Agenda – Health, Social Care and Sport Committee

Meeting Venue:
Video Conference via Zoom
Meeting date: 2 July 2020
Meeting time: 09.00

For further information contact:
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In accordance with Standing Order 34.19, the Chair has determined that the public are excluded from the Committee's meeting in order to protect public health. This meeting will be broadcast live on www.senedd.tv.

Informal pre-meeting (09.00-09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 COVID-19: Evidence session with BMA Cymru Wales and the Royal College of Surgeons

(09.30-10.45) (Pages 1 – 36)

Richard Johnson, Royal College of Surgeons Director in Wales
Alice Jones, Policy and Public Affairs Manager Wales, Royal College of Surgeons
Dr David Bailey, Chair, BMA Welsh Council
Dr Phil Banfield, Chair, Consultants Committee, BMA Cymru Wales

Research brief
Paper 1 – British Medical Association Cymru
Paper 2 – Royal College of Surgeons

3 Motion under Standing Order 17.42(ix) to resolve to exclude the public from item 4

(10.45)

4 COVID-19: Consideration of evidence

(10.45-11.00)

Break (11.00-11.15)

5 COVID-19: Evidence session with the British Dental Association Wales

(11.15-12.30)

Tom Bysouth, Chair of Welsh General Dental Practice Committee
Lauren Harrhy, Deputy Chair of Welsh General Dental Practice Committee
Dr David Johnson, Chair of the Welsh Committee for Community Dentistry

6 Paper(s) to note

(12.30)

6.1 Paper to the Board meeting of Cwm Taf Morgannwg University Health Board regarding the future of the Emergency Department at the Royal Glamorgan Hospital

(12.30) (Pages 37 - 51)

6.2 Letter from the Prison and Probation Ombudsman regarding end of life care in prisons

(Page 52)

7 Motion under Standing Order 17.42 (ix) to resolve to exclude the public from the remainder of this meeting

(12.30)

8 COVID-19: Consideration of evidence

(12.30-12.45)

Agenda Item 2

Document is Restricted

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Health, Social Care and Sport Committee
Welsh Parliament
Cardiff Bay, Cardiff

By email only

22 May 2020

Inquiry into the impact of the Covid-19 outbreak, and its management, on health and social care in Wales

BMA Cymru Wales response

Introduction

BMA Cymru Wales is pleased to provide a response to the Health, Social Care and Sport Committee's inquiry into the Covid-19 outbreak in Wales.

The British Medical Association (BMA) is an independent professional association and trade union representing doctors and medical students from all branches of medicine all over the UK and supporting them to deliver the highest standards of patient care.

The terms of reference for the inquiry states that it will evaluate the impact of the outbreak, and its management, on health and social care services in Wales. It may be useful to outline BMA Cymru Wales' involvement in several important groups which have helped to coordinate NHS Wales' response. Our presence on these groups, alongside our consistent lobbying and campaigning, allows us to actively push for change on behalf of our members. These have included:

- Regular meetings of the NHS Wales Partnership Forum & Partnership Forum business committee, alongside other trade unions
- Weekly meetings with the Minister for Health & Social Services and health & social care unions
- Welsh Government Workforce Planning Cell (Weekly)

- Welsh Government Primary Care Group alongside RCGP Wales (weekly)
- Technical Briefings on issues such as Testing, PPE and the BAME risk assessment work
- Regular CMO calls with Welsh Council Chair

In terms of our thoughts on the outbreak response, we think it would be helpful to firstly describe issues which we have progressed through partnership working with Welsh Government and NHS Wales, and secondly areas that represent ongoing concerns for the Association.

Issues progressed through Partnership working

Ensuring appropriate terms and conditions for Junior doctors, SAS doctors and Consultants working amended hours

Given the substantial and immediate variance in all secondary care doctors' working patterns, we engaged in discussions with Welsh Government and NHS Employers in order to ensure that appropriate terms and conditions were being followed.

- **For junior doctors,** we agreed a joint understanding document with Welsh Government and NHS employers, confirming that the terms of the 2002 junior doctor contract would be applied to a uniform standard, including protections on break and shift rules, appropriate pay banding of emergency rotas, protections for annual leave, and for Less than Full time (LTFT) trainees. We also have also secured an agreement with regard to accommodation for junior doctors with NHS Employers.
- **For consultants,** we agreed a pay advisory notice, which received Ministerial approval as of 17 April. This recommends temporary pay arrangements for consultants required to work amended hours but makes clear this does not represent any change to current contractual terms. The advisory note remains valid until 30 June.
- **For SAS doctors,** we also agreed a joint statement with Welsh Government, confirming that SAS doctors would receive improved Out of Hours rates for the duration of the COVID period, without amending any other contractual terms and conditions.

