding Training Level 3 and "Ask and Act" Training Commencement of IRISi Training to Primary Care staff Monitor and collate information re cases of FGM Contribute to regional Adult & Child Practice Review process Coordinate HB response to PRUDiC	Facilitation of Safeguarding Level 3 and "Ask and Act" Training Progression of IRISi programme	Complete and Provide quarterly FGM report to WG

	Engage and contribute to multi-agency Rapid Response to Suicides in Adults and Children meetings		
To continue to work in partnership to reactivate essential elements of the Regional Clinical Services Plan with HDUHB	Develop regional position on Field Hospitals Develop SLA for paediatric ophthalmology	Agree the position Reactivate regional dermatology plan	Plan to implement
To continue to work in partnership with CTM UHB on the legacy of the Bridgend boundary transfer	Develop a regional position on Field Hospitals Make recommendations on the opportunities around surgery at NPTH	Agree the position	Plan to implement
To continue to work in partnership with C&V UHB	Update the baseline regional risk assessment	Launch supraregional MDT for OGC Cancer Surgery	Develop service specification for spinal surgery

7.0 New Ways of Working

The Health Board's Digital Strategy and the Digital Plan for 2020/21 are key to supporting the delivery of a number of the elements outlined within the Operational Plan. The Digital Plan is being delivered under 6 Digital Transformation/Enabling Programmes, as presented in the figure below.



Covid-19 has presented several challenges and opportunities to the delivery of the Digital Plan. Much of the work completed in Quarter 1 focussed on the response to Covid and whilst some of this effort will not have been aligned to the 2020/21 plan e.g. digitally enabling the field hospitals, ITUs and CTUs, rolling out 1742 VPNs and 1442 mobile devices for remote working, much of the effort is supportive of accelerating the plans outlined in the three year context of our Annual Plan. This includes:

- Roll out of Attend Anywhere has accelerated the delivery of virtual outpatient clinics (was Year 2 of the plan)
- Expansion of roll out of Swansea Bay Patient Portal at an accelerated rate

- Patient Flow system (Signal) now in all hospitals (not planned until later in year) and functionality increased
- Migration to Medicines Transcribing and E-Discharge (MTED) delivered months earlier than planned
- Virtual Ward rounds embedding digital ways of working

- Sharing of live discharge information with Social Care ahead of the implementation of Welsh Community Care Information Solution (WCCIS)

- Covid-19 dashboard and modelling tools have embedded Business Intelligence as a core tool in making decisions as well as monitoring performance and outcomes

- Migration of O365 mailboxes 3 months ahead of schedule
- Roll out of MS Teams 6 months ahead of schedule. Adoption rates far quicker than would normally be expected.

- Migration of personal drives to the cloud piloted 6 months ahead of schedule
- Volume of laptops and mobile workers increased by over 30%
- Digital Capacity and Capability of the workforce increase as remote working solutions have been adopted.

This work represents some of the positive outcomes from the Digital response to Covid-19 and will have a direct impact on facilitating transformational change within SBUHB for the rest of the financial year. The plan for Q2 needs therefore to:

- embed the new ways of working that have been established in Q1
- seize the opportunities for service change as the organisation and its workforce becomes more accepting of Digital ways of working
- assess the temporary digital solutions that have been put in place to understand how they align to the long-term plan and develop plans to either incorporate

them more permanently or disentangle them in favour of the longer-term solutions

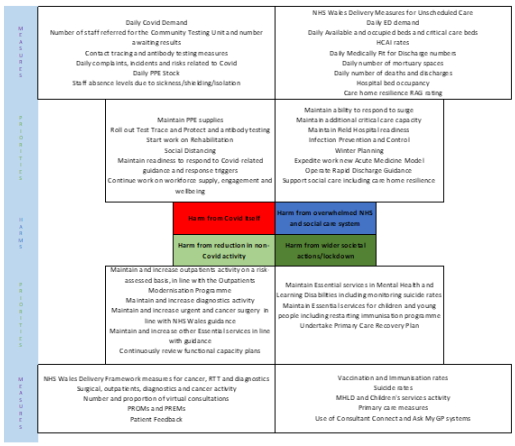
- the plan will need to remain responsive and adapt to the new requirements that the response Covid-19 may need
- consolidate the learning and progression and assess how it impacts on plans for Digital Transformation going forward
- continuously reassess the digital plan to ensure alignment to the organisation's priorities and ensure we reinvigorate the focus on digital inclusion by asking for feedback from staff and patients as appropriate.

Key Actions:

Action/ Programme	July	August	September
	Patient Portal – go live in diabetes	Patient Portal – implement in burns and plastics Text reminders/ PROMs – procurement specification completed	Patient Portal – commence testing of outpatient events
	Develop end of life decision tool Recommence planning for Welsh Emergency Department system (WEDS) ePrescribing (HEPMA) – continue role out in NPTH	Significant upgrade to WPAS Complete development of acute pain tool Digital outpatients – pilot paperlite	Agree development of SIGNAL v3 Sign off WEDs deployment order Commence implantation of Electronic Test Requesting Phlebotomy module, e- prescribing site 2, Nursing e-Documentation and Digital Outpatients
	Pilot electronic letters in community WCCIS – submit FBC to Executive team GP Test Requesting – complete Evaluation Continue to maximise the benefits of Attend Anywhere and Ask My GP in Primary Care		WCCIS – sign Deployment Order and commence implementation
	Develop Essential Services Dashboard Develop a Testing Dashboard: TTP, CTU and community testing	Cancer dashboard – incorporate information from Chemocare	Develop Outpatients transformation Dashboard Develop Theatres Dashboard using Power BI

Streamlined comms, business processes	O365 – go live with Forms in 3 service areas; commence roll out of Pro Plus; proof of concept for booking app; move Occupational Health intranet to SharePoint online Develop stent registry		O365 – realignment of licences complete
Digital Enabling Programmes	Commence rollout of Community and Learning Disability Services WiFi O365 – start pilot of MS Intune	O365 - re-provision Skype conference equipment to teams	Migration of data to new BI server complete Commence infrastructure requirements in readiness for national critical care system WICIS Commence infrastructure requirements for Omnicell in theatres

8.0 Performance



The Health Board has commenced early thinking on a possible internal performance reporting framework based around the 4 quadrants of harm set out in the NHS Wales Covid-19 Operating Framework for Quarter 2. An exercise has been undertaken which maps the current NHS Wales Delivery Framework to these quadrants, along with an assessment of the current measures being reported. This has resulted in 2 draft outputs which will be refined in the early part of Quarter 2 to allow for implementation during the quarter.

The first output is the diagram in the picture and included in Appendix 1. The diagram shows how the Health Board's key priorities over the next 6-12 months map to the Harm quadrants and then extend these to include suggested measures against those priorities. The diagram is draft at present and will be developed further into a final proposal.

The second output is attached as Appendix 9. This more detailed analysis sits behind the quadrant diagram above and makes an assessment of the proposed further measures that could also feature in a performance reporting framework more orientated to the quadrants of harm.

It is encouraging to note from Appendix 9 that a large number of the measures which could be mapped through, are currently already captured routinely and are captured through mature systems where data quality can be taken with confidence. During July 2020 discussions will be held through the Performance and Finance Committee and Quality and Safety Committee to agree the Health Board's approach. This change will be reflected in performance reporting mechanisms through these committees and onwards to the main board meeting by the end of the quarter.

The Health Board is committed to working with colleagues in NHS Wales to support the development of any new framework and to share some local thoughts prior to implementing these locally.

9.0 Protecting Our Workforce

9.1 Supporting Workforce Well-Being

Occupational Health Services
The Occupational Health (OH) service, re-engineered to deliver services 7 days a week, has reduced its delivery times to 8am-8pm reflecting the move into the 'recovery' stage of Covid-19. The team continues to support a Covid-19 triage process, prioritising symptomatic staff or symptomatic family members, who are then referred to the Community Testing Unit on day 1. Staff who test positive are phoned by nursing staff to inform them and offer support if required and staff who test negative are sent a text of their result via PHW. To date, over 3800 staff or family members have been referred for testing and the positive return rate as at June 14th was 25.8%.

The interim BAME risk assessment that was used for a short period has been replaced by the All-Wales Covid-19 Risk Assessment Tool. Use of the self-assessment tool is being promoted across the Health Board and a second targeted reminder has been issued. Staff have been requested to forward a copy of their completed All Wales Workforce Risk Assessment to Occupational Health to store on their record and a number of these have now been received.

The OH service will continue to assess staff at risk, providing appropriate advice on adjustments to managers. In addition, a small executive led review group is being established to consider high risk outcomes to ensure appropriate action is taken to protect staff.

Into Quarter 2 the service will also support the contact tracing of staff and integrate with the serology/anti-body testing of staff including undertaking a surveillance project with PHW to monitor the antibody results of a cohort of 900 staff over a 12 month period.

Well-Being Support
The extended Wellbeing service supported by colleagues from Mental Health Psychology services, Learning and Development and Chaplaincy continues to deliver an extended service, Monday-Friday 8am-8pm with a phone based self-referral model.

Virtual support continues to be offered and the service has developed a pathway for bereavement and trauma for staff during Covid-19. The service has also supported and will continue to support managers and staff within the delivery units, including critical care, through traumatic experiences encountered during Covid-19.

The Health Board has been working with army colleagues and external partners to develop an early intervention/prevention, trauma management approach across the organisation using the TRiM model which focuses on peer support to identify the early signs of trauma. The approach is aimed primarily at frontline/critical care staff through peer-delivery with clinical leaders and supervisory staff trained as practitioner's in order to facilitate the process within their own teams.

A cohort of 23 internal trainers has been established to deliver the programme and funding has been secured to provide a fully comprehensive training programme to key staff within priority critical areas within Quarters 2 and 3.

In Quarter 2 the Health Board is undertaking a staff survey to understand the impact of Covid on staff well-being.

Well-Being and Annual Leave
Initially the Health Board restricted annual leave in order to address the significant higher levels of staff absence that was Covid-19 related. That impact has eased and the Health Board is has put measures in place to ensure that annual leave is managed fairly and effectively over the forthcoming year, as the build-up of untaken annual leave by staff could have a negative impact on staff capacity and the Health Board's ability to deliver services to patients during the pandemic and in the future.

Social Distancing
In partnership with Trade Unions the Health Board is taking a range of steps to ensure that the legal requirement within Wales to ensure social distancing is being complied with. Extensive guidance has been issued incorporating a detailed checklist and risk assessment process. This guidance sets out a number of practical steps that SBU will be considering as hospital and other healthcare environments are reconfigured for the new norm.

Accommodation
To support staff a small amount of hotel accommodation is being retained to enable staff to shield, socially distance and as such continue to work within the Health Board.

9.2 Innovation and Learning

Partnership Working
During Quarter 2 there will continue to be a significant focus of partnership working with staff side organisations to continue to discuss pandemic and BAU issues. Local Partnership Forum (LPF) meetings will continue on a two-weekly basis for the forthcoming period. It is positive that a wider range of staff side organisations are actively engaging in these partnership conversations, including BMA attendance at the LPF. This has enriched the discussions.

Working with Trades Union partners the Health Board has conducted a detailed review of the distribution and impact of Covid on the workforce, with a specific additional focus on the BAME staff. A detailed data analysis has been summarised into a narrative report which has been used to identify issues and lessons to be learnt to improve the Health Board response and staff management of any future peaks in the next period.

Induction
An effective induction process is critical to ensuring that new members of staff are provided with the necessary knowledge and understanding they need to perform well in their new roles and also to help them to feel valued and supported from the outset.

The need to observe social distancing measures prevents The Health Board from delivering staff induction to large numbers via a face-to-face workshop as before. Technology will be utilised to ensure that the same learning and networking opportunities are delivered to staff. Staff will be provided with a virtual induction handbook and welcome video from the Chief Executive and the new arrangements via MS Teams will be in place before the end of the second quarter. In order to allow people the opportunity for an engaging and interactive experience, the attendance numbers will be limited to a maximum of 20 per session and virtual breakout rooms will be used as appropriate to enable staff to discuss topics in smaller groups.

Physical classroom spaces will also be made available for any staff who do not have the means to access the sessions online. A similar approach will be taken for those same people to access their Mandatory and Statutory e-learning modules.

A suite of induction videos were produced for the field hospitals which will continue to be available as required. Along with site inductions these resources will provide a legacy of training and be available for refreshers for any staff or volunteers during the coming weeks and months.

Leadership and Management Development
From April 2020, the decision was made to suspend all Leadership and Management development programmes until September 2020 or such time as delivery could be safely resumed. The intention is now to resume delivery of Leadership and Management Development programmes as soon as possible utilising virtual platforms wherever appropriate.

Many of the Health Board popular leadership behavioural programmes such as Footprints, Bridges and Impact were designed with a heavy focus on physical participant interaction so there is work to be done to revise these programmes in such a way as to meet the same learning outcomes without this element. Discussions are currently underway both internally and externally as to how this might best be achieved with the possibility of expert support from the Open University through HEIW to redesign these courses for a virtual platform. Support from HEIW is also being utilised via their online classroom and learning portal with pilot sessions in the process of being arranged.

The Manager's Pathway which comprises of 9 Core Modules and a large choice of optional modules will also be made available online over the coming months.

Additional courses are in the process of being developed to meet new and immediate demands, supporting people who are moving to virtual working and also who are managing teams virtually.

As an interim measure, for staff or managers requiring more immediate support while the programmes are being transitioned, e.g. those new into line management roles, an internal network of qualified coaches is available to provide 1:1 support as and when required.

A range of courses have become available for staff to sign up to on a no cost basis for a limited period of time. These include ILM levels 3-7 in Management and Leadership and ILM Level 5 coaching qualification. These opportunities are currently being investigated further and offered out to staff wishing to develop their skills.

Just Culture
The Health Board is still fully committed to developing and implementing the Just Culture and compassionate leadership model. Discussions are currently in progress with the training provider to determine how the Just culture workshops planned for September 2020 can best be delivered.

Post Graduate and Undergraduate Services
Multi professional Postgraduate and Undergraduate education and training activities will be fully restored in Q2, albeit some of this will continue to be delivered in different ways. This means that rotations and clinical placements will take place as normal to ensure that the future health professional staff can develop the appropriate skills and competences. The Health Board is are aware that there may be challenges with Trainee Doctors and Medical Students competing for the same learning opportunities. Virtual platforms are being sought where more than one student can participate in virtual clinics, ward rounds and MDTs ensuring they still achieve the required learning outcome.

Induction programmes are being reviewed at the moment with a plan to deliver some of the content virtually where possible for undergraduate Medical Students and Postgraduate Trainee Doctors. The Health Board is in the process of updating facilities within the Education Centres to accommodate lectures to be delivered via Teams. There are some specialities that require the facility to deliver face to face teaching to Medical Students. This is being reviewed with the Clinical Lead and the Undergraduate Managers.

Postgraduate and Undergraduate clinical skills teaching has restarted, however social distancing guidance is being followed during sessions. This has impacted the number of Students/Trainee Doctors attending each session. Additional sessions have been provided to accommodate numbers.

In collaboration with HEIW and our University partners a more strategic approach to the delivery of undergraduate education for the Therapy, Health Sciences and Psychology professions is to be initiated reflecting our learning and engagement at its success during the pandemic.

Wellbeing and Flexible Working Survey
The Covid crisis has created a situation where many colleagues had to work in different ways overnight. A local survey focusing on colleagues' wellbeing and views on working from home has been developed and will be available to complete during the month of July 2020.

The survey is anonymous and provides essential information to check the 'temperature' across the organisation and help identify ways to keep improving the experience of the workforce. The survey helps understand and minimise some of the stress's colleagues may be under, and also supports the Staff Experience Team to continue the work already done as part of #ShapingSBUHB.

Homeworking
The Health Board has made good use of home working options in the short term to maintain services and keep to the Welsh Government guidance. The role of home working will play a much greater part of future staff deployment options even as it now links to the Health Board's plans for social distancing and accommodation use. The organisation has adopted a two-stream approach with a shorter term plan focusing on the practicality of the here and now and a revised policy is in development which will be issued within the context of the issues facing the Health Board today. The longer-term plan is being developed in partnership with staff and staff side. A broad survey of staff is being conducted which will inform home working experiences so far, the ambitions for staff and the type of support they believe is needed to facilitate and effective and safe home working environment.

9.3 Workforce Planning, Recruitment and Deployment

Workforce Supply and Recruitment
There has been significant recruitment to support Covid activity and the additional staffing resource required for the Field Hospitals The majority of staff have been recruited on bank or fixed term contracts. In total over 1495 staff have been recruited (head count). Some of the care worker resource remain time limited as they were students or furloughed staff. There are also ongoing limitations in deployment suitability and hours that can be worked due to people being students or their offer being as a second job.

Looking forward for the remainder of the year registrant workforce availability remains a pinch point for the Health Boards ability to respond and deploy staff for surge and super surge. Only 4 nurses who joined the temporary register have been able to join the Heath Board, this has been for varying reasons including withdrawing interest.

Going forward into Q2, contingency plans are being developed to ensure sustainable workforce planning for the future in line with the draft Workforce Strategy for Health and Social Care.

Assumptions of Staff Availability
Staff absence will continue to be monitored on a daily basis and reported on the Gold Command Covid Dashboard. Covid related absence was at its highest level in mid-March with 1,700 staff isolating and shielding. This has now fallen to just under 600

staff, with just over 100 staff having Covid-19 symptomatic illness. Absence due to Covid is 6.5% overall. This is in addition to the normal sickness absence of circa 6 %. In line with other Health Boards, the operational planning assumption for workforce availability is therefore to plan on overall absence to continue within a range of 13%-16% into Q2 to take into account the impact of annual leave, staff turnover etc.

Further assessment will take place as the pandemic proceeds as wider staff testing is likely to produce more positive results resulting in greater staff absence and fragility and it is assumed that staff who are shielding will continue to be unavailable to support front line care for the foreseeable future. The impact of Test, Trace and Protect is also unknown but could produce further difficulties with entire teams being asked to isolate if a team member tests positive.

Assuming there is an average of 15% of the workforce absent at any time will present the Health Board with ongoing staffing challenges.

