| | | | |
|---|---|---|---|
| **Meeting Date** | **26th November 2020** | **Agenda Item** | **3.1** |
| **Report Title** | **SBUHB Quarter 3&4 Operational Plan 2020-21** | | |
| **Report Author** | Maxine Evans, Head of IMTP Development and Implementation<br>Karen Stapleton, 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 Operational Plan for Quarter 3&4 2020/21 which was submitted to Welsh Government on 16th October 2020 following approval by Chair's Action. | | |
| **Key Issues** | During 2020/21, due to the COVID-19 pandemic, Welsh Government (WG) required the submission of quarterly plans for Qs 1&2 and a six monthly plan for the remainder of the financial year.<br><br>The national Operating Framework for Quarters 3&4 was received on 24th September 2020. Development of the Plan has been considered through Health Board meetings and Independent Member briefings. All Board members received a copy of the final draft plan and had the opportunity to comment on the content. Comments received were reflected in the final plan and submitted to Welsh Government on 16th October following Chair's Action.<br><br>This Plan sets out how the HB plans (within known information at the time of writing) to respond to priorities and service pressures during Q3&4. The overriding priority is to respond to Covid-19-19 and continue to deliver essential services, which will be enabled by an effective Test, Trace and Protect service and vaccination programme.<br><br>Detailed modelling to support alignment of service, workforce and financial requirements has been undertaken, and demonstrates that the Health Board has the physical capacity to respond to modelled demand, however, there would be significant workforce challenges in staffing all super surge capacity. | | |

| | | | | |
|---|---|---|---|---|
| | Essential services can be maintained, although at periods of extreme pressure, some capacity may need to be flexed to respond to Covid-19-19 requirements. | | | |
| **Specific Action Required** ***(please choose one only)*** | **Information** | **Discussion** | **Assurance** | **Approval** |
| | ☐ | ☐ | ☐ | ☒ |
| **Recommendations** | Members are asked to:<br>• **RATIFY** the SBUHB Q3&4 Operational Plan 2020-21 following approval by Chair's Action and submission to Welsh Government | | | |

# SBUHB QUARTER 2 OPERATIONAL PLAN 2020-21

## 1. INTRODUCTION

This paper seeks ratification of the SBUHB's Operational Plan for Quarters 3&4 2020/21 which was submitted to Welsh Government on 16th October 2020 following approval by Chair's Action.

## 2. BACKGROUND

During 2020/21, due to the Covid-19 pandemic, Welsh Government (WG) required the submission of quarterly plans for Qs 1&2 and a six monthly plan for the remainder of the financial year.

WG issued an Accountability Officer letter, Q3&4 Operating Framework and Minimum Data Set on 24th September, requiring submission of the Plan by 19th October. The Accountable Officer response is attached at Appendix 1.

The Q3&4 Plan and supporting appendices (attached at Appendix 2) sets out how the HB plans (within known information at the time of writing) to respond to priorities and service pressures during Q3&4. The overriding priority is to respond to Covid-19 and continue to deliver essential services, which will be enabled by an effective Test, Trace and Protect service and vaccination programme.

Detailed modelling to support alignment of service, workforce and financial requirements has been undertaken, and demonstrates that the Health Board has the physical capacity to respond to modelled demand, however acknowledging that there would be significant workforce challenges in staffing all super surge capacity.

Essential services can be maintained, although at periods of extreme pressure, some capacity may need to be flexed to respond to Covid-19 requirements.

### Priorities within the Plan

<u>Service</u>

Following submission of the Qs1&2 Plans, the Health Board has been continuing its planning, building on the content of the previous plans. This put the organisation in a strong position to develop a plan that reflects agreed Board priorities, but also able to respond quickly to the WG requirements once they were received.

The Plan sets out that the Health Board's absolute priorities are to respond effectively to:

- COVID-19 – emergency admissions, critical care, TTP, testing, vaccination programme
- Other emergency admissions – medical and surgical
- All other essential services

The plan has been based on capacity to meet the anticipated demand and on assumptions around the available workforce and financial framework.

The Plan is written at a point in time, based on the best available information and data at that time. The Plan will be continually reviewed and flexed as actual demand and activity is known against modelled demand and available workforce.

The Health Board is required to set out that it can meet additional capacity requirements of 46 critical care beds and 621 acute beds. The Health Board has the physical capacity to deliver this through utilisation of internal and super surge capacity, however, staffing the totality of this capacity will prove extremely challenging. Plans are being finalised for agreeing the clinically led process through which services will be flexed and adjusted to meet this demand if required. This may mean that the Health Board may need to adjust some services for a period of time to support this.

There is a regionally agreed whole system seasonal pressures and unscheduled care plan, which was approved at the Regional Partnership Board on 15th October, and reflects the six national goals for urgent and emergency care. The Health Board has maintained strong performance in terms of unscheduled care through Qs1&2, and, whilst there is no national performance requirements of this, the expectation is that this will be maintained as far as possible to secure a strong end of year position.

The Health Board plans to continue, and if possible increase, the level of essential services delivery through Q3&4, especially in relation to cancer, diagnostics, planned surgery and outpatient activity. Arrangements have been made to protect elective theatre capacity wherever possible, although it has been agreed not to plan to undertaken elective surgery (apart from urgent cancer surgery) during weeks commencing 28th December and 4th January.

The Plan sets out that the Health Board will deliver Category 1a, 1b and 2 surgery during Q3&4, although there will be a backlog in relation to Category 2 at the end of the year. No priority 3 surgery is planned to be undertaken, with the exception of some paediatric surgery which is being clinically prioritised based on potential future and long term harm. The Health Board will continue to work with partners on regional solutions which may improve the ability to undertaken electivity activity through the remainder of the year.

All primary care services are now operating again, albeit through different arrangements in some cases. The Q3&4 priority areas take into account the refreshed national delivery milestones for the Strategic Programme for Primary Care, set out in the Q3&4 Operating Framework; the range of national guidance issued to primary care contractor services to date; and the extensive Health Board modelling (including Discharge Modelling and Bed Capacity Modelling). This is in addition to the emerging picture being presented by intelligence provided by data as part of the Minimum Data Set collection, and operational ‘on the ground’ knowledge of service demands and pressures.

In terms of mental health services, the pandemic is increasing psychosocial distress, people are fearful and anxious with anxieties relating not only to Covid-19 itself but also the loss of employment, reduced finances and to uncertainties over the future. The main psychological impact to date is elevated rates of stress or anxiety. But as new measures are introduced –especially quarantine- levels of loneliness, depression harmful alcohol and drug use, and self-harm and suicidal behaviour are expected to rise.

The expectation is that the impacts of Covid-19 on people’s mental health and the Health Board services could be felt over at least three years, and the Plan reflects the organisation’s emerging priorities to support this increased level of demand.

Workforce

Maintaining staff well-being is a top priority for Q3&4, with the expected Covid-19 and winter pressures. Detailed workforce modelling has been undertaken to support the plan, and a workforce plan is in place to staff core, surge and the first stage of super surge capacity. Plans to staff the remainder of super surge capacity are being finalised. Recruitment of staff continues to support the ongoing delivery of services.

Finance

The Health Board financial plan builds from the previously reported forecast of £96.180m. The forecast has been refined to reflect the latest demand modelling, service capacity and workforce plans and availability. The forecast reflects the Welsh Government confirmed allocation of £48.2m and assumes funding in respect of national allocations.

The forecast year end revenue outturn position is a deficit of £26.4m which includes revisions for adjusted expenditure assumptions based on the refinement of the plans through the integrated planning process, known funding and assumptions around funding through national funding streams where costs are already included in the Health Board's base plan.

## 3. GOVERNANCE AND RISK ISSUES

Development of the Plan has been considered through Health Board meetings and Independent Member briefings. All Board members received a copy of the final draft plan and had the opportunity to comment on the content. Comments received have been reflected in the final plan attached. Due to the required timing of the submission of the Plan, it was approved through Chair's action.

Delivery of the Plan will be reported through the Health Board's governance structures.

A copy of the risks associated with the Plan are included as an Appendix to the Plan.

## 4. FINANCIAL IMPLICATIONS

These are set out above.

## 5. RECOMMENDATION

Members are asked to:

- **RATIFY** the SBUHB Q3&4 Operational Plan 2020-21 following approval by Chair's Action and submission 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 Q3&4 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 Q3&4Operational Plan 2020-21 | |
| **Appendices** | Appendix 1 - Accountable Officer letter 16.10.20<br>Appendix 2 - SBUHB Operational Plan Q3&4 2020/21 with supporting appendices | |

Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Cadeirydd/Chair: **Emma Woollett**
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**
Un Porthfa Talbot, Parc Ynni, Baglan, Port Talbot, SA12 7BR **Ffôn** 01639 683334

**Swansea Bay University Health Board Headquarters**
One Talbot Gateway, Baglan Energy Park, Port Talbot, SA12 7BR **Phone** 01639 683334

Rydym yn croesawu gohebiaeth yn y Gymraeg ac yn y Saesneg. We welcome correspondence in Welsh or English.

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

Our Ref : TCM/SHG/pp

☎ PA – Ebony Smith (01639) 683302
☎ WHTN (01787) 3302
ebony.smith@wales.nhs.uk

Dyddiad/Date: 16th October 2020

Dear Andrew

**SWANSEA BAY UHB Q3/4 OPERATIONAL PLAN**

Further to your letter dated 24th September 2020, I am pleased to enclose the Health Board's (HB) Q3/4 Operational Plan.

This plan builds on the HB's previous quarterly plans and sets out how we plan (within known information at the time of writing) to respond to priorities and service pressures during Q3/4. The overriding priority is to respond to COVID-19 and continue to deliver essential services, which will be enabled by an effective Test, Trace and Protect service and vaccination programme.

Detailed modelling to support alignment of service, workforce and financial requirements has been undertaken and demonstrates that the Health Board has the physical capacity to respond to modelled demand, however, there would be significant workforce challenges in staffing all super surge capacity if required. Our approach to managing this is referenced below.

We plan to maintain essential services, although at periods of extreme pressure, some capacity may need to be flexed to respond to COVID requirements. Routine services will be delivered in a clinically prioritised manner.

The development of the plan has been considered at Board meetings over recent months, and the final draft plan has been considered virtually by all Board members. Comments from Independent Members have been reflected in the submitted plan, which has been signed off through Chair's Action. Progress against delivery of the Plan will be taken forward through the Board's governance mechanisms.

I have briefly set out below, the key elements of the Plan in relation to the specific points raised in your letter dated 24th September 2020.

**1. Local prevention and response plans, including Test, Trace and Protect**

The regional multi-agency Prevention and Response Plan is a live document which continues to be refined based on learning and experience. The region has staffed its TTP teams to 100% capacity based on increasing demands. Further expansion of the TTP teams would be possible to make it more effective if funding were available, although the availability of specialist health protection staff to maximise the impact of the TTP service is a constraint. Additional testing capacity has been implemented locally and a revised local testing plan is being finalised. The capacity of laboratories – both Public Health Wales and Lighthouse Laboratories - is key to enable the testing plan and capacity to deliver maximum impact. The region is working closely with Universities and other employers to ensure proactive messaging on reducing community transmission, and arrangements for responding to incidents/outbreaks are in place.

Governance arrangements are reviewed regularly to ensure they respond to the changing position – for example the establishment of the regional IMT. There are weekly discussions with the Leaders and Chief Executives of the two local authorities; the Board receives weekly reports on local outbreaks, and there are formal updates at each Board meeting.

**2. Essential Services**

Services continue to be delivered in line with the Essential Services Framework. The Health Board's plans for Q1&2 set out the approach for delivery and ongoing recovery of essential services and these processes remain relevant for the Q3&4 plan with some small changes. The assurance framework for these services is rooted in the organisation's existing governance and assurance framework. Key points to note are:

- Local self-assessments against all service specific guidance issued from Welsh Government (WG) on essential services have been mandated and these are reviewed at the Reset & Recovery Group (now being undertaken by Community Operational Silver);
- Across essential services, a key principle has been to adopt a clinically led prioritisation of patients and a clinical, and where relevant an MDT review of patients on waiting lists. This is to ensure that cases are appropriately prioritised and where appropriate alternative treatments or regimes agreed. In some service areas the use of PROMS is supporting this. More detail on safety netting and clinical prioritisation is included in relevant sections of the Plan
- A Quality Impact Assessment process has been implemented for the restart of services which takes a risk-based approach to the re-commencement of services.
- A similar process will be put in place to support decision making around any adjustments to service levels
- Reporting against the Healthcare Standards for Wales is done through the Quality Assurance Framework and through to Quality and Safety Committee
- A Clinical Advisory Group continues to support the R&R (Operational Silver) programme, providing advice on clinical issues related to essential services.

The cost of the delivery of Essential Services is included within the financial plan set out.

The Health Board is committed to engage in the national and regional work to explore alternative solutions for elective and diagnostic capacity. This particularly relates to elective surgery and use of the independent sector, cancer and diagnostic services.

Specifically it should be noted that:

Surgery and Theatres

- Elective activity increased during Qs1&2 and our ambition is to protect an element of theatre capacity, subject to our COVID escalation framework.
- Category 1a, 1b and 2 patients will be treated – although not all category 2 patients will be treated within 4 weeks.
- No category 3 patients will be treated, with the exception of some paediatric patients which are being clinically prioritised.
- No elective surgery (with the exception of urgent cancer surgery) is planned for w/c 28th December and w/c 4th January

The Health Board does not have access to comparable levels of independent sector capacity as other Health Boards, which hampers our ability to deliver elective care.

Diagnostic and Imaging Services

Activity has increased, however, demand and capacity are not in balance. Additional capacity is being commissioned in Q3/4 to support additional activity to close the Essential Services demand and capacity gap.

Cancer

- Key priorities focus on continuing to manage the backlog of Cancer patients and providing timely Cancer Treatments.
- Radiology and chemotherapy services are protected – but not at pre-COVID levels
- Demand is increasing (although currently not at pre COVID levels) and breach numbers are expected to increase. The Health Board is increasing its essential services diagnostic capacity to respond to these anticipated increases.

Mental Health and Learning Disabilities

The pandemic is increasing psychosocial distress, people are fearful and anxious with anxieties relating not only to Covid-19 itself but also the loss of employment, reduced finances and to uncertainties over the future. The impact on services is likely to be felt over at least the next three years.

We are expecting a 25% increase in referral activity, particularly through “lower level” mental health services, and await the national modelling tool to support local demand and capacity planning. This, and previous plans, cover how we have targeted both our child and adult mental health services to maximise the impact of our current capacity We expect to meet psychological therapies waiting times targets during Q3.

3. **Primary Care Services**
   The priority areas reflect the refreshed national delivery milestones for the Strategic Programme for Primary Care, set out in the Q3/4 Operating Framework; the range of national guidance issued to primary care contractor services to date; and the extensive Health Board modelling (including Discharge Modelling and Bed Capacity Modelling). Access to primary care is now fully restored in line with the "new normal", albeit in different forms, and this will be maintained, as well as maintaining urgent and essential services.

4. **Preparing urgent and emergency care services for winter**
   An integrated Unscheduled Care Plan was approved by the Regional Partnership Board on 15th October 2020, and is an integral part of the Q3/4 Plan. This will provide greater assurance of health and social care system resilience to manage the predicted winter demand, as well as demonstrating preparedness in the event of a second wave of COVID-19 infection. The Plan reflects the six goals for urgent and emergency care.

5. **Working with partners**
   As set out above, an integrated unscheduled care plan has been developed. Multi-agency gold and multi-agency community silver continue to oversee partnership arrangements across all joint working. A local Care Home Action Plan has been developed which addressed all of the recommendations of the national "Rapid Review for Care Homes in Relation to Covid-19 in Wales" by John Bolton. Work continues to ensure contingency arrangements for care homes are in place, and a report will be made to WG by end of October as required.

6. **Organisations' capacity plans**
   The Health Board has undertaken detailed modelling to understand the requirements for core/surge/super surge and critical care capacity. The Health Board has the physical capacity to deliver the required additional capacity set out in your letter dated 24th September 2020. As has been previously notified to you, the workforce challenges of staffing the entirety of this capacity is very challenging. To support this, the Health Board has developed an Escalation Framework and SOP, which give clear trigger arrangements for accessing different levels of capacity. The clinically led approach for flexing capacity and services to release staff to enable all of super surge capacity to be opened (if required) is being finalised.

7. **Organisational workforce plans**
   Staff Health and Wellbeing remains a key priority for us, recognising the importance of supporting our staff in challenging times.

   We have developed a robust workforce model that has helped inform our workforce planning assumptions. Our planning shows that we can staff surge and the first phase of super surge in the Field Hospital, recognising that we will need to take a risk based approach to staff deployment to ensure the safe staffing of our services. To staff beyond the first phase of the Field Hospital would present a significant challenge, although as referenced earlier, plans are being finalised to flex and adjust services which will enable staff to be released to support super surge capacity.

**8. Finance plans (including capital)**

Our financial forecast and the associated assumptions contextualising the forecast are clearly set out in the Plan. The financial plan reflects the detail submitted in the Health Board's Month 6 Financial Monitoring Return and is fully aligned to this submission. There is further detail in the monitoring return letter on the detailed assumptions in terms of income and expenditure. We understand that the Finance Delivery Unit will undertake a support and scrutiny review of the financial plan which we welcome and we will engage fully and transparently with this.

Through Q3/Q4 the Health Board is further developing its response to the review undertaken by KPMG prior to the COVID-19 pandemic. Where it has been possible to do so, findings from the report review have been implemented and through Q3/Q4 the Health Board will continue to bear down on savings opportunities and grip and control mechanisms within an overall financial delivery framework.

The Health Board's capital plan remains balanced and this is described in the Plan. Should the capital position develop over Q3/Q4 to present opportunities for additional capital funding the Health Board would welcome a conversation about how this may be most effectively deployed.

**9. Other issues and Minimum Data Set**

The Plan sets out the work undertaken and progress in terms of Digital and new ways of working and EU Exit. The HB's corporate risk register is attached as an Appendix.

The data set is complete as far as we are able, and is attached. Where the HB has been unable to complete the MDS (eg national organisation completing) then an explanatory note has been added. The service, workforce and financial plans have all been triangulated on multiple occasions, together with the modelling, and are supported by the data and MDS.

As set out in the Plan, the Health Board will continue to strive to maintain, and where possible, improve the level of care to our population, within the confines of a changing picture of demand through COVID, the winter and our available workforce. We look forward to continuing to work with you and your colleagues in WG to be flexible, and respond to changing demands as they arise. As ever, the attached Plan will be refined and re-calibrated as we progress through the remainder of the year, however, I hope it provides you with the assurance that the Health Board has robust plans in place to meet the demands placed upon us.

As set out in your letter, we look forward to further discussions with you and Welsh Government colleagues on the detail of the Plan.

Yours sincerely,

Tracy Myhill

**PROFESSOR TRACY MYHILL**
**CHIEF EXECUTIVE**

c.c. Emma Woollett, Chair
Siân Harrop-Griffiths, Director of Strategy
Darren Griffiths, Interim Director of Finance
Kathryn Jones, Interim Director of Workforce

# Swansea Bay University Health Board

# Operational Plan

# Quarters 3&4 2020/21

## Contents

## 1.0 Overview and Context

The Health Board's Q3&4 Plan builds on the two previous quarterly plans for 2020/21. The Health Board continues to put the response to the COVID-19 pandemic as its top priority, and this is ever more important as the number of COVID-19 positive cases increase, and local restrictions are in place across the Health Board area.

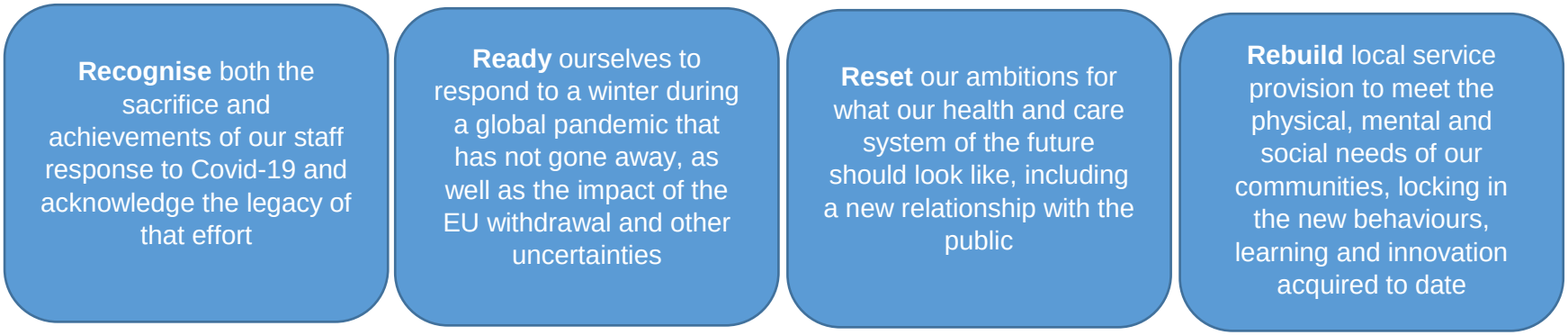
The Health Board's professional and considered response to managing COVID-19 has been recognised by Welsh Government (WG) and cited to support the organisation's de-escalation from Targeted Intervention to Enhanced Monitoring. This approach will be continued, whilst at the same time continuing to respond to unscheduled care pressures, continuing to deliver essential services and maintaining and, where possible, improving elective care – both through surgery and out-patient activity. Access to cancer and diagnostic services will continue – as will many of the routine services that have continued to be delivered through the pandemic.

This plan represents one element of the region's approach to keeping communities safe through the next six months. Other elements of this are the Prevention and Response Plan; Vaccination Plan; Care Homes Action Plan and regional Seasonal Pressures Plan. All of these have been jointly developed with, and will be jointly implemented with, partners.

The strength of the relationships with partner organisations will continue to be a focus, especially the leadership that has been brought to managing the resilience and support of care homes. The Test Trace and Protect (TTP) programme continues to be driven through partnership arrangements.

Within this context, this plan outlines the Health Boards priorities for the management of Covid-19, ensuring an effective Test, Trace and Protect service, planning for a mass vaccination programme, addressing the impact of the end of the European Union (EU) transition period, managing seasonal pressures and delivery of essential services. Detailed action plans to address these priorities are contained within the appendices in addition to the minimum dataset which can be found in Appendix 1.

In a review of the first half of the financial year, and to prepare for the remainder, the Board has confirmed its approach that, six months on, the organisation is working in the context of an emerging 'new normal'. The system has to:



The priorities for the Plan focus on:

- Covid-19 – emergency admissions, critical care, TTP, testing, vaccination programme
- Other emergency admissions – medical and surgical
- All other essential services

The plan has been based on capacity to meet the anticipated demand and on assumptions around the available workforce and financial framework available.

The Plan is written at a point in time, based on the best available information and data at that time. The Plan will be continually reviewed and flexed as actual demand and activity is known against modelled demand and available workforce. Progress against delivering the Plan will be reported through the Health Board's governance frameworks.

## 1.1 Bed Demand, Capacity and Workforce

The following section sets out a brief overview of the capacity and workforce plans to meet the modelled capacity requirements. Detailed modelling and triangulation has been undertaken across the service, workforce and financial elements to provide confidence in the Plan. The Health Board is tracking demand and activity against modelled demand, and plans will be flexed and adjusted as required.

The Welsh Government's operating Framework for Q3&4 requires the Health Board to prepare a capacity plan to deliver an additional 46 Critical Care beds and 621 acute beds. The Health Board is using the Swansea University model and local short-term modelling of demand to guide the bed capacity plan. Whilst multiple models for Covid-19 demand have been considered, the Swansea University model was chosen as being the most realistic, based on evidence from the first wave and is also the preferred RWC scenario of both Public Health Wales and the Technical Advisory Group.

### 1.1.1 Core Bed Capacity (Phase 1)

The table below sets out the modelled demand based on 92% occupancy (low and high point by month) against the core bed capacity and the additional modelled demand requirement.

| | Modelled Demand | | | Additional Modelled Demand Requirement | |
|---|---|---|---|---|---|
| Month | Low | Peak | Core Bed Capacity | Low | Peak |
| October | 1017 | 1065 | 985 | 32 | 80 |
| November | 1014 | 1078 | 985 | 29 | 93 |
| December | 1074 | 1130 | 985 | 89 | 145 |
| January | 1125 | 1208 | 985 | 140 | 223 |
| February | 1025 | 1051 | 985 | 40 | 66 |
| March | 971 | 1088 | 985 | -14 | 103 |

Whilst the Health Board's modelling does not suggest that a level of 621 acute beds will be required, in addition to core bed capacity (Phase 1), the Health Board has further internal surge capacity (Phase 2) of 143 beds available to deliver 1,128 beds, with c130 Covid-19 and c480 emergency respiratory beds built in which gives a bed stock close to this requirement, as set out below. For the majority of Q3&4 the internal bed capacity will deliver the modelled demand, however based on the modelling there is a period in December and January where internal hospital capacity will be insufficient and the Health Board will need to move into super surge (Phase 3) via the Field Hospital to deliver an additional 86 beds. There is physical capacity within the Field Hospital to deliver the required number of additional super surge beds if required, and a plan to mobilise these is in place. The workforce required to staff these beds remains challenging. In light of the current epidemiological picture within the Swansea Bay area, and in Wales, there is a risk that the timing of a peak may be earlier than previously modelled. Further work is underway locally to model the impact of the current epidemiological trends and consider their impact on the wider health and care system.

| Bed Capacity | | | | |
|---|---|---|---|---|
| Core (Phase 1) | Surge (Phase2) | Sub-Total | Super Surge (Phase 3) stage 1 | Total |
| 985 | 143 | 1,128 | 86 | 1,214 |

There is a provision for regional mutual aid with Hywel Dda UHB that can be enacted if required, subject to an agreed workforce model. Discussions are also ongoing on the potential for mutual aid in specialist areas, including critical care.