Ensuring primary care readiness during COVID-19

In discussion with Welsh Government, to allow GP practices to prepare for the COVID-19 and focus on direct patient care, we agreed to suspend all non-core elements of the General Medical Services. We communicated this to GP members in a letter[1]. Most enhanced services have been suspended with some to continue, with relaxed post-payment verification and payment according to the previous financial year's achievement. Welsh Government confirmed that no practices would be financially penalised for amendments to the contract. We have further agreed regulations to enable

[1] Dr Phil White letter to GP practices (23/03/20)

a degree of financial support to practices that cannot deliver services from their main site due to COVID-19.

Easter Bank Holiday opening of GP practices hours to help OOH and secondary care

In order to ensure support for the wider NHS over the Easter Bank Holiday period, in particular the OOH and 111 systems, we negotiated a Directed Enhanced Service with Welsh Government to allow GP practices to open over the bank holiday Easter weekend and provide an additional layer of support in the community. The initiative was well received amongst hospital colleagues in many parts of the country, and anecdotal reports suggested significant reductions in demand on OOH and 111. The DES may continue for the forthcoming bank holidays, depending on whether Health Boards will choose to commission the agreement.

New ways of working through technology

With our support, online videocall solutions have rapidly been rolled out across Wales, allowing doctors to see patients remotely and reserving face-to-face consultation for those that need it the most. GPs have moved rapidly to utilise these platforms (including AccuRX and Attend Anywhere) and take up is increasing within secondary care. These platforms can also allow video consultation between primary and secondary care clinicians. Remote access software has also been enabled allowing doctors to access their clinical systems outside their usual place of work, a necessary measure considering self-isolation and social distancing guidance.

Appropriate terms and conditions for Medical Students entering the NHS workforce

On a pan-UK basis Medical Students were asked to enter into a variety of NHS roles prior to their graduation as part of the COVID-19 response. Whilst this additional workforce has not been utilised to the extent originally anticipated, in Wales, the position for students looking to enter the workforce is far better following BMA Cymru Wales intervention. Unfortunately, the BMA was not involved in these discussions at the earliest opportunity, hence the problems that arose were not anticipated until our involvement.

We worked with Swansea and Cardiff Universities and Healthcare Education and Improvement Wales (HEIW) to develop appropriate Agenda for Change terms and conditions for Welsh medical students who chose to enter take up the new roles on offer. The measures ensured that students would enjoy all the necessary employment rights, including access to the NHS pension scheme, indemnity, sick pay, adequate working hours and breaks, and a commitment to supervision.

Ongoing concerns

The following areas represent ongoing challenges for our members, which also represent priorities for resolution prior to, or as we enter a phase of continuation of most elective NHS activity.

PPE

We know that PPE is only one of a range of control measures necessary to prevent transmission of COVID-19, with others such as hand hygiene being vitally important as the first line of defence.

Nevertheless, inadequate or insufficient PPE puts doctors, nurses and other healthcare staff, as well as patients, at risk of contracting a potentially fatal infection. During the pandemic period we have received a significant number of concerns from our members regarding both the supply of PPE and the adequacy of stock provided. A survey of our members in Wales[2] conducted in late April revealed that 67% of respondents did not feel fully protected from COVID-19 at work, with 60% having to purchase PPE directly or making use of donated equipment. Concerns in particular related to shortages of long-sleeved gowns, with 27% of respondents experiencing shortages. Respondents reported challenges in receiving fit tests for FFP3 masks necessary for the most intensive procedures (17% saying they had failed or not been tested).

Members also reported confusion in the initial stages of the pandemic regarding the guidance on the types of PPE necessary for different environments and procedures. We were concerned about the deviation from WHO guidance on appropriate PPE in the documentation produced by Welsh Government and other UK administrations. The updated guidance produced by all four UK Chief Medical Officers in early April was helpful in realigning toward WHO recommendations, although we remain concerned about its application across all healthcare environments given the that asymptomatic transmission of COVID-19 has been proven.

Moving forward we must have a sufficient supply of appropriate PPE for health, social care and other essential workers for immediate and ongoing health service needs. We need a guaranteed means of supply and distribution for the future across all essential services, including domestic production within Wales and across the UK, and an agreed system of reciprocal supply between UK nations based on demand.