In addition to core demands for workforce TTP and antibody testing are also being supported, and the Board is recruiting to the anti-body testing scheme on a more permanent basis. The effect of TTP on the availability of staff is not yet clear, but some assumptions have been included in the workforce modelling. Whilst large numbers of additional staff through Covid recruitment have been secured, some of these will be returning to permanent employment as lock down restrictions ease.

The Health Board has developed a simple staffing model that allows likely available staffing based on the key factors that influence supply to be considered. Based on existing data and patterns the tool factors in vacancies, sick leave, Covid-19 related absence, and annual leave. The tool sets out three broad scenarios linked to the R number based on data gathered through the progress of the pandemic and the impact on staff. The model also factors in additional staffing commitments for areas such as TTP and Antibody testing. The tool provides for estimated available staff by staff group and a broader % based reduction over budgeted WTE. Q2 assumptions are based on the current Covid-19 impact with R less than 1. This staffing model is attached at Appendix 10.

Within Q2 there are likely to be more small hot spots areas that will need to be managed on a local basis and this may cause some difficulty depending on the speciality of the service. The feasibility of having cohorts of staff to work in one area is being considered; this is complex and considering how this can be done without restricting workforce deployment and supply is underway.

Opportunities will also be considered for a collaborative approach depending on need with local, bordering HB's i.e. CTM and Swansea Bay UHBs in relation to flexible and contingent models of workforce.

Staffing for Field Hospitals

The models for staffing the field hospitals are attached in Appendix 7. In the event of a second surge, adequately staffing the extra beds required would present a significant challenge, which would affect all areas of the Health Board.

In line with the Heath Board Field Hospital Operational Plan, a focussed group is currently exploring a number of initiatives to mitigate this risk including stratifying the Covid-19 Emergency Levels of Care and identifying staffing levels based on clinical need.

Challenges do remain however, and while there is a level of confidence in respect of the availability of the non-registrant workforce, which has been facilitated through significant recruitment, the supply of registrants creates a key risk for the Health Board.

Appendix 11 sets out the staffing principles and the proposed model includes expanding the Registered Nurse to patient ratio and utilising other registrants (e.g. AHPs) as the qualified lead for a cohort of patients. It is important to note that even with the deployment of flexible and creative workforce solutions being able to safely staff the field hospitals cannot be guaranteed.

Staffing for Test, Trace and Protect
The Health Board in conjunction with Swansea and Neath Port Talbot Local Authorities have been working in partnership to establish the Test, Track and Protect Service for the Swansea Bay region.

9.4 Testing
To date the testing workforce has been deployed largely from School Nurses, Audiologists and Sexual Health Nursing. The service has also benefited from the service of the military and support of Public Health Wales. The Health Board is now moving, however, to a situation where the need to recruit the workforce to staff the service has arisen. This is attached in Appendix 12.

9.5 Trace and Protect
The proposed operational model for contact tracing has assumed that the model needs to be implemented to its full extent from the time point when lockdown restrictions are lifted. However, over the last few months there has been the need to establish all the necessary workforce and digital infrastructure to deliver the proposed model.

To address demand, a large workforce was required to undertake contact tracing and follow-up within a defined geographical area. The contact teams will deliver the service outlined in Appendix 13. This above team is expected to be able to address the demand detailed in Appendix 14. The teams will be supported by Environmental Health Officers and the Health Protection Team in PHW to focus on the more complex cases.

9.6 Initial Set Up
The initial teams have been established using employees from the Local Authorities and Health Board. The team operates on a 7-day basis from 9am to 6pm. The teams will be supported by one Business Support Co-ordinator, one Administrative Officer and one Training Officer.

As at 1st July the teams will require resources as following: -

- Swansea – 8 teams (136 staff) and 3 support teams

- Neath/Port Talbot – 6 teams (102 staff) and 3 support teams

The Local Authorities have now commenced external recruitment for contact tracers and advisors. The Health Board is in the process of offering secondments to the clinical leads and will recruit externally to any posts where this is not possible. From the 1st September it is assumed all teams will be staffed with externally recruited staff as it is anticipated that the staff from the three organisations will have returned to their substantive roles as services recommence. The TTP service does introduce an element of uncertainty in overall workforce terms as its impact can be very disruptive if whole teams need to self-isolate. The importance of social distancing and the correct use of PPE will be critical in managing these risks. A full deployment plan is included at Appendix 15.

10.0 Infection Prevention and Control

Implementation of Infection Prevention and Control (IPC) and Health and Safety (H&S) Guidance on social distancing in environments has included:

- Established a dedicated cell to coordinate all activity around social distancing and to provide a single forum for bringing together the risk assessment process for social distancing, as well as implications for IPC and H&S requirements and PPE.
- Reviewing the risk assessments completed to date for consistency and any gaps in assurance.
- A review of clinical areas and identifying potential reasonable steps that can be taken to reduce the risk of nosocomial transmission
- Identifying cross Unit issues that require resolution.

Key Actions:

Action	July	August	September
Implement social distancing for staff and patients in communal and clinical areas	Communications to publicise on social media, internal screens, posters and floor markings Set up social distancing cell	Monitor compliance with social distancing in a variety of areas	Continue to monitor compliance, review signage
Health promotion/education: Raise awareness of general principles of IPC for staff, patients and visitors	Continue to work with procurement around supplies of hand wash and gel Ensure communications are in place in relation to hand hygiene, symptoms, catch it, bin it, use of masks and how to apply etc	Seek feedback on the comms related activity for effectiveness	Review and amend comms strategy as required
Ensure the most up to date guidance is implemented and	Review all IPC related guidance as it is published and ensure it is implemented,	Ongoing review and refresh of SOPs	Ongoing review and refresh of SOPs

disseminated in a timely manner	developing local SOPS or relevant information as appropriate		
Environmental decontamination	Ensure environmental cleaning and decontamination practices are in line with National guidance for COVID or other organisms as appropriate	Develop systems for recording when enhanced cleaning or decontamination are required and completed	

11.0 Value Based Healthcare

Value Based Healthcare (VBHc) is the underpinning ethos to maintain equity and outcomes within resources in support of the Health Board's reset and recovery programme. Applying a value based lens to the prioritisation and restart of services will continue to develop in the Health Board approach.

The Value Based Healthcare (VBHc) team is supporting the collection of patient reported outcome measures (PROMs), which scores the patient's perception of their treatment, symptoms and general quality of life, providing clinical teams with valuable data, which, combined with clinical and costing data, enables services to understand how effective their treatment/surgery has been and whether everything they do contributes to the best outcomes for people.

A PROM is used for direct patient care, follow-up and waiting list management and service level improvement and can be used to underpin our recovery work. The Health Board has recently procured a digital PROM collection solution that will enable the automation of this process to minimise administrative burden on clinical teams, enable remote collection and is user friendly for both clinicians and patients.

Key Actions:

Action	July	August	September
Supporting Essential Services	Develop & roll out Triage and Prioritisation tool in areas/specialties with greatest need aligning with the Essential Services Guidance	Embed approach and methodology	Review
PROMS	Continue collecting PROM's in Heart Failure and Ophthalmology	Implement	Implement
	Review PROM collection processes in existing services in Rehabilitation particularly ELP and MCAS	Implement any changes as a result of review	Monitor

		Implement digital integrations to be able to automate processes and use the full functionality of the PROM's solution (WPAS and DrDoctor)	Commence collection of PROMs & Triage tool in Lymphedema
Outpatients	Reduce Outpatients routine appointments in alignment with the OP Modernisation programme in T&O, MCAS, Ophthalmology, Cardiothoracic Surgery, Gastro, Cardiology, Dermatology, Nephrology and Rheumatology in line with detailed plan	Reduce Outpatients routine appointments in alignment with the OP Modernisation programme in T&O, MCAS, Ophthalmology, Cardiothoracic Surgery, Gastro, Cardiology, Dermatology, Nephrology and Rheumatology in line with detailed plan	Reduce Outpatients routine appointments in alignment with the OP Modernisation programme in T&O, MCAS, Ophthalmology, Cardiothoracic Surgery, Gastro, Cardiology, Dermatology, Nephrology and Rheumatology in line with detailed plan

12.0 Finance

The Health Board financial plan for 2020/21 contained the following key elements resulting in a forecast overspend position at the end of 2020/21 of £24.4m.

	2020/21 Forecast
	£m
2020/21Underlying Deficit	28.0
Inflationary/Demand Pressures	35.5
WG Allocation Uplift	(21.6)
Investment Commitments	5.4
Planned Savings	(23.0)
Year End Forecast - Overspend/(Underspend)	**24.4**

As part of the Health Board's response to Covid-19, a rapid and significant reshaping of the care system has been undertaken. The financial implications of this reshaping have been assessed and this assessment has been made based on a series of planning assumptions to provide a revised financial forecast for 2020/21.

The care system response to the Covid-19 pandemic, changes in population dynamics and the move to reset some core services, require the financial forecast to be routinely revisited and updated. This work will feature routinely in the monitoring returns for the Health Board and this Quarter 2 plan reflects the refinement of the planning assumptions for the second Quarter within the overall forecast. The assumptions which underpin the financial forecast are set out below.

Month 2
The month 2 position for the Health Board has recently been finalised and is summarised in the table below.

	Month 1	Month 2	Cumulative
	Actuals	Actuals	Actuals
	£m	£m	£m
Operational Position	2.118	2.101	4.219
Impact on Savings Delivery	1.749	1.480	3.229
COVID-19 Gross Costs	3.176	8.709	11.885
COVID-19 Cost Reductions	-1.179	-1.589	-2.768
Slippage on Planned Investments	-0.468	-0.468	-0.936
TOTAL COVID-19 IMPACT	**5.396**	**10.233**	**15.629**

The operational position is broadly in line with the initial financial forecast for the year as per the original financial plan. Budgets have been rebased to reflect the 2020/21 plan to facilitate the most accurate possible assessment of the impact of Covid-19 across all services. The table above assumes no additional funding received to offset these costs.

Slippage on savings has been assessed as £3.229m and has been accounted for in line with the original savings plan and factored into the plan based on the original profiling.

Covid-19 gross costs contain a number of elements such as pay cost increases, PPE stock, equipping, loss of income etc. This reflects current understanding of accounting treatment of equipping costs and the national and local funding of PPE. More detailed work is continuing to validate and further refine these assumptions, and this will be accounted for in further iterations of the Quarter 2 and full year forecasts.

Reduced expenditure has been noted in a number of areas, primarily theatre and other clinical consumables related to the reduced provision elective activity, secondary care drugs and variable pay.

The Health Board had a series of investments planned for 2020/21 which have been unable to be implemented because of Covid-19. Slippage against these is separately reported as they were separately identified in the baseline financial plan.

Financial Planning Assumptions for Quarter 2
The financial forecast for Quarter 2 is based on key planning and modelling assumptions. These are used to interpret the impact on the behaviour of the overall care system and the current assessment of these is set out in the preceding sections of this Quarter 2 plan. From a financial forecasting perspective there are key considerations to be made which inform the estimated costs for the rest of the Quarter. The material considerations are listed below:

- Workforce assessment and the management of capacity within the available workforce.

- Field Hospital running costs. Preparedness has been completed and for this Quarter it has been assumed that whilst both the Llandarcy field hospital and a proportion of the Bay field hospital are available to receive patients, the Health Board will not be utilising the beds (based on the modelling) and therefore costs are included for maintaining readiness but not for occupation.
- An assessment of PPE costs has been made based on the modelling and commitments on the books to date, but also based on the assumption that PPE called down through stock requisitions from central procurement will be a zero cost for the Health Board.
- A revised assessment of hotel accommodation costs for Quarter 2, following the review of utilisation.
- An assessment of the costs of increasing theatre throughput as part of plan to bring back online essential services. From a materiality perspective this is largely focussed on theatre consumables. The assumption is linked to the phased plan set out earlier in the Quarter 2 plan.
- A risk of needing to commit additional resource to address the impact of meeting priority patient demand through the use of non-core capacity e.g. outsourcing and insourcing of clinical and diagnostic services. Further discussions would be welcome with Welsh Government on the possibility of implementing these additional elements of activity in the context of the revised plan and in the context of the reduction in maximisation internal capacity. At time of writing this specifically relates to CT, MRI, Endoscopy and Spinal Surgery but is likely to develop.
- An assessment of the operational running of Test, Trace, Protect programme, which currently assumes staffing costs as additional which reflects the requirement for currently deployed staff to return to substantive service roles to support rest and recovery. The position on Antibody testing is still be developed.
- The cost base includes the funding allocations issued in Month 3 for Field Hospital set up costs and staffing costs for Quarter 1. The forecast assumes funding for the balance of Field Hospital set up costs is forthcoming based on current conversations. No further additional funding from any source for Covid-19 pressures in Quarter 1 and Quarter 2 has been assumed. Any additional funding will have the impact of reducing the variance.

Forecast

This section provides the Health Board's month by month and cumulative forecast financial variance for Quarter 2 based on the modelling assumptions described earlier in this plan and based on the financial assumptions above.

The estimated position to the end of Quarter 2 is set out in the table below. The key increase in the forecast for Month 3 is the inclusion of the field hospital construction costs.

	Quarter 1			Quarter 2			
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Cumulative
	Actuals	Actuals	Forecast	Forecast	Forecast	Forecast	
	£m	£m	£m	£m	£m	£m	£m
Operational Position	2.118	2.101	2.100	2.100	2.100	2.100	12.619
Impact on Savings Delivery	1.749	1.480	1.518	1.314	1.324	1.299	8.684
COVID-19 Gross Costs	3.176	8.709	25.213	17.857	4.415	3.581	62.951
COVID-19 Cost Reductions	-1.179	-1.589	-1.335	-1.185	-0.985	-0.985	-7.258
Slippage on Planned Investments	-0.468	-0.468	-0.368	-0.368	-0.368	-0.368	-2.408
TOTAL COVID-19 IMPACT	**5.396**	**10.233**	**27.128**	**19.718**	**6.486**	**5.627**	**74.588**
WG Funding Allocation			-26.828				-26.828
WG Funded Anticiapted				-12.756			-12.756
TOTAL COVID-19 IMPACT AFTER FUNDING	**5.396**	**10.233**	**0.300**	**6.962**	**6.486**	**5.627**	**35.004**

The cumulative forecast to Quarter 2 has been adjusted to reflect the recent Welsh Government funding allocations for Field Hospital set up costs and staff costs for Quarter 1. The assessment anticipates funding for the balance of the Field Hospital set up costs but does not assume any ongoing funding for staff costs in Quarter 2.

Within this overall COVID-19 impact of £74.588m to the end of Quarter 2, there are a number of key cost lines to highlight (based on the assumptions set out above) which explain the position within the table above; in particular the Covid-19 Gross Costs line which has variation between months for a variety of reasons. The impact of funding received to date and the anticipated funding in month 4, is to reduce the forecast cumulative deficit to £35.004m at the end of quarter 2.

The table below expands the major elements of the Covid-19 gross costs line for transparency and to demonstrate the link between the financial planning assumptions and the cost behaviour.

	Quarter 1			Quarter 2			
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Cumulative
	Actuals	Actuals	Forecast	Forecast	Forecast	Forecast	
	£m	£m	£m	£m	£m	£m	£m
Workforce	0.606	2.949	3.276	3.717	2.139	1.442	14.129
Field Hospital Set Up	0.088	1.431	31.234				32.753
Other Equipping	0.037	1.162	0.045	0.345	0.245	0.045	1.879
PPE	0.662	1.455	0.167	0.050	0.050	0.050	2.434
Testing Programme	0.000	0.000	0.345	0.345	0.345	0.345	1.380
TOTAL COVID-19 IMPACT	**1.393**	**6.997**	**35.067**	**4.457**	**2.779**	**1.882**	**52.575**

The assumptions section above explains the drivers for the separate expenditure lines within this table. This table does not provide a full reconciliation back to the gross cost lines but serves to illustrate the material component parts.

Financial Risks and Opportunities (Quarter 2)

Whilst the assumptions are clearly stated there remains a level of financial risk and uncertainty around the financial forecast for Quarter 2. The principal risks and mitigation have been captured in the table below and some of the key opportunities are described thereafter.

Risk	Mitigation
Change in modelled demand assumptions	• Detailed updated modelling undertaken to support the financial assumptions within the plan. • Government intervention though circuit breakers should incidence increase. • Capacity able to flex to within current cost base to meet modelled demand before material variable cost incurred.
Local v national Costs	• Planning assumptions clearly set out around PPE. • Engagement with procurement around assumptions of ownership of equipping costs.
Funding arrangements across Health and Local Authorities	• Routine discussions with Local Authorities around resource commitment (particularly Field Hospital fit out and Test, Trace, Track); large proportion of field hospital set up costs received in month 3 • RPB oversight of revenue through partnership agreements • Escalation through Directors of Finance of matters as they emerge for consideration across Health and Social Care areas.
Accounting treatment of equipping	• Assumed all equipping chargeable to revenue at this point (internal capacity increase and field hospitals).
Workforce availability	• Model developed in tandem with detailed workforce plan. • Assumes reduction in shielding and isolating for Quarter 2. • Oversight of Test, Trace, Protect on workforce.
Test, Trace, Protect service model	• Engagement with local authorities on operation and workforce model.
Essential services delivery	• Cost base linked to operational plan to reset and reinstate surgery including the use of outsourcing and insourcing to support clinical needs as this becomes clear • Material changes identified through detailed activity modelling.
Impact of Shortages on Drug Pricing	• Continue to review, refine and reflect the impacts of global shortages, the impact of price concessions and the impact of Category M drugs.
Impact on Capital plan	• Routine in engagement with Welsh Government regarding treatment of COVID-19 response and movement in existing plan. • Executive oversight of overall plan, risks and mitigations • Slippage on local and national schemes transparently disclosed to aid mutual understanding
Impact on underlying recurrent position	• Projected loss of savings opportunities increases underlying pressure. Savings programmes to be revisited and transformation opportunities through reset and recovery work to be explored and implemented where appropriate
Funds flows – LTA/SLA/NCA	• Quarter 1 All Wales agreement in place to manage financial risk of LTA under provision. • Quarter 2 plan under consideration on behalf of DoFs by DDoFs – understood that continuation of Quarter 1 position will remain for Quarter 2 but not formally confirmed at time of writing.