### 1.1.2 Surge (Phase 2) Workforce

Workforce plans to meet surge demand have been undertaken for each of the Health Board's service groups based on the following assumption:

- During Covid-19 pressures (surge and super surge) maintaining nurse staffing levels will become increasingly challenging. In response, clinical environments will be repurposed and staff will be redeployed.
- As a consequence the Health Board will vary its nurse staffing levels, using professional judgement in line with the national guidance and in line with section 25B taking all reasonable steps to maintain the nurse staffing level. Following risk assessment, reasonable steps might include backfilling Registered General Nursing (RGN) with Health Care Support Workers (HCSW), recruitment, deployment of staff.

| Staff Group | PPE | TTP | Testing | Vaccs | Care Homes | Surge | Super Surge | Covid-19 Pathways | Total |
|---|---|---|---|---|---|---|---|---|---|
| **Medical & Dental** | 0 | 0 | 0 | 0 | 0 | 0 | 8.5 | 0 | **8.5** |
| **Nursing & Midwifery** | 0 | 5 | 0 | 24 | 0 | 87.37 | 30.51 | 0 | **146.88** |
| **Add Prof, Scientific & Tech** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Healthcare Scientist** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **AHP** | 0 | 0 | 0 | 0 | 0 | 15.45 | 0 | 0 | **15.45** |
| **Add. Clinical Services** | 0 | 0 | 32 | 12 | 0 | 188.87 | 180.79 | 0 | **413.66** |
| **Admin & Clerical** | 3 | 0 | 9 | 0 | 0 | 4 | 19 | 0 | **35** |
| **Estates & Ancillary** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Total** | **3** | **5** | **41** | **36** | **0** | **261.66** | **238.8** | **0** | **619.49** |

The above summary table outlines a deficit of 261.66WTE (87.37WTE for Registered Nursing and 188.88WTE for HCSWs) however the following assumes that as surge capacity is utilised, there will need to be a flexing of other services. The following staffing will be repurposed to support surge requirements:

- Allied Health Professionals (AHPs) will be repurposed in line with the Health Board's AHP Addendum created during the first wave;
- Critical Nurse Specialists and off ward nursing;

- Outpatients will be adjusted, and staff repurposed. The on-going assumed use of bank agency is 217.38WTE for HCSW and 212.82WTE for Registered Nursing. This figure is conservative and during the peak times these figures increase substantially.

In addition to repurposing staff, work will continue on:

- On-going bank recruitment and additional fixed term contracts which currently is 190 head in the current cohort and assumed based on 2-3 shifts per week 76WTE.
- During Quarter 3 the work previously undertaken to ensure that medical rotas were ready to deal with a Covid-19 upsurge are being reviewed and if necessary, implemented again to ensure the Health Board is ready to meet demand. These rotas are New Deal and European Working Time Directive (EWTD) compliant and were developed in conjunction with the junior doctors. The Health Board will liaise once more with Health Education and Improvement Wales (HEIW) to gain agreement to flexibly deploy the doctors in training. Work is also planned to consider if the Board should over establish locum doctors in key specialities to provide more resilience overall to cope with challenging workloads. During the first wave the Health Board was successful in over establishing locum doctors and the expectation is that this will be the case for the second wave. There is a close and productive contractual arrangement with the Medacs Agency who successfully source the doctors required in the main.

### 1.1.3 Field Hospital (Super Surge) Phase 3

The clinical model for Bay Field Hospital was refined based on the oxygen cylinder/ concentrator model, and formally approved on 17th September 2020. A clinical model workshop was then held on 28th September 2020 and as a result, adaptation of all clinical pathways, policies and processes are taking place together with a refresh of the workforce plan, to ensure all plans and SOPs are fit for purpose in light of the revised clinical model.

Significant work is already underway to prepare to mobilise Bay Field Hospital in readiness for opening to receive patients; to be triggered by the agreed Health Board escalation parameters. The Health Board has an agreed Covid-19 Escalation Framework developed based on Winter Preparedness Early Warning Indicators and Circuit Breakers which were tested at Exercise Barod on 30th September 2020. The Escalation Framework sets out that Bay Field Hospital would be only be activated in Red 'full response' state, i.e. in super surge capacity. This decision would be made by Health Board Gold Command, resulting in instigation of the 72hr activation plan agreed for Bay Field Hospital.

Field hospital capacity will be deployed in three stages with an increase in physical bed capacity in stage 1 of 86 beds;

Development of a detailed project plan to set out the key milestones and activities required to take place over the next 3 weeks (from W/C 12th October) in order to be in a position to mobilise stage 1 of Bay Field Hospital within 72 hours if indicated by the Health Board escalation status at the time. Stage 1 involves opening a total of 80 beds + 6 assessment beds; these would be opened in a phased approach. The first Phase 1a consists of opening 6 assessment beds + 20 beds (2 x 10 bedded bays) on Pennard ward. Phase 1b adds a further 30 beds and phase 1c brings two further bays in of 10 and 20 beds respectively. Stage 2 involves an additional 244 beds and a further 420 potential beds in stage 3.

Stage 1 of super surge will be staffed predominately from Primary Care, Community & Therapy Services (PCCT) Group through the repurposing of staff from non-essential services. This will be undertaken in line with the Health Board's Quality Impact Assessment (QIA) process for flexing/adjusting services. Within current plans there is a slight deficit of HCSW, but the Health Board is confident that this gap will be met through on-going recruitment campaigns. Senior nursing staff within Primary and Community Care will also be repurposed to the Field Hospital.

In addition, there are 20WTE Specialist Services Assistant (SSA) roles required to staff stage 1. These staff were trained during the first wave and will be released to support stage 1. There is on-going recruitment for Bank SSA staff.

Workforce plans for super surge (stages 2 & 3) currently show a significant deficit for both HCSW and Registered Nursing roles for Super Surge. On-going recruitment is continuing for both areas with high applicant numbers for HCSWs although a drop off rate is expected to these, Registered Nursing recruitment remains challenging. In conclusion the ability to recruit and staff stage 2 & 3 of Super Surge will be significantly challenging for the Health Board (see section 9.0 for further details).

In the event of the use of surge and super surge the level of essential services that could be safely delivered, will be determined using the triggers and SOP in the Escalation Framework. This will also mean that the Health Board will need to repurpose/redeploy staff from other, non-essential services, and an approach to confirming this is being finalised.

During super surge (stage 2) the Health Board will plan to deliver only the services that are deemed absolutely necessary on acute sites, so that staff can be released for the Field Hospital. During the two weeks commencing 28th December and 4th January, elective surgery will not be planned, other than urgent cancer surgery.

We are working with Cwm Taf Morgannwg UHB to determine the potential role of the Bay Field Hospital in supporting a regional approach to capacity if required. The details of this will be worked through imminently, including operational details and impacts.

All necessary governance and quality processes have been tested and are acceptable; for example, the Fire Strategy was formally approved by the Field Hospital Estates Group on 18th June 2020. In respect of infection control measures, the Health Board's Infection Prevention Control (IPC) Team have visited Bay Field Hospital and advised on social distancing and IPC processes. All measures have been put in place and formally approved by the Field Hospital Establishment Group.

### 1.1.4 Critical Care

Critical care capacity was rapidly developed during the first wave of Covid-19 and two new units, Enfys and Tawe, were built but not commissioned as the Health Board was able to manage the maximum demand of 43 within its core bed stock and utilising the redeployment of theatre staff to support the nursing workforce requirements.

The Health Board has sufficient ventilators and oxygen supply to support up to 84 physical critical care beds. Further work may be required to understand the second wave requirements in the event of a prolonged time period for CPACP and O2 demand.

There is a baseline staffing for General Intensive Care Unit (ITU) for 14 level 2 patients and 14 level 3 patients which equates to 21 level 3 beds. The phasing to step up into the beds will require:

- Baseline (21 level 3 bed equivalent) -
  Workforce actions to bridge to 28 level 3 bed equivalents -
  - Agency nursing

- Phase 1 - 28 level 3 bed equivalents
  Workforce actions to bridge from 28 to 39 level 3 bed equivalents -
  - Cardiac ITU
  - Non theatre additional support staff (increase level of non-theatre additional support staff from 1st wave)

- Phase 2 - level 3 bed equivalents
  Workforce actions to bridge from 39 to 49 level 3 bed equivalents -
  - Incremental reduction in the theatre programme back to July 2020 programme to deliver 49 bed coverage

The above equates to 49 level 3 bed equivalents.

Ahead of the first wave, an additional 115 support staff were trained by critical care, split between theatre and other staff, with around 80 staff undertaking consistent shifts in ITU during the first wave. Unlike during the first wave, the ambition during any second wave

will be to continue to maintain a level of surgical capacity for emergency and category 2 patients in line with the four harms principle wherever possible. In making this decision, a balanced approach between the harm caused directly by Covid-19, and harm as a result of a reduction in non-Covid-19 activity will need to be undertaken within an operational context. With a theatre programme at July 2020 levels in place, it is estimated that circa 51 WTE theatre workforce staff could be released to support critical care surge requirements. Beyond the 49 beds there are insufficient critical care trained staff to maintain the 1:2 ratio outlined by WG as the critical care staffing levels. The Health Board will vary nurse staffing levels, using professional judgement in line with the national guidance and in line with section 25B taking all reasonable steps to maintain the nurse staffing level. Following risk assessment, reasonable steps might include backfilling RGN with HCSW, recruitment, deployment of staff etc.

In addition, it is anticipated that specific operational issues such as staff unwillingness to return to ITU for wellbeing/psychological reasons, or a need to balance staff skill mix across services may reduce this calculation further. A detailed piece of work to understand any further potential reduction will be undertaken in a sensitive and compassionate way, as required.

Options to increase access to critical care nursing skills would be to suspend operating on Post Anaesthetic Care Unit (PACU) cases for a period, to release CITU skilled nurses and increase the level of critical care nurses available. If the theatre programme is to be maintained at July 2020 levels, with no further reduction, then staff from other areas would need to be identified to support ITU. The Health Board is working with agencies, undertaking recruitment and training existing staff who would wish to work in critical care. Further detail can be found in section 9.2 and 9.3.

The Medical workforce plan for critical care would also need to be adjusted for any second wave, based on the need to maintain July 2020 theatre programme. This would reduce the additional support provided by anaesthetics from 2 tiers of consultants to 1 tier and would be supplemented, during a second wave, by critical care Advanced Critical Care Practitioners (ACCPs) delivery 24/7 rota to support the Enfys critical care unit.

The escalation triggers for activating Enfys capacity will involve three clear escalation levels:

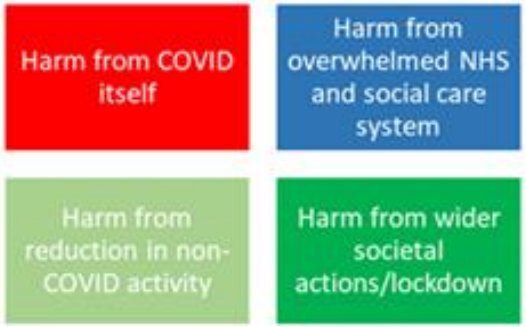
| Escalation Level | Description |
|---|---|
| 1. Readiness | • (Re)Prepare Enfys surge unit<br>• (Re)Establish staffing models and ‘ghost’ enhanced rotas |
| 2. Steady | • Move all services out of Enfys |

| | |
|---|---|
| | • Prepare drug stocks and last-minute items (e.g. consumables)<br>• Ensure staffing models are ready to activate <48hours |
| 3. Go | • Enact enhanced staffing rotas<br>• Move all COVID-19 positive patients to Enfys <48 hours |

### 1.1.5 Addressing the Four Harms

The Health Board has taken positive action to reduce the impact of the four harms which include:

- Remaining ready to provide the full range of services needed to prevent, diagnose, isolate and treat COVID-19 patients
- Ensuring that essential services continue to be provided. This includes services that are urgent and life threatening or life impacting as well as services that without timely intervention could result in harm over the longer term such as maintaining vaccination programmes
- Reinstating routine services where it is has been operationally possible and safe to do so, with strict adherence to infection prevention and hygiene procedures and maximising the use of virtual consultations
- Undertaking clinical led review of referrals of those waiting to ensure people have been prioritised according to clinical need.
- Further development of testing capacity, through the Test, Trace and Protect Strategy for Wales, as well as delivering an expanded and comprehensive flu vaccination campaign.
- The Performance Framework has been re-designed to reflect the four harms, which brings a greater focus to these areas.



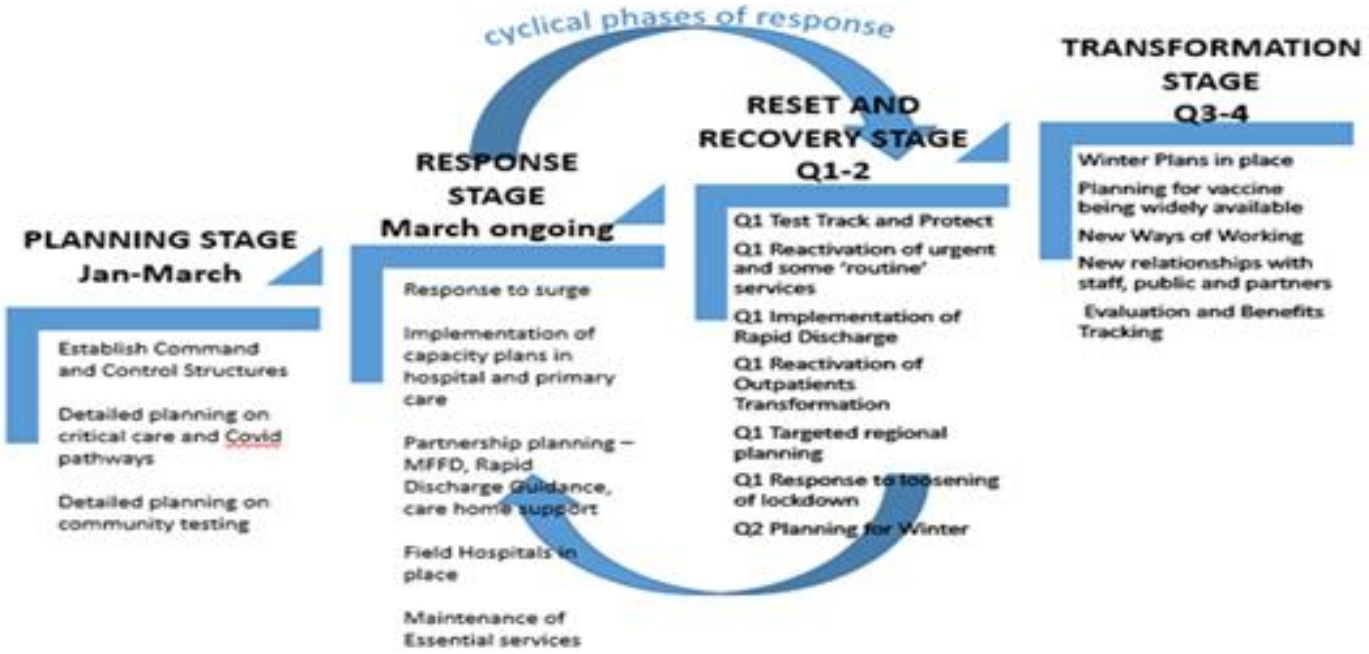

The Q3&4 Plan sets out what is needed over the coming months to provide safe and effective healthcare services to support both patients and the workforce.

### 1.1.6 Financial Plan

- The financial forecast builds on the previous forecast position and reflects the costs of the additional surge capacity to support the modelled level of demand and essential service provision with the supporting workforce requirements. The forecast reflects the Health Board confirmed funding allocation and anticipated funding from National allocations.
- The financial forecast does not include any costs that may be incurred for the opening of phase 2 and phase 3 of the field hospital.
- The financial assessment includes the costs of the extended flu programme, testing and winter protection plan along with assumed WG funding support.
- The financial forecast also recognises the need to utilise external providers to support the sustainability of essential services in some areas, however the accessibility of such support locally is limited.
- There is work continuing to assess the impact of a potential Covid-19 mass vaccination programme, this is referred to within the plan but is not included within the financial forecast at this stage. The Health Board's expectation is that this programme will be fully funded.
- The Health Board's capital plan is balanced

## 1.2 Operational Planning Approach

The Health Board's Operational Planning Approach has been set out previously and continues to be followed. There are elements of the transformation phase which will be progressed during Q3&4, however, the priority will continue to be to respond to the COVID-19 pandemic.




## 1.3 Planning Principles

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

- A Swansea Bay **system wide** service, workforce and capacity response to Covid-19 and non-Covid-19,
- **Cautious and adaptive** approach to the delivery of non-Covid-19 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 Infection Prevention Control (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 Health Board's planning assumptions have been refreshed

## 1.4 Operational Planning Assumptions for Quarter 3&4

- The Health Board is planning based on an R0 of 2.5 and an Rt which scales from approximately 1.1 in August to 1.3 in September and 1.5 in November (for 30 days). Originally this provided a modelled position which resulted in a surge in cases during Q3&4, particularly during December/ January for which the planning assumptions within this plan have been aligned. However, at the time of submitting this report current activity monitoring shows that demand is potentially 6 weeks ahead of this peak despite the aforementioned Rt Values being used within the model. It has not been possible to rerun the modelling based on this intelligence within the timeframe for preparation of the Plan, however, actual demand and activity will continue to be tracked against the model, and so deviations will enable the plan to be adjusted as required
- The Health Board is using the Swansea University model and local short-term modelling to guide the Plan.
- 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 physical distancing guidance for infection prevention and control guidance.
- The Q3&4 Operating Framework occupancy guidance of 92% has been included to give headroom to respond to a surge.
- Operating theatre capacity will be sustained in Q3&4. Elective activity is being prioritised as described in the Essential Services guidance, but the plan is to deliver all Priority 1, 1a and 2 cases.
- The Health Board will continue to adhere to Table 4 of the current Personal Protective Equipment (PPE) guidance, recognising that this is a major constraining factor in operating capacity.
- In the event of a surge, the Health Board's principle from a quality standpoint, is to use all internal substantive bed capacity first. This will require a divergence from the physical distancing guidance.
- During Covid 19 pressures (surge and super surge) maintaining nurse staffing levels will become increasingly challenging. In response, clinical environments will be repurposed and staff will be redeployed. As a consequence nurse staffing levels will be varied, using professional judgement in line with the national guidance and in line with section 25B taking all reasonable steps to maintain the nurse staffing level. Following risk assessment, reasonable steps might include backfilling RGN with HCSW, recruitment, deployment of staff etc.
- During super surge the Health Board will plan to deliver only services that are absolutely necessary on acute sites so that staff can be released for the Field Hospital. Current workforce assumptions are that staffing of Stage 1 can be achieved through

the PC&C plans of adjusting services and repurposing staff. Staffing requirements for Stage 2 of super surge remains a deficit in the plan and will be a significant challenge for the Health Board to achieve

- This principle along with the bed capacity modelling suggests that the Bay Field Hospital will be required for super surge during December/January
- 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.
- Primary Care activity will return to pre COVID-19 levels, with the subsequent knock on impact on diagnostics, outpatients and secondary care activity.
- In the event of the use of surge and super surge the level of essential services that could be safely delivered would be determined, using the Escalation Framework triggers and SOP.
- Capacity will be increased for both testing and trace and protect in partnership with Local Authorities to meet demand for testing of the population and to respond to outbreaks.

The Plan for the remainder of the year concentrates on the detail underpinning the system-wide demand & capacity modelling and throughput for March 2021.

## 1.5 Learning from Q1 & 2

A significant number of changes have rapidly been made to ways of working and services delivered. To learn from these and inform on-going COVID-1919 planning and delivery of the Organisational Strategy, Clinical Services Plan and future Operating Framework hundreds of patients, staff and partners have been engaged with to identify changes and innovations to adopt, adapt or amplify in the following areas,

- Patient Experience
- Staff Home Working
- Staff Well-being
- Emergency planning and response
- Service change delivery and innovation
- Changes to ways of working
- Partnership working
- Digital ways of working

Some of the early learning from this has been used in the development of this plan, for example adapting the military approach to testing the Field Hospital plan to a whole system test of the winter plan ‘Exercise be Prepared’. Additionally, adopting or amplifying some service changes and innovations made or learned from other areas, for example; phone first, consultant connect and cluster hubs, all of which will enable more patients to be cared for safely outside of a hospital setting where appropriate.

The key learning points are being brought together into a summary: “Better Health, Better Care, Better Lives” INSIGHTs 2020 which will inform further decisions about changes to services and ways of working.

## 2.0 Managing Covid-19

The Board's response to managing Covid-19 in Q3&4 recognises that the landscape over the next 6 months is different to the response during the first wave of Covid-19 in March and April. The plan needs to support a range of priorities as set out previously, the potential significant impacts on staff absence as a result of an effective TTP system, as well as planning for a mass vaccination programme and addressing the impact of the end of the EU transition period. An escalation framework has been developed to help to identify key decision points in line with local triggers /and circuit breakers that are in line with the national Coronavirus Control Plan, see Appendix 2. The escalation framework was tested as part of a local exercise to test out winter preparedness held on 30th September and some key learning points and recommendations have been identified which will be reviewed as part of a broader suite of actions to strengthen the current response.

The principles underpinning the approach to managing further waves of Covid-19 remain broadly the same. Pathways are in place across all of sites to ensure that confirmed and suspected Covid-19 cases are managed appropriately. Pathways remain under review and subject to national and local learning and surge capacity has been identified on all sites.

A Health Board wide Command Centre has been developed that can be operationalised to support patient flow in the event of specific triggers being reached, including a trigger to bring field hospitals into active use. The Command Centre will draw on existing functions within the Board (e.g. Bed management) but will operate in a live environment to coordinate flow across the system – including into primary care and community services. The function has been equipped and is established with an operational SOP to support deployment.

Response arrangements in terms of Health Board Command and Control continue to operate and Gold has continued to function throughout the period since March with regularity determined by the extant situation. A review of the response arrangements has been undertaken and an updated governance structure is in place, see Appendix 3. A new 'Operational Silver' has been established which provides a cross system forum to agree operational priorities and deliverables, workforce deployment and make tactical decisions reporting to Gold. Operational Silver will oversee the deployment of the Field Hospital, medicines management, HB Command Centre, plans to manage mass fatalities (linking with the South Wales Local Resilience Forum (SWLRF) and oversee workforce deployment when required.

An Incident Management Team (IMT) is operational overseeing the public health response, and in addition special Outbreak / cluster management arrangements are in place to manage in-hospital transmission and provide Executive oversight of outbreak management. A separate Nosocomial Transmission Group has also been established to provide a tactical level response to

nosocomial transmission, to oversee the implementation of pathways to minimise nosocomial transmission, oversee effective IPC service, share learning and provide assurance on outbreak management.

A Mass Fatalities plan is in place and was enacted in Q1, aligned with the Excess death/mass fatalities work undertaken through the Local Resilience Forum. A number of additional body storage facilities remain in place, however, these were scaled back from the initial capacity secured in Q1. A mass fatalities model is being developed and the planning and provision of excess deaths will be aligned through Operational Silver arrangements.

Other elements of the response structure have been reviewed and re-aligned where necessary.

Key Actions for Q3&4 in terms of the overall Covid-19 planning and response structure include:

- Reviewing Response and Command arrangements including establishment of Operational Silver (October)
- Establishing Nosocomial Transmission Silver (October)
- Ensuring effective record keeping through employment of archivist (November)
- Continual communications and engagement with staff, stakeholders and patients/public (ongoing).

## 2.1 Swansea Bay Modelling Cell

The Health Board's Modelling Cell has continued to provide modelling and advanced analytical support with the release of a range of models, dashboards and reports.

A number of models have been created in order to plan and explore what might happen during the Q3&4 period and beyond.

Each model makes use of the existing Health Board data sources as well as data from models released by Technical Advisory Cell (TAC). The planning assumptions within the Plan have been based on modelling work from several models all of which have the final release of the Swansea University SEIR model (adapted from the London School of Hygiene and Tropical Medicine) at their core.

Whilst multiple models for Covid-19 demand have been considered the Swansea University model was chosen as being the most realistic based on evidence from the first wave and is also the preferred Reasonable Worst Case scenario of both Public Health Wales NHS Trust and TAC. Non Covid-19 demand was taken from various data sources with a 3-year average growth rate applied to the 2019/2020 financial year (utilising a smooth arithmetic mean for March 2020). Subsequent adjustments were then made to these data based on other available data, planning assumptions and scenarios.

The key overarching models based on the Swansea University model and existing Health Board data have been produced for:

1. Emergency Department (ED) attendances
2. Emergency Admissions
3. Bed Capacity and Demand
4. Discharges and
5. Community Care
6. Cancer Services

Each modelled distribution is also being used to complete the National Q3&4 Minimum Data Set returns.

### 2.1.1 Bed Capacity Model Adopted for Q3&4 2020/21

The model adopted for Q3&4 outlined below is based on capacity across all three acute sites and the community site 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 still be providing sufficient bed capacity as outlined in the Welsh Government Covid-19 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.