In recent weeks, we have been reassured by Welsh Government and NHS Wales Shared Services Partnership that there is currently enough PPE stock in Wales to cover demand. Focus must now shift toward ensuring the robustness of supply in light of the resumption of services being considered, which will of course increase demand.

Nevertheless, our survey data demonstrates that the medical profession remains concerned about PPE. We feel that increased transparency about the supply and availability of PPE would go some way toward alleviating these concerns: this could take the form of a regular newsletter from Health Board Chief Executives to their staff as has been done in Cardiff & Vale Health Board.

Face coverings in non-clinical settings

We would welcome a clearer recommendation about the wearing of non-medical face coverings in public places where social distancing cannot be guaranteed, including non-

[2] https://www.bma.org.uk/news-and-opinion/bma-survey-reveals-that-67-of-doctors-in-wales-do-not-feel-fully-protected-from-covid-19-at-work

clinical areas of healthcare settings. We note the Chief Medical Officer's statement[3] that compulsory wearing of face coverings on leaving home is not recommended and appreciate his concerns about the potential impact on supplies of clinical masks (even if the recommendation would not be for clinical-grade face-coverings). His statement rightly recognises that face-coverings of some sort may be useful on public transport where the 2m social distancing recommendation cannot be maintained during the journey.

Maintenance of this appropriate distancing measure would also be difficult to maintain in many healthcare settings across primary and secondary care. Due to the existing design of much of the healthcare estate it would be extremely difficult to appropriately distance from others in many communal areas, corridors and other non-clinical settings. Our members have reported instances where they have been spoken to by management and told to cease the practice of wearing face-coverings in corridor areas. This is despite them wearing face coverings as an infection control measure in these shared spaces due to concerns for their own and colleagues' health.

This problem is likely to become even more acute as services begin to resume and we would strongly urge that further consideration is given to the Welsh Government's position on face-covers in the settings described above.

Testing: healthcare staff and patients

As discussions around methods of leaving lock down continue, rather more cautiously in Wales and the other devolved nations than in England, it is clear that community testing on a large scale must be implemented. The recent decision by Welsh Government to align with the UK-wide community testing portal is welcomed, although we are aware of issues that still need to be addressed with regards to results being added to the Welsh clinical record.

At the same time, as plans are discussed for the resumption of areas of the health service that have been suspended, it is vital that a system of regular and repeated testing is available to healthcare staff to allow them to both return to work after self-isolation, and to provide ongoing assurance to staff and patients. Our members are particularly concerned about the ongoing impact of service suspension on the health of the public, with 37% of respondents to a recent survey of Welsh members stating they felt care for non-COVID patients was significantly worsening. It is imperative that all necessary steps are put in place to ensure the safe continuation of services, with patient and staff testing being at the very centre

The antigen PCR testing approach (based on throat swabs), whilst being an internationally recognised approach for viral detection and highly calibrated in Wales, detects only for the presence of viral infection (as RNA) in the swab sample taken. This attest to the relatively high false negative rate, as the swab may not have acquired enough of the virus. This can be due to either ineffective swabbing technique (a

[3] Chief Medical Officer Written statement 'Face coverings: coronavirus' (https://gov.wales/face-coverings-coronavirus)

concern for home testing) or the fact that the virus expresses itself in different cells over the course of the initial infection period. It is therefore necessary that symptomatic individuals are tested more than once on a regular basis before they return to work from self-isolation. Going forward, we suggest that asymptomatic staff should be regularly tested as the service opens up to provide regular assurance on viral transmission.

The rollout of blood antibody testing (serology test), delivered by a handheld device, helps to detect for antibodies and confirms if someone has previously had the virus. However, the body takes time to develop antibodies post-infection and it is not yet known if the presence of antibodies against COVID-19 provides longer term immunity. Wider antibody testing will provide invaluable knowledge about community transmission and also assist with the development of treatment for COVID-19 positive patients.

Without wishing to comment on the specific issue of target numbers, we would commend Welsh Government on their increased transparency around testing data, now published on a weekly basis, and their regular briefings with trade union colleagues. However, it is apparent from the data and member feedback, that the increased capacity within the testing system is not being used to its fullest extent and there are still clear operational challenges in accessing tests from within health boards and in primary care. The increase in drive-through swabbing centres, community sampling teams, and mobile testing units, will help to alleviate concerns from our members based in rural parts of Wales about the significant travel times needed to access sampling sites. We also understand that more laboratory capacity is being used across Wales, which should begin to eliminate delays in receiving test results that our members have reported to us. The recent alignment with the UK online portal enabling home testing may further help to address these issues.