Opportunities
Review contracts in place to test whether changes in modelling can inform commitments made to block contracts for products and services.
Increased activity will reduce loss of income where income remains recoverable outside of agreed national position on LTAs, SLAs and WHSSC.
Engagement with clinical teams to assess whether innovative practice currently being demonstrated can form part of sustainable models of care

Increased levels of partnership working could identify opportunities for joint working for patient and financial benefit
Test, Trace and Protect could positively influence planning assumptions and reduce planned cost.

These will be routinely monitored, not just through Quarter 2 but for the duration of the response to the pandemic.

Financial Summary and Forward Look
The sections above set out the Health Board's position in respect of the original financial plan, the month 2 variation from that plan and the assumptions driving the financial forecast for the remainder of Quarter 1 and Quarter 2.

Through Quarter 2 the finance team will make assessments of the financial benefits and opportunities arising from new models of care. This work is in its infancy but will be developed to support the sustainability agenda through the reset and recovery group.

A full year financial framework has been developed and is under routine scrutiny and refinement based on the movement in the care system across the Health Board. The commitments within this plan are also under routine review to ensure that the Board retains its commitment to work in the public interest and also that due diligence and value for money are observed and enacted.

As the financial approach matures further opportunities to support the care requirements of the population in the presence of Covid-19, maintain good governance and deliver clarity of analysis to support the best decision making in the dynamic environment will be considered. The KPMG support identified opportunities for the Health Board to enhance financial control, governance and reporting and also to pursue a sustainable, improved level of financial performance, which are being incorporated within the Health Board response to new ways of working. By working in this way it is intended to maintain absolute transparency in the financial forecasts and to engage fully with Welsh Government colleagues on the resource handling at this unprecedented time.

13.0 Capital

Response to Covid-19
The Health Board's initial response to Covid-19 has been the main focus of the capital work over Q1, with updated estimates recently submitted for funding related to construction and equipping costs. Construction work on both Field Hospitals and internal critical care surge capacity was completed in June. Subject to the agreement of final accounts on the construction packages, estimated costs of £37.634m will require a mixture of capital and revenue funding. As funding for Local Authority delivery partners is being is being routed via the NHS, work will continue with local authorities and colleagues in Specialist Estates Services, to validate the work packages and ensure timely payments for the Field Hospitals. As work continues to evaluate the future capacity requirements of the pandemic, further assessments will be required for the Field Hospital reinstatement costs and possible adaptions should

changes be made to the clinical model at the Bay Field hospital, if support is required to provide oxygen.

As essential services continue to expand, there may be further requirements for adaptions to the working environment involving construction and equipping, including digital solutions to facilitate social distancing and a reduced on-site physical presence.

CAPITAL	Equipment	Construction	Total
Llandarcy	0.250		**0.250**
Bay	0.271		**0.271**
Surge	2.120	1.991	**4.111**
Total	**2.641**	**1.991**	**4.632**
REVENUE	**Equipment**	**Construction**	**Total**
Llandarcy	0.863	2.901	**3.764**
Bay	0.554	27.408	**27.962**
Surge	1.276		**1.276**
Total	**2.694**	**30.309**	**33.003**
TOTAL	**Equipment**	**Construction**	**Total**
Llandarcy	1.113	2.901	**4.014**
Bay	0.825	27.408	**28.233**
Surge	3.396	1.991	**5.387**
Total	**5.335**	**32.300**	**37.634**

Revised Capital Plan

Due to the limitations on additional capital funding through the All Wales Capital Programme (AWCP), work is underway to assess the local risks associated with non-delivery of a number of critical investments. These include the fully designed and tendered schemes previously submitted for the replacement of the sole CT-SIM at the West Wales Cancer Centre and the Anti-Ligature phase 2 improvements across the Mental Health and Learning Disabilities estate. A number of other major investments are also in advanced development, some with expected commencement of works this year, including the replacement of the cladding at Singleton hospital. Along with a discretionary capital programme that was already impacted by a significant level of backlog maintenance and replacement of estates and equipment, the Health Board is reviewing a number of scenarios and risk assessments to fully understand the impact of delivering these schemes with the approved funding in sections Group 1 and Group 2 of the Capital Resource Limit. The initial assessment is that the approved funding will require some material adjustments, as the initial restatement of the plan forecasts a deficit of £1.428m - this assumes the receipt of the Covid-19 funding of £4.632m. It is highly likely that without a significant curtailment of planned spend, this forecast could increase, given the extremely fragile nature of the sole CT-SIM at the West Wales Cancer Centre and health and safety risks with the Singleton Cladding and Anti-Ligature works.

Assumes WG fund COVID capital spend submitted 8/6	4,632
Scenerio 1. Updated Opening Position for WG Funding Constraints	
	£000
Approved Plan Position	0
Includes Contingency	196
Opening Position -under / over	**-196**
Changes to Reflect Q2 Plan WG Funding Constraints	
Morriston Access Road	1,000
Cladding, Singleton - Prior Year Business Case fee funding	204
Anti-Ligature, P2 - Prior Year Business Case fee funding	105
Environmental Modernisation SOP BJC 2.2 - Prior Year Business Case fee funding	20
Adult Acute Mental Health I/P SOC- Prior Year Business Case fee funding	17
Transitional Care Unit - COVID Overspend (Social Distancing)	197
Adjusted Opening Position (with no contingency) -under / over	**1,347**
Planned AWCP Schemes with No Further Spend Beyond Committed Design	
Ward G Refresh - Design Fees	10
ITU Refurbishment - Design on AHU. Med gases and UPS/IPS Design	30
Thoracics - Design fees	10
Adult Acute Mental Health SOC - QS and design work	11
Linacc C Replacement - Design and Tender fees	20
Adjusted Opening Position (with no contingency) -under / over	**1,428**

Key Actions:

Action	July	August	September
Field Hospitals	Agree final accounts for Field Hospitals. Scope & design potential oxygen adaptations for the Bay Field Hospital. Agree reinstatement costs for Llandarcy Field Hospital	Agree final accounts for Field Hospitals. Scope & design potential oxygen adaptations for the Bay Field Hospital. Agree reinstatement costs for Llandarcy Field Hospital	Undertake works for possible oxygen adaptions at Bay Field Hospital
Updated capital plan	Agree revised capital plan with local risk assessment, with no funding available from the AWCP for schemes in development		
Replacement of CT-SIM, West Wales Cancer Centre	Place orders for CT-SIM equipment. Enter construction contract	Commence construction works.	Continue construction works
Replacement of Cladding, Singleton Hospital	Design of technical options for replacement of cladding.	Design of technical options for replacement of cladding.	Completion of technical business case for cladding replacement.

	Design of enabling package for contractor car park.	Submission of enabling package for contractor car park.	
Anti-Ligature Phase 2	Review of risk associated with a reduced level of initial works.	Review of risk associated with a reduced level of initial works.	Commencement of initial reduced level of capital works.

14.0 Risks and Mitigations

Effective risk management is integral to enabling the Health Board to achieve the Health Board aims, objectives and deliver safe, high quality services.

Recognising the pandemic as an "issue" there is a separate risk register and the Board and relevant sub-Committees of the Board oversee these risks. The Health Boards Risk Appetite has changed in recognition of the pandemic and the tolerance level has increased from 16 to 20 in terms of "high risks".

In June 2020 there are 16 high risks of which three relate to Access to Cancer Services. The Health Board is managing through agreed action plans to mitigate the risk during this challenging period as set out in Table 1. The Board received the Health Board Risk Register in April 2020 and the sub-Committees of the Board are assigned risks form the Health Board Risk Register to monitor implementation of the actions and scrutinise/challenge the mitigation of risks on behalf of the Board.

Table 1

Risk Reference	Description of risk identified	Current Score
16 (840)	**Access to Planned Care** Failure to achieve compliance with waiting times, there is a risk that patients may come to harm. Also, financial risk not achieving targets.	**25**
50 (1761) **66** **67**	**Access to Cancer Services** • Failure to sustain services as currently configured to meet cancer targets could impact on patient and family experience of care. • Delays in access to SACT treatment in Chemotherapy Day Unit • Clinical risk – Target breeches of radical radiotherapy treatment	**25**
3 (843)	**Workforce Recruitment** Failure to recruit medical & dental staff	**20**
51 (1759)	**Nurse Staffing (Wales) Act** Risk of Non-Compliance with the Nurse Staffing (Wales) Act	**20**
4 (739)	**Infection Control** Failure to achieve infection control targets set by Welsh Government could impact on patient and family experience of care.	**20**
62 (2023)	**Sustainable Corporate Services**	**20**

	Health Board's Annual Plan and organisational strategy, and with the skills, capability, behaviours and tools to successfully deliver in support of the whole organisation, and to do so in a way which respects and promotes the health and well-being of staff and their work-life balance.	
64 (2159)	**Health and Safety Infrastructure** Insufficient resource and capacity of the health, safety and fire function to maintain legislative and regulatory compliance.	**20**
39 (1297)	**Approved IMTP – Statutory Compliance** If the Health Board does not have an approved IMTP signed off by Welsh Government, primarily due to the inability to align performance and financial plans it will remain in escalation status, currently "targeted intervention".	**20**
49 (922)	**Trans-catheter Aortic Valve Implementation (TAVI)** Failure to provide a sustainable service for Trans-catheter Aortic Valve Implementation (TAVI)	**20**
63 (1605)	**Screening for Fetal Growth Assessment in line with Gap-Grow** Due to the scanning capacity there are significant challenges in achieving this standard.	**20**
69 (1418)	**Safeguarding** Adolescents being admitted to adult MH wards	**20**
60 (2003)	**Cyber Security – High level risk** The level of cyber security incidents is at an unprecedented level and health is a known target.	**20**
65 (329)	**CTG Monitoring on Labour Wards** Risk associated with misinterpreting abnormal CTG readings in delivery rooms.	**20**
70 (2245)	**National Data Centre Outages** The failure of national systems causes severe disruption across NHS Wales, affecting Primary and secondary care services.	**20**

The Health Board has recognised the pandemic as an issue which is being managed, and in recognition of this there is a separate Risk Register which contains 5 high risks which are set out in Table 2. The risks linked to the pandemic are overseen and reviewed and updated on a weekly basis by Gold Command Covid-19 meetings and reported to the Board in April 2020 and Audit Committee in June 2020.

Three new risks regarding the financial context are currently being drafted and will feature in governance processes for quarter 2. These are: -

- Cost pressures in 2020/21
- Impact of Covid-19 on underlying sustainable financial position of the Health Board
- Revised capital plan to fit challenging CRL

Table 2

Risk Reference	Datix ID	Description of Risk Identified	Current Score
R_COV_004	2369	**Workforce Shortages** Number of staff who are absent from work through self-isolation or family illness will impact on ability to deliver safe care for patients; and will impact on ability to keep capacity open and to staff surge and super surge capacity	20

R_COV_005	2370	**Care Homes** Potential failure in local care home sector to manage staff absences could result in emergency closure of care home which will place undue pressure and therefore on community health and social services to support and/or lead to an increase in patient admission to hospital. Risk of patient harm if care homes are not adequately covered.	25
R_COV_008	2373	**Capacity** Capacity requirements against national modelling mean that the HB capacity may be either insufficient to cope with demand, resulting in an inability to care for patients as well as an increased risk of excess death. Alternatively, if demand is lower than predicted by the modelling, we could develop capacity where it not needed resulting in avoidable expenditure.	20
R_COV_009	2374	**Workforce** Inability to recruit sufficient workforce to fulfil requirements for super surge capacity in field hospitals leading which leads to impact on ability to provide additional capacity and therefore impact on delivery of patient care.	20
R_COV_010	2375	**Delivery of Essential Care** Following the guidance to step down routine activity issued by Welsh Government and the pandemic Health and Social Care Response Plan. There is a risk that the HB's normal business will not be given sufficient focus and that this could lead to a negative impact on patient outcomes and experience, and cause delays to patient treatment resulting in harm	20

15.0 Communications and Engagement

Throughout the pandemic the Health Board has maintained communication with its main engagement groups, albeit by email or virtual meetings. In particular briefings have been held weekly with the Swansea Bay Community Health Council to update them on necessary service changes due to Covid and responding to issues raised by them. A log of these issues / changes has been kept and updated on a rolling basis to ensure there is continuity of discussions on these important issues. A revised Communication and Engagement Framework is being developed and will be agreed with the CHC during Q2.

Engagement mechanisms such as the Stakeholder Reference Group and Accessibility Reference Group are planned to start meeting again virtually from July 2020, with virtual meetings of the Regional Voluntary Sector Network continuing from May 2020.

The regional communications cell, including SBUHB, Swansea Council and NPT Council communications leads has developed a register of region-wide reference groups and stakeholders to share messages communally, and is also building a joint list of hyper-local social media groups to share joint messages. These will be used to promote key messages around essential services, TTP and other issues to support Q2 and future operational plans.

MEASURES	Daily Covid Demand Number of staff referred for the Community Testing Unit and number awaiting results Contact tracing and antibody testing measures Daily complaints, incidents and risks related to Covid Daily PPE Stock Staff absence levels due to sickness/shielding/isolation	NHS Wales Delivery Measures for USC Daily ED demand Daily Available and occupied beds and critical care beds HCAI rates Daily Medically Fit for Discharge numbers Daily number of mortuary spaces Daily number of deaths and discharges Hospital bed occupancy Care home resilience RAG rating
PRIORITIES	Maintain PPE supplies Roll out Test Trace and Protect and antibody testing Start work on Rehabilitation Social Distancing Maintain readiness to respond to Covid-related guidance and response triggers Continue work on workforce supply, engagement and wellbeing	Maintain ability to respond to surge Maintain additional critical care capacity Maintain Field Hospital readiness Infection Prevention and Control Winter Planning Expedite work on Single Medical Take Operate Rapid Discharge Guidance Support social care including care home resilience
HARMS	**Harm from Covid itself**	**Harm from overwhelmed NHS and social care system**
	Harm from reduction in non-Covid activity	**Harm from wider societal actions/lockdown**
PRIORITIES	Maintain and increase outpatients activity on a risk-assessed basis, in line with the Outpatients Modernisation Programme Maintain and increase diagnostics activity Maintain and increase urgent and cancer surgery in line with NHS Wales guidance Maintain and increase other Essential services in line with guidance Continuously review functional capacity plans	Maintain Essential services in Mental Health and Learning Disabilities including monitoring suicide rates Maintain Essential services for children and young people including restarting immunisation programme Undertake Primary Care Recovery Plan
MEASURES	NHS Wales Delivery Framework measures for cancer, RTT and diagnostics Surgical, outpatients, diagnostics and cancer activity Number and proportion of virtual consultations PROMs and PREMs Patient Feedback	Vaccination and Immunisation rates Suicide rates MHLD and Children's services activity Primary care measures Use of Consultant Connect and Ask My GP systems

COVID-19 GOVERNANCE ACROSS WEST GLAMORGAN

Links to National and LRF Cells:
SBUHB - Sian Harrop-Griffiths, Dorothy Edwards, Keith Reid, Karen L Jones
Swansea - Craig Gimblett, Adam Hill
NPT – Karen Jones, Nicola Pearce, Mike Roberts

National and LRF Cells

Links to National and LRF Cells

Joint Leaders Teleconference

Military Liaison Officers

CCC Co-ordination Centre (CCC-19)

- Volunteering
- Field Hospital Delivery Cell
- Digital including Modelling Cell
- Mass Fatalities Cell
- Communications and Engagement Cell (PW)
- PPE Cell (GH)
- Staff Health and Wellbeing (HR)
- Medicines Management (JV)
- Social Distancing Cell
- Scientific Technical Advisory Cell (KR)

Health Board GOLD Command
Keith Reid

Operational Silver will be mobilised in line with escalation/trigger plan
Operational Workforce silver (deployment)

Reset and Recovery Coordinating Group
(separate Governance chart)

West Glamorgan Health and Social Care Media Cell

Extraordinary Regional Partnership Board

Health and Social Care Interface Board
Chair: JS

Neath Port Talbot
IMT
Steven Phillips

Logistincs and Distribution Group Peter Jackson	Warning, Informing & Digital Services Group Karen Jones	Social Services & Health Group Andrew Jarrett	Mass Fatalities & Care of the Dead Group Craig Griffiths & Mike Roberts	Workforce Planning Group Nicola Pearce
Facilities Cleaning, Deep Cleaning Group Simon Brennan (TBC)	Regulatory Services & Enforcement Group Ceri Morris	Community Resilience & Humanitarian / Voluntary Assistance Group Caryn Furlow-Harris	Key Worker Provision & Vulnerable Learning Support Group Aled Jones	Financial Resilience Group Hywel Jenkins / Huw Hones

Swansea
COVID-19
CMT Group
Phil Roberts

Workforce
Lead:
Adrian Chard
Reported via Adam Hill

Core Group
Rob Stewart
Phil Roberts
(Steering Group)

Community Safety Partnership
Safer Swansea
Adam Hill
Paul Thomas
Weekly Update

Sit Rep for LRF
Collated by Craig not a group

Unit Silver Command

PCS Silver	Singleton Silver	Morriston Silver	NPT Silver	MH&LD Silver

Unit Bronze Infrastructure (as required by units) to manage operational issues

Health Board Wide Silver Groups

Infrastructure (DOF)	Workforce	Testing Cell Chair: KR
Equipment Supplied (Ordering) Financial Returns Capital Spend	Recruitment OH Training Operational Workforce Medical Workforce Training	Health Board Testing Workstream

Multi Agency Test, Trace & Protect Silver Chair: SHG

Multi Agency Testing Workstream	Multi Agency Workforce	Multi Agency Comms & Engagement	Multi-Agency Track & Trace

Health Board Operational Group - Testing

COVID-19 Community Silver Command
Chairs: HD, DH, AJ

Third Sector Community Group (Critical Care)	PPE / Infection Control	Building Capacity and Resilience in the Community for Critical Care	Externally Commissioned Care	Children and Young People Group	Medically Fit for Discharge (MFFD)

Business Support
Communications
Finance

Neath Port Talbot – Safe and Well Programme
Karen Jones – Programme Director
Elinor Wellington: Programme Manager