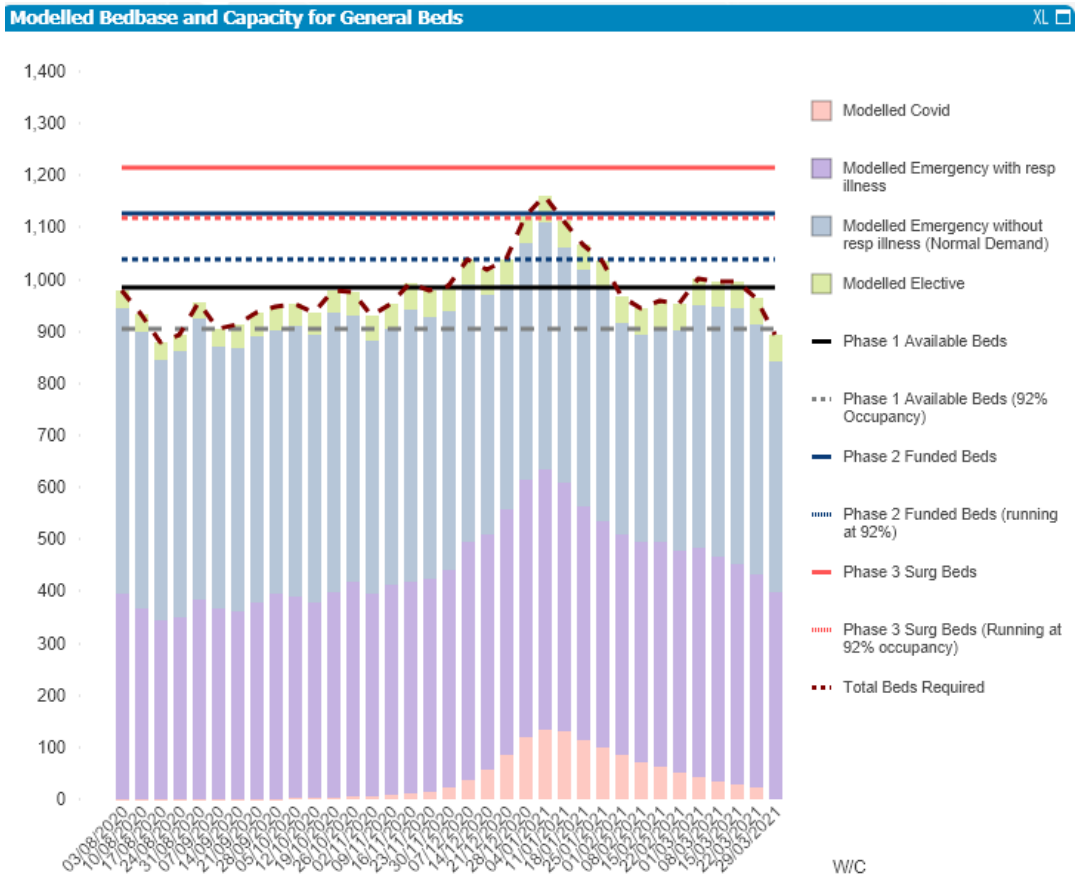
The Health Board assumptions are:

- Covid-19 demand– based on the Swansea University model (shown in red)
- Emergency Admissions – based on a 3-year average growth rate broken down by respirator (shown in purple) and non-respirator (shown in blue)
- Elective cases – based on modelling and planning work performed by the Health Board (shown in green)
- Physical Bed capacity and staffing provided by Health Board Delivery Unit Leads

Furthermore, a predicted level of 15% staff absence has been factored into the model for phase 1 capacity, 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, and staff that may not be available but who are required to reopen these areas at any one time.

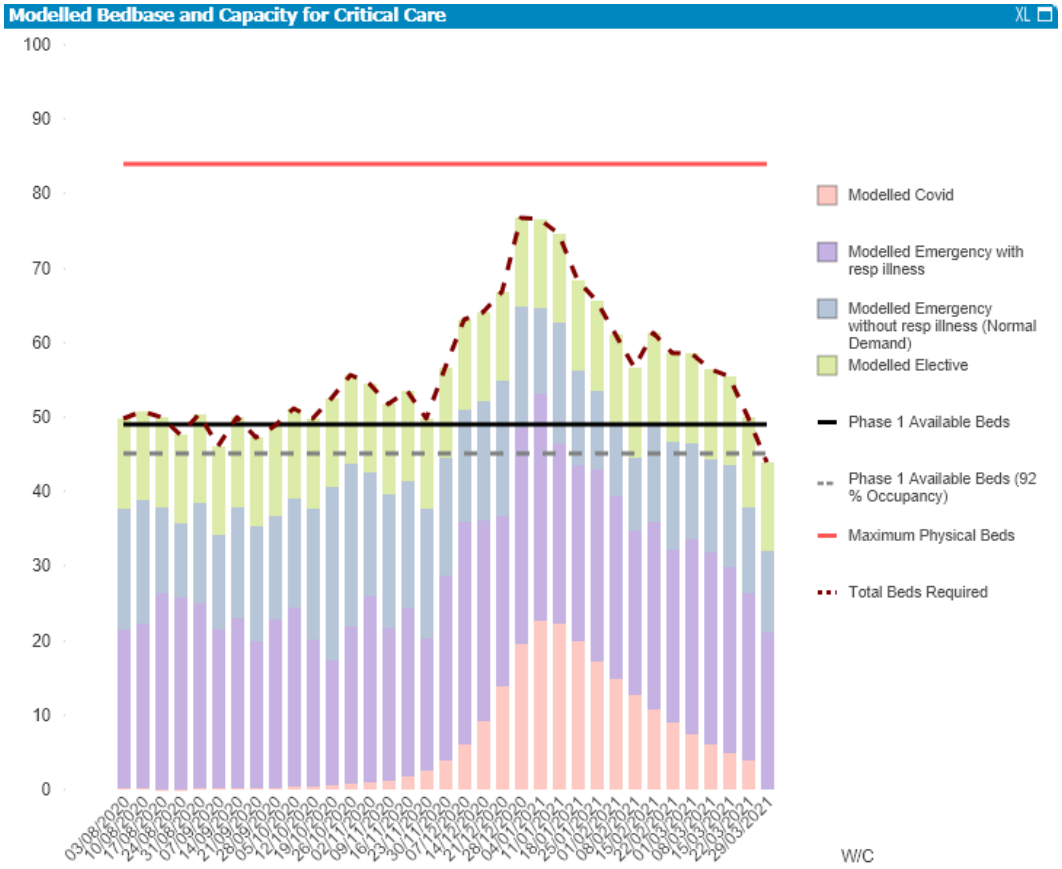
Each of the models shown demonstrates occupancy levels within the Health Board's staffed beds (Phase 1 available beds) at 100% and 92% to show the impact of each scenario. Physical bed capacity is also shown at various phased levels including the 92% level of occupancy commitment.

## General Beds for Quarters 3/4




Based on this modelling, the graph above displays the likely weekly occupancy from the w/c 5th October 2020 to the w/c 29th March 2021. The graph demonstrates occupancy levels at 100% (solid black line), 92% (dashed black line) of current staffed beds. It also shows the total number of physical funded and Surge bed capacity that could be brought online.

## Critical Care Beds




The graph above displays the likely weekly occupancy from the w/c 5th October 2020 to the w/c 29th March 2021 and uses the same legend characteristics as the General Bed Chart for demand and phase 1 capacity (49 beds). The maximum physical bed capacity is also shown as a solid red line indicating the overall Critical Care Bed stocks (84 Beds).

The graph demonstrates that there will not be enough capacity to meet Critical Care demand using phases 1 available beds for a prolonged period of time, elective cases would need to be cancelled and others reviewed. Risk assessments would be needed to

consider adherence to IPC distancing guidelines. The 92% commitment for safer patient flow would also not be achievable using phase 1 bed capacity.

**Future modelling**
The Health Board will continue to monitor changes in demand daily through the newly developed internal Covid-19 phase 2 dashboard which is refreshed constantly throughout the day and includes early warning and circuit breaker indicators. 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 daily, with appropriate changes to capacity being made as required.

## 2.2 Brexit / EU Transition

The final EU transition Health Board, (D20) planning is overseen within the Emergency Preparedness, Resilience and Response, (EPRR) Strategy Group, where there are EPRR leads from all services across the Health Board. The Executive Lead is the Director of Strategy. The Health Board actively participates in all regional and national groups.

Due to the synergies between the Covid-19 response and EU transition preparedness there are regular updates to Covid-19 Gold meetings, Executive Board and the Health Board.

A series of Covid-19 interim debriefs were undertaken during May and June to ensure lessons identified can be applied in current planning arrangements. This includes key learning points, particularly regarding the supplies of medicines management, clinical and non- clinical consumables, workforce, health and well-being, communications, emergency preparedness, resilience and response, Command, Control and Coordination, multi-agency collaboration and community tension issues. Planning includes:

- Full-service risk assessment
- Service Business Continuity plan and impact assessment review
- Review of Emergency Response plans
- Completion of an Assurance proforma in order that key risks, further mitigations and training requirements are identified, as well any additional gaps, planning and interdependencies can be noted
- Support for staff in undertaking the settled status applications has continued and preparations are underway for the new Immigration Control system in 2021. Staff are also supported through a robust health and wellbeing programme
- Compilation of an EU transition preparedness document

The Health Board has remained in response for the Covid-19 pandemic and strategic, tactical and operational command and control arrangements are in place in accordance with emergency response plans and Joint Emergency Service Interoperability Programme, (JESIP). Therefore, any issues arising from the D20 process that require an escalated response can be appropriately managed. To support this, there is an escalation framework with early warning indicators and circuit breakers, with a key decision-making tool incorporated at each level, where the consideration of the ending of the EU transition without a deal is embedded.

## 2.3 Pharmacy and Medicines Management

Pharmacy continues to monitor the ongoing availability of medicines and supply chain resilience at a local, national and UK level. The access to critical care medicines, trial treatments for Covid-19, dialysis fluids and palliative care medicines in community remains a concern with the dual impact of Covid-19 and Brexit on the medicines stock and supply. The principles of mutual aid across health organisations has been agreed across Wales, with the introduction of treatment protocols to ensure equal access for all Welsh patients. This is being closely managed by the SBU Pharmacy procurement team and national colleagues.

The Critical Care Pharmacists are now embedded in the clinical teams and will reinstate the additional ITU Pharmacist on-call rota if a further Covid-19 surge is experienced.

In order to respond to winter pressure demands and Covid-19 related absences across the Pharmacy team, 'Patient Prioritisation of pharmacy services will be implemented across the sites. This will target high acuity patients and ensure a basic level of safe medicines management for all patients in SBU.

- The Primary care MM team will target support to vulnerable patients in care homes and those receiving domiciliary care and support primary care contractors to identify and resolve of Covid-19 issues.
- PMM are leading the logistics cell for the mass vaccination programme and continue to support the supply arm of the extended flu vaccination programme.
- Pharmacy have developed the medicines policies for the Field hospitals and have identifying and trained staff to work on the site on a rota basis, if required.
- Due to Covid-19, trainee pharmacists were unable to undertake the final assessment. Regulatory changes have allowed for provisional registration with mandate for additional support and supervision.

**Other PMM plans for Q3&4**

- There has been investment in an additional pharmacist into the critical care team. Further options will be explored to develop a single team that will work across all the critical care specialities at Morriston

- Recruitment of a Consultant Pharmacist for Older People to provide strategic leadership to the newly formed integrated Older Peoples Pharmacy team has commenced and is planned to impact in Quarter 4 and will improve medicines management and health outcomes in the frail elderly population
- Despite the demonstrated benefits of a pharmacy team working in the Emergency Department (ED), daily operational site pressures at Morriston result in limited input only. This results in an increase in drug costs and delays in medicines reconciliation which can have a detrimental impact on patient safety. In addition, pharmacy cannot consistently support the older person's assessment service (OPAS) despite a 2-week evaluation demonstrating the quality and safety benefits of pharmacy input. Support is being sought to provide adequate resource for a team to be based in ED who will also support OPAS.
- Pharmacists recently appointed to work with the Community Mental Health Teams (CMHTs) will prioritise antipsychotic reviews, prescribing of valproate in females, clozapine clinics and safe prescribing of dementia medicines.
- Management of existing Training & Education programmes for pharmacy (trainee pharmacists and technicians), including delivery of new HEIW curricular and multisector rotations (hospital, GP practices & community pharmacies) and transition to single lead employer NHS Wales Shared Services Partnership (NWSSP).

## 2.4 Infection Prevention and Control

In response to the Welsh Government Covid-19 guidance for bed spacing in healthcare settings, the Health Board undertook a review of the physical bed-spacing to assess the impact of changes across the Health Board estate. Additionally, IPC made recommendations to the Physical Distancing cell for mitigating measures that can be used where beds did not meet the minimum bed spacing guidance.

Within the IPC report, a Red Amber Green (RAG) status approach was used to define the bed spacing measurements across the Health Board. Beds that were highlighted as Red were reviewed by Health and Safety (H&S) and IPC and removed if not compliant with a minimum of 2m between bed spacing. Beds that were highlighted as Amber require mitigating measures to minimise the risk of patient harm and reduce the risk of having to remove beds, and any beds that were highlighted as Green were meeting the minimum WG Bed Spacing Guidelines. As a result of the risk assessment, mitigating measures were agreed for amber beds which include a combination of clear curtains and screens as appropriate to the individual area. An installation plan has been agreed which will take place by mid November.

It was agreed that no physical mitigation will be required in the Mental Health wards due to the potential risks of having these in place as they may pose an additional hazard/risk for the patients/staff.

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

- Establishing 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.
- Completing 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.
- Reviewing practice in relation to the use of PPE and physical distancing on an ongoing basis

Key Actions for Q3&4:

- Implement social distancing for staff and patients in communal and clinical areas (October)
- Raise awareness of general principles of IPC for staff, patients and visitors (October)
- Ensure the most up to date guidance is implemented and disseminated in a timely manner (Ongoing)
- Ensure environmental decontamination practices are in place (October)
- Undertake regular review of IPC practices and compliance with physical distancing (October)

.

## 2.5 Personal Protective Equipment

At the national Executives PPE group facilitated by WG, all lines of PPE are reported as green, this means a minimum of two weeks supply at national level, with the majority of lines holding up to 12 weeks. NWSSP have published their winter plan and this includes taking PPE supplies to 24 weeks of holding stock by March 2021. Most PPE lines have been removed from the restricted supplies and are ordered through the normal routes, they do not have to go through HQ stores where the restricted items are distributed from.

Current restricted items:

- FFP3 (overall nationally and locally this is green), the only exception being certain models of FFP3 (8833 and 9332+) – contingencies in place locally as reusable options have been, and continue to be purchased (Half masks with filters and versaflow power packs with hoods) for critical care areas being the priority;
- Plans to move HQ stores to the Bay Field Hospital to enable build-up of supplies to a minimum of two weeks of holding stock in addition to local PPE hubs held at each Group/unit;
- Each service delivery group has at least 48hrs of supply, with 24hrs of supply in each ward/department;

- Locally negotiations are underway to purchase alternative supplies of PPE (FFP3), this is currently going through SMTL for verification and if passed will be sample fit tested prior to purchase to ensure a reasonable pass rate of fit testing is achieved;
- NWSSP continue to look at alternative manufacturers/supplier and have a number of Welsh based manufacturers/suppliers in place;
- NWSSP are bringing forward PPE stock orders to have a holding stock of 24 weeks and have secured additional warehousing.

## 2.6 Research and Development

Swansea Bay UHB is fully engaged in the UK Covid-19 research response, with 16 open studies of which 13 have Urgent Public Health (UPH) status. There are 3 Primary Care Covid-19 studies open across the SBUHB locality. 56 patients have been recruited into the influential UPH 'RECOVERY' trial. Swansea is also fully engaged in the Vaccine programme, with discussions underway to open as a site in the GSK vaccine study.

The Re-Start of paused studies and opening of new studies has been continuing at a steady pace across the Health Board. A Re-start plan was implemented based on the National Institute for Health Research (NIHR) Framework, which has ensured studies have been opened without creating additional pressure on support departments. The HB has received favourable comment from a commercial Sponsor for the speed of being able to re-open their study which led to the HB being selected as a site in a new trial with the same company. 32% of research activity has been re-started so far, for example 50% of Cancer studies have re-started, 60% of diabetes studies, 77% of cardiovascular studies. The Level 1 priority of Covid-19 studies has limited the amount of re-start activity of non-commercial portfolio studies supported by the Delivery team due to the need to manage staff resource to ensure rapid response to Covid-19 research priorities.

The detailed Action Template is at Appendix 4.

## 3 Test, Trace and Protect Programme

The Swansea Bay TTP Programme continues to evolve as demands and policy requirements change. The regional Prevention and Response Plan is an iterative document, which has been reviewed in the light of Public Health Wales comments with an action plan that is regularly reviewed and updated reflecting local and national learning. In Q3&4 the impact of the increasing incidence of Covid-19 in the community, the increasing number of outbreaks and the settings being affected and the demand on testing, will see TTP expand accordingly. The service was initially staffed at 50% of potentially required workforce, however Tracing teams are being staffed at 100% capacity. The challenge in terms of workforce is the specialist health protection staff required, where there is a national shortage.

Testing capacity has been increased at the two existing Drive Through sites at Margam and Liberty to cope with additional demand. In addition, a walk-in testing site will be opened at the Grand Theatre in Swansea, particularly targeted at students, the public locally and hard to reach groups and will be operational from mid-October. A Mobile Testing Unit (MTU) is also being deployed from end of September, rotating around 7 community-based locations within Swansea Bay to increase access to remote communities and those with low car ownership. Testing capacity could be further increased locally, however, this is also dependent on the availability of laboratory capacity to enable timely reporting of results.

Building on the Multiagency Testing Plan, a revised local testing plan is being finalised that responds to the recently issued Welsh Government Testing Framework and the 6 priorities identified by the Minister. This plan will focus on four main areas:

- Controlling and preventing transmission of the virus by supporting contact tracing
- Protecting Our NHS services
- Protecting vulnerable groups and managing increased transmission rates
- Developing future delivery

Work is underway to prioritise TTP and testing capacity within the available capacity, to meet national and local priorities.

The Health Board's testing capacity is outlined in forecast for antigen testing within the minimum dataset showing that this is planned to increase by 50% in Q3&4. Testing is offered to all symptomatic general population and key workers, patients requiring testing before elective procedures and for emergency care homes placements. The Community Testing Units (CTUs) also provide staff resource to "home test" key workers that are unable to drive to the units and to react to Covid-19 outbreaks in care homes (within 24 hrs of notification) and to respond to other outbreaks if emergency MTUs are not available.

The table below sets out the testing facilities offered by the region and how the different cohorts/sectors across the communities can access them:

| | Testing Options | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | CTU drive through HB swab - PHW lab process | CTU drive through HB swab - Lighthouse Lab process | Community Testing Team | Mobile Testing Unit | national outbreak MTU | care homes portal | general population - postal home tests |
| Asymptomatic "Screening" | care home staff - general | | | | | | ✓ | |
| | care home agency staff | | | | | | ✓ | |
| | patients | ✓ | | | | | | |
| | care home admission | | | ✓ (home tests) | | | | |
| | returned overseas travellers | ✓ | ✓ | | | | | ✓ |
| | | | | | | | | |
| Outbreak Events | care homes | | | ✓ | ✓ | ✓ | | |
| | prisons | | | | ✓ | ✓ | | |
| | schools | | | ✓ | ✓ | ✓ | | |
| | F.E. colleges | | | | ✓ | ✓ | | |
| | universities | | | | ✓ | ✓ | | |
| | traveller sites | | | | ✓ | ✓ | | |
| | at risk communities | ✓ | | ✓ | ✓ | ✓ | | |
| | tourist hotspot | | | | ✓ | ✓ | | |
| | large employers | ✓ | | ✓ | ✓ | ✓ | | |
| | large gatherings | ✓ | | | ✓ | ✓ | | |
| | | | | | | | | |
| | Symptomatic Testing - general | ✓ | ✓ | ✓ (home tests) | | | | ✓ |

For Q3&4, the Health Board will work closely with the private providers that UK Government have commissioned for delivering community and mobile testing units locally.

Testing for Care Homes will be included within the Health Board's priorities within the local testing plan, and work will continue respond to outbreaks and incidents in care homes and other locations. The Health Board will continue to work closely with Local Authorities to ensure safe discharge of patients' home from hospitals to care homes, adhering to the guidance set out for testing.

Antibody testing continues to operate out of the Bay Field Hospital, having tested nearly 10,000 people since June. The focus for antibody testing in Qs3&4 is to continue to respond to Welsh Government requirements. This is likely to include the testing of social

and domiciliary care staff, healthcare staff associated with a PHW sero-surveillance study and the retesting of a cohort of the education staff tested in the summer.

An Incident Management Team (IMT) has been established due to the increasing prevalence and local restrictions across Swansea Bay. The IMT will continue to meet, as required, and lessons learnt from this will inform future planning arrangements. At an appropriate point, opportunities to release local restrictions will be considered with partners locally and nationally.

**Lessons Learnt**

- Establish joint working arrangements with local partners at the outset. This has worked well within TTP where the two local authorities and Public Health Wales (PHW) work through issues and determine action together.
- Strong engagement links with local authorities and decision-makers within local partners in regards the care home testing agenda, which has received significant focus since May 2020. Without this joint working arrangement, it would not have been possible to deliver testing of 130 care homes within six weeks; over 5000 people (staff and residents) tested.
- Establishment of robust governance arrangements within the TTP programme to enable quick reaction to escalating situations, activate testing within 24 hrs where possible, report up/down comprehensively between the region and Welsh Government. This has also allowed changes to Welsh Government policy to be adopted swiftly when required.

**Workforce planning**

During Quarter two the Health Board has been building its testing capacity and has carried out several recruitment campaigns to staff the service. The requirement for Quarter 3 is to move to double the testing capacity and staff this accordingly. Staff will be recruited and trained to run the two testing sites at 100% capacity or to meet demand. In the interim to increase capacity, the Bank will provide staff in all roles to ensure the service is sustainable and robust. At present Antibody testing is not being scaled in the same manner. This could change dependent on Welsh Government priorities.

During September the Trace and Protect teams across the Health Board and two local authorities have been urgently increasing the number of teams and the associated staffing. During Quarter 3 the Health Board's prime responsibility is to provide Clinical Leads. Currently ten are seconded to the service with the need to deploy a further four. Given the sharp increase in cases however tracers and contact advisers are currently being seconded to the Local Authority teams to boost the numbers. These staff are drawn from the Health Board's shielding list and at this time there are currently circa fifty members of staff working in the teams. This number could increase if cases continue to increase.

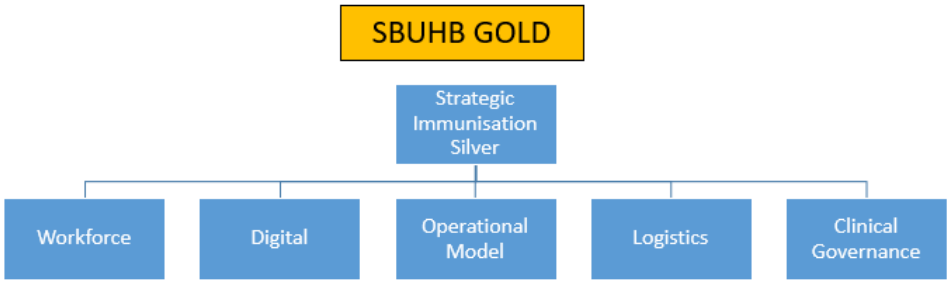
**Key Actions for Q3&4:**

- Implement walk through testing facility at Grand Theatre for students, local public and hard to reach groups - Mid October 2020
- Implement MTU rolling programme for testing across Swansea Bay to increase access – Start October 2020
- Increase capacity at drive through testing centre at Liberty Stadium – Start October 2020
- Increase Trace and Protect workforce to meet additional demands – October 2020
- Increase Testing workforce to meet additional demands – October 2020
- Continue to provide Antibody testing as required to meet policy demands – throughout Q3 and 4 as required

The detailed Action Template is included at Appendix 5.

## 4 Vaccination Delivery Plan

A mass vaccination plan for delivery of the Covid-19 vaccination has been developed and submitted to Welsh Government. The plan is divided into phases that align with the anticipated delivery of vaccine. As a consequence of revisions to the timetable, and to reflect the latest planning parameters (v4) released in early October, including changes to the prioritisation set out by the Joint Committee on Vaccination and Immunisation (JCVI), the local Health Board plan will be revised during October. The initial plan was tested via a table-top exercise on 19th August 2020. Governance arrangements are in place with an overarching Silver Immunisation cell and a number of supporting work cells as set out below. The Senior Responsible Owner (SRO) is the Director of Public Health, dedicated project management is in place and from early October, the SRO is supported by a Programme Director.




The initial plan is based on a mass vaccination model to maximise throughput. A mass vaccination centre will be located at the Bay Field Hospital serving both peripatetic health and social care workers and the local population. The Bay Field Hospital already has a track record in supporting large-scale antibody testing and more recently, the delivery of phlebotomy services. This centre will be supplemented by a small number of centres that will be ramped up as availability of the vaccine scales up. Initially, the plan is to deliver a mass vaccination centre in both Swansea and Neath Port Talbot counties, and as availability of vaccine improves, this could be scaled to a centre for each primary care cluster. To maximise the uptake amongst healthcare workers, each hospital site will host a hospital vaccination centre for a defined period (likely to be up to 2 weeks in duration). The model will be supported by an 'in reach' teach and potentially a mobile service, to support closed settings (such as care homes), inpatients within Mental Health and Learning Disability settings and housebound patients. To date, the assumption is that Primary Care will be unable to support the vaccination programme, but discussions will continue to consider how primary care could be engaged, subject to national discussion on the contractual framework.

The biggest constraint and risk identified is workforce availability and it is critical that the legislative framework facilitates a broader range of staff being able to support a mass vaccination programme. The workforce and flow model has been developed, but a significant range of staff will be required to deliver the programme including:

- Immunisers (to prepare and administer)
- Support workers (to support the preparation and administration and observation of patients)
- Administrative support (to support booking, reception, data entry)
- Clinical Supervisors (to support professional staff and respond to emergency situations)
- Booking clerks (to support call/recall systems)
- Security & support workers (marshalling, car parking & security duties)
- Pharmacy staff (to respond to queries from patients and professionals during immunisation session)
- Volunteers (who may have a role in supporting the general flow of patients).

A recruitment programme is underway for both HCSW and administrative staff via the bank, with flexibility to switch to fixed term appointments. The intention will be to recruit sufficient staff to be able to deploy flexibly over the winter to support key requirements which will include the Covid-19 vaccination programme, testing, as well as operational requirements. This would enable the release of experienced staff into key functions as required.

A risk register is in place and high-level risks and assumptions have been shared with the Covid-19 Vaccination Board in early October. A significant risk at this stage, is understanding the functionality within the proposed Welsh Immunisation System and its ability to interface with other clinical systems, and to support the wide range of functions required locally to ensure a 'high flow' model including booking systems and data upload. The current timelines suggest that a system will be available in mid-December, which coincides with the start of the programme. There is concern that this doesn't provide sufficient time locally to ensure other digital issues to be resolved. A request for clarification on a number of key areas has been shared with the national Covid-19 Vaccination Board, and it is recognised that the planning parameters continue to evolve in light of advice from JCVI released.

The flu vaccination programme has now mobilised and early indications from the first few weeks suggest a high demand for the vaccine, with reports of shortages of supplies across some community pharmacies. The staff flu programme for 2020/21 is being delivered through 300 peer vaccinators supported by hubs at each key location. A local booking solution is being trialled in corporate areas to maintain physical distancing and encourage those who are working from home. Formative discussions are taking place with General Practitioner (GP) Clusters to seek support for delivery of the expanded flu programme. It is understood that national discussions may facilitate a Locally Enhanced Service (LES)/Directive Enhanced Service (DES) which would greatly support ensuring a standardised approach. There are around 50,000 people in the extended range of eligible groups within the Health Board and given workforce constraints, the ability to employ a distributed model would significantly support.