Finally, we would suggest that a concerted effort is made to explain the testing regime to the general public, as the difference between tests and who is eligible for what is not widely understood. Mixed messages being delivered by the media between Welsh Government and UK Government announcements have no doubt contributed to this, and we would push for as much alignment in testing regimes as possible as not to perpetuate this confusion.

Contact tracing

We welcome the recent publication of Welsh Government's Test Trace Protect strategy, which sets out how two different types of testing will be used in combination with extensive contact tracing measures. However, it is clear that more detail is required, at a rapid pace, due to the scale of the infrastructure, technological rollout and recruitment exercises that need to be put into place to realise this strategy. Development should be guided by public health principles and make best use of the clinical and epidemiological expertise in Wales' public health doctors. Additionally, the rapid operationalisation of the plan would be aided through social partnership work alongside trade unions. Maximising the best use of resources within the Welsh public sector for this purpose is vital, given that it has been estimated that contact tracing

teams would identify between 7,500 and 30,000 new contacts per day and 100,000-400,000 individuals being tracked at any one time.

Risk assessments for staff, including BAME workers

There is emerging evidence of the disproportionate impact that COVID-19 is having on some individuals from Black, Asian and Minority Ethnic (BAME) backgrounds. A report by the Intensive Care National Audit and Research Centre (ICNARC) found more than a third (34%) of people critically ill with coronavirus in English, Welsh, and Northern Irish hospitals were from BAME backgrounds, compared with making up 18% of the UK population.

In response to this disturbing trend, the Welsh Government has undertaken a range of measures to better understand the data to inform measures to protect people from BAME backgrounds in the community and within the healthcare workforce. This includes establishing a subgroup to develop an All-Wales Risk Assessment tool for individuals who are more vulnerable in the workplace, building on existing rapid risk assessment work already underway in Health Boards. This is an area in which the BMA has a keen interest.

There are similar pieces of work being developed across the UK including a forthcoming study by members of the BMA's Medical Academics Sub-Committee[4] which describes a risk stratification tool. We have shared this work with Welsh Government, and are working in social partnership with Welsh Government and other agencies to develop a suitable tool that will help protect a wide sector of our workforce and membership, building on emerging studies and tools that are already in use.

Once the risk assessment is rolled out, we would expect to see it being used consistently in all Health Boards, and the recommendations for mitigating steps routinely followed. We wish to see a firm commitment, from Welsh Government and NHS Wales, that should an individual be redeployed to alternative duties upon completion of the risk assessment, they should not suffer any financial consequences from not being able to perform their usual role (e.g. being removed from on call rotas).

We support Welsh Government's decision to share data with the researchers working on the UK Government's COVID-19 risk factor work. If the review is to have any meaningful impact, it needs to be informed with real-time data. The data must include daily updates on ethnicity, circumstance and all protected characteristics of all patients in hospital as well as levels of illness in the community. However, such data is not recorded, particularly on the occasion of death, in sufficient detail as to allow for the identification meaningful trends.

[4] Strain, D et al '*Risk Stratification for Healthcare workers during the CoViD-19 Pandemic; using demographics, co-morbid disease and clinical domain in order to assign clinical duties* '(https://www.medrxiv.org/content/10.1101/2020.05.05.20091967v1.article-info)

Additionally, we would suggest that workers in 'at risk' groups, such as retirees who offered to return as part of the pandemic response, should be deployed away from front-line care in favour of non-patient facing roles.

Death in Service

Healthcare workers are working in unprecedented times as a result of the current COVID-19 pandemic. They are having to work in extremely difficult circumstances and by doing so they are putting both themselves and their families at increased risk. Unfortunately, at the time of writing a significant number of healthcare professionals have sadly died in the UK as a result of COVID-19. The NHS pensions scheme provides death in service and ill-health retirement benefits, which helps provide long term support to the deceased individual's dependents. To be eligible to receive these benefits, you must be an active member of the NHS pension scheme, with over 2 years membership of the scheme and not currently in receipt of pensions. Therefore, a significant number of doctors are excluded having either: deferred their pension, primarily working as a GP locum, returned after retirement, or being new to the scheme.