Food and Logistics D Griffiths	Contact and Referrals C Cole	Volunteer Coordination J Heaney	Area Coordination Organised into 6 areas A Harris

Escalation Only

Regional Homelessness Cell

Swansea Council- Daily Updates 1 hour
Martin Nicholls

Field Hospitals Nigel Williams	ICT Group Sarah Lackenby	Contact Centre Tracey McNulty	Food Support Sue Reed	Local Area Coordination Jon Franklin	Other Links Voluntary Groups Tracey McNulty
Building and Ongoing Discussions for Transport of Paitents	Ensuring Website / Email and Concerns Dev of New WebSite	New Contact Centre respond to queries from 6000 Shielded Letter	Food banks, Food Parcels and Sign Posting	Volunteer Groups, Shopping, Prescriptions, Signposting has been expanded across city	Links to SCVS Prescription Delivery and coordinate volunteer effort

Key

- Coordinated via CC
- Reports directly to GOLD
- Reports to Board with input from Gold
- Chaired by DPH to support response

Decision Making

Advice

For Information and Sharing

GOLD: Decision Making
SILVER: Tactical Decision Making
BRONXE: Operational Decision Making
CELLS: Cross system wide planning and delivery (reporting and action via RAID logs with escalation to GOLD on key risks and issues)

WALES WIDE GOVERNANCE

National

Minster for Health and Social Care

NHS Wales Executive Board

Andrew Goodall

Albert Heaney, Frank Atherton, Jean White, Samia Saeed-Edmonds

NHS Wales Medical Directors of Nursing & Midwifery, Directors of Public Health, Directors of Social Services

NHS Wales Health Boards, Trusts, HEIW, National Supporting Organisations

HSSG COVID-19 Planning & Response Cell

HSSG COVID-19 Planning & Response Group
Chair: Samia Saeed-Edmonds
Vice Chair: Gill Richardson

Technical Advisory Cell
Chair: Rob Orford

UK COVID-19
Health Countermeasures Network
Chair: David Goulding

Social Care
Co-chairs: Albert Heaney and Andrea Street

Primary & Community Care
Co-chairs: Dr Liam Taylor (ABUHB) and Paul Labourne

Acute Secondary Care
Co-chairs: Chris Jones, Andrew Sallows & Steve Curry (C&VUHB)

Workforce Deployment & Well-Being
Co-chair: Helen Arthur & Julie Rogers (HEIW)

Regional

Gold
South Wales Strategic Coordinating Group (DHP)
Weekly Meetings

Recovery Coordination Group
(Not yet established)

Silver
South Wales LRF Tactical Coordinating Group

Media Cell

Mass Fatalities

Bronze
Operational Co-ordination

Discussions and will task as and when required

- PPE
- Food Supply including dist to vulnerable groups
- Organisation resilience in the Social Care Sector
- Transport for Key Workers
- Information on vulnerable persons / shielded
- Homelessness
- Prison Releases
- Grass Fires
- Strategic Information and Intelligence Products
- Assess Risk and Develop a Working Strategy

Group:	Name:	Chair of Cell/Silver:	Exec Lead:	CCC Leads:	RAID Log Support	Finance Support
Silver	Infrastructure (Equipping)	Darren Griffiths	Darren Griffiths	Michelle Shorey, Sam Lewis, Ian MacDonald & Joanne Abbott-Davies	Sonja Anderson	Darren Griffiths (Lead) Sam Lewis Ian MacDonald Karen Evans Geraint Norman / Michelle Shorey
Silver	Workforce	Julian Rhys Quirk	Hazel Robinson	Julian Rhys-Quirk	Julian Rhys-Quirk	Sam Lewis Michelle Shorey / Geraint Norman
Silver	Workforce - Occ Health	Julian Rhys Quirk	Hazel Robinson	Paul Dunning		
Silver	Workforce - Operational	Julian Rhys Quirk	Hazel Robinson	Julian Rhys-Quirk		
Silver	Workforce - Recruitment	Julian Rhys Quirk	Hazel Robinson	Guy Holt		
Silver	Workforce - Deployment	Julian Rhys Quirk	Hazel Robinson	Kathryn Jones		
Silver	Community	Rotas between; Dave Howes (Swansea Council); Andrew Jarret (NPTC) and Hilary Dover (SBuHB)	Hilary Dover	Nicola Johnson		Michelle Shorey Sally Killian Richard Bowmer
Silver	Recovery		Hannah Evans	?		Darren Griffiths Sam Lewis Charlie Mackenzie / Paul Harry Michelle Shorey / Geraint Norman Chris Bimson
Silver	Multi-Agency Health Protection (Track & Trace)		Sian Harrop-Griffiths	Joanne Abbott-Davies, Patricia Jones,		
CELL	Capacity Delivery	Chris White	Joanne Abbott-Davies	Michelle Davies NPT, Rhian Edwards & Maxine Evans Singleton, Karen Stapleton, Stephen Evans Morriston, Gareth Bartley MH&LD, Kerry Broadhead - Surge Capacity, Vicky Thomas		Darren Griffiths Charlie Mackenzie / Paul Harry Karen Evans - COVID Chris Bimson - non-COVID
CELL	Field Hospital	Chris White	Joanne Abbott-Davies	Aileen Flynn, Calvin Smith & Thomas Howley MLO's		Julie Field Ian MacDonald
CELL	PPE	Mark Parsons	Gareth Howells & Cathy Dowling	Mark Parsons		Richard Bowmer
CELL	Digital	Sian Richards	Matt John	Carl Mustard, Gareth Westlake & Lee Morgan		Geraint Norman Paul Harry
CELL	Medicine Management	Judith Vincent for SMT Roger Williams for procurement	Judith Vincent	?		Chris Stevens Chris Bimson
CELL	Scientific Technical Advisory	Haven't met yet as of 24/4/20	Keith Reid	Keith Reid		N/A
CELL	Mass Fatalities	Christine Morrell	Chris White	Christine Morrell, Jordan Tucker	Jordan Tucker	Chris Bimson
CELL	TRIM		Dougie Russell	Khan Prince ?		
CELL	Communications	Susan Bailey	Tracy Myhill & Irfon Rees	Sue Bailey - public Lee Leyshon - Staff		N/A
CELL	Psychological Health & Well Being	Paul Dunning	Hazel Robinson	Paul Dunning		Rachel Hook Emma Doolan
CELL	Training	Ian Langfield	Hazel Robinson	Ian Langfield		
CELL	Testing	Julie Morse	Keith Reid Jennifer Davies	Julie Morse		Michelle Shorey Jeremy Lewis
QUERY	Volunteering Cell			Alison Clarke		
QUERY	Professional Leads		Dorothy Edwards - Operations Commander Aidan Bryne - Medical Craige Wilson - Operations	Lisa Hinton - IPC Helen Griffiths / Allyson Rees - Nursing Karen Jones & Jocelyn Jones - EPRR Kerith Jones, Andrea Folland & Juhi Uddin - CCC Support		
CCC-19						Sam Lewis
Gold						Darren Griffiths

Reset & Recovery Programme Structure

Appendix 3

SENIOR LEADERSHIP TEAM (Execs plus triumvirates)
Role - Strategic steer and decision making

CLINICAL ADVISORY GROUP

Clinical Lead - Conor Marnane
Multi professional membership
Areas of Focus:
- Consideration of clinical guidance Prioritisation Framework
- Pre-operative process
- Clinical input into operational solutions/zoning

RESET & RECOVERY COORDINATING GROUP

CW/HE Co-Chair

Modelling Cell

Workforce cell

Social Distancing Cell

National Guidance and responses

PRIMARY AND COMMUNITY

Operational Lead - Hilary Dover/Sharon Millar

Clinical Lead - Anjulha Mehta

Planning Lead - Ruth Tovey

Areas of Focus
R*ecovery plans for independent contractors in line with WG issued guidance*
Communtiy services

MEDICINE/SINGLE ACUTE TAKE

Operational lead - Jan Worthing

Clinical Leads - Aidan Byrne with
Andrea Bradley - Acute Take
Rhodri Edwards - Older People

Planning lead - Karen Stapleton - Acute Medical Take
Heledd Rehab/Older People

Areas of Focus
- Feasibility on single acute take including timescales, workforce, displacement -
- Ambulatory Care Model
- Older People
- Rehab model - national guidance (These may be sub groups)
- discharge pathway
- H2H

SURGICAL & THEATRES

Operational Lead - Deb Lewis

Clinical Lead - Conor Marnae

Planning lead - Maxine Evans

Areas of Focus

- Pre-assessment / screening
Theatre Capacity
Emergency / Trauma
Transfer of services to Singleton
Orthopaedics at NPTH
COVID-Lite at Morriston
Paediatrics

CANCER & PALLIATIVE

Operational Lead - Jan Worthing

Clinical Lead - Martin Rolles

Planning Lead - Michelle Crossland

Areas of Focus
- Non surgical cancer services
- Cancer network and national guidance
- Guidance on palliative care - link with clinical prioritisation work
- Engage with WCN/WG on regional solutions (as per Op F/W)

DIAGNOSTICS

Operational lead - Brian Owen

Clinical Leads - Rhodri Stacey/Derrian M/Toby Wells

Planning Lead - Steven Evans

Areas of Focus
- access to urgent diagnostics path, endoscopy, rad
Impact of service increases in other areas that will impact on diagnostic demand/capacity
- National guidance expected

MENTAL HEALTH & LD

Operational Lead - Dai Roberts/Janet Williams

Clinical Lead - Richard Maggs

Planning Lead - Gareth Bartley

Areas of Focus
- Link with WG MH incident Group
- National guidance on LD
- National guidance on substance misuse

OUTPATIENTS

Clinical Lead - Phil Coles
Operational Lead - Craige Wilson
Programme/Planning lead - Michelle Davies
Unit leads - Sam Williams, Michelle Mawson Gawne, Sue Jones, PCS

Areas of Focus
- Analysis of performance legacy position
- Prioritised plans
- Chronic conditions with PCS/Demand management
- Digital solutions rolle out - Anytime
- National guidance on SOS
- National Outpatients Framework
- Plan to respond to additional monies

MORRISTON SERVICE AND SITE PLAN (Deb Lewis)

SINGLETON SERVICE AND SITE PLAN (Jan Worthing)

NPT SERVICE AND SITE PLAN (Brian Owen)

GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

Service Status Code:
Do not provide or commission this service 0
Essential services unable to be maintained 1
Essential services maintained (in line with guidance) 2

June 2020 Essential Services Status Review

Essential Services	SERVICE CODE	
Access to primary care services (providing essential, additional and a limited range of enhanced services that fulfil the WHO high priority categories)		**KEY RISKS AND ISSUES**
Service Status - Primary Care Services	2	Plans developing in line with Recovery guidance, Each service area has already been impact assessed and a risk rating allocated to that service area
Service Status - General Medical Services	2	Plans developing in line with WG Recovery plan.
Service Status - Community pharmacy services	2	CPW have expressed concerns with re staffing issues if community pharmacy staff are required to self-isolate as part of the TTP scheme. HB PMM have advised local resilience plans should be made between pharmacies in clusters/ groups of multiples to ensure continuity of service.
Service Status - Red Alert urgent/emergency dental services	2	CDO indication that progress from Red to Amber in July 2020. Action to implement being undertaken
Service Status - Optometry services	2	All wales move from Red to Amber in July 2020. Action to progress being undertaken
Service Status - Community Nursing and Allied Health Professionals services	2	
Service Status - 111/Out of Hours Services	3	Services remodelled in line with guidance
Safeguarding services		**KEY RISKS AND ISSUES**
Service Status - Safeguarding services	2	Good arrangements in place with partners
Urgent Eye Care		**KEY RISKS AND ISSUES**
Service Status - Urgent Eye Care	2	Although we maintained the most urgent eye care services, many patients on follow-up lists/ waiting lists for surgery have exceeded the desired timeline for their delayed appointments. Plans are being drawn up for activity to be increased in outpatients. However, surgical services are still severely limited
Urgent surgery		**KEY RISKS AND ISSUES**
Service Status - Urgent surgery - overview	2	Limited theatre capacity available with theatre lists being allocated through a twice weekly Theatre Timetable Meeting. Theatre capacity is assigned from detail within a Health Board wide priority list compiled by the Surgeons. Limited capacity is resulting in a further backlog of patients and the risk of poorer outcomes. Plans consistently being received and challenged. Capacity is restricted due to workforce constraints, PPE , IPC and social distancing.
Service Status - Urgent surgery - Gynaecology and Breast	2	Gynaecology & Breast Surgery - cancer surgery has continued albeit with reduced capacity - alternative treatments offered where appropriate. No benign elective operating taking place.

Essential Services	SERVICE CODE	
Service Status - Urgent surgery - Ophthalmology	2	Ophthalmology - surgery has continued for emergency and very urgent cases where there is a high risk of irreversible sight loss. Loss of theatre capacity has prevented access to routine surgery for most patients
Service Status - Urgent surgery - Thoracic	2	Thoracic - surgery has continued on very urgent cases. We have 2x surgeons in each of the 3 MDTs and a pooled operating list. Patients are proposed on the HB wide priority list as per other specialties for theatre access. Initially we did not have an elective non-COVID PACU pathway but this was put in place and thoracic surgery commenced. Significant reduction in patients being discussed at MDT and suitable or consenting for surgery. Combined discussions with C&V and WHSSC and Wales Cancer Network to develop South Wales supra MDT to consider prioritisation and response to fluctuating capacity and demand in both centres.
Service Status - Urgent surgery - Plastic Surgery	2	Plastic Surgery - limited trauma and elective access as per other specialties. Nature of some plastics cancer surgery e.g. melanoma allowed private hospital capacity to be utilised productively protecting available NHS theatre capacity. Plastics trauma has been limited due to increased ortho trauma but improving. Plastics surgery treatment centre in Morriston has been key to elective an minor trauma operating for plastics providing day case capacity and encouraging change sin practice (anaesthetic method etc..) to facilitate treatment previously done under GA in main theatres improving efficiency and outcomes/risk for patients
Service Status - Urgent surgery - **Elective Orthopaedics**	2	Elective Orthopaedics- severely restricted services. level 1a and 1b cases are being treated with trauma capacity increased at Morriston. level 2 spines being treated. Significant challenge with Level 3 and 4. . Orthopaedic theatre staff prioritising trauma operating. Majority of cases are RCS Priority 3 so wouldn't fit into the HB wide prioritisation of priority 2 theatre cases. Project group established to consider strategic direction of service and use of Neath Port Talbot Hospital as an elective orthopaedic centre post COVID. Capital design options being developed and implementation timescales will follow.
Service Status - Urgent surgery - Spinal	2	Spinal Surgery - limited emergency and elective capacity. Limited to priority 2 cases as per HB process. Flexible approach to capacity to deal with spinal trauma e.g. electives needing to be rescheduled. Around 1 list a week (sometimes 2) for spines at present versus 5 lists per week pre COVID.
Hip fracture surgery - Trauma	2	#NOF surgery has continued as level 1a and 1b. Capacity was restricted at start of COVID but trauma theatre lists have increased. Self assessment against WG Hip Fracture guidance underway. The HB wide #NOF improvement plan continues with weekly operational meetings with the multi - agency teams to improve the pathway and ensure all avenues are optimised for access to treatment.
Urgent cancer treatments		**KEY RISKS AND ISSUES**
Service Status - Urgent cancer treatments	2	**Oncology**- Reduction of capacity to deliver SACT and RT to meet social distancing rules of 2m and ensure safe Covid environment. Significant concern about coping with high volume of patient numbers as cancer surgery increases / screening resumes / delayed presentation of disease and ability of oncology team to assess and initiate treatment in a timely manner due to consultant clinic capacity / ability of treatment unit to accommodate numbers / pharmacy pressure etc. Haematology- Ability to maintain 'clean' access and limited exposure to personnel for patients attending hospital for assessment and treatment as general foot fall increases with resume of more services. Screening for patients prior to treatment in line with new Cancer Covid Framework for all Cancer oncology patients including Blood cancers and Solid tumours. **Endoscopy** - Reduction of capacity to deliver Diagnostic Endoscopy due to social distancing and need to allow for air flow changes. Workforce deployed back into the Endoscopy service and plans in place to re-instate all funded sessions. Due to IPC and SD requirements this will only provide 50/60% of previous capacity. Recovery plan developed and use of alternative diagnostic tests such as FIT Test utilised to aid diagnosis. No routine Endoscopy currently being undertaken as focus on prioritising Cancer and emergency work. Backlog of 1200 patients currently over 8 weeks. Re-introduction of National Bowel Screening service will further impact on timeliness of test.