**Key Actions for Q3&4:**

- Finalise workforce model and flow calculations (mid-October) and populate first phase of rotas
- Identify digital requirements in line with national Welsh Immunisation System (WIS) including booking solution once full functionality of WIS is known (October)
- Secure locations for Mass Vaccination Sites (beyond the Bay Field Hospital) and undertake site/logistics visits to finalise (mid-October)
- Finalise in-reach/mobile model (mid-October)
- Finalise Standing Operating Procedures (SOPs)/Action Cards (mid-October).

The detailed Action Template is at Appendix 6.

## 5 Essential Services

The Health Board's plans for Q1&2 set out the approach for delivery and ongoing recovery of essential services including the architecture of the Reset and Recovery Programme (R&R), the priority cells and the Health Board's commitment and approach to a clinically led and quality driven process. These processes remain relevant for the Q3&4 plan and have continued to mature.

The assurance framework for these services is rooted in the organisation's existing governance and assurance framework and supplemented with some key features:

- Both Performance and Finance Committee and Quality and Safety Committee have received focused reports on Essential Services;
- The Board has reviewed its risk appetite during the period and the management of risks has been reported through committee level and then onto Board;
- The Health Board's performance report has been redesigned around the 4 quadrants of harm. This continues to evolve and enables a line of sight to Covid-19 and non Covid-19 (and therefore essential services) indicators – performance, demand and Q&S measures;
- Local self-assessments against all service specific guidance issued from WG on essential services have been mandated and these are reviewed at the Reset & Recovery Group (chaired by the Chief Operating Officer/Director of Transformation);
- Across essential services, a key principle has been to adopt a clinically led prioritisation of patients and a clinical, and where relevant a Multi-Disciplinary Team (MDT) review of patients on waiting lists to ensure cases are appropriately prioritised and, where appropriate alternative treatments or regimes agreed. In some service areas the use of Patient Reported Outcome Measures (PROMS) is supporting this. More detail on safety netting and clinical prioritisation is under the relevant service sections
- A Quality Impact Assessment (QIA) process has been implemented for the restart of services which takes a risk-based approach to the re-commencement of services. These are considered by a panel and then approved at Reset & Recovery Group;
- Reporting against the Healthcare Standards for Wales is done through the Quality Assurance Framework and through to Quality and Safety Committee
- A Clinical Advisory Group continues to support the R&R programme, providing advice on clinical issues related to essential services;
- As preparations are made for a second wave of Covid-19, some elements of the R&R programme will move into a refocused Covid-19 Operational Silver cell to ensure system wide (Covid-19 and non Covid-19 services) consideration and planning response in terms of capacity, workforce, availability of medicines, PPE, blood, consumables, equipment and other supplies.

- To further support essential services planning and to provide insight into the demand position, there was increased attention and work during Q2 into supporting modelling of essential services. In relation to the surgery and theatre cell, a live dashboard for all surgical demand (coded against levels 1a, 1b, 2, 3 and 4) has been developed to support better understanding of the demand on the waiting list, the relative clinical risks and volumes, speciality by speciality. This has been supplemented by a scheduling tool to ensure that the available capacity can be used to maximum benefit.

The approach to governance and assurance during Covid-19, including delivery of essential services, was subject to an advisory review by internal audit in addition to being looked at by Audit Wales as part of the Structured Assessment. These reviews commended the approach taken with respect to the planning for and assurance around essential services.

The Health Board financial plan recognises the assessed impact of maintaining current levels of the Essential Services delivery and this will be reviewed routinely through Q3/4. In terms of recovering any backlog and additional activity, the Health Board may be able to undertake additional activity subject to available funding being made available and would welcome further discussions on this. This particularly relates to elective surgery and use of the independent sector for category 2 patients, cancer and diagnostic services. The following sections of the plan provide more detail on local priorities within the essential services framework and each section is underpinned by a more detailed service specific plan.

## 5.1 Unscheduled Care and Winter Planning

Context for Q3&4:

- ED and Minor Injury Unit (MIU) attendance has now recovered to pre-Covid-19 attendance levels between 170 and 282 attendances per day with a median of 213 attendances for the Q2 reporting period.
- The separation of flows within the ED will continue into Q3&4 with additional nursing support.
- The Respiratory Assessment Unit (RAU) at Morriston serves as a second ‘front door’ for Covid-19 presentations, reducing ED demand
- The Health Board awaits the delivery and installation of the ambulance offload POD at Morriston ED to support timely patient handover from ambulance. – in Q2, there were a total of 5422 ambulance arrivals at Morriston ED with 87.5% being offloaded within 1 hour. However, just 57% were offloaded within the handover target time of 15 minutes.
- There is an increasing medically fit position impacting acute hospital flows Medically Fit For Discharge (MFFD) as of 12/10/2020: 149)
- The separation of bed pools for unscheduled and planned care will remain a feature of the operational footprint in Q3/4.

- The introduction of a 'Phone first' model locally is aimed at patient redirection into appropriate alternative pathways thus reducing ED demand. An initial review of 111 data suggests a potential 70% redirection opportunity of pts referred by 111 to both MIU and ED, approximately 26 pts per day.
- The extension of ambulatory emergency care will also serve to reduce ED demand and acute admission to hospital. Services are being configured to meet with the national Ambulatory Emergency Care (AEC) target of 30% of Unscheduled Care (USC) attendance being managed on ambulatory pathways, in Singleton the Acute GP unit redirects between 40-52% of the acute GP referred medical intake into ambulatory pathways.
- West Glamorgan Regional Partnership Board (RPB) Community Early Warning System continues to be developed. Current service provision, based on existing demand and service capacity, is at level 3 (community level 3 is equivalent to NHS level 3) and highlights the continued pressures felt across the Health and Social Care systems.

**Swansea Bay University Health Board & West Glamorgan Regional Partnership**

The advent of Covid-19 and the impact of the pandemic on NHS service operating along with Social Care and Third Sector has resulted in less certainty and predictability in terms of unscheduled care demand for the 2020/21 winter. The recent Academy of Medical Sciences report highlights that the degree of uncertainty facing all health and care systems is unprecedented. The suspension and reduction in core services and social care thresholds and subsequent the reset and recovery process will also directly impact on the Health Board and Social Care's capacity requirements during Q3&4 and a number of variables remain uncertain, including the:

- degree to which the pre-Covid-19 unscheduled care activity will present;
- timing and degree of a second wave of Covid-19 infection;
- ability to maintain planned services; and
- resilience of the care sector, impacting on the ability to maintain the current reduced level of medically fit patients occupying acute hospital beds.

The following key unscheduled care risks have been identified, along with mitigating actions:

- The emerging surge in Covid-19 infection with the predictable winter demand pressures, which has been mitigated by Field Hospital capacity and workforce plans being developed to accommodate a 'super surge' level of demand.
- Balancing unscheduled care demand and the requirement to maintain and expand essential services in line with national guidance, mitigated through the protection of 'green' pathways to enable essential services delivery.

- Workforce numbers and resilience (including Health and Social Care Community Staff) – linked to Covid-19 shielding/isolation, resilience and wellbeing, test, track and trace, mass vaccination campaigns. Through robust workforce modelling, there is the potential to enhance frontline staff through aligning medical and nursing students to the front line as in the first wave.
- Maintaining flow of patients out of acute care; known fragilities in care home and domiciliary care sector. Plans to mitigate this involve workforce modelling to increase Domiciliary Care/community services capacity with opportunity for WG funding via the Regional Partnership Board.

Whilst unscheduled care pressures remained relatively low during the start of Quarter 2, there has since been a recovery to the pre-Covid-19 levels of ED attendances with a correlating increase in acute admissions to hospital.

An integrated Unscheduled Care Plan has been developed with regional partners, including the Local Authorities, Third Sector and WAST which sets out the ambition for unscheduled care and will provide greater assurance of health and social care system resilience to manage the predicted Winter demand, as well as demonstrating preparedness in the event of a second wave of Covid-19 infection. This has been approved by the West Glamorgan Regional Partnership Board, see Appendix 7.

The unscheduled care plan is informed by the adopted Health Board modelling for acute beds and ED demand, and this has been described in the Overview to the plan and is covered in detail in the Appendices – the modelling methodology is described in the modelling section. The plan is also based on the WG publication; Six Goals for Urgent and Emergency Care and aligns to the emerging Welsh Access Model. The plan is aimed at service transformation to ensure robust service plans are in place to optimise patient safety and flow across the Health and Social Care System by:

- managing the whole system flow;
- reducing unnecessary delays within the primary community and acute system and facilitating timely ‘discharge to recover and assess’ pathways.
- promoting alternative pathways to ED attendance through a ‘Phone first’ approach in partnership with Welsh Ambulance Service Trust (WAST) and ‘111’
- promoting and extending same day/ambulatory emergency care pathways and services
- ensuring system resilience in General Medical Services to respond to the health needs of patients in the community
- securing third sector services to support discharge from hospital and to provide support to patients in their own homes
- Providing additional support for carers and private providers including care homes

**Key priorities for Q3&4**

The key priorities align to the Six Goals for Urgent and Emergency Care and are based on local service transformation as follows:

- Implementation of a local 'Phone first' model through the development of an internal advanced triage hub to redirect patients away from ED directly into alternative pathways to meet their presenting clinical need.
- Development of ambulatory emergency care in acute medicine to allow redirection of patients from ED and from the acute medical intake into same day emergency care pathways, thus reducing acute admissions to hospital
- Right sizing community capacity to respond to the 'discharge to recover and assess' pathways in place and to reduce unnecessary delays for patients.

The embedded table sets out the high impact areas of transformation for the health and social care system locally and maps the anticipated impact against organisational and WG priorities:

Six Goals for Urgent and Emerge

## 5.2 Surgery & Theatres

**Context for Q3&4:**

- As at 5/10/20 there are 16,254 patients waiting on the surgical treatment list, 6,501 inpatients and 9,753 day cases
- Of the 16,254, 1,181 are the highest priority category 2 patients, which includes urgent surgical cancer patients
- Pre-Covid-19, the level of elective surgical activity undertaken across all hospital sites was circa 359 cases per week
- Elective surgical activity levels have consistently grown throughout quarter 1 and 2 in line with previous plans. This has seen activity rise from an average of 62 per week during April to 157 a week during July and finally to an average of 191 per week in September.
- This latest figure equates to around 54% of pre Covid-19 levels of activity
- The Royal College of Surgeons (RCS) has issued updated guidance which extends the types of procedures for the category 2 list which will increase the demand through new referrals in addition to the re-assignment of some patients from the category 3 list
- The category 2 list is 7.3% of the overall surgical waiting list
- Currently 70% of category 2 patients who have received treatment are treated within the 4 week timeline and 87% within 6 weeks
- Since June 2020 the category 2 list is running with a weekly demand and capacity gap ranging between 1 and 56 per week, dependent on the variation between demand and activity levels.

- The modelling for a 2nd wave of Covid-19 in December and January presents a risk to the elective theatre programme due to potential staff redeployment to critical care. Decisions will be based on the balance of risks between elective and non-elective services in line with the four harm principles
- Access to the independent sector is limited in Swansea Bay Health Board area due to the limitations of the main private facility, this is in contrast to the access other Health Boards have to independent sector and so engaging with regional and national discussions on equitizing access is a priority.

The Health Board continues to manage the recovery of surgical services in line with the Essential Services Guidance.

During Q2 the focus was on:

- Consolidating the emergency and elective theatre capacity for Category 1a, 1b and 2 patients (RCS Guidance)
- Prioritising the full surgical treatment waiting list into Categories 2, 3 and 4 to provide a full analysis of the backlog
- Re-zoning theatres and recovery areas in line with guidance and emerging evidence which released supplementary support staff
- Progressing discussions with neighbouring Health Boards around the sharing of capacity within the independent sector, however this proved unsuccessful. This has also been raised with Welsh Health Specialised Services Committee (WHSSC).
- Commencing operating in Neath & Port Talbot Hospital week of 7th September for Orthopaedics, sharing 50% of the theatre capacity with Cwm Taf Morgannwg Health Board in line with contractual obligations
- Launching the Major Trauma Network in September
- Developing the enabling analytics and real time power BI tools through the Healthcare System Engineering approach to ensure a common understanding of the demand (against the new RCS criteria), this includes:
    - tools that allow for visual representation of demand and capacity ("vitals charts") to support decisions on the volume of activity that is required to deliver full range of essential surgical services
    - a tool to allow theatre activity to be optimised taking into account IPC requirements

For Q3&4 The Health Board will address the following top priorities:

- **Assessing Potential Harm** – Clinically led work on developing assessment mechanisms and tools to identify potential harm as a result of delays to treatment will be a key focus during the next quarter in line with the Harm principles, and in conjunction with Welsh Governments efforts around waiting list risk-stratification and management. The teams continue to apply Royal College of Surgeons (RCS) priority status levels to their patients during this review process, enabling the Health Board to clearly identify and track those patients more clinically urgent and therefore at risk. Recent changes to the RCS guidance,

extending the group of procedures under category 2, which will increase the demand on the list for these highest priority patients. Through Q3&4, clinicians will continue to review the category 3 patients for signs of deterioration and through clinical discussion and agreement will re-assign patients to the category 2 list as appropriate. These patients will be listed equitably across the dedicated planned theatres available to ensure each specialty has access to a weekly or bi-weekly list. A Clinical Group, which meets weekly, has been established to develop high-level clinical principles to feed into the theatre list allocation process, adhering to RCS prioritisation guidance. A Clinical Prioritisation Framework is being developed to support this process.

There is a patient portal for surgical patients who may have had treatment delayed or changed, and additional information available providing pre-habilitation advice to support patients to maximise their health and well-being whilst preparing for treatment.

- **Increasing and Sustaining Emergency Theatre Capacity** - Emergency activity has incrementally increased over the period from March 2020. Typical pre-Covid-19 levels for emergency surgery equated to 181 cases per week. The current emergency surgery levels are circa 88% of pre-Covid-19 levels. Due to the high demand, the released theatre workforce, repatriated from ITU and non-patient facing roles are being used to implement additional Emergency CEPOD and Trauma lists for prioritised emergency category 1a and 1b cases. This will increase activity by 4.4% for CEPOD based on 2 cases per list taking it to 92% of pre-Covid-19 activity levels. This focus on emergency theatre capacity is not only important for outcomes and care for these patients but also helps protect the reduced elective capacity.

- **Supporting Alternative Environments for Critical Care Patients** – As Post-Anaesthetic Care Units (PACU) evolve as an alternative environment for provision of care that cannot be delivered on a ward but does not require a critical care setting, the development of a PACU on the Morriston site to support the flow of elective and emergency cases will be implemented. Recruitment will commence at pace to enable this facility to be fully functioning in December/January when the predicted second Covid-19 peak will be at its highest.

- **Sustaining Elective Theatre Capacity** – The ambition in Q3&4 will be to sustain elective capacity across all 3 hospital sites in line with the August 2020 theatre programme delivering an average volume of 157 cases per month. With the redeployed workforce returned to their substantive posts and shielding paused, the available theatre staff are being utilised to deliver the maximum theatre programme to the highest priority (category 2) patients. In line with plans to increase critical care to 43 staffed beds, the theatre programme will be incrementally reduced as required, balancing the risks between elective and non-elective services consistent with the four harm principles, only reducing elective theatre activity further where workforce, activity

and service pressures are significant and in line with the critical care plan and escalation of Covid-19 demand. During the two weeks commencing 28th December and 4th January when the modelling suggests the highest Covid-19 peak will be seen, elective surgery will not be planned other than urgent cancer surgery.

- **Theatre efficiency** will also be a major focus, building on the re-zoning already put in place and continuous scoping of the evidence-based changes that can be implemented immediately. In addition, enhancement to the Theatre Operations Management Systems (TOMS) will enable an understanding of theatre pathways by accurately capturing the right information to monitor the utilisation of theatre capacity and target improvement work at the right areas. A TOMS Development Plan will be progressed within Q3.

  Variation in the equitable access to surgical capacity will continue to be managed and monitored through the weekly, clinically led, theatre group in line with the clinical priority of patients. Variation in performance between specialties will continue to be monitored and reported through this group and escalated within the Health Board as appropriate.

- **Establishing Orthopaedic Surgery at Neath Port Talbot Hospital** – Through Q3&4 the capacity will be utilised for category 2 orthopaedics and spinal surgery cases, which includes screened, ambulatory trauma cases where treatment is time critical. Following an embedding of the operating and training of theatre and ward staff, the complexity of the cases undertaken will increase during November. The development of Neath Port Talbot Hospital as the Health Board's cold elective musculoskeletal operating site will be progressed through the capital business case route with the submission of a Strategic Outline Case (SOC) to Welsh Government.

Key Actions for Q3&4:

- Develop a TOMS Development Plan and identify necessary resource requirements to support (mid-October)
- Develop an integrated workforce plan for theatres and anaesthetics to support a phased delivery plan (November)
- Complete outline business case process for elective musculoskeletal centre at Neath Port Talbot Hospital (March 21)
- Completion and collation of speciality specific harm assessments (November)
- Develop workforce and equipment requirements for PACU (October)
- Engage in the nationally established work to explore national and regional solutions including the potential for establishing 'green sites' and the equitable allocation of capacity available within the independent sector (October)

The detailed Action Template is at Appendix 8.

## 5.3 Diagnostics & Imaging Services

**Context for Q3&4:**

Pathology

- Pre Covid-19 backlog stood at 3,000 cases, post Covid-19 backlog cleared, now rising significantly given increasing demand and complexity
- Workload at 70% of numbers but running at 97% capacity
- Projected 100%+ capacity by December at current rates

Endoscopy

- Pre Covid-19 activity above demand at around 1,200 monthly, Covid-19 near zero, only emergencies
- Activity now increased to 550 (Aug)
- Waiting times pre Covid-19 in line with Referral To Treatment (RTT) 8 and 26 week, at Aug, total of 1,469 over 8 weeks, projected 1,500 by Sep

MRI

- Pre Covid-19 annual demand 26,317 with capacity at 19,651, gap at 1,921
- Waiting list pre Covid-19 891 increasing to 1,736 (July)
- Demand running at 85% of pre Covid-19 but capacity at 75%

CT

- Pre Covid-19 annual demand 44,042 with capacity at 40,079, gap at 3,963
- Waiting list pre Covid-19 1,306 increasing to 1,427 (July)
- Demand running at 58% of pre Covid-19 but capacity at 69%

NOUS

- Pre Covid-19 annual demand 38,871 with capacity at 35,700, gap at 3,171
- Waiting list pre Covid-19 1,220 increasing to 3,743 (Aug) in just 17-week period, now reduced to 2,902
- Demand running at 85%+ of pre Covid-19 but capacity at 75%

Neurophysiology

- Pre Covid-19 demand at 5,283 across all areas, with capacity at 4,500 – always running at deficit
- Demand consistent through Covid-19 but complexity rising, post Covid-19 activity at 28%
- Waiting lists electroencephalogram (EEG) from 120 to 600, Electromyography EMG/NCS 190 to 883
- Routine tests (EEG) wait National Institute for Clinical Excellence (NICE) guidance 6 weeks), routine up to 17 weeks, complex tests up 33 weeks.
- EMG/NCS usually RTT of 8 weeks, increased for routine up to 24 weeks and complex up to 60 weeks

Nuclear Medicine

- Throughout Covid-19 Clinical Nuclear Medicine continued with no backlog, approx. 75 scans weekly
- Dual X-ray absorptiometry (DXA) service regionally at 5,500 demand, backlog established when service stopped
- Up to 28 week wait expected from 12 week (Swansea Bay) and 5 week (Hywel Dda)

Echocardiography

- Current monthly demand at 1,409, with capacity at 1,200, deficit of 209
- Backlog pre Covid-19 3,450, post Covid-19 following list validation 3,000
- Projection >8 weeks forecast 4,615 for December

Diagnostic procedures for USC and emergency services emergency cases have continued to be delivered throughout the pandemic in line with Essential service guidance. The focus has been, and continues to be, to increase capacity to better match demand. Routine procedures, however, are not being delivered.

Infection control measures around social distancing requirements and ensuring cleaning routines as per guidance are in place, which has been the most significant challenge in terms of diagnostics recovery. Capacity has steadily increased in line with Q1 and Q2 plans, although pre Covid-19 levels are not yet achievable and are unlikely to be for some time. The problem is not unique with the Health Board and engagement in the national and regional discussions regarding solutions continue.

### 5.3.1 Cellular Pathology

In contrast to the remainder of Diagnostics, with Covid-19 demand dropping to approximately 60% of normal, this enabled Cellular Pathology to clear case backlogs. This was done via revised working patterns - extended days/weekend working and home working, due to social distancing, self-isolation and shielding, there were no virtual or digital alternatives during this period.

Workload remains below normal for normal specimen numbers but reporting capacity of pathologist has risen significantly due to the complexity of the cases. If, as projected, there is a return to previous demand levels with the highlighted change in acuity, Pathology will again move to a backlog situation.

It is projected that a return to normal capacity will happen in December, and laboratory efficiency will be improved to support the expected recovery surge. There will be a focus on Digital Slide scanning to maximise the ability of pathologists to report cases digitally to improve the overall resilience and performance of the department. This will be achieved through the utilisation of

specialised Voice Recognition software, as well as home working hardware, to enable pathologists to view and report cases in 'real-time' from anywhere, they would also be able to refer cases to each other for second opinion and support.

**Priority**: Improvement in processes to drive efficiency through the utilisation of specialised voice recognition software.

### 5.3.2 Endoscopy

There continues to be a phased and sustainable approach to 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. Services are currently only dealing with Urgent Suspected Cancers (USCs) and inpatient demand.

There is clear decision making and tracking of USCs deferred and new referrals maintained through use of the National Endoscopy Programme (NEP) deferred patient spreadsheet to record all tracking and booking of deferred procedures, surveillance, screening and USC patients. An additional 3 sessions will be implemented from October onwards increasing to 36 sessions a week. Additional services in NPT are planned for Capsule Endoscopy procedures. Faecal Immunochemical Test (FIT) will also be implemented in low risk groups (as per NICE DG30 guidance) supporting the triaging of referrals from primary care.

Work to redesign Straight to Test (STT) pathway will commence, supporting the Single Cancer Pathway (SCP) developments with a planned implementation in Q4.

The Health Board continues to engage with the NEP on the options for regional and national solutions.

**Priority**:

- Increase capacity to support the Urgent Suspect Cancer Pathways
- Implement FIT in low risk groups to support triaging of referrals from Primary Care
- Redesign the Straight to Test pathways to support SCP

### 5.3.3 Radiology

Radiology have maintained USC and Urgent diagnostics throughout the pandemic and have triaged all referrals before assigning an appropriate prioritisation. Routine referrals have not been addressed and continue to be placed on a waiting list.

Generally, the current demand for Magnetic Resonance (MR), Computerised Tomography (CT) and Non Obstetric Ultra Sound (NOUS) is around 80-85% of the pre Covid-19 demand position with the capacity available at ~85% of the original capacity, due to

the requirements of social distancing, enhanced cleaning between patients and examinations that carry a potential post Aerosol Generating risk (NOUS only).

MRI/CT

MR capacity will be extended across the service, through utilising the Mobile Unit to cover a bridging period whilst recruitment to additional positions continues. The CT service will extend access to CT across the service, through regional working, utilising mobile CT unit availability in Hywel Dda UHB, staffed by locums to cover a bridging period, whilst recruitment to additional positions continues.

The additional MR/CT workforce will allow the implementation of extended working days (8am to 8pm) across all 3 sites, in staged approach, and also allow weekend working on one site.

**Priority**:

- Increase capacity to maintain support for the Urgent and USC patients
- Implement recruitment process to enable expansion of services
- Utilise mobile CT unit at Hywel Dda UHB

NOUS

Access and capacity will be extended across the service, through recruitment of additional workforce and the utilisation of the Field Hospital, as an added location within the community. These additional posts will allow extended working days (8am to 8pm) across all 3 sites, in staged approach, and also allow weekend working on one site.

**Priority**:

- Increase capacity to maintain support for the Urgent and USC patients
- Implement recruitment process to enable expansion of services

The provision of diagnostic services will be reliant on available workforce given potential demand and requirement to support surge and super surge capacity. Services would need to be tailored to priority areas and align with need, and this will be addressed through the agreed process.

### 5.3.4 Neurophysiology

Prior to Covid-19, service targets and maintaining best practice relied heavily on additional resources. The service is recognised as fragile service with an All Wales Service Specification due for completion. The specific challenges the pandemic has brought coupled with the increasing complexity relating to the testing and reporting requirements for patients referred to Neurophysiology indicates the need for additional staffing, enhancing competencies creating expert practitioners and an agile workforce. Working hours will be extended with longer working days and some weekend working. Recruitment to some posts will be required to cover this requirement and so a phased approach will be taken. The work to reform and modernise the service will be initiated during Q3 but is expected to run beyond Q4 with the benefits being realised in 2021.

**Priority**:

- Increase capacity to reduce waiting lists and address demand
- Implement recruitment process to enable expansion of services

### 5.3.5 Nuclear Medicine

Nuclear Medicine has continued to scan all referred cancer and urgent cardiac patients throughout the pandemic, with capacity remaining constant, although there was a drop in referrals during this period. Remote consultations were initiated and will continue to manage waiting lists appropriately.

There are two DXA lists operating: one with a static scanner at Singleton which has restarted services and the other mobile scanner, operating between Withybush and Carmarthen which will restart in Q3.

When both DXA restart, services are expected to return to pre-Covid-19 levels and be maintained.

**Priority**:

- Restart regional mobile DXA unit in HD UHB

### 5.3.6 Cardiac Investigations and Interventions - Echocardiography

All referrals into the system are triaged and appropriately prioritised to ensure consistency and delivering equity to access of service. It is recognised that a solution is required to resolve the backlog.

The service is carrying a baseline deficit to meet recurrent demand, however recruitment to this deficit would present issues with space and machine time. A series of options have been presented for consideration including capital development of cardiac outpatients, extension of the working day and redirection of some routine outpatient scanning off the acute sites into primary care.