Essential Services	SERVICE CODE	
Major Trauma		**KEY RISKS AND ISSUES**
Major Trauma	3	Focus on emergency operating has dedicated provision to trauma cases and increased T&O and plastics consultant availability has meant double operating possible where required. However, post operative monitoring of skin flaps has been a challenge due to ward reconfiguration to support limited covid elective operating and specialist staffing availability. Plan to re introduce in next 2/52 with changes to layout of theatres in Morriston.
Cardiac services		**KEY RISKS AND ISSUES**
Rapid access clinics	2	Enhanced telephone triage and surveillance of waiting lists (including patients graded routine and urgent) and bringing clinically urgent patients into rapid access clinic as require. There is a sizeable waiting list for the rapid access chest pain clinics which has prompted review of the acceptance criteria and service model, to ensure that the rapid pathway can be maintained for the most urgent patients within 4-6 weeks, and create a 12-15 week pathway for those less urgent but still require diagnostic assessment.
Admission pathways (MI, class IV heart failure, arrhythmias, ACS, endocarits, aortic stenosis)	2	Urgent and emergency admission pathways remain open with beds being managed via both green and red admission streams.
Essential diagnostics - ECG	2	Diagnostic services are available for very urgent patients only on Gorseinon Hospital site. ECG available to support urgent hot clinics.
Essential diagnostics - ECHO	2	Diagnostic services are available for very urgent patients only on Gorseinon Hospital site
Essential diagnostics - 24 hour ECH/event monitoring	2	Diagnostic services are available for very urgent patients only on Gorseinon Hospital site
Essential diagnostics - CT coronary angiogram	2	Service is available for very urgent patients only
Essential diagnostics - invasive coronary angiogram	2	Service is available for very urgent patients only
Essential diagnostics - stress/exercise tolerance test	2	diagnostic services are available for very urgent patients only on Gorseinon Hospital site
Essential diagnostics - Doppler stress echo	2	diagnostic services are available for very urgent patients only
Essential diagnostics -myardial perfusion scanning	2	Service is available for very urgent patients only
Essential diagnostics -cardiac CT/MRI	2	Service is available for very urgent patients only
Intervention - cardiac surgery	3	Intervention is available for urgent patients. Elective admission process fully adhered to and service is treating some elective patients alongside inpatient urgent cases. ITU bed capacity has increased for the service which can now start more fully utilising theatre staffing. ODP capacity has increased, creating a full second theatre team on many days. Standard risks of sickness within theatre teams and CITU having the potential to impact on ability to deliver
Intervention - ICD implantation	3	Intervention is available for clinically urgent patients. Elective patients as well as inpatients are being treated. Bed capacity on ward is part of capacity planning process to maximise capacity. Risk of sickness within teams having potential to impact on ability to deliver
Intervention -CRT implantation	3	Intervention is available for clinically urgent patients. Elective patients as well as inpatients are being treated. Bed capacity on ward is part of capacity planning process to maximise capacity. Risk of sickness within teams having potential to impact on ability to deliver
Intervention -cardiac ablation	3	Intervention is available for clinically urgent patients. Elective patients as well as inpatients are being treated. Bed capacity on ward is part of capacity planning process to maximise capacity. Risk of sickness within teams having potential to impact on ability to deliver
Intervention - PCI	3	Intervention is available for clinically urgent patients. Elective patients as well as inpatients are being treated. Bed capacity on ward is part of capacity planning process to maximise capacity. Risk of sickness within teams having potential to impact on ability to deliver
Intervention -NSTEMI	4	
Intervention - Primary PCI	3	Intervention is available for clinically urgent patients. Elective patients as well as inpatients are being treated. Bed capacity on ward is part of capacity planning process to maximise capacity. Risk of sickness within teams having potential to impact on ability to deliver
Intervention - congenital heart surgery	0	
Intervention - TAVI	3	Intervention is available for clinically urgent patients. Elective patients as well as inpatients are being treated. Bed capacity on ward is part of capacity planning process to maximise capacity. Risk of sickness within teams having potential to impact on ability to deliver

Essential Services	SERVICE CODE	
Artificial Limb & Appliance Services (ALAC)		**KEY RISKS AND ISSUES**
ALAC	2	Limited appointments have been undertaken from patients vehicles, as patients were not able to access the building due to environmental issues and the risk of infection for this vulnerable group of patients, which has caused a significant backlog. Patient access to the building will recommence on 29/06 and the service is following specific guidance from the British Society of Rehabilitation Medicine in line with all other Artificial Limb Appliance Services in the UK. Social distancing within the guidance will caused a reduction of capacity of approximately 60%, which will also effect interdependent services including Physiotherapy, OT and Psychology.
Life-saving medical services		**KEY RISKS AND ISSUES**
Service Status - Gastroenterology	2	All USC referral vetted and alternative to face to face appointment offered. Telephone Assessment and clinical validation undertaken and limited appointments available for USC Referrals. No capacity for routine referrals currently and backlog of over 900 patients waiting over 26 weeks. Administrative and clinical validation, attend anywhere and virtual assessment will support reduction of backlog.
Service Status - Stroke Care	3	Pathway for Stroke rehabilitation from Morriston to Singleton re-established during June 2020. SSNAP was suspended for April and May. It has been resumed from the 1st June 2020.
Service Status - Diabetic Care	3	The diabetes service has been maintained remotely during COVID 19. This has involved diabetes specialist nurses being responsive to patient's telephone queries and also doctors prospectively reviewing patients records to review any particularly problematic areas which need proactive intervention. However, we need to re introduce the regular review of patients with diabetes. In view of the social distancing measures which will be in place in OPD we propose to re introduce clinics in a combination of virtual and face to face clinic sessions.
Service Status - Diabetic Care (Diagnosis of new patients)	3	Limited capacity to see new patients but plan is to run on alternate weeks be re started on a weekly basis for 6-8 patients. Focus on problem cases such as emergency referrals, new patient referrals, patients with multiple problems and co-morbidities.
Service Status - Diabetic Care (DKA / hyperosmolar hyperglycaemic state)	4	Urgent DKA care provided via embedded pathway within hospital.
Service Status - Diabetic Care (Severe Hypoglycaemia)	4	Urgent DKA care provided via embedded pathway within hospital.
Service Status - Diabetic Care (Newly diagnosed patients especially where insulin control is problematic)	3	Reduced capacity but plan in place that problematic patients on insulin pumps continue to attend the face to face sessions if they are having problems whilst others who are more stable would be followed by virtual review. If diabetes clinics are not reinstated there will be an increase in the number of admissions to hospital with acute complications of diabetes such as hypoglycaemia and DKA. There will also be a risk of acute decompensation of chronic conditions such as acute kidney injury and foot sepsis. There will be an increased risk of cardiovascular complications in the longer term. Failure to provide adequate follow up for patients with diabetes also poses a threat of litigation.
Service Status - Diabetic Care (Diabetic Retinopathy and diabetic maculopathy)	3	
Service Status - Diabetic Care (Emergency podiatry services)	3	There are risks from increased reliance on virtual consultation in terms of identifying physical complications such as foot disease, Blood pressure management and injection site problems. Failure to adequately assess these areas will lead to increased risk of complications. There will need to be a strategy to identify these issues in the community with communication of the information between primary and secondary care.
Service Status - Neurological conditions	2	Most urgent cases only have been seen face 2 face - minimal ability. Clinics have been maintained via virtual review / telephone consultation generally - but this has reached a point where by reinstating face to face clinics has become a key priority. Neurology is predominantly an outpatient based service that reduces the number of emergency admissions that would otherwise occur.
Service Status - Rehabilitation	3	Rehabilitation services reinstated on the Singleton Site for Orth geriatric and Stroke Rehabilitation

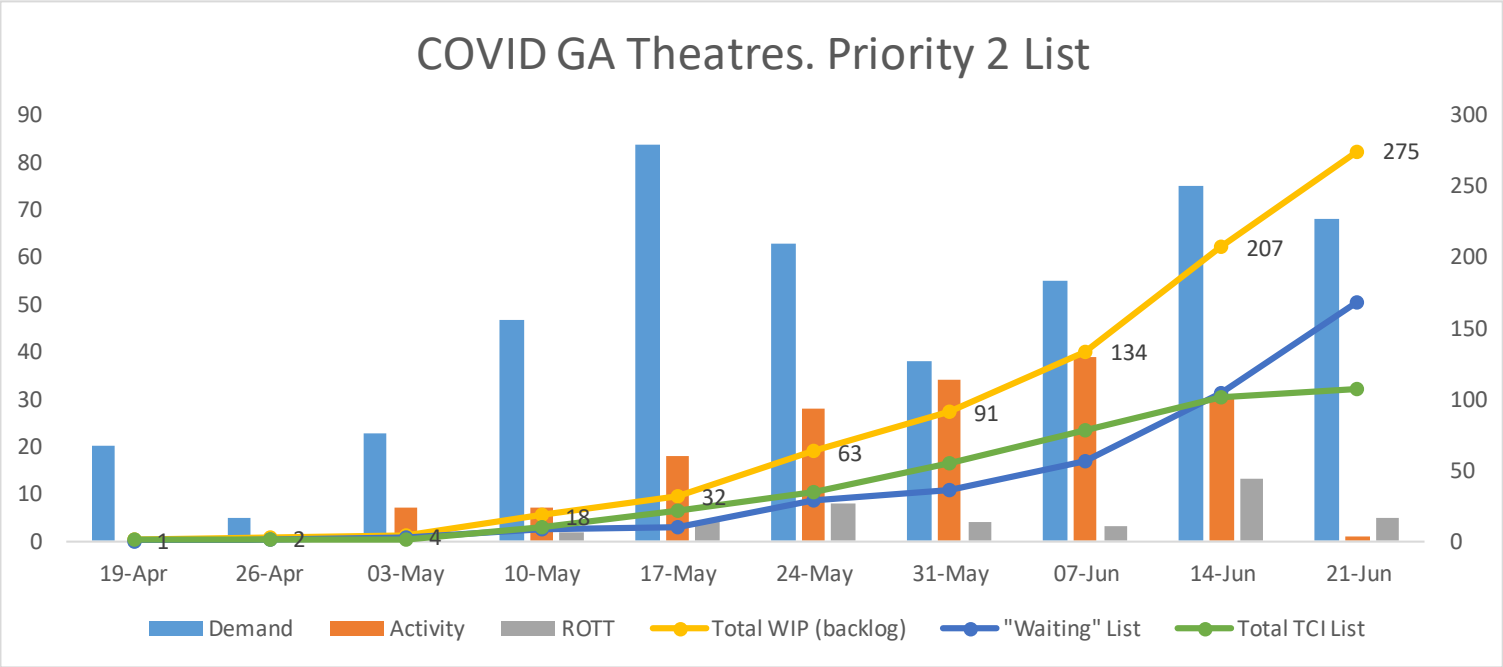
Essential Services	SERVICE CODE	
Life-saving or life-impacting paediatric services		**KEY RISKS AND ISSUES**
Service Status - Paediatric intensive care and transport	2	Concern with staff sickness and shielding in a service which is already under pressure for staffing challenges
Service Status - Paediatric and neonatal emergency surgery	3	Risks of the lack of appropriate space/theatre time to undertake the number of urgent work necessary.
Service Status - Urgent cardiac surgery (at Bristol for South Wales population)	2	
Service Status - Urgent illness	4	
Service Status - Immunisations and vaccinations	4	
Service Status - Screening (Blood Spot)	4	
Service Status - Screening (Hearing)	4	
Service Status - Screening (New Born)	4	
Service Status - Screening (6 week physical exam)	4	
Service Status - Community paediatric services for children (with additional / continuous healthcare needs including care closer to home models and community hubs)	4	
Paediatric specialist services		**KEY RISKS AND ISSUES**
paediatric cardiology	2	
cystic fibrosis	2	Currently unable to bring patients on site due to shielding restrictions, however maintaining contact through virtual clinics. Concerns regarding available OPD space when patients can be seen face to face.
sleep service	2	
neurology and neurorehabilitation	2	Maintaining contact with patients, but requirement to bring on to site for appropriate meds management. General concern around OPD space availability.
Paediatric and neonatal emergency surgery	3	Risks of the lack of appropriate space/theatre time to undertake the number of urgent work necessary.
paediatric surgery	3	Risks of the lack of appropriate space/theatre time to undertake the number of urgent work necessary.
Neonatal services	2	Concern with staff sickness and shielding in a service which is already under pressure for staffing challenges
oncology services including paeds radiotherapy	2	Increased risk around bringing the patients onto site, also the lack of available OPD space.
Cleft lip and palate services	2	Risk regarding the available space and appropriate theatre availability to see urgent patients Currently only a few primary palate surgeries are being undertaken where lists are available. As a service we are prioritising • Lip and vomer flap repairs between 3-6 months to facilitate the palate repair between 6-9 months • Palate repairs between 6-9 months • Paeds palate re-repair by age 5yrs 11mo. Surgery to this group is time sensitive and unless regular lists are allocated, patients outcomes will be affected. We are seeking to re-instate MDT outpatient clinics to address urgent concerns and treatments. Currently only baby clinics are taking place. Delay in outpatient treatment will also affect patient's long term outcomes in speech, dental, hearing and psychological well being.
Renal services	2	Reduced vascular access capacity due to fewer elective lists running at Morriston and Singleton Waiting lists growing due to only essential services being maintained. Risk of increased need for dialysis in future due to CKD patients deteriorating.
Endocrinology services	2	
Gastroenterology services	2	

Essential Services	SERVICE CODE	
Inherited metabolic disease	0	
cochlear implants	0	
transplantation	0	
Termination of Pregnancy		**KEY RISKS AND ISSUES**
Service Status - Termination of Pregnancy	2	scored from a community perspective only
Other infectious conditions (sexual non-sexual)		**KEY RISKS AND ISSUES**
Service Status - Other infectious conditions (sexual non-sexual)	2	Integrated Sexual Health Service
Service Status - Urgent services for patients	2	Integrated Sexual Health Service
Maternity Services		**KEY RISKS AND ISSUES**
Service Status - Maternity Services	2	Self assessment against maternity guidance demonstrated good compliance
Neonatal Services		**KEY RISKS AND ISSUES**
Service Status - Surgery for neonates	0	
Service Status - Isolation facilities for COVID-19 positive neonates	2	Self assessment against neonatal guidance demonstrated good compliance
Service Status - Usual access to neonatal transport and retrieval services	2	Self assessment against neonatal guidance demonstrated good compliance
Mental Health, NHS Learning Disability Services and Substance misuse		**KEY RISKS AND ISSUES**
Service Status - Crisis Services including perinatal care	3	Potential for increased referrals in next 12 months linked to COVID 19.
Service Status - Inpatient Services at varying levels of acuity	3	Potential for increased referrals in next 12 months linked to COVID 19.
Service Status - Community MH services that maintain a patient's condition stability (to prevent deterioration, e.g. administration of Depot injection)	3	Potential for increased referrals in next 12 months linked to COVID 19.
Service Status - Substance Misuse services that maintain a patient's condition stability (e.g., prescription and dispensing of opiate substitution therapies)	3	Potential for increased referrals in next 12 months linked to COVID 19.
Renal care-dialysis		**KEY RISKS AND ISSUES**
Service Status - Renal care-dialysis	2	some limitations in access to vascular access, resulting in backlog of patients
Urgent supply of medications and supplies including those required for the ongoing management of chronic diseases, including mental health conditions		**KEY RISKS AND ISSUES**
Service Status - Urgent supply of medications and supplies including those required for the ongoing management of chronic diseases, including mental health conditions	2	Shortages of a number of common drugs in acute and primary care. Supplies of critical care, renal dialysis fluids and palliative care drugs in the event of a second COVID surge. Staff availability as a consequence of shielding/social distancing and TTP and therefore ability to provide timely access to medicines and clinical services. Patients shielding and collection of medication from community pharmacy. Sustainability of systems implemented during COVID surge period.
Blood and Transplantation Services		**KEY RISKS AND ISSUES**
Service Status - Blood and Transplantation Services	4	
Service Status - Blood and Blood components	4	Potential shortage of available blood components due to reduction in capacity of blood service for collections as a consequence of social distancing measures at collection sites
Service Status - British Transplantation Society	0	
Service Status - Transplantation services	0	
Service Status - Stem Cell transplantation services	0	Decisions regarding proceeding to stem cells transplant are being risk assessed on a case by case basis with balance of benefit to increased infection risk paramount. Patient reluctance to consider stem cell transplant in the current climate once risk assessment discussions are undertaken is likely to be main deciding factor in uptake
Service Status - Solid Organ Services	0	
Service Status - Platelet Services	4	
Palliative Care		**KEY RISKS AND ISSUES**
Service Status - Palliative Care	2	

Essential Services	SERVICE CODE	
Emergency Ambulance Services		**KEY RISKS AND ISSUES**
Service Status - Emergency Ambulance Services		

Additional Services	
CT	2
MRI	2
US	2
X-ray	2
CT - Cardiology	2
Endoscopy	2
Bronchoscopy	2
Physiological testing	2
ECG	2
Electroencephalogram	2
Electromyography	2
Microbiology	2
Pathology	2
Haematology	2
Biochemistry	2
Phlebotomy	2
Occupational Therapy	2
Speech and Language Therapy	2
Dietetics	2
Podiatry	2
Physiotherapy	2

COVID GA Theatres Priority 2 List Analysis (28.6.20)

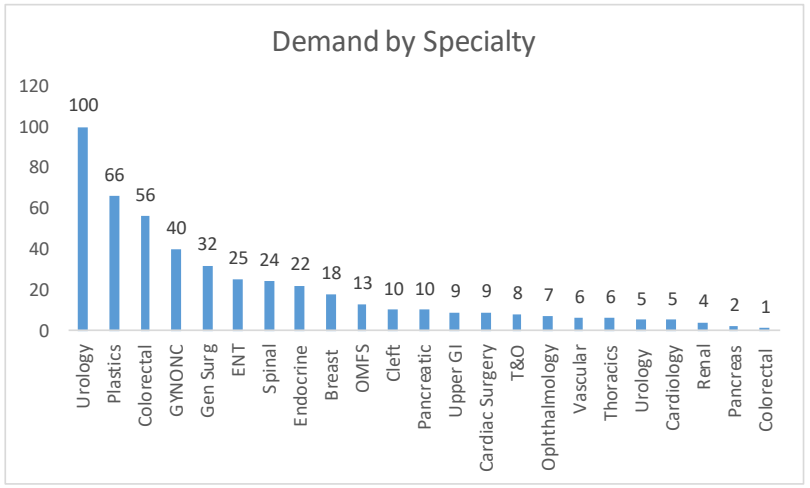


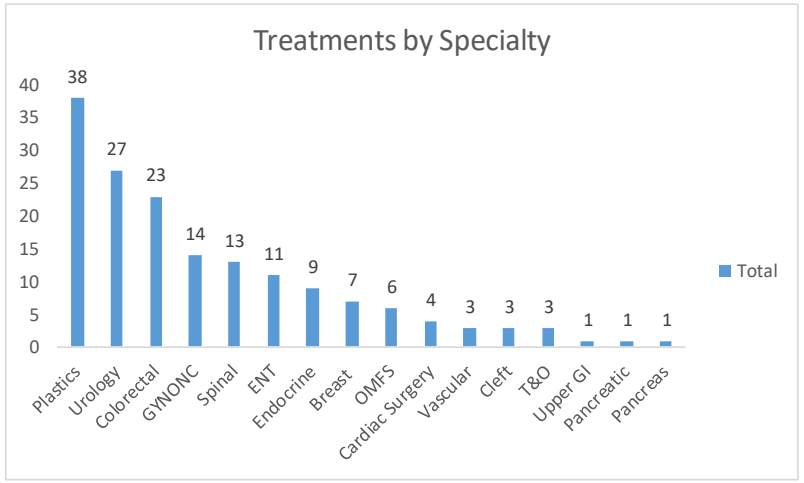
Week Beginning	19-Apr	26-Apr	03-May	10-May	17-May	24-May	31-May	07-Jun	14-Jun	21-Jun
Demand	**20**	**5**	**23**	**47**	**84**	**63**	**38**	**55**	**75**	**68**
Activity			7	7	18	28	34	39	30	1
ROTT	0	0	**0**	**2**	**4**	**8**	**4**	**3**	**13**	**5**
Additions to WIP	**1**	**1**	**2**	**14**	**14**	**31**	**28**	**43**	**73**	**68**
Total WIP (backlog)	1	2	4	18	32	63	91	134	207	275
Additions to Waiting per weel		1	2	5	2	19	7	20	49	63
"Waiting" List	**0**	1	3	8	10	29	36	56	105	168
Additions to TCI List	1	0	0	9	12	12	21	23	24	5
Total TCI List	1	1	1	10	22	34	55	78	102	107