**Priority**:

- Options appraisal to extend working day and redirection of services

Key Actions for Q3&4:

- Phased increase of Endoscopy capacity (October to February 21)
- Case for MRI increased capacity, including reporting, and progress implementation (October)
- Case for CT increased capacity, including reporting, and progress implementation (October)
- Case for NOUS increased capacity progress implementation (October)
- Change workflow process for Cellular Pathology through Digitisation Case (October)
- Case for Neurophysiology increased capacity and progress implementation (October)
- Reinstate Nuclear Medicine services across the Region (November)
- Case for Echocardiology increased capacity and progress implementation (October)

The detailed Action Template is at Appendix 9.

## 5.4 Cancer & Palliative Care Services

**Context for Q3&4:**

- Post-lockdown phase, there is a 'new normal' waiting list shape being seen which is larger and more elongated (longer waiting times) than the 'normal' pre-Covid-19 waiting list, with a reduced removal rate
- At the start of Covid-19 the backlog of patients waiting at 1st outpatient appointment was 614 this is now at 1,490
- Diagnostic waits prior to Covid-19 were 500 patients waiting (144 of which >32days) this is now at 687 patients waiting (361 of which >32days)
- Demand levels have been increasing steadily since June although they remain below pre-Covid-19 levels, End Sept saw referrals at almost similar level to same time last year. September saw stepped increase in Radiotherapy referrals compared to previous months. Although some tumour sites remain low.
- Breach numbers will increase without additional activity at OPA and diagnostics in particular.

- Radiotherapy is running at 75% protected capacity (compared to pre-Covid-19). Break down of LINAC machine at end August which has been now out for several weeks impacted on our August capacity where we delivered only 55%.
- For solid tumour Chemotherapy the impact of social distancing has reduced the number of SACT chairs from 16 to 13 which is equal to a full day of 13 chairs lost capacity (which equates to a loss of 20% capacity pre Covid-19). The utilisation rate of the 13 chairs now available is running at 70% the target is 80%. Workforce has been main factor in this performance.
- The TENOVUS bus was providing alternate Saturdays off site treatments for our oral chemotherapy patients but this permanently ceased in 2020 at very start of pandemic, instead we are providing this activity within the unit on Saturdays.
- End of Life care experiences for staff were more positive following changes made by our Specialist Palliative Care team due to Covid-19.

The Health Board continues to manage the recovery of Cancer Services in line with National Framework for the Recovery of Cancer Services.

It is anticipated that there will be a growing demand for Cancer Services and the Health Board has been working and engaging with the Cancer Network and the Delivery Unit around Capacity and Demand Planning since start of the pandemic.

### 5.4.1 Patient and Staff Safety

In line with National Guidance, there is a robust plan in place to offer a Covid-19 test for all patients starting Oncological and Haematological treatments and for those undertaking Surgery. The Health Board will continue with this process in line with Recovery framework to ensure the safety of patients and staff as part of their cancer journey.

Key priorities in Quarters 3 & 4 focuses on continuing to manage the backlog of Cancer patients and providing timely Cancer Treatments. The Health Board is continuing to provide radiotherapy treatments, with 75% capacity protected (compared to prior to the pandemic) and Chemotherapy treatments, with 80% capacity protected (compared to prior to pandemic). The focus will be on increasing capacity for Non-Surgical Cancer Treatments and supporting patients and clinicians with improving end of life care following the learning during first phase of the pandemic.

There is a patient portal for surgical patients who may have had treatment delayed or changed, and additional information available providing pre-habilitation advice to support patients to maximise their health and well-being whilst preparing for treatment. This is also being shared with non-surgical patients as there is useful advice on well-being for all cancer patients even those undergoing Oncological treatments.

### 5.4.2 Increasing and Sustaining Radiotherapy Treatment Capacity

The Health Board is in discussion with WHSSC regarding a case for Stereotactic Ablative Radiotherapy (SABR) Lung hypo fractionation work to be undertaken locally in the South West Wales Cancer Centre (SWWCC). If agreed, mentoring between SWWCC and Velindre Cancer Centre would commence November 2020 and equipment would be commissioned on site by the end December 2020, and SABR could be offered from January 2021 onwards.

A Radiotherapy Covid-19 Recovery Plan is in place – for *implementing Hypo fractionation for specific tumour sites*.

- Following the implementation of the Clinical Trial data (Fast Forward) introduced as a part of the Covid-19 response, (SWWCC) have released 10% radiotherapy LinAcc machine capacity by reducing the frequency of Breast radiotherapy fractions (treatment attendances). The released 10% capacity will allow the Centre to offer radiotherapy treatment to an additional 200 patients per year
- Like Breast, changes made in hypo fractionation case noted above, there is further potential to shorten prescriptions for prostate radiotherapy as part of SWWCC's Covid-19 recovery plan and to continue with these clinical changes permanently. As well as enhancing patient experience, improving the service by hypo-fractioning prostate radiotherapy could further increase LinAcc Machine capacity.
- The Health Board is exploring Clinical leadership fellow to support QI and shortened fractionation work with HEIW. The move to hypo fractionation in tumour sites such as prostate, pancreas and lung require consultant expertise. However, the presence of a clinical fellow with the flexibility to support the different parts of the pathway when required will aid the implementation of these techniques more quickly, as has been this, and neighbouring cancer centre's experience, in the past with other radiotherapy techniques.

### 5.4.3 Increasing and Sustaining SACT Treatment Capacity

A SACT recovery plan is being developed**,** which is a proposal for optimising SACT capacity in Swansea Chemotherapy Delivery Unit (Joint project with Merck Sharp & Dohme (MSD) and General Electric (GE). The plan is to implement some changes following review of processes in pathways after peer review of SACT unit with St Helens (sharing of best practice).

### 5.4.4 Supporting Patients and Clinicians by Improving End of Life Care following learning from Covid-19

The Health Board is developing a number of recommendations for Improving End of Life Care (EOLC) and engaging with the Current Advanced Care Planning Team. One area to be considered will be for an EOLC educator type role; not only for training and education, but having the capability to provide direct clinical support to the staff and wards enabling them to obtain the confidence to embed it in their clinical practice.

The Care after Death Programme will be supported and continue to deliver and support Advanced Care Planning work. The Health Board will continue to support roll out of Care Decision Tool, as this supports good documentation on EOL decisions.

### 5.4.5 Review Cancer Tracking Resource for Single Cancer Pathway (SCP)

An agreement to develop two Operational Cancer Hubs one in Singleton Hospital and one in Morriston Hospital is in progress. The hubs will have two clear functions MDT and Cancer Tracking to support and focus on the backlog and improved data quality (as admin delays or chasing of results can potentially put the focus on the wrong patients, as the data is not clean).

For SCP reporting significant work to enable prompt and early identification of patients at the point of suspicion has already been undertaken. However, further work is required to ensure all patients referred for USC radiological investigations are, if not already, registered for monitoring and reporting purposes. This project will support this requirement and the work of the Cancer Improvement Team (CIT).

Key Actions for Q3&4:

- Develop SACT recovery plan (December)
- Develop Radiotherapy Treatment (RT) Case for released capacity from Breast to undertake additional RT work (October)
- Develop RT case for hypo fractionations for Prostate case to be developed jointly with Hywel Dda and SBU Urology Surgical colleagues (November)
- Clinical leadership fellow in place to support QI and shortened fractionation work (January 21)
- To undertake SABR treatment for Lung Cancer patients in SWWCC (January 21)
- Review cancer tracking resources (December)
- Develop recommendations for Improving End of Life Care and engaging with Current Advanced Care Planning Team to take these forward along with the wider Health Board community including primary care (December)

The detailed Action Template is at Appendix 10.

## 5.5 Primary Care, Community & Therapy Services

**Context for Q3&4:**

- All primary care contractor services in GMS, Dental, Optometry and Community Pharmacies fully restarted in the context of working as the ‘new normal’ in line with national guidance. Contractor services are reporting increasing demand and pressure, e.g.

- As at 01/10/20, out of 49 total GP practices, 4 reporting at level 3 and 0 at level 4, in contrast to August were 0 practices were at level 3 and 4.

- The Care Home position continues to be closely monitored within the West Glamorgan Regional Partnership arrangements. As at 12/10/2020 there were a total of 9 Care Homes closed to admissions of which 8 were related to the 28 day post outbreak requirement.
- A total of 25 primary care, community and therapy services that were stepped down in Q1 due to Covid-19, have been supported to resume delivery. Delivery of urgent and essential services throughout Q3 Q4 will remain in place, providing support available to protect vulnerable patients at home and prevent escalation to hospital services.
- Health Board primary care, community and therapy planned care services describe breached waiting lists and a worsening performance position over the past six months. This is reflective of the suspension of face to face appointments as a result of Covid-19 and the phased reset and recovery of Health Board services, e.g.
  - Restorative Dental RTT <26 weeks - Waiting lists have breached in five of the last six months (April – August 20 inclusive). This compares to 1 breach in the months prior to the Covid-19 pandemic (July 2019 – Jan 20)
  - Audiology waiting lists have breached in the last six months (Mar to Aug 20) with Aug showing 30.9% of patients < 14 weeks, however this is an improvement on July 2020 where only 22.8% were seen < 14 weeks. At August 2020 443 patients currently waiting > 14 weeks.
  - Podiatry waiting lists have breached in the last six months (Mar 20 to Aug 20) with Aug showing 20% of patients < 14 weeks - this is an improvement on July 2020 where only 13.5% were seen <14 weeks. At August 2020 764 patients currently waiting > 14 weeks.
  - Speech and Language Therapy waiting lists have breached in the last five months (April 20 to Aug 20) with Aug showing just 50.7% of patients < 14 weeks - this is an improvement on July 2020 where 48.5% were seen <14 weeks. At Aug 2020, 166 patients currently waiting > 14 weeks.

Based upon learning and experiences gained in Q1&2, throughout Q3&4 the Health Board will continue to embed the key principles that underpin the planning and delivery of primary and community care, aligned with A Healthier Wales and the National Strategic Programme for Primary Care, whilst remaining focused on service resilience and ability to rapidly respond to the changing landscape of health and social care services being shaped by the Covid-19 pandemic.

The Q3/4 priority areas take into account the refreshed national delivery milestones for the Strategic Programme for Primary Care, set out in the Q3/4 Operating Framework; the range of national guidance issued to primary care contractor services to date; and the extensive Health Board modelling (including Discharge Modelling and Bed Capacity Modelling). This is in addition to the emerging

picture being presented by intelligence provided by data as part of the Minimum Data Set collection, and operational 'on the ground' knowledge of service demands and pressures.

### 5.5.1 Maintain access to essential, additional and enhanced services in all primary care contractor services; General Practice, Dental, Optometry and Community Pharmacy, in line with national guidance

At the end of Q2 all primary care contractor services in GMS, Dental, Optometry and Community Pharmacies were fully restarted in the context of working as the 'new normal'. The Health Board remain committed to ensuring the Swansea Bay UHB population are provided with timely, equitable and safe access to these 'front line' primary care services. Due to the emerging picture of increased pressure on all contactor services (as a result of increased Covid-19 cases and normal seasonal demand), the key actions to sustain the delivery of essential primary contractor services include:

- Ensuring GP practices are Covid-19 ready, able to comply with infection control and social distancing measures by supporting premises adaptations.
- Developing proposals for winter holiday opening for GP practices and extending hours opening for contractor services as required.
- Proactive support and early engagement with practices informed by monitoring of daily reporting of GP and Community Pharmacy pressures at practice-level through the National Escalation Tools. Continuing to provide enhanced support for practices reporting at Level 3 and Level 4. Given this position is multi-factorial and changes on a daily basis, it is very difficult to forecast the levels at which GPs and Community Pharmacies will be operating at over the next two quarters; however it must be noted in general a position of increased pressure from October 2020 onwards is forecast.
- Support the continued roll out of digital platforms, e.g. Ask My GP for General Practices (agreed as part of the Whole System Cluster Transformation Programme), Attend Anywhere in Dental and Optometry Practices, and Consultant Connect in Urgent Primary Care Services. Increased use of digital technology will support improved access and availability of services to the public, who may become more reluctant to present to primary care due to local lockdown measures and as the levels of Covid-19 in the community increase.
- Support to protect the most vulnerable people in communities; this includes plans to expand the number of care home residents covered by the new GMS directed enhanced service (DES) through increased uptake of this by GP practices.

### 5.5.2 Maintain provision of urgent and essential Health Board primary care, community and therapy services

- Maintaining urgent and essential primary care, community and therapy services is critical due to their roles in providing support to protect vulnerable patients at home, prevent escalation to hospital services and facilitating safe discharge of patients from acute/ community hospitals to their homes. This also includes maintaining strong partnership support (with Swansea, NPT Social Services and third sector) to ensure optimum community services available for Hospital2Home/ Rapid Discharge

services, and coordinated support to the Care Home and domiciliary care sector. This is aligned to the workforce plan for surge and super surge; all services with elements identified as essential or urgent will mobilise their own staff to prioritise delivery of own service priority areas first and foremost.

- In Q2 a large number of primary care, community and therapy services were formally approved for reactivation by the Health Board Reset & Recovery Group. The aim is to maintain provision of such services throughout Q3&4 as this will support the recovery plans to 'work through' waiting list backlogs for services that provide outpatients clinics, e.g. Podiatry, Speech & Language Therapy, Restorative Dental, Audiology and Physiotherapy services. Continuation of these services would support the identified unmet need within the population. This is due to lack of availability of face-to-face & routine services throughout the pandemic, coupled with the reluctance of people to access non-urgent services, as demonstrated by recent data. As such the Health Board would be forecasting an increased demand for these services in Q3&4. However, service delivery will be guided by the Health Board Reset & Recovery Group and the emerging picture on the increased demand on emergency, urgent & Covid-19-specific services across the Health Board footprint. Again, this is aligned with workforce plans for deployment of staff in surge and super surge. As such, in the event of surge and super surge, the Health Board would not be able to deliver a zero breach position on waiting lists; would forecast breached waiting lists and a worsening position reported as part of the Health Board Performance Framework.
- As above and where safe to do so, the Health Board would look to bring forward proposals to restart a wider range of services delivered in primary care and community settings, including the provision of routine consultations and interventions, in line with national guidance.

### 5.5.3 Remaining responsive and prepared for subsequent Covid-19 waves

Based on local and national intelligence, the ability to respond quickly, effectively and safely in the face of another Covid-19 resurgence remains at front and centre of plans for Q3&4.

- The service-level Business Continuity Plans which informed the revised Covid-19 Response Plan for Primary Care, Community & Therapy Services have been refreshed. This describes plans to protect capacity in business critical & service priority areas (as outlined by Priority Areas 1&2 above)
- Key actions that would be undertaken in the event of a surge of Covid-19 include:
    - Support Primary Care Contractor professions to implement nationally issued guidance. Depending on the escalation level, this may involve the reinstatement of the full scope of Urgent Dental Care Centre at Port Talbot Resource Centre providing emergency and urgent dental care including Aerosol Generating Procedures for Covid-19 and non Covid-19 patients. Activation Plans which were agreed in Q2 for Covid-19 Cluster Hubs may need to be enacted (3/8 in dormancy, these would take between 3-6 days to reactivate) and the Urgent Eye Centre (6 days to reactivate).

- Implementation of Covid-19 specific pathways across community and therapy services as per actions undertaken in Q1-Q2 - a number of these new / changed services have been retained and would continue in surge and super surge situations, e.g. the sexual health ambulance delivering one stop TOP medication, STI treatment and contraception, the Heart Failure hub based in Gorseinon, and widespread telephone triage/ screening of referrals models across community and therapy services.
- Retain Gorseinon Hospital 36 bed profile as per national IPC guidelines on reducing nosocomial transmission in inpatient areas.
- Opening the Bay Field Hospital would take place in super surge in line with the Health Board Escalation Framework based on levels of capacity in acute sites. Further detail on this set out elsewhere in the Plan.

### 5.5.4 Deliver the Flu Vaccination Plan:

The following points are also included in Health Board Vaccination Plan referenced in section 4.

- The 2020/21 Flu Plan developed follows the advice in WHC (2020) 009 and ensures planning and activity across the breadth of primary care is captured, with additional explicit emphasis on collaborative cluster working across GMS practices and Community Pharmacy. The 2020/21 plan ensures a risk management approach, identifying possible pitfalls and mitigating actions that may help to reduce identified risks.
- All GP practices (44/49) that have submitted GMS reactivation returns to the Health Board have confirmed full uptake of the Influenza Vaccination Enhanced Service for 2020-21
- Community Pharmacies have been asked to complete a service level agreement to deliver the flu vaccinations. In addition, Community Pharmacy have a key role in vaccinating care home staff, carers and domiciliary care workers – these are key priority areas as described in the Flu Plan

### 5.5.5 Deliver the Rehabilitation Framework

Further detail on the Health Board Rehabilitation Framework is included in section 5.9. This will be aligned with the Strategic Programme for Primary Care, and rehabilitation services will be assessed using the modelling tool (in development) to analyse rehabilitation demand across the 4 population groups identified in the Framework. This will inform the development of a ‘short term’ plan to mitigate the impacts of the pandemic on the most vulnerable groups i.e. planning for winter, and a long term plan which will focus on embedding the Rehabilitation Framework into core business and taking forward opportunities to reshape the Recovery & Rehabilitation Service Model for the Health Board.

### 5.5.6 Cross-system working and with partners to deliver key transformational initiatives

There are a number of transformative whole system initiatives in which Covid-19 has accelerated the pace of progress and refocused the need to change and provide services differently, working as an integrated Health & Social Care system. In Q3-Q4, this will be progressed across the whole system and with partners to support delivery of key initiatives, these include:

- **Delivery of the Whole System Cluster Transformation Programme funded by Welsh Government**
  In Q2 the existing Transformation Programme was restarted, resulting in a refreshed suite of projects to be taken forward for implementation. Q3-Q4 high-level milestones have been produced for all projects, examples include:
  - Remodelling of Community Phlebotomy Service
  - Extended roll out of Ask My GP
  - Provide virtual wards in all clusters

In light of forecasted increased demand on primary care services, an approach to re-prioritising the delivery of the agreed Transformation projects is being developed. This will be a key priority for Q3.

- **Supporting the Redesign of Acute Medical Services in SBUHB -** recognises the key role that many primary care, community and therapy services play in emergency & acute admission avoidance, front door triage models of care and ambulatory emergency care pathways. Aligned to this the Health Board will implement the 24/7 Urgent Primary Care Model in development by the Strategic Programme for Primary Care, adapting this to local delivery as required. This is expected to include adoption of Phone First, Consultant Connect and remote consultations.

The detailed Action Template is at Appendix 11.

## 5.6 Mental Health and Learning Disabilities

**Context for Q3&4:**

- Local Primary Mental Health Services (LPMHSS) referrals reduced dramatically during Q1 but have risen steadily during Q2 and are approaching pre pandemic levels, more so in Swansea than NPT but this is expected to equalise. Increasing demand for primary mental health support continues to be monitored.
- Crisis Resolution Home Treatment (CRHT) activity is now back to pre-pandemic levels as are admissions to adult wards.
- Older People's Mental Health Services (OPMHS) admissions are also back in line with previous years.
- Adult Community Mental Health Team (CMHT) referrals are still way down against previous years

- Older Peoples' CMHT referrals more or less match previous years in Swansea and are slightly down in NPT
- Psychiatric Liaison activity was down reflecting the reduced general hospital and Emergency Department activity in Q1 but is now above pre pandemic levels.
- Outpatient referral rates dropped considerably in Q1 and despite increasing are still below previous year's activity.
- Feedback from the third sector is that contact from citizens for wellbeing and mental health support has increased and contact with the National Domestic Abuse Helpline increased.

The pandemic is increasing psychosocial distress, people are fearful and anxious with anxieties relating not only to Covid-19 itself but also the loss of employment, reduced finances and to uncertainties over the future.

The main psychological impact to date is elevated rates of stress or anxiety. But as new measures are introduced –especially quarantine- levels of loneliness, depression harmful alcohol and drug use, and self-harm and suicidal behaviour are expected to rise.

Findings in relation to similar outbreaks include:

- four times higher Traumatic Stress scores in children who had been quarantined,
- 50% increase in generalised anxiety,
- 28% increase in Post-Traumatic Stress and depressive symptoms in adults (three years on from quarantine),
- 10% maladaptive psychological reactions such as not reporting to work and current alcohol abuse/dependence symptoms (three years after the outbreak) associated with having worked in high-risk locations (such as SARS wards) and having been quarantined.

As the number of cases of Covid-19 falls and tails off the mental health impact on the population will be steadily rising as people come to terms with the psychological, social, economic and physical effects of the pandemic. This impact could extend beyond 3 years.

Priority areas:

### 5.6.1 Modelling for additional demand expected for 'lower level' mental health in the community

It is anticipated that increased demand will manifest itself predominantly in primary mental health care as part of the Local Primary Mental Health support service through autumn and into winter. After initially dropping drastically as people remained in their homes and with reduced attendance at GP surgeries activity levels have increased which will be maintained during the second wave as the importance to the population is emphasised that services remain available.

Based on examples and evidence from elsewhere in the UK, the Health Board has a working assumption of a 25% increase in referral activity. Based on 2019 data, local demand modelling indicates that this would represent, on average, another 98 referrals a month across all clusters in Swansea and another 40 a month across all clusters in NPT.

The national NHS Modelling tool will be available in early November in order to determine current activity and future demand and this will be blended with local demand and capacity modelling in Q3. This will tie into plans for Q3 and through Q4 to undertake a rapid review of local primary care mental health services (LPMHSS). The Health Board has been successful in having proposals agreed for the use of Welsh Government's mental health service improvement fund to increase resource recurrently in the LPMHSS in terms of 1wte per cluster for assessment and support across the Health Board. The "rapid review of local primary care mental health services" referenced in the action plan is already underway and is looking at the best use of this resource so recruitment can start immediately to increase the support for people at the primary care level. This will include a review and feasibility for rollout of the Primary Mental Health Practitioners role that has been piloted across pilot four clusters (Llwchwr, Cwmtawe, Neath and Upper Valleys) as part of the Whole System Transformation Programme.

As with other services the Community Learning Disability Teams have continued to provide all services in an adapted form to prevent a deterioration in their mental health or wellbeing. Examples of this include:

- Maintaining phone contact and details of how to contact team and following up telephone calls via vulnerable list weekly
- Regular feedback and team discussion around deterioration of mental health or social situation
- Providing assessment and recommendations over the phone with visual information re strategies offered to service users and their families / carers
- Creation of easy read documents which are individualised around corona virus
- Providing information to avoid admission and remain healthy at home. Checking that people are self-isolating and shielding.
- Letters sent to families with contact details and reassurance given with phone calls where needed
- Providing reassurance that the Team is still here to support
- Nursing team have supported psychiatry colleagues with nurse led epilepsy and psychiatry clinics. Following phone consultations, linking in with GP practices and ensuring that any medication changes are communicated and acted upon

In addition, the Health Board is undertaking actions with partners under the Welsh Government's Improving Lives programme that aim to address health inequalities in the long run including the uptake of annual health checks and operation of LD liaison nurse in acute hospitals.

### 5.6.2 Timely access to Psychological therapies

Social distancing and restrictions on contact between individuals has meant that whilst access to psychological therapies has not been suspended one approach to providing interventions - group work - has been significantly curtailed.

Consequently there has been a reduction in activity for delivery of high intensity psychological therapies and an increase in the number of people waiting for interventions as well as an increase in the number of people waiting more than 26 weeks for high intensity psychological therapy to commence.

Using local demand and capacity modelling the predictions for future breaches of the 26 week target indicated a worsening position and plans have been developed during Q2 for implementation going through Q3 and Q4, resulting in an expectation to have recovered compliance with the 26 week target by November 2020.

Work to develop a more refined understanding of service capacity, improve monitoring of breach demand, streamline waiting list management processes and improve waiting list data that takes account of potential impact of further Covid-19 waves will be built upon. The transformation programme, supported through the Integrated Care Fund, to implement a stepped care service model that will give us long term sustainability and improved patient experience for psychological therapies continues to be prioritised.

### 5.6.3 Improving access and simplified referral pathways

Whilst admissions to acute psychiatric units for adults and older people matched previous year's activity levels during Q1 and Q2 an increased acuity across all acute wards has been experienced, with additional resources deployed accordingly to meet complex needs and maintain patient safety. This is also being experienced elsewhere and recent reports by the Royal College of Psychiatrists and NHS Confederation highlight the effect of people being referred to services later, of a deterioration in existing conditions due to Covid-19 and of people developing serious mental health problems for the first time. Activity based on this continues to be modelled, for the early identification of an increasing demand trend for in-patient care. The National Modelling available in November will assist with this.

Acute service models for Mental Health and Learning Disability have been adapted purely on the basis of infection prevention and control and increasing the ability to care for people with increased physical health difficulties due to the virus.

This position is likely to be maintained for at least the next 12 months whilst the pandemic is managed, and it is a priority to ensure that positive patient and staff experience is at the core of service delivery. In Q3a review of the experience of staff in managing the access points will be undertaken, as well as the impact to the other clinical areas because they no longer receive direct admissions from the community. These findings will be consolidated in Q4, with the use of QI methodology, seeking to develop a clinical admission pathway model of expectation.

Through the Transforming Mental Health Programme the pathway to urgent care within the community via Single Points of Access is being refined. These single points of access deal with all requests for secondary mental health care from GPs across 7 days and 24 hours simplifying the route to support and ensuring that all new referrals are reviewed daily and triaged appropriately. The service will be evaluated through Q3 and Q4 with partners including the Third Sector, service users and carers to ensure that changes to access for services are communicated effectively across the whole system of care.

An outpatient modernisation plan is being progressed, based on local demand modelling during Q3 and Q4 to maximise the adoption of technology such as "attend anywhere" and processes which offer increased flexibility and simpler routes to medical reviews for patients and to establish whether productivity increases reducing average waiting times further.

Work is also being progressed in Q3 and Q4 to ensure that the development of the regional Mother and Baby unit to improve access to essential services for this vulnerable group of patients is in place for April 2021.

Key Actions for Q3&4:

- Undertake modelling for increased demand for primary care lower mental health care (November)
- Recovery of access times for Psychological therapies (January 21)
- Embedding revised Covid-19 Pathways for community and inpatient care including review of single point of access (October)
- Progress development and commission interim Mother and Baby unit (March 21)
- Establish detailed plans to support outpatient modernisation (October)

The detailed Action Template is at Appendix 12.

## 5.7 Children & Maternity Services

Context for Q3&4:

- The Paediatric waiting list has grown. Pre-Covid-19 a zero backlog position was maintained, there are now 147 children waiting over 26 weeks for their first appointment
- The pathway for Neurodevelopmental Disorders (NDD) remains under review on an All Wales basis as the number of referrals into the service has increased over the last 2 years. The NDD Team were the first to pilot "Attend Anywhere" which has allowed appointments to continue for children and young people with suspected Autistic Spectrum Disorder and in excess of 200 appointments concluded.
- Child & Adolescent Mental Health Services CAMHS -

- The number of children & young people waiting has been decreasing over the last 18 months. In 2018/19 the average number of referrals received during 2018/19 was 78, this decreased slightly to 64 a month during 2019/20. Referrals have increased since the pandemic, and will potentially increase further once schools reopen.
- The Part 1 waiting list has reduced significantly due to targeted work and a treat in turn approach. In June the part 1 compliance was 100% and part 2 at 91% against a target of 80%.

- The School nursing service will focus solely on the delivery of the Fluenz vaccination programme to over 29,000 pupils aged 4 – 11 years in 141 Primary School sites across the HB area during quarter 3. During quarter 4 delivery of the HPV programme to all year 9 pupils will be the priority, across 24 comprehensive school sites.

For the purpose of the quarter 3 and quarter 4 planning the following services are included in this section:

- Childrens Services
- Child & Adolescent Mental Health Services (CAMHS)
- Health Visiting
- School Nursing
- Maternity Services

Some of the key challenges for services that support children & young people are:

- Re-starting services to meet the needs of children, young people and their families to reduce the numbers waiting and the length of time waiting, and the availability of accommodation to re-start face to face appointments;
- Addressing and funding existing staffing gaps within some children's services to build resilience;
- Maintaining service changes to ensure services are robust to deal with winter pressures in addition to Covid-19;
- The potential for staff to be re-deployed to respond to increased Covid-19 activity;

For Q3&4 the following key priorities will be addressed:

### 5.7.1 Maintain Essential Services – re-start of services

The Outpatient reset & recovery programme will continue to be a key priority across all outpatient services, and for Children's Services particularly to meet the need to re-start face to face appointments, and to maximise the use of technology and digital solutions to improve access to services for children & young people, where appropriate. There are some particular challenges in relation to suitable accommodation due to the need to social distance, and also the effectiveness of virtual appointments for some families.

School nursing will be introducing its Immunisation programme during Q3&4 and will also be catching up on some areas that have fallen behind as a result of the pandemic. School nursing will deliver the flu vaccine to over 29,000 pupils aged 4-11 years in Q3 and the HPV programme to all year 8 & 9 pupils, plus Teen Booster and Men ACWY programme to all year 9 pupils in Q4. Due to Covid-19 and subsequent school closures the Teen Booster/Meningitis ACWY programme was not completed. The CMO letter (3/4/2020) confirmed that when schools reopen the programme will need to be recommenced and identified vaccinations as a high priority for school nursing nationally.

Health Visiting have now increased the number and length of face home contacts and are looking at alternative ways to increase contact including virtual and walk and talk groups. There will also be support for immunisations and appropriate follow up with children and increase promotion in primary care to ensure that children with outstanding immunisations, with particular emphasis on MMR, are actively followed up and attendance promoted at the GP clinic.

During the pandemic maternity services maintained essential services in line with RCOG Covid-19 clinical guidance. All antenatal screening continues to be delivered, in line with the antenatal screening standards. Screening for new born babies will also continue with only one minor change in response to the pandemic. Currently the Newborn Blood Spot check is undertaken one day earlier, at the same time as the 72 hour screening to reduce the number of interactions. The next steps are for the service to evaluate the impact of the changes made and consider how a number of the changes to the provision of care are re-introduced. As part of the evaluation, the maternity service launched a woman's survey in August 2020 to gain the views of women who have been pregnant and had a baby during the pandemic.

### 5.7.2 Improving services to build resilience against Covid-19

Planning is ongoing to enable the safe management of pathways across services for children and young people, including increasing capacity in some areas, and maintaining safeguarding. The Children's Emergency Unit model was implemented during the pandemic at Morriston Hospital, by creating a single point of access with existing staff. However, there are a number of factors likely to influence a significant increase in demand for Q3&4, and the priority is currently to look at options to maintain access, including the recruitment of additional nursing staff.

School nursing has good relationships with partners including local authorities, and the police, particularly in relation to safeguarding, and the priority will be to maintain this and to support and protect children & young people, and their families. Maintaining contact with children, young people and their families will be a priority, and both school nursing and CAMHS have responded to this specifically. A phone advice line will be piloted by school nursing for comprehensive pupils and their parents/ carers, and CAMHS will continue to deliver its single point of access to ensure that support is provided to access appropriate services, and to provide

expert advice as necessary. There is also a regional website in development to support children & young people with their emotional health & wellbeing, and that is scheduled for launch in November.

The CAMHS Emotional Health & Wellbeing Service is due for implementation in Q3 with staff recruited to the role of emotional health & wellbeing officer, whilst a service specification has been developed for these services it is likely that the focus of this service will be feedback from children and young people on the challenges they are facing in relation to the pandemic.

During the pandemic sustaining community maternity services has been challenging – partly due to an aim of reducing contacts and visits to homes in order to protect staff and women. However, maintaining contact with women during pregnancy and the early postnatal period is essential for monitoring maternal, foetal and neonatal wellbeing. A maternity helpline was established and run by midwifery staff who could not be 'front facing', which has assisted in providing virtual contact. There have been reported benefits to this such as early first contact with a professional when pregnancy confirmed. The aim would be to establish this as a permanent system in the future.

### 5.7.3 Developing sustainable and safe services

**I**n addition to the operational challenges that arise during Q3&4, Services are also working towards progressing a number of strategic work programmes, and their sustainability will have an impact on the ability of services to become resilient to deal with the challenges of winter pressures and any increased activity in relation to Covid-19. Whilst there is a great deal of positive work ongoing in relation to Neonatal Services with the provision of the Transitional Care Unit, there remains a significant gap in the Neonatal Unit workforce. The Health Board has been pro-active in ensuring that staffing gaps are kept to a minimum, however specialist agency staff are already being utilised.

Plans will also be progressed to improve staffing gaps in other services such as the Neurodevelopment service, and a review of the safeguarding service is also required, as a result of the retirement of the named doctor for safeguarding and a failure to recruit.

The response to the Organisational Additional Learning Needs (ALN) implementation will be submitted on behalf of children's services to Support the DECLO in progressing the preparations for the requirements of the ALNET Act. This will generate an action plan and a Map and Gap exercise.

In addition to maintaining essential services a number of strategic aims exist for maternity services including the Welsh Government key performance indicators and the implementation of the Maternity Care in Wales. A number of these strategic areas are included with the action plan for maternity services, and the role of the Specialist Midwife for Perinatal Mental Health due to the increase in poor mental health in communities is being considered. The implementation of the Smoke-Free Premises and Vehicles (Wales)

Regulations 2020, and the way in which this may be able to support pregnant women and mothers to stop smoking will also be considered, this will support the Health Board to reduce the number of still births within Swansea Bay which in 2020 has seen an increase in the rate, and which has been raised internally and with Welsh Government. Thematic reviews of the stillbirth reported have identified the following:

- 60% women had mental health issues
- 53% had a raised BMI
- 46% were smokers
- 73% of all the cases were of women who had more than one of the above risk factors

All Antenatal screening has been maintained and will continue to be, in line with the antenatal screening standards.

Key Actions for Q3&4:

- Improve access times to paediatric outpatients through a range of initiatives including digital working (October)
- Deliver the full range of immunisation and vaccination programmes (December)
- Complete review of neonatal workforce gaps against BAPM standards (December)
- Develop virtual women's engagement plan for maternity services (November)
- Increase the number of contacts for Health Visiting through face to face and alternative ways of working (October)
- Develop joint staffing model to maintain the Childrens Emergency Unit in Morriston (December)
- Implementation of Emotional Health & Wellbeing Service for CAMHS (December)
- Progress Neonatal 24-hour transport proposal (December)
- Complete children' Services response to the Organisational ALN Implementation Action Plan including Map and Gap exercise (December)

The detailed Action Template is at Appendix 13.

## 5.8 Outpatient Transformation

Context for Q3&4:

- In March 2020 a rapid reduction in weekly stage 1 additions to around 18% of pre-lockdown levels was seen as national lockdown was initiated. Since April, however, there has been a steady weekly increase in these numbers and are currently seeing around 75% of pre national lockdown levels being added to the stage 1 waiting list.

- Similarly, there was a marked decline in monthly outpatient activity as a result of Covid-19, with April 2020 new patient activity being around 20% that of April 2019. This has increased steadily over the months to just over 50% of monthly activity as compared to 2019, and continues to increase.
- This pattern of initial reduction in activity followed by a period of recovery has been mirrored with follow-up patients who initially saw a reduction of monthly activity to around 35% of 2019 levels, increasing to around 55%. This too continues to increase.
- The use of non-face-to-face/virtual outpatients appointments, for both new and follow up patients, has also continued to increase since April 2020, seeing a 57% increase in their use during the first four months of the year.
- However, as there have been reduced removals at stage 1 due to lower overall outpatient activity levels, at the same time as increasing additions-to-list to almost pre-lockdown levels. This has led to increasing stage 1 waiting list numbers and times, and increasing waiting times for follow-up patients.
- Since April 2020, there has been a 21% increase in RTT stage 1 waiting list numbers to just under 41,000 patients. This continues to increase weekly.
- Since April 2020, there has however, been a 2% reduction in the total number of patients waiting for a follow up appointment, but an increase in waiting times for those still waiting - with a 19% increase in those patients delayed over 100% of their target date.

Prior to the Covid-19 Pandemic, the Health Board's Outpatients Transformation Programme was developed to support the National Outpatient strategy. Subsequently during Q2 (May 2020) using WG Essential Services guidance, Phase 2 - Reset and Recovery Plans for Outpatient Services was developed, building on activity that due to the urgency had continued during Phase 1. The focus has been those patients who are urgent, high priority and high impact services or increased activity based on urgent clinical priority (response during Covid-19).

It has been necessary during the pandemic to implement and increase the pace of a number of service changes to ensure patients get the support they need, including a number of digital solutions e.g. Attend Anywhere virtual clinics. Face to face appointments have now re-started for essential services only, however digital solutions should continue where appropriate which will allow services to become more resilient to deal with the challenges of winter pressures, and any potential second surge of Covid-19. As part of the planning for the Outpatient Transformation Programme, funding was secured, via Welsh Government in July 2020, to support a number of outpatient initiatives and the associated workforce requirements. The outpatient transformation programme is a key enabler to maximising the available digital solutions including Dr Doctor, See On Symptom (SOS), and Patient Knows Best (PKB). These digital solutions will support the priority areas as identified in the individual service group implementation plans.

The Health Board has now implemented Phase 2 in line with Welsh Government guidance, and operationally the key challenges for the services are as follows:

- The current activity is operating at approximately 50% capacity, this includes both face to face and virtual consultations. Whilst there are a number of contributors to this position, the lack of physical space as a result of social distancing and the additional time allowed for each patient is a challenge to increasing activity;
- During quarter 2 and as part of the response & recovery work programme it was identified that the number of patients waiting had not increased as referrals had reduced, however patients were waiting significantly longer. During Q2 this has shifted, and referrals are increasing – a significant number of patients are now being added to the waiting list each month;
- As virus rates increase, there is an impact on the work force with staff absence and the risk of new impending local lockdown rules; there is a need for staff to self-isolate and if family members are symptomatic - sickness rates particularly will increase moving into the winter period. The outpatients workforce were also re-deployed to respond to Covid-19 to support hospital admissions during the first surge of Covid-19 activity;

In preparation for Q3 and Q4, plans to increase capacity, within the current guidelines, and increase the pace of rolling out digital solutions e.g. dashboard, Dr Doctor have been agreed.

The 5 key priorities for Outpatients in the Health Board during Q3&4 are:

**Priority 1 – Maximise roll out of Outpatients Transformation Programme**
It has been necessary during the pandemic to implement and increase the pace of a number of service changes to ensure patients get the support they need, including a number of digital solutions e.g. Attend Anywhere virtual clinics. Face to face appointments have now re-started for essential services only, however digital solutions should continue where appropriate which will allow services to become more resilient to deal with the challenges of winter pressures, and the likely second surge of Covid-19. As part of the planning for the Outpatient Transformation Programme, funding was secured, via Welsh Government in July 2020, to support a number of outpatient initiatives and the associated workforce requirements. The outpatient transformation programme is a key enabler to maximising the available digital solutions including Dr Doctor, See On Symptom (SOS), and PKB. These digital solutions will support the priority areas as identified in the individual service group implementation plans.

To address the increasing numbers to Health Board waiting lists, each priority specialty “Improvement Packs” have been developed, which contain detailed data of highest volume specialities down to individual consultant level, with the view to develop, share and

agree on reporting and tracking progress. The aim is to work towards increasing activity and reducing the follow-up waiting list by 20% by March 2021. The outpatients programme team have agreed a number of priorities with Delivery Units, and these priorities will form the basis of their Q3&4 plans.

**Priority 2– Implementation of waiting list management solutions via Digital, service redesign solutions (e.g. Pathways).**
This includes rollout of the principles and processes within the nationally developed SOS/PIFU Handbook. Key stakeholder clinical engagement events will be held to deliver the toolkit and the roll out of Clinical validation, using digital tools such as Dr Doctor quick question tool, where individual Consultant list of patients (particularly over 100% target) will be validated. Clear lines of clinical governance and clinical responsibility for these patients will be in place, and a review and development of the SOS/Patient Initiated Follow Up (PIFU) pathway to help with validation will be completed. A robust SOS pathway will be set up for each service as well as PIFU for specialties where this will work well, e.g. Rheumatology, dermatology, diabetes, (mainly self-managed long-term conditions), ENT. The DNA policy will undergo a complete review of all patients who have DNA'd more than once and discharge. Demand will be continuously reviewed and more rounded approaches to tackle this via service redesign, pathway/integration with services e.g. community and primary care will be implemented.

**Priority 3 - Increased access to consistent and accurate outpatient analytics (Hourly updates or Daily – TBC)**
The Outpatients Transformation Programme will commission a bespoke dashboard report outlining key metrics, highlighting 'real-time' analytics across all departments. It will be designed to consistently show a full outpatient picture across all sites, demonstrating key high activity areas including referral and clinic management, appointments, RTT and waiting times, pathway figures for SOS/PIFU.

**Priority 4 - Re-start of face to face essential services**
As services re-start the demand and capacity for each clinic has been mapped. The physical accommodation is significantly reduced due to the need to enforce social distancing, and reduce the risk to patients and staff. In June, Implementation Plans with a breakdown of those specialties to be prioritised in Phase 2 were developed. These plans have provided a clear understanding of demand, where redesign is necessary and what areas need to pick up pace and roll out of digital solutions such as PKB, PROMS and Attend Anywhere, moving forward into Q3&4. Demand & capacity plans will be revisited, with any lessons learnt applied to see if activity could be increased.

Outpatients are currently working at an estimated 50% capacity, and there are concerns that not all clinically urgent patients are being seen in a timely manner. Discussions have been initiated to identify new ways of working, including extending working days and utilising evenings, however, early indications suggest that this will not enable significant levels of additional activity, these discussions will continue into Q3 across all sites. As the footfall increases at hospitals sites, the increased need for initiatives such as virtual

waiting rooms and alternatives venues will be required; these discussions will be progressed into Q3, however the availability of capital funding will be a consideration associated with some of the solutions.

**Priority 5 – Demand Management via working collaboratively/service redesign new care models for better integrated working in the Primary Care and Community Setting**

A focus at looking at demand and how this can be managed via new models of working between Primary and Secondary care, will be critical, as it is recognised that opportunities to shift traditional hospital based care out into the community wherever possible to help with the increasing demand need to be explored and implemented. This priority will look at areas that are suitable to transfer outpatient services to primary care setting for example; expand self-management apps, minor surgery, clinics for chronic illnesses and diagnostic centre approaches (ambulatory unit), seeing where relocating specialists into community would be an opportunity, better and joined up liaison between primary care and specialist's and professional behaviour change. Whilst these discussions are in their infancy, there is an appetite to progress from leaders within both primary and secondary care. Streamline/redesign of pathways has led to the introduction of FIT-testing within lower GI services. In addition to the above, there will be a continued focus on demand management by greater use of Consultant Connect to prevent referrals.

Key Actions for Q3&4:

- Agree 'high' priority speciality areas with Service Groups (November)
- Redesign approaches to improve waiting list management via pathways and digital solutions (December)
- Develop Outpatient dashboard (November)
- Re-start of face to face essential services (October)
- Undertake Collaborative working/redesign for better integrated working in the community (December)

The detailed Action Template is at Appendix 14.

## 5.9 Rehabilitation

The Health Board established a Rehabilitation Group in June 2020 and has developed a rehabilitation framework in response to the national work programme. The framework is a patient centred approach to rehabilitation and is structured around the needs of the individual rather than existing services and it is linked to the recently published modelling resource. The group has also recognised the impact of Covid-19 on people accessing rehabilitation services, so have been working to develop a Swansea Bay rehabilitation website. The website is currently being developed and will include educational content, information on services and how to access

them, along with some videos. This content will align and support the national Covid-19 app that is currently under construction and Swansea Bay have several representatives on this group

The framework encompasses all aspects of rehabilitation, including pre-habilitation, children and young people and community services and is now an integral part of all the work streams associated with Restart and Recovery Group. There is specific work being planned to assist with waiting list management and an information leaflet has been sent out to all those on waiting lists with advice on how to stay fit and healthy whilst awaiting a review by a healthcare professional.

The recently published HEIW rehabilitation playlist has been circulated widely within the Health Board and will be used to highlight the need for rehabilitation to be “everyone’s business”.

The Health Board has developed a new Intensive Care Physiotherapy Outreach programme. This is led by the physiotherapy intensive care team and provides on-going community-based rehabilitation for those individuals (both Covid-19 and non- Covid-19) who require it. The physiotherapy assistant practitioners visit people in their own homes to progress mobility, provide strength and balance exercise and advice following their admission to intensive care. The project was recently featured on BBC Wales.

The rehabilitation work plan within Swansea Bay is in the early stages of development and it is anticipated that a more detailed report will be available soon.

# 6 Partnership Working

## 6.1 West Glamorgan Regional Partnership Board

Revised structures for partnership working with Local Authority and Third Sector colleagues as well as citizens and carers were described in Quarters 1&2 Operational Plan and have remained fit for purpose. Although the partnership is still in emergency response, a number of the work streams within it are restarting, not least to deal with future recovery planning for their area of the programme. In addition to Community Silver Command meeting weekly, a Recovery Board meeting is held on a bi-monthly basis to oversee the transformation elements.

The priorities for Q3-4 are:

- **Stabilisation and Reconstruction:**
  Work with (and invest in) communities, third sector and volunteers in maintaining and strengthening an asset and strengths based approach to safely supporting vulnerable individuals within their communities without unnecessary recourse to critical/essential health & social care services, building upon the Our Neighbourhood Approach model - making sure there is a particular focus on support for carers.
- **Transforming Complex Care**
  Establish fit for purpose joint funding arrangements to support the provision or commissioning of integrated/ collaborative health/ social care services to support children and adults with complex needs. This is intended to:
  - Safely support regional Looked After Children (LAC) reduction anywhere on the continuum of need
  - Safely support adults with complex needs to remain or return to living as independently as possible within their families or local communities within the region rather than within more institutional health or care settings.
  - Ensure seamless transition between services across all services including young people into adulthood
- **Transforming Mental Health Services**
  - Develop a continuum of support for the population who require Mental Health and Well Being Services
  - Safely support children and young people with emotional mental health and wellbeing needs to receive the support they need to live as fulfilled a life as possible with the minimum levels of intervention and receiving integrated care in a timely manner when they do

Other work streams will be progressed and programme managed by the West Glamorgan Transformation team through the existing work stream groups. Any final completed products will be escalated to the Recovery Board for approval.

In addition, Community Silver Command will continue to progress work on Covid-19 related activities such as:

**Rapid Discharge Process**
This process was implemented in July 2020 as a Covid-19 response, further detail is outlined in section 5.1.

**Care Home Support**
The Health Board chairs the Externally Commissioned Care Homes Group as part of the multi-agency Community Silver arrangements, which includes local authorities, Public Health Wales, the Third Sector and Care Home contractors to ensure coordinated support to Care Homes. The West Glamorgan Regional Care Home Protocol (version 11.0) can be found at http://www.westernbay.org.uk/care-homes-covid19/ 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. A review of the way in which the region had supported and responded to the pressures in Care Homes was completed in Q2, and submitted as part of the region's response to the national review of care homes.

To further enhance the Protocol, 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.

The "Rapid Review for Care Homes in Relation to Covid-19 in Wales" report completed by John Bolton on behalf of Welsh Government has recently been received and all recommendations have been addressed in the local action plan.

There are ongoing discussions to support contingency arrangements for care homes, with a phased approach being developed. Short term failure might necessitate support with care staff / nurses; step up additional bed capacity (Swansea) and working with administrators in the event of short term failure (if care home is attractive to other buyers).

Discussions are underway across Wales to consider the approach set out in the Q3&4 Operating Framework about the provision of support to care homes, and a report will be provided to Welsh Government by the end of October.

## 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 3/4 through the ARCH Partnership (which includes Swansea University) the focus for regional working between SBUHB and with Hywel Dda UHB will continue as follows:

- **ARCH Innovation Forum** – was established in July 2020 and will provide guidance, advice, support, and signposting from a multi-disciplinary stakeholder group to innovation projects from across the region. The purpose of the forum is to accelerate

innovation in Health Boards, academia and industry across the health and care sector to improve the health, wealth and wellbeing of South West Wales.

- **City Deal Campuses Programme** – A programme business case is being developed for resubmission during October. The programme has multiple projects underneath it, including developments on the Morriston hospital and Pentre-Awel sites.

Across other service areas and as part of the Essential Services Framework, the following will continue:

- **Eye Care –** Following a Regional Eye Care workshop the following areas were agreed as priorities, Glaucoma, Diabetic Retinopathy, and Cataract. Glaucoma is seen as the greatest priority initially with an immediate need to stabilise services and an agreement to joint consultant appointments with a clinical lead to support the service in Hywel Dda. There is also an agreement for joint implementation of Open Eyes. Further work will be carried out across all areas through Digitisation and Value Based Healthcare approach.
- **Dermatology –** Regional project group meetings have resumed following cessation through Covid-19 and a review of priorities and implementation plan commence to establish current position. A Clinical Lead role for Hywel Dda needs to be identified following retirement to support. In addition, the recruitment of joint consultant posts between HBs, both dermatology and plastic surgery will be pursued. The sub project, funded by Wales Cancer Network Innovation bid, to utilise AI and mobile phone continues with expected pilot in Q4.
- **Endoscopy –** Work in this area has been deferred pending the outcome of the work on being undertaken nationally to establish regional facilities and the wider focus on the provision of planned care.
- **Orthopaedics –** Plans are being put in place to potentially utilise NPT Hospital as an elective orthopaedic unit for the HB but this will require capital investment and a business case has been developed in readiness for submission to Welsh Government. Discussion are also taking place with CTM UHB with a view providing orthopaedic surgeons from Princess of Wales Hospital further access. In addition, HDUHB plans for elective services at PPH are underway and it was agreed that the leads from both Health Boards should make links across these areas of work to ensure best use of resources.
- **Pathology –** Following the submission of the SOC for a Regional Pathology Service, there will be a co-ordinated approach to the Infrastructure Investment Board (IIB) in October 2020. A focussed regional group, that will include PHW, will attend with shared key messages and priorities.
- **Diagnostics –** A regional approach to Diagnostic recovery will be undertaken with utilisation of the mobile CT Unit at based Glangwili Hospital.

- **Test, Track, Protect** – Discussions are being held to investigate if there can be a wider regional community response to reduce impact of second wave and reduce reliance on National systems and share lessons learned. Strong links with LAs across SW Wales have been established and closer links with partners are planned.
- **Field Hospitals –** The situation with regards to the utilisation of field hospitals is constantly being reviewed with the potential for a regional field hospital and a regional workforce model.

## 6.4 Cwm Taf Morgannwg UHB

Formal meetings between the two Health Boards have restarted in order to explore the regional opportunities and to manage the dual track aims set out in the Quarter 3/4 Operating Framework. Contracting and Commissioning meetings are being held regularly to deal with the legacy of the Bridgend boundary transfer. Both organisations have undertaken a provider assessment of the essential services the findings of this will be shared to provide each other with assurance the needs of their populations are being met.

The two Health Boards have restarted elective surgery at Neath Port Talbot Hospital on 7th September, in the light of the Essential Services guidance. 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, as well as on the longer term surgical model, especially for orthopaedics. Both organisations are mindful of the need to collaborate together to reduce urgent waiting times whilst recognising the longer term strategic change.

Health Boards are also reviewing the regional opportunities to work together during Covid-19 and winter plans recognising the requirement to maximise capacity in what will be a difficult winter.

## 6.5 Cardiff and Vale UHB

The Regional and Specialised Services Provider Planning Partnership continues to meet on a bimonthly basis, and is taking forward the following as part of the Q3 work programme:

Oesophageal Gastric Cancer – the partnership is engaging with Community Health Councils (CHCs) and Health Boards to determine the scope of an engagement exercise to inform the future service model for oesophageal gastric cancer surgery. In the interim work continues to develop a supraregional MDT, and the partnership has formally requested that the Wales Cancer Network undertake further work on the patient care pathways for these cancers.

Spinal Surgery – the partnership is leading a project to inform the future provision and commissioning of spinal surgery services in South and West Wales. The project is due to launch in mid-October, and will make recommendations on the regional models for the South East and South West, as well as the supraregional model for South and West Wales.

HepatoPancreatroBiliary Services – the partnership is working with the Wales Cancer Network to develop a service specification for these services. This work commenced in September and is due to conclude in February 2021.

Collaborative working – the partnership has identified a series of key principles for collaborative working across the two Health Boards. Over the course of Q3, these will be developed into a formal Memorandum of Understanding (MoU) between the two organisations and will be used as the framework for all future collaborative work.