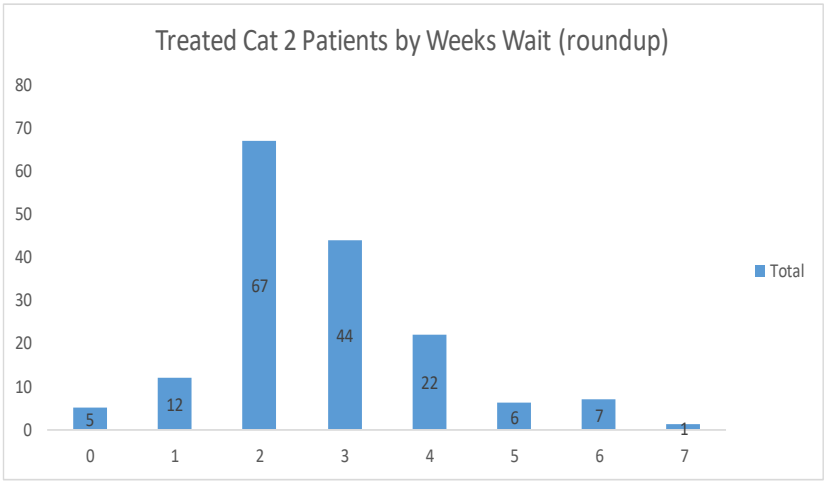
SUMMARY

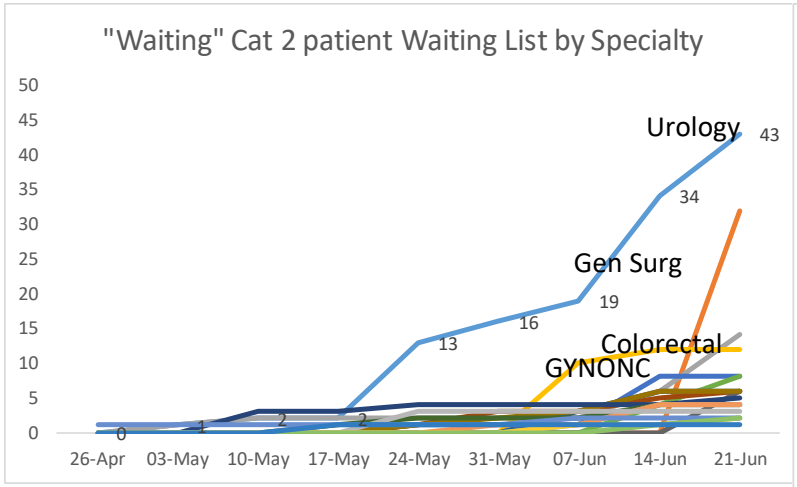
- 92% of treated patients have received treatment within 4 weeks
- There is a risk of deterioration due to demand exceeding activity (mostly within urology) and TCI booking dates increasing past 4 week target
- Of all Work In Progress (TCI and ‘Waiting’) 67% are currently within 4 week target, and 33% over.
- Of those over 4 weeks, 60% have a TCI
- This situation could be worse if current ROTT levels also decline (unknown risk)
- Total WIP increasing in size weekly, again mostly driven by mismatch in urology demand vs activity
- TCI booking % has improved weekly, mostly driven by urology once again.
- Plastics have undertaken the most treatments to date.

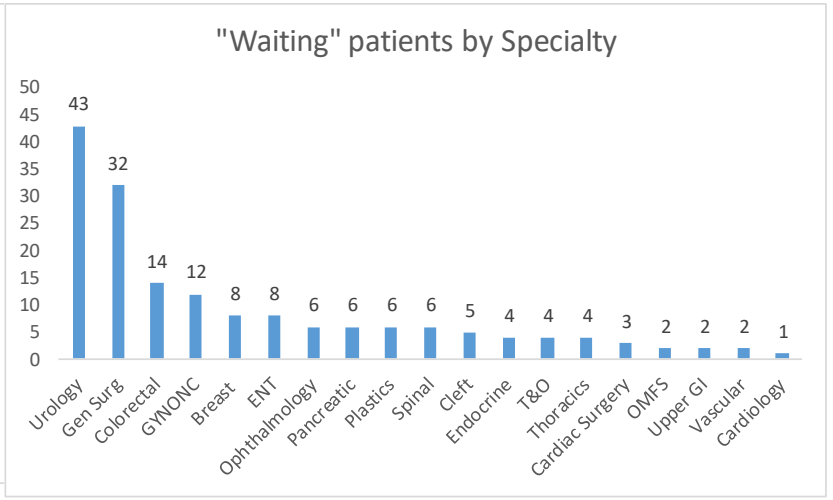
COVID GA Theatres Priority 2 List Analysis (28.6.20)

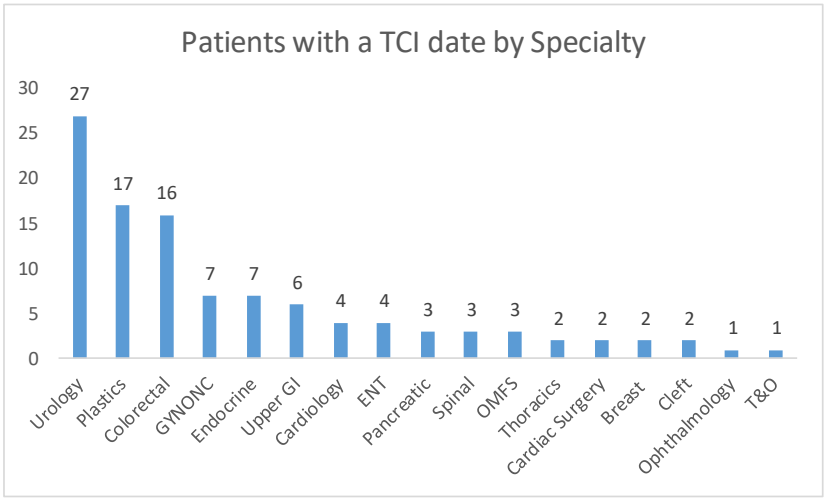






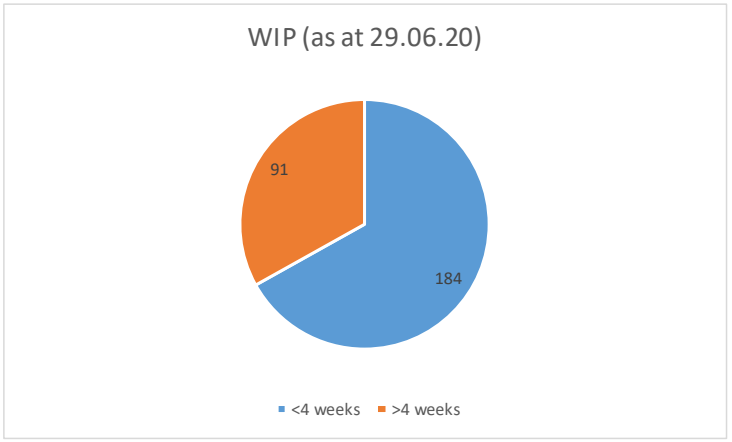


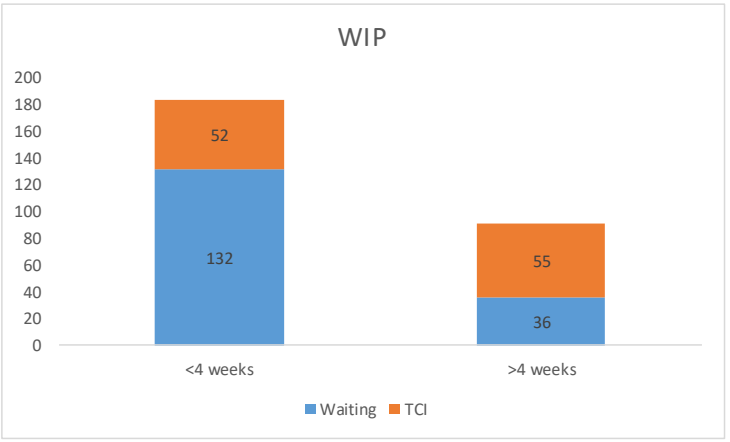


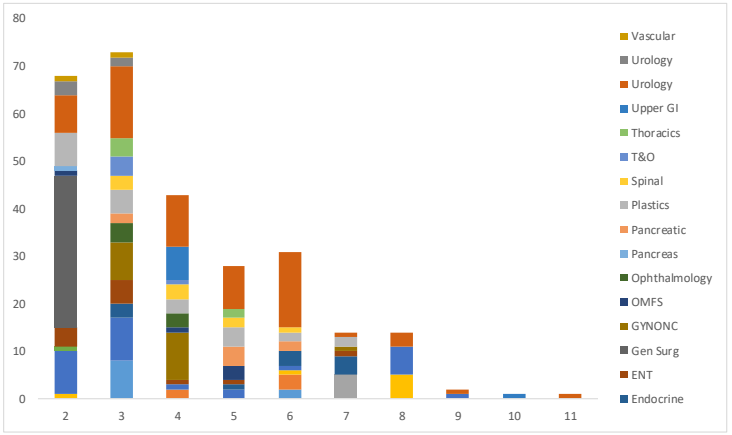


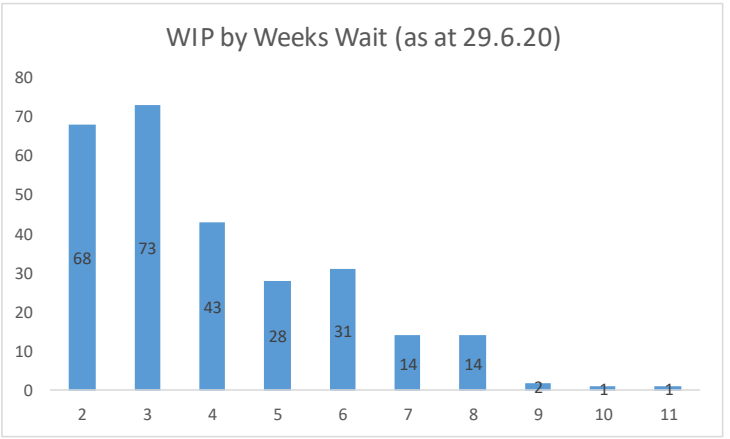
COVID GA Theatres Priority 2 List Analysis (28.6.20) = WIP Analysis

	Weeks Wait										
Specialty	2	3	4	5	6	7	8	9	10	11	**Grand Total**
Breast		8			2						10
Cardiac Surgery			2		3						5
Cardiology						5					5
Cleft	1				1		5				7
Colorectal	9	9	1	2	1		6	1			29
Colorectal	1										1
Endocrine		3		1	3	4					11
ENT	4	5	1	1		1					12
Gen Surg	32										32
GYNONC		8	10			1					19
OMFS	1		1	3							5
Ophthalmology		4	3								7
Pancreas	1										1
Pancreatic		2		4	2						8
Plastics	7	5	3	4	2	2					23
Spinal		3	3	2	1						9
T&O		4	1								5
Thoracics		4		2							6
Upper GI			7						1		8
Urology	8	15	11	9	16	1	3	1		1	65
Urology	3	2									5
Vascular	1	1									2
Grand Total	68	73	43	28	31	14	14	2	1	1	**275**









Functional Capacity for Essential Services (Levels 1a, 1b and 2)

Elective - Inpatient/Daycase

Hopital Site	Theatre Designation	Jul-20					Aug-20					Sep-20				
		Avg. Sessions per Week	Avg. Cases per Session	Avg. Cases per Week	Avg. Cases per Month	Minimum Staff Requirement	Avg. Sessions per Week	Avg. Cases per Session	Avg. Cases per Week	Avg. Cases per Month	Minimum Staff Requirement	Avg. Sessions per Week	Avg. Cases per Session	Avg. Cases per Week	Avg. Cases per Month	Minimum Staff Requirement
Morriston	Main theatres	25.00	1.62	40.50	162.00	6.00	35.00	1.62	56.00	224.00	6.00	35.00	4.63	162.00	648.00	6.00
	Plastic Surgery Treatment Centre	20.00	4.66	93.25	373.00	6.00	20.00	4.66	93.25	373.00	6.00	20.00	4.66	93.25	373.00	6.00
	Head & Neck OPD	3.00	3.58	10.75	43.00	6.00	3.00	3.58	10.75	43.00	6.00	3.00	3.58	10.75	43.00	6.00
Singleton	Main Theatres	20.00	2.78	55.50	222.00	6.00	20.00	2.78	55.50	222.00	6.00	20.00	2.78	55.50	222.00	6.00
	Day Surgery Unit	5.00	8.70	43.50	174.00	6.00	5.00	8.70	43.50	174.00	6.00	5.00	8.70	43.50	174.00	6.00
Grand Total		**73.00**	**21.34**	**243.50**	**974.00**	**30.00**	**83.00**	**21.34**	**259.00**	**1036.00**	**30.00**	**83.00**	**24.35**	**365.00**	**1460.00**	**30.00**

Emergency/Trauma

Hopital Site	Theatre Designation	Jul-20					Aug-20					Sep-20				
		Avg. Sessions per Week	Avg. Cases per Session	Avg. Cases per Week	Avg. Cases per Month	Minimum Staff Requirement	Avg. Sessions per Week	Avg. Cases per Session	Avg. Cases per Week	Avg. Cases per Month	Minimum Staff Requirement	Avg. Sessions per Week	Avg. Cases per Session	Avg. Cases per Week	Avg. Cases per Month	Minimum Staff Requirement
Morriston	Main theatres - * in hours and weekends	133.87	1.43	174.00	694.00	6.00	137.87	1.43	197.00	766.00	6.00	137.87	1.43	197.00	766.00	6.00
	Plastic Surgery Treatment Centre	6.00	3.79	23.00	91.00	6.00	6.00	3.79	23.00	91.00	6.00	6.00	3.79	23.00	91.00	6.00
	Head & Neck OPD	2.00	2.00	4.00	16.00	6.00	2.00	2.00	4.00	16.00	6.00	2.00	2.00	4.00	16.00	6.00
Singleton	Main theatres - * in hours and weekends	54.80	0.24	13.00	52.00	6.00	54.80	0.24	13.00	52.00	6.00	54.80	0.24	13.00	52.00	6.00
	Day Surgery Unit	6.00	3.63	22.00	87.00	6.00	6.00	3.63	22.00	87.00	6.00	6.00	3.63	22.00	87.00	6.00
Grand Total		**202.67**	**11.09**	**236.00**	**940.00**	**30.00**	**206.67**	**11.09**	**259.00**	**1012.00**	**30.00**	**206.67**	**11.09**	**259.00**	**1012.00**	**30.00**

Bay Field Hospital
Staffing Proposal

Phase 1		Beds:	419			Level 1 Routine Care			
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds	RN + Reg Prof Ratio to Beds	HCSW Ratio to Beds	SSA Ratio to Beds
Early (7.5 Hours)	14	5	52	12	12	1/ 30	1/ 22	1/ 8	1/ 35
Late (7.5 Hours)	14	5	52	12	12	1/ 30	1/ 22	1/ 8	1/ 35
Nights (9.5 Hours)	13	3	41	12	12	1/ 32	1/ 26	1/ 10	1/ 35
Total WTE Req (no Uplift)	62.25	19.32	218.31	54.88	54.88				
Total WTE Req (26.9%)	79.00	24.52	277.03	69.64	69.64				

Phase 2		Beds:	582			Level 1 Routine Care			
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds	RN + Reg Prof Ratio to Beds	HCSW Ratio to Beds	SSA Ratio to Beds
Early (7.5 Hours)	20	6	73	17	17	1/ 29	1/ 22	1/ 8	1/ 34
Late (7.5 Hours)	20	6	73	17	17	1/ 29	1/ 22	1/ 8	1/ 34
Nights (9.5 Hours)	18	4	58	17	17	1/ 32	1/ 26	1/ 10	1/ 34
Total WTE Req (no Uplift)	87.92	23.89	307.25	77.75	77.75				
Total WTE Req (26.9%)	111.57	23.89	389.90	98.66	98.66				

Total		Beds:	1001						
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds	RN + Reg Prof Ratio to Beds	HCSW Ratio to Beds	SSA Ratio to Beds
Early (7.5 Hours)	34	11	125	29	29	1/ 29	1/ 22	1/ 8	1/ 35
Late (7.5 Hours)	34	11	125	29	29	1/ 29	1/ 22	1/ 8	1/ 35
Nights (9.5 Hours)	31	7	99	29	29	1/ 32	1/ 26	1/ 10	1/ 35
Total WTE Req (no Uplift)	150.17	43.21	525.56	132.63	132.63				
Total WTE Req (26.9%)	190.57	48.41	666.94	168.30	168.30				

Llandarcy Field Hospital
Staffing Proposal

Triage / Escalation		Beds:	8			Also support triage / escalation
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds
Early (7.5 Hours)	1		0	0	0	1/ 8
Late (7.5 Hours)	1		0	0	0	1/ 8
Nights (9.5 Hours)	1		0	0	0	1/ 8
Total WTE Req (no Uplift)	4.57		0.00	0.00	0.00	
Total WTE Req (26.9%)	5.80		0.00	0.00	0.00	