Tertiary Services Project – A clinical lead has been identified, and over the course of Q3 and Q4, further work will be undertaken to develop the Health Boards vision for these services.

## 6.6 Welsh Health Specialised Services Committee (WHSSC)

The Health Board will continue to work closely with WHSSC to support the commissioning of essential specialised services, to minimise harm from the reduced provision being seen and where possible improve the commissioned volumes of activity. This will include scoping opportunities to access treatment outside of the Health Board where clinically appropriate. Joint Service Level Agreement Performance meetings have been re-established to review contracts from a quality and activity perspective and to provide assurance through the WHSSC Quality and Patient Safety Committee and Joint Committee in line with usual governance processes.

Work has commenced in the development of the WHSSC Integrated Commissioning Plan for 2021/22. In total 44 schemes were submitted from providers with a potential revenue cost of £15m. Due to the volume of the schemes submitted WHSSC has undertaken a preliminary sifting exercise and propose that:

- 16 Submissions to be taken forward to the Clinical Implementation Advisory Group (CIAG) prioritisation process.
- Submissions requiring further detail before being taken forward
- 24 Submissions to be managed through alternative routes

For SBUHB provided services, this process has excluded 8 out of the 10 schemes submitted. The Health Board has provided a response on these decisions and will work with WHSCC through Q3 to understand the rationale and the potential for alternative ways to support these services

## 6.7 Emergency Ambulance Services Commissioner (EASC)

The Health Board continues to work closely with EASC and Welsh Ambulance Service Trust (WAST) colleagues to plan, commission and deliver the ongoing response to Covid-19 and recovery of Essential and routine services. This includes consideration of the review of the EASC and WAST Integrated Medium Term Plans and the Demand and Capacity review through the EASC Management Group.

The status on the Health Boards unscheduled care and essential services recovery has been well received by EASC in terms of significant improvement in ambulance handover and escalation.

Focussed areas of work in Q3&4 will include:

- WAST Gateway review-roster reviews and sickness absence trajectories being developed to inform demand and capacity work
- Cluster proposal and scoring system which is largely driven by WAST data
- NEPTS capacity recognising the impact of social distancing on patient conveyance.
- External company supporting a demand and capacity work programme in WAST
- Mobile testing units
- Ministerial Ambulance Availability taskforce

## 6.8 Trade Unions

Throughout this period, there have been regular meetings with Trade Union colleagues, to ensure they are fully informed and updated and have the opportunity to raise issues of concern.

The detailed Action Template is at Appendix 15.

## 7 New Ways of Working - Digital Services Programme

The 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.

Covid-19 has continued to be both a disruptor and an enabler to the delivery of Digital Transformation within SBUHB throughout the first half of the year. Whilst Digital resources have continued to be diverted to support Covid-19 activities, such as the Test, Trace and Protect programme, focus has further increased on the delivery of the programme of Digital transformation outlined in the IMTP. Opportunities presented to the Health Board to exploit the need to change caused by Covid-19 to accelerate the Digital Transformation plan have been seized and used to support the delivery of the original plan. This step forward has been clearly demonstrated in Q2 when Neath Port Talbot Hospital became the first hospital in Wales to have E-Prescribing implemented across all Wards. Combining this with the other Digital implementations across all sites, including NPT, such has SIGNAL (patient flow), Medicines Transcribing and E- Discharge, virtual ward rounds, virtual social services assessments, electronic patient visiting etc. is a massive step forward towards achieving the Digital Ward. Significant progress has continued to be made across all Digital Enabling Programmes

Whilst it is recognised that Digital Services will have to accommodate the future, ever changing, requirements that Covid-19 will bring (including the emerging plans to support the immunisation programme) the Health Board has maintained an ambitious delivery plan across all of its Digital Transformation Programmes.

The key priorities and actions of the Q3/4 Digital plan are outlined below and support the requirements of the SBUHB operational plan outlined above.

Patient and Citizen Empowerment:

- Build on the success for the roll out of Attend Anywhere (over 11,000 outpatient consultations taken place by the end of September and 94 services live) and continue to roll out the service to more specialties and embed virtual working within outpatients. (Ongoing)
- Continue to develop the functionality of the Swansea Bay Patient Portal and continue to roll out to specialities as required, further supporting the modernisation of Outpatients and new ways of working in areas such as Diabetes who are now live on the solution (e.g. Nov - exercise and lifestyle programme go live)

Hospital Patient Safety and Flow:

- Hospital Electronic Prescribing and Medicines Administration (HEPMA) is now live across Neath Port Talbot Hospital (NPTH). Implementation will commence at Singleton Hospital in January following a significant system upgrade
- Continued development of the national Welsh Nursing Care Record (WCNR) solution and roll the solution out across NPTH (March 21). This, combined with SIGNAL, Welsh Clinical Portal (WCP) and HEPMA, supported by digital devices, will mean that NPTH will have taken a huge step towards the delivery of a Digital Ward in 20/21
- The WCP's Discharge Summary (Medicine Transcribing and Electronic Discharge MTED) has now been rolled out across all wards in NPTH and will now be rolled out across Singleton (Q4). By the end of the FY all MTED implementations will be complete. This will be a large step forward in terms of convergence with national solutions and help support improvements in the discharge process.

Integrated Health and Care:

- Roll out of Primary Care pathology electronic test requesting (GPTR) will continue in Q3&4 and will be complete across all practices by end Q4.
- Subject to the approval of the Welsh Community Care System (WCCIS) business case that was completed in Q2 the Health Board will sign the deployment order and commence the implementation of WCCIS. 500 Health Board staff will go live on WCCIS in January 21 as part of the Swansea council implementation.

Information and Business Intelligence:

- Covid-19 dashboard and modelling tools will continue to be enhanced
- Work packages for the modelling cell include developments to the Cancer Services Dashboard (phase 1 completed in Q2 using Power BI) to support the delivery of the single Cancer Pathway (December) and the stage 2 development of the Outpatients Dashboard (March 21) for the rest of the year including the delivery of work packages for the modelling cell

Streamlined Comms, Business Processes:

- The Health Board will build on the success of the roll out of MS365 and continue to roll out new functionality to the 12,833 users. By the end of March 21 Intune and Power Apps will have been rolled out further enhancing the user experience of virtual working delivering administrative efficiencies.
- In Q3&4 the health Board will commence the scoping and planning work required for the redevelopment of the Theatres system (TOMs) with the view to improve theatre efficiencies through streamed lined processes and improved BI.

Digital Enabling Programmes:

- Infrastructure improvements to support mobile and agile working will continue through Q3&4 with the completion of the community WiFi rollout and the single point of contact for community services (December completion)
- Work will continue on the reconfiguration of the Field Hospital to ensure new services to be operated from there are digitally enabled.
- Digital infrastructure will be a key element of the ward refurbishments e.g. ward 20, G and ITU (in preparation for the Welsh Critical Care System WICIS) to underpin the move towards the digital ward.
- Infrastructure support for Covid-19 through the rollout of devices and software will continue in Q3&4 (over 3,000 users have been mobilised since March 20).

SBUHB also recognises that the rapid deployment of digital solutions and hardware over the last 6 months has resulted in an increased pressure on Digital Services Team to support business as usual. The roll out of over 2,200 additional devices and new applications such as Attend Anywhere, Teams, SIGNAL etc. has meant that more and more staff have adopted digital ways of working and are using digital solutions to transform their services. This has resulted, on average, an increase of 45% in calls logged with the Digital Operations team compared to the same period in the previous year. During Q3&4 the impact of this will be reviewed to support future management arrangements.

Key Actions for Q3&4:

- Continued roll out to support outpatient transformation including Attend Anywhere (Ongoing)
- Upgrade WPAS to include SOS and PIFU functionality (October)
- Complete development of V3 SIGNAL – phase 1 (December)
- Progress and implement WCCIS (January 21)

- Enhancements to Cancer services dashboard to support delivery of single Cancer Pathway (December)
- TOMs - Support the Surgery Workstream to derive a TOMS development plan and associated resource requirements (October)
- Complete Digital infrastructure changes to support new services in field hospital (December)

The detailed Action Template is at Appendix 16.

## 8 Performance

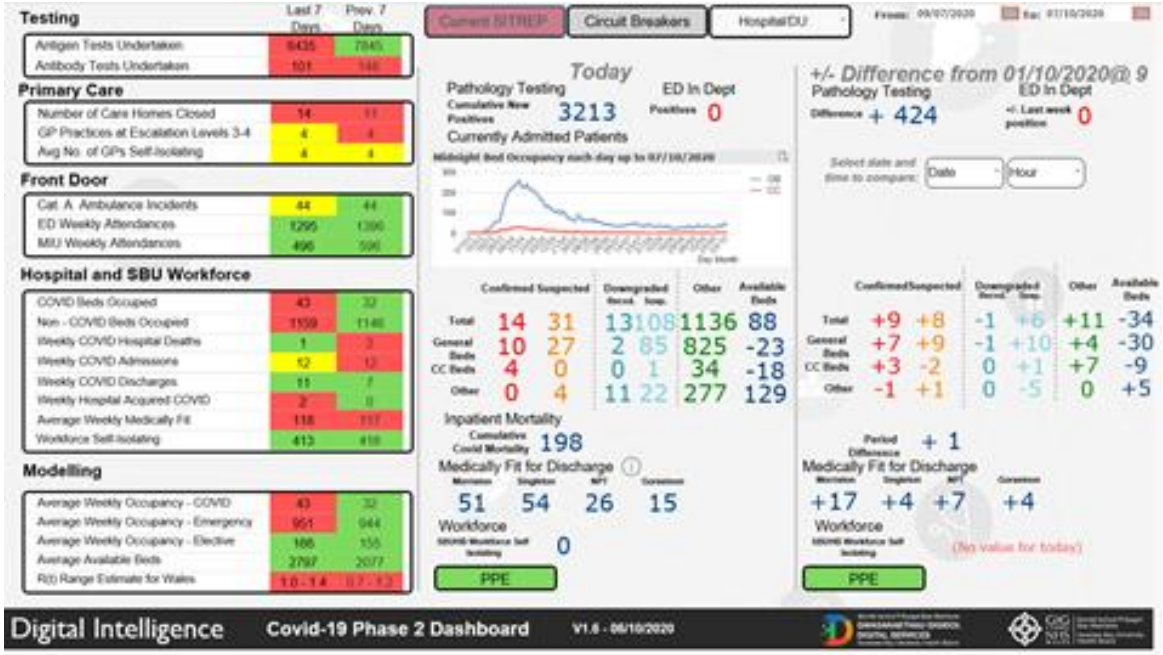
The Health Board has an established performance management system however, the Covid-19 pandemic shifted the focus to measuring the impact of harm in the system as a result of the outbreak as well as the immediate operational pressures. A significant amount of work was completed in quarter 2 to realign performance reporting arrangements against the quadrants of harm whilst continuing to present the Health Board position against the national measures in the NHS Wales Delivery Framework. An Operational Plan Dashboard was also developed to report performance against the measures in the Q2 Plan.

The focus of quarters 3 and 4 will be to build on the work already completed in quarter 2 and further improve the Health Board's visibility of measuring harm in the system as a result of the Covid-19 pandemic.

- Enhancing reporting of harm:
  - Further work is required in conjunction with Digital and clinical services to improve reporting of harm through the introduction of additional local measures as well as looking at capturing and reporting more outcome based measures.
  - The importance of routinely measuring the impact of Covid-19 on patients is recognised, therefore, patient experience measures such as complaints and incidents will be introduced into the twice weekly reports as well as including additional patient feedback measures in monthly performance reports.
  - Actively engage with the work Welsh Government is leading on to move Health Boards from the traditional way of reporting waiting times to a new informed risk stratification approach.
- Reinstating internal performance management arrangements
  - In March 2020, formal performance management of Health Boards by Welsh Government was temporarily suspended, although reporting to Board and Performance and Finance Committee has been maintained throughout.
  - The Health Board has maintained an open dialogue with Welsh Government during 2020/21 and has continued to submit performance information, however this information is being utilised to keep an overview of the healthcare system rather than to hold organisations to account. The same approach was taken internally, however as more formal arrangements with Welsh Government have recommenced, the Health Board feels that it is important to do the same through the reinstatement of the quarterly Planning, Quality & Delivery reviews with the Service Groups.

A number of dashboard applications have been produced and will continue to be used in order to monitor the developing Covid-19 situation on a daily basis. A Phase 2 Covid-19 dashboard has been created and is automatically updated multiple times each day with links into the main hospital systems. The same product also has Circuit Breaker and Early Warning Detection metrics based on local and national guidance which can be used to help understand the Health Board's position against escalation plans and how far

the organisation might be away from reaching them. The dashboard will continue to be updated and refined throughout the remainder of the year.




Key Actions for Q3&4:

- Patient Experience measures to be included in the weekly monitoring report (November)
- Monthly performance reports continue to be enhanced to include additional measures that measure harm in the system (January 21)
- Visible reporting of planned care waiting times using new deferred target dates, based on a clinical assessment (March 21)
- Reinstatement of quarterly Planning, Quality & Delivery meetings with Service Groups (October)

The detailed Action Template is at Appendix 17.

# 9 Workforce

## 9.1 Health and Wellbeing

### 9.1.1 2020/21 Staff Flu Campaign

Due to social distancing, this year's campaign which commenced 23rd September will not include Occupational Health drop-in clinics or mobile vaccinators in clinical settings and a greater emphasis on training peer vaccinators will be key to ensuring availability/access to the vaccine and maximum take-up amongst staff. The fixed term appointment of the staff flu coordinator role has helped to identify 270 peer vaccinators who, upon completion of appropriate training, can vaccinate their peers against flu. It is anticipated that this workforce will support the rollout of the Covid-19 vaccination when available.

### 9.1.2 Covid-19 vaccinations for staff

The Head of Staff Health and Wellbeing is attending the immunisation silver meetings, chaired by the Executive Director of Public Health to inform the strategic plan for staff Covid-19 vaccines. It is anticipated that the vaccine may be available late November and National guidance is awaited from UK Government regarding non-registered staff being able to administer the vaccine, along with a National training programme for vaccinators. A 12 month, fixed-term Band 7 Staff Immunisation Coordinator role has been secured to coordinate the staff Covid-19 vaccination and it is anticipated that the flu peer-vaccinators may support the Covid-19 staff immunisation programme.

### 9.1.3 Occupational Health Supporting Staff

At the commencement of the pandemic, over 30 additional staff were deployed to Occupational Health to support the assessment of symptomatic staff and to advise on capability for work and ensure managers received the correct advice to support their staff in work. There has been a significant increase in management referrals to the Department since July 2020, particularly related to Shielding staff and the commencement of the All Wales Workforce Risk Assessment.

Additional investment from the Health Board until March 31st 2021 will facilitate the following services aimed at supporting staff to remain in work and to provide prevention based interventions to help staff to remain well at work:

- Supporting the All Wales Workforce Risk Assessment
- Additional management referrals related to Covid-19 health concerns
- Supporting the rollout of the Covid-19 vaccine
- Advising on underlying health conditions and pregnancy as the situation continues to evolve and possible future peaks develop
- Supporting staff with testing and SBU contact tracing

- Integration with serology/antibody testing of staff and related surveillance

### 9.1.4 Staff Wellbeing Service

The Staff Wellbeing Service which provides staff with a single point of access to gain timely health and wellbeing support continues to be developed and additional counselling resource during Covid-19 has helped to reduce waits, particularly related to stress, anxiety and depression. Current waits are 5 working days for emotional health and 3 days for musculoskeletal problems. The service was shortlisted in the National Advancing Healthcare Awards Covid-19 ESTEEM Awards and more recently within the Personnel today UK Occupational Health and Wellbeing Awards 2020 under the category of 'best multidisciplinary initiative'. The significant increase in mental health referrals to the service between June and August, particularly stress and anxiety related to Covid-19, is in line with the increased absence shown above due to these reasons. Plans include increasing community resources and services to expand the offer of support to staff and to work with Charitable Funds to secure fixed term mental health resource to support staff during the pandemic. The Staff Psychological Wellbeing cell continues to meet monthly and will be the planning mechanism should the need arise to increase the offer of Wellbeing services due to a second wave of Coviod-19.

Plans continue to develop a staff trauma pathway with specific interventions to support staff e.g. provision of G-TEP (trauma-based intervention on a group basis).

Additionally, the team are undertaking the following measures to support the Health and wellbeing of staff:

- Conversion of Mindful & Meaningful Living course (a mindfulness & ACT based resilience-based course for staff) & Managing Your Wellbeing Course to remote delivery.
- Promotion of & support in the delivery of Taking Care Giving Care Rounds across the Health Board.
- Working with Medical Education colleagues in Swansea University to implement Taking Care Giving Care rounds
- Continuing to develop the network of 380 Wellbeing champions, supported by a regular programme of workshops.
- Working closely with related organisations such as Time to Change Wales to reduce the stigma and discrimination of mental health.

### 9.1.5 Delivery of TriM (Trauma Risk Management)

The programme is an early intervention/prevention approach to trauma-focused peer support compliant with the PTSD management guidelines produced by NICE and although it was first developed in the UK military, it is now used by a range of public and commercial organisations, including the emergency services and army. The approach is through peer-delivery with identified and suitably trained team members trained as practitioner's in order to facilitate the process within their own teams.

In light of time and capacity pressures there is a phased approach to the implementation of TRiM in the Health Board:

Phase 1
A cohort of twenty-three colleagues from across the Health Board have been trained to deliver REACTmh training to frontline employees. REACTmh enables supervisory staff to recognise when colleagues may be experiencing adverse effects of trauma and provides a framework to help them have a psychologically minded conversation and signpost to appropriate internal and external professional services where necessary. To date, 34 training cohorts have been run and 240 staff have been trained as REACTmh practitioners and during September managers have been asked to nominate further participants that may have been missed during the first tranche of training.

Phase 2
A successful charitable funds application has been made enabling the procurement of an externally sourced 2 day training programme to develop an infrastructure of trauma risk management practitioners and supervisors across key priority areas of the Health Board. The tender process for this is currently being undertaken and will be delivered during Quarters 3 and 4.

### 9.1.6 Taking Care Giving Care (TCGC) Rounds
TCGC Rounds enable staff from different areas (or whole teams) to focus specifically on the emotional impact of their work related to the flow of compassion and is undertaken through posing questions for discussion within a group context. To date over 45 TCGC rounds have been facilitated and 96 individuals have provided feedback. A wide variety of staff have taken part in the rounds including AHP's, Administrative and Clerical staff, Health Care Support Workers and Nurses and Midwives. Plans continue to expand the number of facilitated and there is commitment from Medical colleagues to work collaboratively to expand this model into the medical workforce.

### 9.1.7 Delivering the ESF funded in Work Support Service
Working in partnership with Welsh Government, the ESF funded team continue to deliver the 'In Work Support' service which supports the health and wellbeing of employees in small-medium enterprises (SME's) along with business support to enable SME's to develop related policies and procedures. Many of the resources are being converted to remote delivery and a series of webinars has been planned/delivered to support local SME's during the Covid-19 outbreak. Promoting, adapting and delivering this service will continue during Q3&4 to support local employee health and wellbeing.

## 9.2 Workforce Planning

The workforce planning process continues to be a live process that will be updated in line with on-going delivery of recruitment and in line with decisions taken regarding the Health Board's Escalation Framework. It must be noted that the workforce plans have been undertaken based on a number of assumptions which may change or develop over the next few months.

The Health Board developed in internal planning tool that has been used to underpin planning assumptions throughout this year. The tool helps units understand the numbers of staff who are likely to be available for deployment as compared to the current WTE bearing. The tool allows units to factor in elements including baseline underlying sick absence, Covid-19 related absence, turnover and recruitment activity.

The tool has three scenario models for Covid-19 related absence based on actual HB position at the peak and mid points of the first Covid-19 Wave. The model also has a scenario for a particularly severe winter flu pandemic and its impact on sick absence. The tool allows for a tailored approach to planning by staff group and can be used down to costs centre level.

### 9.2.1 Priority Areas:

Workforce capacity plans have been developed for the following priority areas and the detailed plans are included in the relevant sections within the plan:

- Surge (Phase 2) (see section 1.0)
- Super Surge (Phase 3 Field Hospitals, broken down into Stage 1 and 2) (see section 1.0) and further details below
- Critical Care (see section 1.1.4)
- Trace and Protect (see section 3.0)
- Testing (see section 3.0)
- Vaccination Program (see section 40
- Support to Care Home Sector - this continues to be in the planning stages no workforce numbers have been submitted at this stage

### 9.2.2 Super Surge – Field Hospital Plans

| STAGE1: BED CAPACITY | | STAGE 2: BED CAPACITY | |
|---|---|---|---|
| | Bay | | Bay |
| | 10 bedded bays | | 10 + 12 bedded bays |
| Triage/Assessment | 6 | Lower acuity | 244 additional |
| Higher acuity | 60 | | |
| Palliative care | 20 | | |
| TOTAL | 86 | | |
| WORKFORCE WTE : STAGE 1 (10 BED BAYS) | | WORKFORCE WTE: STAGE 2 (10 + 12 bedded bays) | |
| | Bay | | Bay |
| RN | 40.62 | RN | 52.23 |
| Registrants (AHP or RN) | 7.11 | Registrants (AHP or RN) | 18.71 |
| HCSW | 61.58 | HCSW | 167.5 |

| STAGE 1: WORKFORCE RATIOS | | |
|---|---|---|
| | **Bay** | |
| | **10 bedded bays** | **WTE** |
| | **(60 HA beds)** | **(+ 26.9%)** |
| **Triage/Assessment** | | |
| RN | 01:10 | 5.8 |
| **Higher acuity** | | |
| RN | 1:15 / 1:15 | 23.21 |
| Registrants (AHP/RN) | 1:10 / N/A | 7.11 |
| HCSWs | 1:8 / 1:10 | 38.37 |
| **Palliative care** | | |
| RN | 1:10 / 1:10 | 11.61 |
| HCSWs | 1:5/ 1:5 | 23.21 |

Stage 1 will be staffed predominately from Primary and Community Care Group through the repurposing of staff from non-essential services. Currently within the plans there is a slight deficit of HCSW, but there is confidence that this gap will be met through on-going recruitment campaigns. Senior nursing staff within Primary and Community Care will also be repurposed to the Field Hospital.

In addition to the above there are 20WTE Specialist Services Assistant (SSA) roles required to staff Stage 1. These staff were trained during the first wave and will be released to support Stage 1. There is on-going recruitment for Bank SSA staff.

| STAGE 2: WORKFORCE RATIOS | | |
|---|---|---|
| | **Bay** | |
| | **10 + 12 bedded bays** | **WTE** |
| | **(244 beds)** | **(+ 26.9%)** |
| **Lower acuity** | | |
| RN | 1:30/1:30 | 52.23 |
| Registrants (AHP/RN) | 1:20/1:24 | 18.71 |
| HCSW | 1:8/1:10 | 167.5 |

Currently the workforce plans for super surge show a significant deficit for both HCSW and Registered Nursing roles for Super Surge. On-going recruitment is continuing for both areas with high applicant numbers for HCSWs although a drop off rate for these is expected. Registered Nursing recruitment remains challenging. In conclusion the ability to recruit and staff Stage 2 of Super Surge will be significantly challenging for the Health Board.

There has been continued engagement with individuals who have expressed an interest in volunteering at the Field Hospital and the validation of who remains interested will be on-going. Currently there are:

- 96 people on the Reservist Field Hospital Bank (further 3 to be interviewed shortly)
- 34 of these are currently doing another role (Antibody Testing Unit - 30, Phlebotomy Morriston - 3, Phlebotomy Singleton – 1)
- 78 have attend induction – 54 had their induction at Llandarcy and 28 at Bay (18 people have not yet attended a site visit/induction)
- Breakdown of field hospital roles; Ward Helper 44, Ward Runner 39, Ward Reception 13

Liaison continues with the British Red Cross and St John's Ambulance about any additional support they may be able to provide. There has been discussion with neighbouring Health Board and recognise in principle the need to support each other with staffing should the need arise.

### 9.2.3 Deployment

A key action for this period will be the on-going live workforce planning required to ensure capacity for all areas deemed a priority through the winter period and in line with managing Covid-19 activity. The workforce plans outline the need for additional recruitment and the deployment of existing resources in line with the Health Board's Escalation Framework. As outlined in the Escalation Framework a green, amber, red escalation process will be in place throughout the period and in line with each level, local staffing and deployment plans will be instigated.

There is an on-going review of individuals who have been and/or remain shielding. At the peak of the impact of Covid-19 during the first wave over 850+ staff were reported as being absent asymptomatic (shielding), at the end of September 2020 that had reduced by 65% down to 28 meaning 580 staff have returned to work in some capacity. Where staff have not been able to return to patient facing roles following the appropriate OH advice these individuals have been considered for deployment to TTP.

### 9.2.4 Bank/Agency Usage -

The Health Board is currently undertaking large scale bank recruitment for HCSW to join the nurse bank both a bank and fixed term contract basis for up to six months. There are 90 candidates in the current cohort and the next cohort already has 195 candidates. Based on a 66% success rate, a headcount of approximately 190 can be assumed and based on the assumption that the individuals will work 2-3 shifts per work, this will translate to 76WTE. Recruitment will continue on a rolling basis in line with training capacity.

All existing bank workers are being contacted for interest to join us on a fixed term contract. The Health Board will continue to run a rolling bank advert for Registered Nurses.