POD 1		Beds:	59			Level 2 Care Pathway			
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds	RN + Reg Prof Ratio to Beds	HCSW Ratio to Beds	SSA Ratio to Beds
Early (7.5 Hours)	4	2	7	3	3	1/ 15	1/ 10	1/ 8	1/ 20
Late (7.5 Hours)	4	2	7	3	3	1/ 15	1/ 10	1/ 8	1/ 20
Nights (9.5 Hours)	4	0	6	3	3	1/ 15	1/ 15	1/ 10	1/ 20
Total WTE Req (no Uplift)	18.29	5.60	30.24	13.72	13.72				
Total WTE Req (26.9%)	23.21	7.11	38.37	17.41	17.41				

POD 2		Beds:	240			Level 1 Routine Care & Care Beds			
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds	RN + Reg Prof Ratio to Beds	HCSW Ratio to Beds	SSA Ratio to Beds
Early (7.5 Hours)	0	0	0	0	0	1/ 30	1/ 22	1/ 8	1/ 34
Late (7.5 Hours)	0	0	0	0	0	1/ 30	1/ 22	1/ 8	1/ 34
Nights (9.5 Hours)	0	0	0	0	0	1/ 34	1/ 27	1/ 10	1/ 34
Total WTE Req (no Uplift)	0.00	0.00	0.00	0.00	0.00				
Total WTE Req (26.9%)	0.00	0.00	0.00	0.00	0.00				

POD 3		Beds:	19			End of Life Care (variable Beds #s but Staffing assumes full capacity)			
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds	RN + Reg Prof Ratio to Beds	HCSW Ratio to Beds	SSA Ratio to Beds
Early (7.5 Hours)	0	0	0	0	0	1/ 10	1/ 10	1/ 10	1/ 10
Late (7.5 Hours)	0	0	0	0	0	1/ 10	1/ 10	1/ 10	1/ 10
Nights (9.5 Hours)	0	0	0	0	0	1/ 10	1/ 10	1/ 10	1/ 10
Total WTE Req (no Uplift)	0.00	0.00	0.00	0.00	0.00				
Total WTE Req (26.9%)	0.00	0.00	0.00	0.00	0.00				

Total		Beds:	326						
	RN Min	Reg Prof	HCSW	SSA	Volunteers	RN Ratio to Beds	RN + Reg Prof Ratio to Beds	HCSW Ratio to Beds	SSA Ratio to Beds
Early (7.5 Hours)	5	2	7	3	3	1/ 65	1/ 47	1/ 47	1/ 109
Late (7.5 Hours)	5	2	7	3	3	1/ 65	1/ 47	1/ 47	1/ 109
Nights (9.5 Hours)	5	0	6	3	3	1/ 65	1/ 65	1/ 54	1/ 109
Total WTE Req (no Uplift)	22.87	5.60	30.24	13.72	13.72				
Total WTE Req (26.9%)	29.02	7.11	38.37	17.41	17.41				

Partneriaeth Ranbarthol Gorllewin Morgannwg | West Glamorgan Regional Partnership

COVID-19 COMMUNITY SILVER

Regional Care Home Protocol

Region: West Glamorgan Regional Partnership

✉ west.glamorgan@swansea.gov.uk

Version Number: 0.8 Date Valid From: 24/04/2020 Approved by: Silver Community

Document Version Control[1]				
Version no.	**Author**	**Date**	**Summary of Change**	**Approver**
0.1	Melanie Blake, Karen Gronert, Regional Externally Commissioned Care Group	24/04/2020	Initial Document	Community Silver Group
0.2	Melanie Blake	28/04/2020	Addition of PHE Guidance Addition of HIW and CIW Joint Statement on advance care planning	Community Silver Group
0.3	Melanie Blake	29/04/2020	Updated confirmed or suspected cases process Addition of Welsh Government step up/step down process	Community Silver Group
0.4	Melanie Blake, Karen Gronert, Regionally Externally Commissioned Care Group	30/04/2020	Removal of PHW Guidance from 08.04.2020 due to being out of date Addition of Local Testing Procedure	Community Silver Group
0.5	Melanie Blake, Karen Gronert Regionally Externally Commissioned Care Group	13/05/2020	Additional Guidance released 07.05.2020 added into Appendix 1 Updated process for suspected or confirmed cases	Community Silver Group
0.6	Melanie Blake, Karen Gronert Regionally Externally Commissioned Care Group	14/05/2020	Testing Guidance for all care homes released 13.05.2020	Community Silver Group
0.7	Melanie Blake, Karen Gronert Regionally Externally Commissioned Care Group	21/05/2020	Revised PHW Guidance released 17/05/2020 Addition of Health and Wellbeing Links Testing contact update	Community Silver Group
0.8	Melanie Blake, Karen Gronert Regionally Externally Commissioned Care Group	15/06/2020	Refresh of whole document with most up to date guidance and additional guidance added	Community Silver Group

[1] Version control has been applied as this document will need to be updated to reflect anticipated updates to national guidance, as the COVID-19 outbreak progresses

Contents

1. West Glamorgan Regional Partnership Community Silver

1.1. Overview

The West Glamorgan Regional Partnership includes the following organisations as Partnership Bodies for the purposes of the Partnership Arrangements (Wales) Regulations 2015:

- Swansea Bay University Health Board [SWANSEA BAY UHB];
- Swansea Council [SC];
- Neath Port Talbot County Borough Council [NPTCBC].

The regional governance arrangements for West Glamorgan Regional Partnership Board [RPB] also includes representation from the Third Sector, Trade Unions, citizens, carers and other key stakeholders involved in health and social care transformation across the region.

1.2. Arrangements

In response to the COVID-19 pandemic, new governance arrangements have been put in place on a temporary basis to allow the regional partners to work together in responding effectively to the challenges faced by our regional health and social care sectors during this time of unprecedented demand.

This document is one of a series of emergency protocols to be implemented in support of the COVID-19 response and is subject to approval from the COVID-19 Community Silver membership. Any references to other documents related to the COVID-19 pandemic response will be **highlighted** in this document. The latest versions of these documents – which may be subject to change as these temporary arrangements progress – are available on request from the West Glamorgan Transformation Office.

1.3. Governance

Further information about the temporary governance arrangements is detailed in the **Emergency Planning for Community Silver Governance Structure** document.

2. Purpose and Scope

2.1. Purpose

This guidance has been put in place in response to the unprecedented situations and challenges that care homes are facing due to the COVID-19 pandemic. The guidance has been agreed by the Community Silver Group and will take place with effect from 24th April 2020.

All care homes are expected to have a robust COVID-19 business continuity plan and risk assessments in place which includes surge capacity for staffing and volunteers. It is expected that the plan would include safe measures around medication administration by ensuring adequate numbers of staff are trained to administer medication during this period.

2.2. Scope

During this emergency period, we aim to:

- Ensure all care homes schemes are aware of the Welsh Government guidance for care homes
- Ensure all care homes are aware of the Welsh Government Test, Trace and Protect Policy (TTP)
- Pool the relevant expertise and learning at local, regional and national levels.

This document applies to all settings where there are residents who are sharing communal areas and receiving care from a single care team:

- Residential care homes
- Nursing care homes
- Dual registered care homes

It does not apply to:

- Private care homes outside the West Glamorgan region

3. National and Local Guidance

3.1. How to protect care home residents and staff during a Coronavirus outbreak

Primary prevention in care homes is through hand washing / cleansing, appropriate use of Personal Protective Equipment (PPE) and adhering to social distancing at all times within the home.

The Test, Trace & Protect programme, which started across Swansea Bay on 1st June 2020 means that where any positive COVID-19 cases are identified in care homes (who could be symptomatic or asymptomatic) the member of staff will be contacted by the Contact Tracing team to identify any contacts within the key timeframes below [*taken from the Welsh Government Covid site*]:

- within 1m of someone for 1 minute or longer
- within 2m of someone for 15 minutes or longer
- anyone travelled in a vehicle with, or people sat near on public transport

The Contract Tracers will contact these people and advise them to self-isolate. It is therefore critical that care home staff are social distancing at all times. Where the positive case is a resident, the care home will be asked to confirm that PPE has been used at all times in relation to care for that resident in which case there will no requirement for staff to self-isolate. If staff have been in contact with the affected resident without PPE then they will need to be identified and if they have been exposed to the virus they will be identified to the Contact Tracing team and depending on their exposure, may be required to self-isolate.

A copy of the latest Public Health Wales (PHW) guidance to prevent COVID-19 among care home residents and manage cases and outbreaks in residential care settings in Wales can be found in Appendix 1 (version 3.1, dated 07th May 2020). It sets out how to admit and care for residents safely and protect staff and is intended for registered providers of care homes.

It also confirms the PHW advice that when residents attend hospital and have been assessed in a setting reserved for non COVID19 suspected patients, they should, after receiving treatment, return to their original residential setting and will not need to isolate.

A Test Trace Protect poster is available in Appendix 1 along with flowcharts describing return to work following a test for asymptomatic and symptomatic staff.

3.2. PPE Guidance

A copy of the **West Glamorgan Regional PPE and Infection Control Protocol for Social Care Staff and Providers** v0.3 can be found in Appendix 3 and further national guidance can be found in the link below:

https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/information-for-healthcare-workers-in-wales/

3.3. Testing in Care Homes and the Community

The Swansea Bay UHB testing plan reflects the current guidance issued by Welsh Government on 27th May 2020. Further information can be found at:

https://gov.wales/care-home-testing-guidance-html

In line with recent Welsh Government guidance, testing is advised for:

- all residents and staff of care homes with ongoing cases of COVID-19 and any home reporting a new outbreak
- larger care homes registered for 50 or more beds
- all people being discharged from hospital to live in care homes regardless of whether or not they were admitted to hospital with COVID-19
- all people who are being transferred between care homes and for new admissions from the community

3.4 British Geriatric Society

The British Geriatric Society (BGS) have recently published guidelines to help care home staff support residents through the pandemic (updated 2nd June 2020)

https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes

3.5 Infection Control Guidance

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

4. Monitoring and Early Indications

4.1 Monitoring

Each care home is currently contacted as a minimum on a weekly basis by local authority contract officers. The information collated in addition to the care home responsibility to ensure that Care Inspectorate Wales (CIW) is informed of any **suspected** and **confirmed** cases of COVID-19. As part of the TTP, Swansea Bay UHB also informs CIW of any cases every Friday.

As COVID-19 is a notifiable disease, PHW will be automatically notified when a resident is symptomatic or if a test carried either in hospital or via the CTU.

Contract officers will hold further discussions with care homes that are showing early indications of difficulties. It is not possible to list every scenario, so these will happen as and when required. As the situation with care homes change daily, care homes are expected to report any increasing risk associated with suspected/confirmed cases, work force depletion and other factors as soon as they become apparent.

See Appendix 2 for contact details of your relevant officer

4.2 Risk Assessments

Each care home should be able to rate their level of risk in terms of their resilience to infectious outbreaks based on the following challenges:

Organisational:

- Financial viability
- Leadership
- Workforce
- Environment

Health and Well-being:

- Individual resident's complexity/acuity
- Safety and wellbeing of all residents
- Safety and wellbeing of all staff

Every nursing and residential home should also have a business continuity plan which complies with the Local Authorities guidance.

4.3 Testing

Anyone who has symptoms of Coronavirus (COVID-19) can apply for a test. The main symptoms of Coronavirus are:

- a high temperature – this means you feel hot to touch on your chest or back (you do not need to measure your temperature)
- a new, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours (if you usually have a cough, it may be worse than usual)

- a loss or change to your sense of smell or taste – this means you've noticed you cannot smell or taste anything, or things smell or taste different to normal

To protect others, **do not** go places like a GP surgery, pharmacy or hospital if you have any of these symptoms. Stay at home (self-isolate) and get a test.

ARRANGING A TEST
A single point of contact within Swansea Bay Health Board has been set up for care homes to request a test visit:

01639 862757

Staff should ring the number select **option 1** to book a test at one of the drive through Testing Units (Margam, Longlands Playing Fields or Liberty Stadium, Swansea). Phone line open from 9am to 8pm daily.

The care home manager should select **option 2** to request testing of care homes residents.

There is also an email address for general care homes testing enquires:

SBU.COVID19CareHomeTesting@wales.nhs.uk

Emails to this address are monitored Monday to Friday 9am – 5pm

Please do not contact hospital switchboards as they do not have information to share with you by telephone and they will not be able to connect you appropriately. The health board will use email communication to ensure that they are able to communicate effectively and in a timely way.

Further information about the new weekly testing programme and the ongoing testing programme can be found in the guidance listed below (number 22)

5. Process to follow for a Suspected or Confirmed Case of COVID19

Any resident presenting with symptoms of COVID-19 should be promptly isolated and separated in a single room with a separate bathroom, where possible. If symptoms worsen during isolation or are no better after 7 days contact their GP for further advice around escalation.
You should immediately notify Public Health Wales 0300 00 300 32 who will advise on infection prevention and control measures – **do not wait for testing**. Staff should immediately instigate these infection control measures to care for the residents with symptoms.
All residents at the home are supported to remain in isolation in their rooms wherever possible (advice on how to deal with legal issues relating to deprivation of liberty can be provided by our safeguarding lead to enable this to be done lawfully)
All residents who are symptomatic or where concerns exist about possible infection, should be supported to wear protective face masks when receiving care where possible.
All staff who cannot maintain safe distancing (because the nature of their work requires them to come within 2 meters of residents), whether infected or not, should wear PPE. The nature of the PPE to be determined via risk assessment but may need to include; mask, gloves and aprons as required.
Protective face masks are for use per session (unless damaged), or single use when used with an individual that is symptomatic
All correspondence with families will be handled as sensitively as possible and in particular will offer careful re-assurance about the steps taken to manage any further risk of the spread of infection. Correspondence should be accompanied by telephone calls to next of kin to offer reassurances where appropriate.
Care homes should notify CIW (via CIW Online) of confirmed and suspected cases of COVID19 of people using the service, and members of staff.
Any press statement intended to be made by the home must be shared with the Council prior to any disclosure of any information.

6. Multi-Agency Response to Care Home in Difficulties

Health and Local Authority colleagues have been working together to develop an integrated approach to support the sustainability of care homes in each Local Authority during the COVID19 outbreak.

Where a care home is in difficulties and requires immediate support, a crisis response/multi-agency meeting which will include RI and/or RM, will be convened within 24 hours of a notification of difficulties having been highlighted. The aim of the meeting will be to provide a forum for:

- Sharing information
- Agree responsibilities
- Develop an action plan with timescales

Please contact your local officer if you are experiencing difficulties or would like support. Contact details can be found in Appendix 2.

7. Appendices

Appendix 1 – Supporting Guidelines

No.	Guidelines	Attachment
1	Swansea Bay UHB Emergency Guidance for Nursing Care Homes (no change)	Emergency guidance for care homes April 2
2	West Glamorgan PPE and Infection Control Protocol for Social Care Staff and Providers v0.3 (no change)	West Glamorgan PPE and Infection Control
3	HIW and CIW Joint Statement on Advance Care Planning in Wales – 21st April 2020 (no change)	200421-Joint-statement-on-advance-care-p
4	Guidance - Putting on PPE for Care Homes (no change)	Putting_on_PPE_Care_Homes.pdf
5	Guidance - Taking off PPE for Care Homes (no change)	Taking_off_PPE_Care_Homes.pdf
6	Public Health England Guidance v2 – How to Work Safely in Care Homes (updated)	COVID-19_How_to_work_safely_in_care_hor
7	PHW - Guidance to prevent COVID-19 and manage cases and outbreaks in residential care settings in Wales – 2nd June 2020 v3.2 (updated – 14 days changed to 28 days)	020620 Prevention and management of i
8	Community Contact Details – Access to the Swansea Bay Community Specialist Palliative Care Advice and Referral Line (new)	Community Contact Details.pdf
9	PHE Flowchart for return to work – asymptomatic (new)	Flowchart_for_return_to_work_asymptomatic
10	PHE Flowchart for return to work – symptomatic (new)	Flowchart_for_return_to_work_symptomatic.p
11	Welsh Government Test, Trace, Protect Flowchart (new)	WG TTP Flowchart ENG 01.06.20.pdf
12	Covid-19 Workforce Risk Assessment Tool – A risk assessment to see if people working in health and social care are at higher risk of developing more serious symptoms if they come into contact with COVID-19 (new)	Covid-19-workforce-risk-assessment-tool.p

13	British Geriatric Society – Managing the COVID19 pandemic in Care Homes v3 (updated 02.06.20) (new)	 BGS Managing the COVID-19 pandemic i
14	Protocol for Accessing Urgent Palliative Care Medication in the Community during the COVID-19 Pandemic within hours (v1.1) (new)	 Protocol for Accessing Urgent Palli
15	Welsh Government Welsh Health Circular (30th April 2020). Guidance for Local Health Boards and NHS Trusts on the reuse of end of life medicines in hospices and care homes (new)	 Welsh Health Circular 2020 008 - CPhO Lette
16	Swansea Bay UHB Covering Letter for urgent palliative care medicines (20th May 2020) (new)	 Covering letter for urgent palliaitve care
17	Novel Coronavirus (COVID-19) standard operating procedure. Running an END OF LIFE medicines reuse scheme in a care home or hospice setting (v1 April 2020) (new)	 Running an END OF LIFE medicines reuse s
18	Flowchart for Accessing Urgent Palliative Care Medicines in the Community during the COVID-19 Pandemic (v1.1) (new)	 Flowchart for Accessing Urgent Palli
19	Memo – Reuse of medicines in care homes (new)	 Memo - Reuse of medicines in care hon
20	Welsh Government – Update on guidance for visits to care home services and reconnecting safely (5th June 2020) (new)	 2020-06-05 Letter from Albert Heaney re
21	Regional West Glamorgan Flowchart – Testing for Discharge (new)	 Testing for Discharge V7 Placement.pdf
22	Test, Track, Protect Guidance for Care Homes 12th June 2020 (new)	 Care Homes Guidance for TTP soci  how-to-test-care-ho me-staff-for-covid-19
23	Welsh Government - Guidance for providers of social care services for adults during the COVID-19 pandemic. 8th June 2020 (new)	 COVID-19 pandemic_ Welsh Government Gu
24	Public Health Wales – 28 day period following an outbreak/incident of COVID-19 in a Care Home (3rd June 2020) (new)	 28 days period following an outbreak

Appendix 2 – Contact Details

Neath Port Talbot CBC

Name	Role	E-mail
Chele Howard	Principle Officer for Commissioning	c.howard@npt.gov.uk
Gemma Hargest	Children and Young People	g.hargest@npt.gov.uk
Paula Greenhalgh	Learning Disability and Mental Health	p.greenhalgh@npt.gov.uk
Gill Lawson	Older Adults	g.lawson@npt.gov.uk

Out of Hours – information will be circulated weekly

Swansea Council

Name	Role	E-mail
Peter Field	Principle Officer for Commissioning	Peter.field@swansea.gov.uk
Amy Jenkins	Children and Young People	Amy.jenkins2@swansea.gov.uk
Paul Bee	Learning Disability and Mental Health	Paul.bee@swansea.gov.uk
Ian George	Older Adults	Ian.george@swansea.gov.uk

Out of Hours – please contact the **Emergency Duty Team on 01792 775501**

Swansea Bay UHB

Elaine Harris	Swansea Long Term Care Team	01792 601800
Amanda Davies	Neath Port Talbot Long Term Care Team	01639 684500
Clare Morgan	MH and LD CHC and Long Term Care Team	01656 753899/ 07980 709801

Out of Hours:

Swansea - please contact on-call 01792 561155 leave a message and you will be contacted by a member of the team.

NPT - please contact on-call 01639 862000/561155 leave a message and you will be contacted by a member of the team.

Appendix 9

Proposed measures that could identify harm in the system

Theme	Topic	Measure	Currently reported	Comments	Quadrant of harm			
					Harm from covid itself	Harm from overwhelmed NHS and Social Care System	Harm from reduction in non-covid activity	Harm from wider societal actions/ lockdown
Patient perspective	Serious Incidents	Number of serious incidents	Yes	Already reported however, data could be split by themes and the level of harm identified.		✓	✓	
Patient perspective	Never Events	Number of Never Events	Yes	Already reported however, data could be split by themes.		✓	✓	
Patient perspective	Complaints	Number of complaints and 30 day response rate	Yes	Already reported however, data could be split by themes.		✓	✓	
Patient perspective	Claims	• Number of Redress Cases • Number of Clinical Negligence Cases • Number of Personal Injury Cases	No	Not currently included in performance report but data is routinely available	✓	✓	✓	
Patient perspective	Patient feedback	Results of friends and family surveys	Yes	Already reported however, data could be split by themes.		✓	✓	
Patient perspective	Falls	Number of falls and falls per 1,000 beddays	Yes			✓		

Theme	Topic	Measure	Currently reported	Comments	Quadrant of harm			
					Harm from covid itself	Harm from overwhelmed NHS and Social Care System	Harm from reduction in non-covid activity	Harm from wider societal actions/ lockdown
Patient perspective	Pressure Ulcers	• Number of pressure ulcers, • Number of grade 3s • Number of pressure ulcers per 10,000 admissions	Yes			✓		
Patient perspective	Infection control	Number of healthcare acquired infections	Yes			✓		
Patient perspective	Mortality	Universal Mortality Reviews (UMRs)	Yes		✓	✓		
Patient perspective	Mortality	Hospital mortality rate	Yes	Could look into splitting the deaths between covid and non-covid	✓	✓	✓	
Patient perspective	Readmissions within 30 days	Patients readmitted following surgery	No	Will need to liaise with Digital Services to obtain routine data		✓	✓	
Patient perspective	Vascular amputations	TBC	No	Will need to source data		✓	✓	
Patient perspective	Mental Health	Number of ligature incidents	Yes			✓	✓	✓
Patient perspective	Mental Health	Number/ rate of suicides	No			✓	✓	✓

Theme	Topic	Measure	Currently reported	Comments	Quadrant of harm			
					Harm from covid itself	Harm from overwhelmed NHS and Social Care System	Harm from reduction in non-covid activity	Harm from wider societal actions/ lockdown
Patient perspective	Mental Health	Number of patients detained under the Mental Health Act as % of all admissions	Yes					✓
Patient perspective	Mental Health	Number of patients subject to DOLS	Yes					✓
Patient perspective	Alcohol	European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales (episode based)	No					✓
Patient perspective	Discharge summaries	% of completed discharge summaries	Yes			✓		
Process measures	Emergency flow	111 access targets	Yes			✓		
Process measures	Emergency flow	Ambulance response times	Yes			✓		
Process measures	Emergency flow	Ambulance handovers	Yes			✓		
Process measures	Emergency flow	4 & 12 hour A&E waits	Yes			✓	✓	✓
Process measures	Emergency flow	Attendance at ambulatory care clinic and re-attendance	No	Not currently reported however, data is readily available		✓	✓	

Theme	Topic	Measure	Currently reported	Comments	Quadrant of harm			
					Harm from covid itself	Harm from overwhelmed NHS and Social Care System	Harm from reduction in non-covid activity	Harm from wider societal actions/ lockdown
		within 7 days of discharge						
Process measures	Emergency flow	Stroke access measures	Yes			✓		✓
Process measures	Cancer	Cancer 31/62 day access measures and Single Cancer Pathway	Yes	Already reported however, data could be split by tumour site.			✓	✓
Process measures	Cancer	Radiotherapy waiting times	Yes				✓	
Process measures	Cancer	Chemotherapy waiting times					✓	
Process measures	Waiting times	26 and 36 waiting times position	Yes				✓	
Process measures	Waiting times	Compliance with surgical priority levels and timescales	No				✓	
Process measures	Diagnostics	8 weeks waiting times position	Yes	Already reported however, data could be split by diagnostic test.			✓	
Process measures	Therapies	14 weeks waiting times position	Yes				✓	
Process measures	Follow-ups	Number of patients waiting for a follow-up/ number of patients waiting past target date	Yes				✓	
Process measures	Screening services	Uptake of cancer screening for: - bowel - breast - cervical	No	Data currently published annually, would need to source more frequent data locally			✓	✓

Theme	Topic	Measure	Currently reported	Comments	Quadrant of harm			
					Harm from covid itself	Harm from overwhelmed NHS and Social Care System	Harm from reduction in non-covid activity	Harm from wider societal actions/ lockdown
Process measures	Primary Care	Percentage of children regularly accessing NHS primary dental care within 24 months	Yes				✓	✓
Process measures	Mental Health	Mental Health Measures access targets	Yes				✓	✓
Process measures	Mental Health	Crisis Resolution Home Treatment Team gatekeeper assessments	Yes				✓	✓
Process measures	Mental Health	Referrals to Community Drug and Alcohol Team (CDAT) and % seen within 20 days	Yes				✓	✓
Process measures	Child and Adolescent Mental Health Services (CAMHS)	CAMHS waiting times measures	Yes				✓	✓
Process measures	Fractured Neck of Femur (#NOF)	#NOF bundles	Yes				✓	
Process measures	Childhood immunisations	% uptake of childhood vaccinations	Yes	2 measures routinely reported however, further measures can be added to cover the complete spectrum of vaccinations			✓	✓

Theme	Topic	Measure	Currently reported	Comments	Quadrant of harm			
					Harm from covid itself	Harm from overwhelmed NHS and Social Care System	Harm from reduction in non-covid activity	Harm from wider societal actions/ lockdown
Process measures	Ophthalmology	Eye care outcome measures	Yes	Currently report % of R1 patients seen within target. Could also report: • % R2 seen within target • % R3 seen within target • Number of patients with no allocated HRF status			✓	
Process measures	TAVI	TBC	No	Awaiting details from service regarding the data available.			✓	
People perspective	Sickness	In-month and 12 month rolling sickness rates	Yes			✓		
People perspective	Statutory and mandatory training	% completion of statutory and mandatory training	Yes			✓		
People perspective	Personal appraisal and development reviews (PADRs)	% of 12 month PADRs completed	Yes			✓		
Productivity and activity	Theatres	Theatre utilisation, late starts, early finishes	Yes				✓	
Productivity and activity	Emergency flow	A&E attendances	Yes			✓		
Productivity and activity	Emergency flow	Emergency admissions	Yes			✓		

Theme	Topic	Measure	Currently reported	Comments	Quadrant of harm			
					Harm from covid itself	Harm from overwhelmed NHS and Social Care System	Harm from reduction in non-covid activity	Harm from wider societal actions/ lockdown
Productivity and activity	Planned Care	Inpatient and daycase activity	Yes				✓	
Productivity and activity	Planned Care	Outpatient attendances	Yes				✓	

Definitions		Comment
Base Number	Staff in post by Staff group as at 20th June 2020	
Additional Covid 19 Workforce	Staff recuited Specifically as part of SBU Covid 19 Related response	Staff recruited specifically for Covid 19 on a range of contract types but NOT in supstantive ful time positions.
Vacancy Factor	Underlying staff turnover - pre Covid 19	Factor applied for each staff group based on HB average as at 20th June 2020. Vacancy rates post covid reflect some variation in pattern compared to Pre Covid position.
Underlying Sickness Absence	Non Covid impacted sickness rate based on Pre Covid 19 position	
Covid related Symptomatic absence R 0.7 - 0.9	Covid related absence where staff have Covid Symptoms based on data 20th June 2020	
Covid related Symptomatic absence R1.0+	Covid related absence where staff have Covid Symptoms based on data 10th May 2020 **ESTIMATED MID POINT**	
Covid related Symptomatic absence R1.0++	Covid related absence where staff have Covid Symptoms based on data 14th April 2020. This includes staff formally sheilding, those advised to sheild by OH and folowing RISK ASSESSMENT **NOTE WORST CASE SCENARIO**	
Covid related Asymptomatic absence R 0.7 - 0.9	Covid related absence where staff DO NOT have Covid Symptoms based on data 20th June 2020This includes staff formally sheilding, those advised to sheild by OH and folowing RISK ASSESSMENT	
Covid related Asymptomatic absence R1.0+	Covid related absence where staff DO NOT have Covid Symptoms based on data 10th May 2020 **ESTIMATED MID POINT**	
Covid related Asymptomatic absence R1.0++	Covid related absence where staff DO NOT have Covid Symptoms based on data 14th April 2020. This includes staff formally sheilding, those advised to sheild by OH and folowing RISK ASSESSMENT **NOTE WORST CASE SCENARIO**	
TTP Workforce	Staff redeployed to support TTP	
AntiB Testing	Staff redeployed to support AntiBody testing	
Additional Recruitment (Anticipated)	Factoring additional workforce available	
Additional Bank staff available	Bank staff recruited since Covid 19 pandemic	

Retirements staying stable over the last 6 months - per month 6 nurses, 2 medical, 2 AHP, 3 ACS.

Staffing Principles Appendix 11

COVID-19 Emergency Levels		Welsh Levels of Care	COVID-19 Care Descriptor	Location	Safe Staffing Triangulated Methodology	Risk Assessment & Mitigation
Level 1	**Level 1 Intensive Care**	**Level 5** *(1:1 Care)*	Patients needing advanced respiratory and therapeutic support of multiple organs	Critical Care Level 3	1: 1 in compliance with BACCN NSL standards	* Guidance & Joint Statement Critical Care Workforce Guide
Level 2	**Level 2 NIV / ⇧ Flow O_2**	**Level 4** *(Urgent Care)*	Patients in acute respiratory failure, requiring non-invasive ventilation or respiratory support using CPAP or BiPAP Frequent de-saturations on high flow oxygen	Critical Care Level 2: Hospital identified CPAP ward	1:2 in compliance with BACCN NSL standards	* Guidance & Joint Statement Critical Care Workforce Guide
Level 3	**Level 3 COVID Ward O_2**	**Level 3** *(Complex Care)*	O_2 Dependent The patient may have a number of identified problems, some of which interact with one and other making it more difficult to predict the outcome of any individual treatment Requiring IV therapy, O_2 therapy	Hospital Ward	Triangulated approach in line with requirement of Nurse Staffing Act *RN 1:6/1:7*	RN 1:10 HCA 1:7/8
	Level 3 COVID Ward No O_2	**Level 3** *(Complex Care)*	**Not** O_2 Dependent Requiring IV therapy such as antibiotics	Hospital Ward or consider LLandarcy Field Hospital	Triangulated approach in line with requirement of Nurse Staffing Act *RN 1:6/1:7*	RN 1:10/ 1:15 HCA 1:8 Night 1:15
		Level 2 *(Care Pathway)*	**Not** O_2 Dependent Enabling, assistance or prompting with varying degrees of support for some activities of daily living; pressure area care 4 hourly; may exhibits periods of confusion or mild challenging behaviour; assistance taking medication; IV antibiotics	Hospital Ward or consider Field Hospital	Triangulated approach in line with requirement of Nurse Staffing Act	RN 1:15/ 1:20 AHP 2:60 HCA 1:8 Night 1:10 SSA 1:25
		Level 1 *(Routine Care)*	Self-caring and independent or requiring occasional assistance with some activities of daily living, for example the assistance of one person to mobilise, or experiences occasional incontinence; mobile, with or without use of aids; confused patient not at risk; self-medicating; may require	Consider Field Hospital	Triangulated approach in line with requirement of Nurse Staffing Act	RN 1:30 **with other available registrants and AHPs within field pod* AHP 2:60 HCA 1:8 Night 1:10 SSA 1:25

			therapy input before direct discharge			
		***Care Bed** **not part of Welsh Levels of Care*	Patient is clinically well and suitable for discharge + ○ Patient medically optimised* ○ Management can be continued as ambulatory care* ○ Management can be continued outside the acute hospital*	People able to recover in their own home/ care home / nursing home.	CSSIW standards	RN 1:30 **with other available registrants within pod* HCA 1:8 Night 1:10 SSA 1:25

References

Guidance & Joint Statement Critical Care Workforce Guide	Critical care joint statement _2020_CO	Specialty guide_ critical care workfor
Welsh Levels of Care	Welsh Levels of Care.pdf	
All Wales Guidelines for Delegation 2020	delegationPosterFinal-eng-PRINT.pdf	Guidelines-A4Wide-NoDots-Eng.pdf

Key	
RN	Registered Nurse
AHP	Allied Health Professional

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Cadeirydd/Chairman: **Andrew Davies**
Prif Weithredwr/Chief Executive: **Tracy Myhill**

gofalu am ein gilydd, cydweithio, gwella bob amser
caring for each other, working together, always improving

Pencadlys Bwrdd Iechyd Prifysgol Bae Abertawe Headquarters
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Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg. We welcome correspondence in Welsh or English.

☎ **01639 683302**

O**ur Ref/Ein Cyf**: TCM/els

SBU Health Board Headquarters
One Port Talbot Gateway, Seaway Parade
Port Talbot
SA12 7BR

Date: 3rd July 2020

Dr Andrew Goodall
Director General
Health & Social Services/
NHS Wales Chief Executive
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Dear Andrew

Re – Submission of SBUHB's Operational Plan Q2 2020/21

Please find attached Swansea Bay University Health Board's Operational Plan for Quarter 2 of 2020/21. The Plan has been approved for submission through Chair's Action and will be ratified by the Board in July 2020.

The document sets out our Operational Planning Assumptions for Quarter 2 and it includes the conclusions of our local capacity and workforce modelling for the quarter. The Health Board is maintaining its readiness to respond to a future peak in Covid demand as well as delivering our Test Trace and Protect services. More detail on our progress regarding Essential and routine services across our system is included in the document, as well as our work in partnership to ensure resilience in the social care sector. Our plans to respond to winter pressures are set out, although further detail will be worked up during Quarter 2. We are also developing a new, rounded performance management framework based on the four harms and our capital and financial plans are outlined.

The Health Board financial forecast for the quarter is set out in the document. There are important elements to the forecast I would wish to draw to your attention as Accountable Officer.

Firstly, our financial forecasts for the quarter are made in full recognition of our baseline financial plan for 2020/21 and the impacts of our Covid-19 response to that plan. At a high level, the forecast can be described across 4 key components as set out below:

- the baseline plan itself
- the cost of the service response to Covid-19
- the impact of the shift in service delivery on the Health Board's ability to deliver its 2020/21 savings programme; and
- the costs and planned investments which have not been incurred or implemented as a result of the response.

The forecast cumulative revenue position to the end of quarter 2 is an overspend of £35.004m. This assumes application of £39.584m of funding from Welsh Government, of which £26.828m has been received in month 3. This funding is for workforce costs incurred in Quarter 1 and the revenue costs of establishing field hospitals and core service surge. Our officers are working together routinely to ensure that there is clarity around the planning and financial assumptions within the forecast and I welcome the work to be undertaken shortly to review all projections for Quarter 2 and beyond. The Board has been appraised of this position and has supported the Covid-19 response and recognises the impact on the base financial plan for 2020/21.

As we approached the end of Quarter 1 it became apparent through our reset and recovery work that some of our essential services are likely to not have sufficient capacity to meet our estimates of what essential service demand is likely to be. This has been driven by reduced workforce availability, revised working practices in terms of PPE and working with a Covid-19 risk present and, as we move forward, the limitations of social distancing in terms of productivity and throughput.

Our quality impact assessment process provides the scrutiny to assess that the base level resource is working as efficiently as possible and in some cases, even where this is evident, I anticipate that in order to deliver the volumes required to meet the demand for essential care we, as a Board, are likely to have to commission additional support above base resource levels.

Detailed modelling work is underway in diagnostic services in particular (but not exclusively these services) to determine the actions we may need to take to provide sufficient capacity to meet the demand for essential services. At this stage we have not included any financial assessment of what an increased capacity base could be. The Board is clear at this stage that whilst this is Covid-19 related it does not relate directly to our Covid-19 response and therefore any decision to address any capacity shortfall will be in addition to our baseline plan. I would therefore welcome discussion with you around the most appropriate handling of these emerging challenges from a service and financial perspective, as at this stage we have not made any commitments to proceed with these additional solutions without the granular modelling and a clear understanding of the appropriate handling in the context of the governance of the overall financial forecast.

I look forward to receiving your feedback on the Quarter 2 Plan. As a Health Board we would also welcome further guidance on planning and performance reporting expectations for Quarters 3 and 4 and into 2021/22.

Yours sincerely

TRACY MYHILL
CHIEF EXECUTIVE