Within the above demand / capacity modelling a continued used of bank and agency has been assumed which has been factored in based on average usage and usage during the first wave across April and May. This continued usage currently backfills against sickness, vacancies and acuity. The following table outlines the capacity through bank that was achieved through the peak period in April and May, and August due to increased backfill of annual leave.

| Sum of WTE | | Bank/ Agency | | | |
|---|---|---|---|---|---|
| Month | Staff Group | Agency | Bank | Non-Contract Agency | Grand Total |
| 01-Apr | HCSW | 18.19 | 238.8 | | 256.99 |
| | Registered | 142.54 | 59.98 | 7.24 | 209.76 |
| 01-Apr Total | | 160.73 | 298.78 | 7.24 | 466.75 |
| 01-May | HCSW | 8.44 | 184.6 | | 193.04 |
| | Registered | 153.69 | 46.07 | 0.76 | 200.52 |
| 01-May Total | | 162.13 | 230.67 | 0.76 | 393.56 |
| 01-Jun | HCSW | 2.51 | 158.77 | | 161.28 |
| | Registered | 143.86 | 53.17 | 1.25 | 198.28 |
| 01-Jun Total | | 146.37 | 211.94 | 1.25 | 359.56 |
| 01-Jul | HCSW | 2.46 | 191.75 | | 194.21 |
| | Registered | 160.19 | 58.97 | 3.09 | 222.25 |
| 01-Jul Total | | 162.65 | 250.72 | 3.09 | 416.46 |
| 01-Aug | HCSW | 3.4 | 277.99 | | 281.39 |
| | Registered | 166.39 | 65.35 | 1.59 | 233.33 |
| 01-Aug Total | | 169.79 | 343.34 | 1.59 | 514.72 |
| Grand Total | | 801.67 | 1335.45 | 13.93 | 2151.05 |

### 9.2.5 Nurse Recruitment -

Newly Qualified Nurses – 147 Newly Qualified Nurses will be joining the Health Board by the end of October 2020 with a further 100 due to qualify and join in March 2021.

Overseas Nurses – anticipated start dates are outlined in the table below. However, it should be noted that both the newly quailed cohort and overseas cohort of nurses have already been matched against current established vacancies and this has been factored in the overall demand / capacity template.

| Cohort size | Start date (Band 4) | OSCE training (5 weeks) | OSCE exam (week 6) | Band 5 post | Comment |
|---|---|---|---|---|---|
| | 2 week Covid-19 quarantine | | | | |
| 6 | Mar-20 | 14/09/2020 | 09/10/2020 | w/c 12/10/20 | March 2020 arrivals currently on temporary NMC register as band 5s due to Covid-19 |
| 9 | 28/09/2020 | 12/10/2020 | w/c 16/11/20 | w/c 23/11/20 | |
| 8 | 16/11/2020 | 30/11/2020 | w/c 11/01/21 | w/c 18/01/21 | |
| 8 | 11/01/2021 | 25/01/2021 | w/c 01/03/21 | w/c 08/03/21 | |

### 9.3 Training Programme

The training cell enables a joined up approach to demand and capacity planning in relation to training across the Health Board and has already scoped the training requirements of a number of key roles and volunteering positions. With regards to the management of Covid-19, the Training Cell has identified that there are four main categories of training:

1. **Refresh** - Refresher training for recently retired clinical staff, and staff in management roles with a clinical background e.g. Infection control – using PPE, infection control procedures, cannulation, caring for patients on a ventilator, etc.
2. **Retrain** - Retraining for clinical staff (including bank staff, medical and nursing students, etc.) to ensure competence to deal with an infectious disease outbreak.
3. **Redeploy** - Training for existing staff and volunteers' employed in technical and support service roles, to support redeployment into service critical roles. This will include training on health and safety, infection control and manual handling.
4. **New** - Training for newly appointed recruitment campaigns including HCSW, switch board, catering, domestics and portering.

There is also additional all Wales training continuing to be scoped and organised by HEIW in partnership with universities and partners which will be fed into the cell. The Cell will work with Subject Matter Experts and Training Leads to ensure any training is fit for purpose and in line with that delivered by the Health Board.

The Health Board has established an accelerated programme of training for HCSW with a capacity of 120 training places per month delivered from the Liberty Stadium. Capacity has been adjusted in accordance with the numbers of new recruits in the pipeline and

is monitored weekly. Based on expected candidate numbers this should be sufficient to support a reasonable number of new starters in bank/FT roles starting in each month. Opportunities to flex up training if required will be explore.

Due to the restrictions around social distancing the Nurse Education team have taken steps to ensure a continuation of skills training and induction for existing and new HB staff. Programmes have been condensed and modified to ensure less face to face contact. Since April 2020 large conference rooms in the Liberty Stadium have been made available to deliver sessions that have required face to face teaching. This has had the added advantage of reducing footfall on acute hospital sites.

The main priorities for Q3 and Q4 will be HCSW clinical induction and upskilling/refresher training for existing registered nurses who may be required to work in alternative roles due to increased pressure on services due to Covid-19. There are three cohorts of overseas nurses to go through Objective Structured Clinical Examination (OSCE) training programme (October, December and February) resulting in an additional 25 band 5 nurses into adult areas where there are most vacancies.

Having already delivered training for 270 peer vaccinators for the HB Flu immunisation programme resource has been identified to manage the training needs for the wider Covid-19 Vaccination programme. This would be in the short term for priority individuals and for a broader requirement delivered in 2021. The outcome of the recently completed consultation into regulation change to allow other health care professionals to be able to deliver vaccines is key to expanding the pool of potential candidates for this role in 2021.

***AHP Training***

There are three different types of training available to Allied Health Professionals:

***AHP Registrant*** – The Band 6, 7 and 8 registered practitioners will undertake professional clinical interventions within their scope of practice as per their professional body guidelines. However, where delegated clinical and care tasks are considered to be outside of the scope of practice, training and instruction will be provided for existing AHPs and those who are returning to practice.

***AHP Upskilling*** – The aim of this training is to upskill existing staff to support nursing colleagues on busy wards and in the community. Due to some practices already being part of their professional duties, some registrants may not require the full AHP core training. The Heads of Service for each profession will be able to identify if and where gaps exist. Upskilling sessions may be required externally e.g. Some Occupational Therapists and Dieticians, require training in identifying the sick patient and checking & recording vital signs. Other training may take place internally, provided by departmental trainers; following clear set competency based training e.g. physiotherapy.

***AHP Health Care Support Worker*** – The aim of this training is to reskill existing staff to undertake Health Care Support Worker roles within acute clinical settings.

Specific AHP staff groups:

**Physiotherapists**

- 20 physiotherapists attended the CPAP/NIV training provided by Critical Care nurses – Morriston Hospital
- Approx. 65 Physiotherapy staff attended Day 3 of the critical care training at Swansea University
- Approx. 40 non-ward based physiotherapy staff went through manual handling updates for ward related manual handling – deliver by the in house manual handling trainer.
- Approx. 40 non-ward based physiotherapy staff went through the competencies below with physiotherapy ward based staff
- Approx. 20 staff attended the HCSW training provided by Swansea University
- Staff on all 3 sites (approx. 120) viewed a presentation by the Critical Care physiotherapist regarding the Covid-19 disease process and what the expectations of physiotherapy would be
- All of the critical care team and respiratory on call teams (approx. 55) attended training on the 'proning of ITU patients' which was delivered by the critical care physiotherapy lead and their senior team
- Several links to various online training provided by Cardiff School of Physiotherapy, CSP and Government have been circulated to all staff. (approx. 240)
- An online webinar provided by the national respiratory physiotherapy group was accessed by approx. 30 staff
- Staff have completed the ESR modules on Covid-19
- 'Physiotherapy rehab guidance for Covid-19 patients' was collated by the clinical leads and sent to all physiotherapy staff (Approx. 240)

The following training has been coordinated and delivered during wave 1 of Covid-19:

| **Staff Group** | **Training** |
|---|---|
| Years 1 – 3 medical students | • Manual Handling |
| Year 4 medical students | • PPE training<br>• Death and Dying training<br>• Radiology Information – How to access systems |
| HCSW | • Clinical Induction 5 day Programme |
| Mental Health Nurses (Dual qualified RMN/RGN) | • Refresher Course in Physical Health |
| Morriston Service Unit | • 3 day HCSW Course |

| | |
|---|---|
| Non-Critical Care Staff | • Non-Critical Care Staff working in Critical Care |
| AHP upskilling | • 0.5 day course including:<br>  ○ Identifying the sick patient<br>  ○ Checking & recording vital signs<br>  ○ NEWS charts |
| AHP reskilling (HCSW training) | • 1 day course<br>• Following feedback, it is anticipated that further training will be required for this cohort |
| Emergency Mortuary Volunteers | • Department induction<br>• H&S Induction<br>• Manual handling training<br>• HTARI incident awareness<br>• Stacker truck training<br>• Specific emergency mortuary competencies |
| Fire service volunteer mortuary drivers | • Site induction<br>• H&S Induction<br>• Manual handling training<br>• Surge and super surge site familiarity<br>• HTARI incident awareness<br>• LA van use and awareness |

| **Staff Group** | **Category** | **Training (Classroom)** | **Days** |
|---|---|---|---|
| Domestics | New Staff | COSHH | 2 |
| | | Fire | 0.5 |
| Portering | | Manual Handling | 0.5 |
| HCSW | New Staff | Clinical Induction | 5 |
| | | Manual Handling | 2 |
| | | Fire | 0.5 |
| Med Students (Y1 - Y3) | Upskilling | Clinical Induction | 5 |

| | | | |
|---|---|---|---|
| | | Manual Handling | 2 |
| | | Fire | 0.5 |
| Primary and Community Services staff who normally work in non-essential services | Redeployment into HCSW/HCA role | Recognising the sick patient<br>Taking physiological measurements | 1 |
| | | Manual Handling | 1 |

A Training programme was developed for Support Service Assistants which is a combination of training and is delivered over a 2 day period.

Moving into wave 2 a robust training programme will continue to be developed based on the identified demand and capacity within the Workforce Planning Frameworks and plans.

### 9.3.1 Medical & Dental Education

Lectures and Inductions are being delivered virtually for both Postgraduate and Undergraduate teaching. Clinical Skills and Simulation continue to be delivered face to face with restricted numbers. The Health Board has provided facilities in Morriston and Singleton Education Centres for onsite consultants to deliver teaching as Swansea University Campus is not accessible. Agreement remains between the Health Board and Swansea University for the Bay Hospital to host Swansea University OSCE exams for this academic year. Clinical Placements have restarted requiring the Medical Students to undergo risk assessments before attending placements. Scrubs are also being provided to Students.

Dental Foundation and Section 2 teaching is being delivered virtually until December 2020. This is planned to be reviewed by HEIW early 2021. Dental Core training is currently a combination of virtual and face to face teaching with restricted numbers. This will again be reviewed by HEIW early 2021.

Postgraduate and Undergraduate Teams are in regular contact with HEIW and Swansea University and review processes as rules and regulations change.

The Medical Education Team are risk assessing the use of the Clinical Skills Labs on Morriston and Singleton Sites in partnership with the university and Health and Safety Colleagues.

Key Actions for Q3&4:

- Extend/expand Occupational Health and Wellbeing services to support staff health & wellbeing (October)

- Early intervention/prevention to support staff in critical areas with TRiM training (trauma identification and management model) (Ongoing)
- Recruitment of Overseas Nurses (Ongoing)
- Recruitment of newly qualified nurses (October & March 21)
- Additional recruitment to Nurse, HCSW, Facilities and A&C bank (October through March 21)
- Recommence Covid-19 Training Cell and Training Group (October)
- New Registrant induction programme (November)
- Increase in HCSW induction programme to provide 120 places per month (October through December)
- Requirement to re skill some of the workforce in readiness for redeployment (October through December)

The detailed Action Template is at Appendix 18.

## 10 Value Based Healthcare

Value Based Healthcare (VBHc) methodology will support demand management and clinical prioritisation via patient empowerment and self-management. A Patient-reported Outcomes Measure (PROM) is a Digital Health Assessment, which is a measure of the patient's perception of their treatment, symptoms and general Quality of Life. Systematic collection of PROMs with the use of technology will increase the throughput. Covid-19 recovery is all about equity and outcomes and the Health Board has to maintain everybody's outcomes with the finite resources available. VBHc methodology will also help in identifying technical, allocative and population health benefits as evidenced with the Heart Failure Service re-design approach. Similar benefits are anticipated for other prioritised specialities as identified within the VBHc action plan.

The following areas describe the focus of actions from VBHc programme in Q3&4 to reduce harm from reduction in non- Covid-19 activity:

- **Outpatient Transformation**- VBHc methodology using asynchronous Digital communication (Store and Forward techniques and PROM's) will enable capacity to be used more effectively.
- **Implementing the Quick Question Triage Tool** to check the severity of patient's symptoms on holding waiting list, and to understand how much a patient has deteriorated or improved. Those very urgent or urgent will be prioritised and seen quicker. The process involves validating of the waiting lists- as an example 400 patients in Rheumatology were sent the quick question- 64% patients responded within three hours and 11 patients were removed off the waiting list. The plan is to roll this out to all OP priority specialities areas by December 2020.
- **Developing sustainable service models that align with outcomes that matter to patients**- The Heart Failure redesign project is an excellent example where approximately 201 appointments, 408 echocardiograms, 282 acute admissions and 5816 bed days have the potential to be reduced and 81 deaths prevented. The PROMs data collected pre-March 2020 and post March 2020 (since service was reconfigured) also shows a positive impact on all the indicators of patient's wellbeing including Quality of life and social limitation. The VBHc programme will build on the HF project and roll out in other Chronic conditions
- **Implementing PROMs** in Lymphoedema which is a National VBHc project, Rheumatology, Heart Failure and IBD in Q3&4- All these are anticipated to have significant efficiency and patient outcome benefits.
- **Developing a toolkit for VBHc** to empower and enable colleagues to understand and implement VBHc methodology.
- **Develop visualisation** of PROMS and increase PROMS collection above by **50%** above baseline figure

Key Actions for Q3&4:

- Scope out use of Patient Knows Best (PKB) for IBD, Dermatology to share blood tests, imaging and PROMs via Patient Portal (December)
- Use of new digital platform to utilise Quick Question tool (waiting list validation) (January 21)
- Collect PROMs in new Heart Failure Pathway (November)
- Heart Failure service redesign & Business Case (December)
- Develop visualisation of PROMs and increase PROMs collection above 50% above baseline figure (December)
- Toolkit for triage /PROM's/TDABC (December)

The detailed Action Template is at Appendix 19

## 11 Finance

The Health Board financial plan builds from the previously reported forecast of £96.180m, which included the re-purposing of baseline allocations, where service models and plans have been impacted by the pandemic. The forecast has been refined to reflect the latest demand modelling, service capacity and workforce plans and availability. The forecast reflects the Welsh Government confirmed allocation of £48.2m and assumes funding in respect of national allocations including:

- Test, Trace, Protect
- PPE
- Set up, de-commissioning and consequential losses of approve Field Hospital developments
- Funding for the extension of the flu vaccination programme
- Independent sector provision
- Funding for NHS and jointly commissioned packages of care for the first 6 months of the financial year.
- The transformation of urgent and emergency care.

The forecast does not include the cost for the delivery of the Covid-19 vaccination programme as the delivery models and timescales are still being developed. The Health Board is anticipating that this is programme is fully funded. The forecast year end revenue outturn position is a deficit of £26.4m which includes revisions for adjusted expenditure assumptions based on the refinement of the plans through the integrated planning process, known funding and assumptions around funding through national funding streams where costs are already included in the Health Board's base plan.

| Financial Forecast | |
|---|---|

| | £m |
|---|---|
| Year end forecast deficit/(surplus) | **96.18** |
| | |
| **Expenditure adjustments** | |
| Field Hospital Planning Assumptions | **(13.88)** |
| Additional Surge Capacity cost estimates | **2.01** |
| PPE increased requirements | **1.67** |
| LAC financial pressure | **1.20** |
| Additional Digital requirements | **0.54** |
| essential Services Support | **1.85** |
| Extended Flu Campaign | **1.99** |
| Winter Priorities | **3.88** |
| Revised Year end forecast deficit/(surplus) | **95.44** |
| | |
| **Funding assumptions (costs already in plan)** | |
| Funding Allocation as per Operating Framework | **(48.20)** |
| PPE | **(8.25)** |
| Field Hospital - Decommissioning | **(2.91)** |
| Field Hospital - consequential losses | **(0.46)** |
| Testing | **(2.51)** |
| Extended Flu Campaign | **(1.99)** |
| Winter Priorities | **(3.89)** |
| Independent Sector | **(0.80)** |
| **Year end forecast deficit/(surplus)** | **26.43** |

The forecast reflects the assumptions supporting the integrated planned service model; however given the potential impact of local and national mitigations and localised outbreaks, further changes to service delivery and workforce availability may be seen. As the plan has been refined through this process the Health Board has significantly reduced the level of potential variability in the financial forecast.

Whilst the forecast reflects the Health Board's financial assessment based on the planned service modelling, there are a number of risks and opportunities:

- HCSW banding – the Health Board is in negotiation with staff side regarding the potential re-banding of this staff group. If the claim is successful it is likely to increase costs by £0.3m.
- Final pension charge costs – the Health Board has initially assessed this risk as £1m based on the costs incurred during 2019/20. It is inevitable that invoices will continue to be received for these costs. It is extremely difficult to assess the scale of the impact for the year, however the Health Board is aware of some employees who may have triggered this on retirement.
- NICE and high cost drugs – the impact of changes in service provision on NICE and high cost drugs are being closely monitored along with the implementation of new technologies. The expenditure remains very volatile and impacted by service provision.
- Essential Services – the Q3/4 plan has reflected the key additional capacity to support Essential services including some use of external capacity. As service demands increase, there may be further requirements identified and supported to minimise patient harm.
- Additional Capacity – the Q3/4 plan has been developed around demand and capacity modelling. The operational plan and financial forecast reflects the requirement for surge and super surge capacity to be deployed, the workforce required to support this and the implications on services and risk profiles to ensure workforce availability. There is a potential for further costs should workforce availability assumptions change.
- Funding Assumptions – the forecast recognises the funding allocation noted in the Operating Framework and also assumes funding from National allocations. If these are not fully agreed then the forecast position would be adversely impacted.
- LTA arrangements – the forecast assumes that the LTA block arrangements in place during 2020/21 remain in place for the remainder of the financial year.
- Primary Care Prescribing Price Concessions – the forecast has included an increased level of price concessions based on Quarter 1 data. This is an area of volatility and if price concessions reduce then the forecast will also reduce.
- Further Savings Delivery – the Health Board has reinvigorated its focus on savings delivery opportunities, particularly those focussed on service efficiency to support the reset and recovery of services to the most efficient new norm. However, as the Health Board move into the challenging winter period, the ability to focus and drive efficiency opportunities is likely to reduce.
- Demand requirements – if the actual demand does not reach the modelled levels, then some elements of surge and super surge capacity may not need to be deployed.
- Slippage on planned expenditure – the forecast already includes the assessed slippage on planned investments, however there is a potential for further slippage against planned expenditure, including directed and ring-fenced funding.
- Decommissioning costs – the forecast includes decommissioning costs of both the field hospital and internal surge capacity, however it is as yet unclear whether the decommissioning will take place in 2020/21. The field hospital is assumed funded and therefore not included as an opportunity, the internal surge has however been included as an opportunity.

The Health Board has in place clear governance arrangements to review and scrutinise changes to service plans and proposals including investment and disinvestment, this will support the management of service delivery within workforce and financial constraints. The detail of the savings plan is being revisited across the Health Board, reflecting on the learning from the KPMG reports to test where best to focus the savings efforts in light of the current care delivery context.

The recurrent impact of the changes made as a result of the pandemic are being reviewed and assessed to ensure that impacts are fully understood and to ensure that service efficiencies are maximised with changes in service models.

Key Actions for Q3&4:

- Develop and further refine the financial forecast to ensure alignment with service and workforce models and constraints (October)
- Ensure assumptions around national funding are clearly described (October)
- Align and prioritise service response to within the Health Board funding envelope, including assessment of national allocations (October)
- Ensure focus on efficiency measures to maximise core funding allocations and ensure benefits from rapid service changes are maximised and opportunities identified through recent reviews are not overlooked (November)
- Ensure clear and consistent mechanism in place for managing investments and disinvestments (October)
- Assess any recurrent impact of decisions made/service model changes during the pandemic (November)
- Ensure core financial controls remain “fit for purpose” are reflective of the KPMG findings and support the core business assurance framework of the Health Board (October through March 21)

The detailed Action Template is at Appendix 20.

## 12.0 Capital Programme

### 12.1 Covid-19 Bed Capacity & Equipping

Following the completion of additional Covid-19 super surge capacity in the Llandarcy and Bay Studio Field Hospitals and additional critical care capacity in Morriston, funding allocations of £33.1m from the original estimate of £37.6m have been received. Work to agree the final accounts on all three projects will be completed in October. Following the decision to decommission Llandarcy, the scope of reinstatement works, and costs is being finalised, with completion of the works expected late October. Additional work is required to facilitate the provision of oxygen supplies in the Bay Studios, which should be within the original cost envelope. In addition to the £37.6m, the financial plan assumes estimated costs of £4m for decommissioning of the three sites.

Urgent estates work is being undertaken with Public Health Wales in the Morriston Pathology department during October to facilitate the creation of a hot lab for Covid-19 testing.

Work is underway to design the installation of a mobile 5 bed Emergency Department at Morriston Hospital to receive patients from Ambulance drop-off or alternatively as a red zone for Covid-19 patients. The Health Board is also designing proposals to create a new outpatient waiting area in the Multi-storey Car Park at Moriston Hospital, to act as a holding area.

### 12.2 Maintain a Balance Capital Finance Plan

As the national capital funding position remains challenging, work will continue to deliver the revised capital plan which was agreed in July 2020 by the Health Board and Welsh Government Capital & Estates team. To enable design works to continue on the replacement Cladding at Singleton Hospital and undertake the works and equipment delivery for the replacement CT-SIM at the West Wales Cancer Centre, this negated a substantial reduction of £1.4m on planned spend in the replacement programmes for equipment and estates. Ongoing reviews are being undertaken by the Capital Prioritisation Group, to ensure appropriate risk assessment can be undertaken and decision making around these areas, as the level of essential services increases.

### 12.3 All Wales Capital Programme

Alongside decisions taken by the Board to reallocate funding within the original capital plan as described above, work continues to deliver business cases in priority areas. These are summarised in the key actions table below. The key priorities which involve the submission of business cases in Q3 are:

- Replacement of the cladding at Singleton Hospital. Business case due for submission in October.
- Refurbishment of main ITU, Morriston. Design is nearing completion and following a tender exercise, the cost forms will be submitted in Q3

- Refurbishment of Ward G, Morriston. Design is complete and following a tender exercise, cost forms will be submitted in Q3.

The detailed Action Template is at Appendix 21.

## 13.0 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.

In October 2020 there are 16 high risks and the Health Board is managing these action through agreed action plans to mitigate the risk during this challenging period as set out in Appendix 22. The Board received the Health Board Risk Register in April and August 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.

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. There are three high risks on this risk register as set out in table 2. 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”.

**Covid-19 High Risks**

The Health Board has recognised the Covid-19 pandemic as an issue and therefore a separate risk register has been created to mitigate and manage these risks. There are four high risks on the Covid-19 risk register which are detailed within the appendix together with the mitigating actions the Health Board is taking.

## 14.0 Communications and Engagement

Throughout Q3&4, the Health Board will continue to work with the regional communications cell – which includes Swansea Bay University Health Board, Swansea Council and Neath Port Talbot Council leads – to promote key messages around essential services, TTP, and broader Covid-19 issues in support of Q3&4 and future operational plans. These will complement an extensive and ongoing internal Covid-19 comms programme. These joint messages will continue to be sent out broadly via standard channels, and targeted at specific communities and groups using hyperlocal media and social platforms in particular. The Health Board website is also being developed to ensure patients have access to updated information on service availability, as well as general advice on managing conditions where suitable.

The Health Board will review its communications to patients on the waiting lists to ensure that the most accurate information is shared. The section on the Health Board website will also continue to be updated that confirms for patients and their families and carers the status of current services from a general perspective.

Several ongoing campaigns will be enhanced, including those around physical distancing, flu vaccinations and winter pressures to respond to and target key problems as they become apparent, building on the foundations already in place.

In addition, a new external campaign is being developed on the future design of acute medical services and the implementation of the phone first for emergency services strategy. These aim to ensure the public is fully informed and engaged in how unscheduled care services can be delivered and accessed in the future.

During the pandemic the Health Board agreed with the CHC (at its Executive on 17th March 2020) the approach to be collectively taken to Service Change during the pandemic, which was formally confirmed and agreed retrospectively by the Health Board. From March onwards the Health Board and CHC have a joint Risks, Actions, Issues and Decisions (RAID) log which is held in a shared Teams location and which is updated on a live basis by both organisations as issues arise and need resolution. In addition after the CHC Executive was stood down in March, the Chief Officer and Deputy Chief Officer of the CHC have met with Health Board representatives, initially every week, and then every two weeks to review the RAID log and update on key issues / changes. The Health Board's Chair and Chief Executive have also met with the CHC Chief Officer regularly during this time to ensure that engagement between the two organisations has been effective and to address any issues raised. CHC meetings restarted from 30th June and so these are now picking up these issues, and update meetings between the Health Board and the CHC Chief Officer and her Deputy continue between these meetings.

The ongoing engagement mechanisms the Health Board utilises, such as the Stakeholder Reference Group, Accessibility Reference Group, Regional Third Sector Health, Social Care and Wellbeing Forum, Regional Coproduction Network, Regional Carers Partnership were initially paused during the pandemic, but have now restarted and are being used to keep stakeholders, citizens, patients and carers updated on service changes and the Health Board's preparedness. In addition the Health Board has been running a series of fortnightly Focus Groups with patients and carers, particularly representing groups who have been particularly effected by the pandemic including the partially sighted and blind, physically disabled, parent and sibling carers, older people and young people to understand the impacts on them and actions the Health Board can take to assist them and to explain the changes in services which may affect them.

The Engagement and Consultation Framework which was put in place back in 2017 between the Health Board and the CHC has been revised and approved by the Health Board on 25th September, having been coproduced with the CHC along with an accompanying proforma for service change developed and Covid-19 agreement. (Appendix 23 and 24)

In addition, the Health Board has compiled a spreadsheet showing all the service changes undertaken in Swansea Bay over the past 8 months as part of the response to the Covid-19 pandemic, which has been shared with Welsh Government and the CHC. During Q3&4 work will continue with the CHC to agree those service changes which the Health Board wish to continue going forward and those where they will revert back to pre-Covid-19 provision, so that requirements for engagement and consultation on these changes can be agreed.

**Key Actions for Q3&4:**

- Implement revised Engagement and Consultation Framework – start October 2020 onwards
- Review Covid-19 service changes and agree associated engagement and consultation – December 2020
- Continue using ongoing engagement mechanisms to understand issues from the public and to engage with them on service changes proposed – throughout Q3&4