Welsh Government's announcement of £60,000 of financial support to an eligibly beneficiary of frontline staff working in NHS and Social Care should they die in service as a result of COVID-19 mirrors the UK Government scheme. However, we still consider that this falls short – the two-year qualifying rule should be waived as not to disadvantage the families of newly qualified doctors. We believe that families of all NHS staff, regardless of whether they are in the scheme or not and including people returning to service, should receive full Death-in-service benefits as well as the £60,000 lump-sum. We await further information on the detail of the DiS scheme for Wales.

Summary and recommendations

We hope the information provided above gives an indication of BMA Cymru Wales' views on the handling of the COVID-19 pandemic in Wales thus far.

Working in social partnership with 16 other trade unions and professional associations, we have developed a high-level blueprint for the return of NHS services across the UK[5]. Broadly, this calls upon all UK Governments and employers to:

- Guarantee sufficient and suitable PPE for all staff
- Ensure proper risk assessments are carried out for all staff
- Enable access to testing with rapid return of results
- Extend pay arrangements to ensure staff are properly compensated, including appropriate application of overtime
- Provide wellbeing support to all staff, whilst maximising opportunities for achieving work life balance through reviewing shift patterns, encouraging breaks and annual late, and also enhancing access to childcare.

[5] NHS Trade Unions' *Blueprint for Return* (May 2020). Available at www.unison.org.uk/content/uploads/2020/05/26086.pdf

- Make use of the additional capacity from new and returned staff to ensure safe staffing levels
- Give a firm statement that the contribution of all NHS staff will be reflected in future pay discussions.

Finally, it may be useful to outline the steps we recommend are put in place as the Welsh Government considers a gradual easing of lockdown and resumption of routine services in Wales:

1. **Guarantee supply of sufficient and appropriate PPE as services resume**
   - We must have a sufficient supply of appropriate PPE for health, social care and other essential workers for immediate and ongoing health service needs.
   - We need a guaranteed means of supply and distribution for the future across all essential services, including domestic production.

2. **Prioritise the ongoing needs of NHS and social care, public health staff, key workers and their dependents.**
   - It is vital that schools remain open and adequate childcare provision and care needs for vulnerable dependents are in place for key workers, including NHS staff.
   - Support should be offered for the direct and indirect impacts of COVID-19 on NHS and social care staff, including physical, mental and social health and wellbeing impacts.

3. **There must be a widescale, accurate and systematic approach to test, track, isolate and follow up with people with Covid-19 symptoms or those who have come into contact with people with symptoms.**
   - Public health expertise should be used to devise the test, track, isolate and follow-up strategies which will most effectively and efficiently help to identify and control new cases or outbreaks.
   - All Governments across the UK must assess the current capacity and urgently seek to expand, reinforce and supplement any deficiencies, with adequate funding provided to deliver this programme.

4. **Use additional resources, innovative new care pathways and new uses of technology to gradually restart routine care and address pre-COVID-19 capacity issues.**
   - Ensure the protection of staff workloads and wellbeing, including through appropriate rest and recuperation, as well as ensuring vital PPE supplies are not depleted.
   - Utilise additional workforce capacity created in response to Covid-19, to ensure that staff working during the pandemic do not become excessively fatigued and have their wellbeing prioritised.
   - Build on new uses of technology and other beneficial efficiencies of working adopted during the outbreak

- Ensure local public health input into decisions regarding priorities for the resumption of routine care.

5. **Ensure that NHS Wales can flex back to a Covid-19 footing if there is a 'second wave' or local outbreaks of the pandemic.**
   - There must be appropriate capacity and planning to support NHS Wales, community and social care to respond to further outbreaks if they occur.

6. **Take mitigating actions to prevent people from contracting and spreading the virus while carrying out essential duties.**
   - Employees should only be encouraged to return to their place of work once their employer can provide a Covid-free workplace that they will be able to do so safely and to work in a manner consistent with social distancing guidelines
   - Further consideration of Welsh Government's stance on wearing facial coverings where social distancing cannot be maintained, including public transport and communal areas of healthcare settings.

7. **Support the public in adhering to social distancing measures as restrictions are relaxed**
   - There must be clear guidance on social distancing in all other relevant public spaces, including for exercise, as any restrictions are relaxed in line with the Welsh Government strategy.

8. **Appropriate restrictions on all arrivals into the UK by quarantining for two weeks.**
   - A list of exemptions for any restrictions should be set out by Government, for example, those travelling within the common travel area.
   - Exemptions should allow for key personnel involved in the import and export of materials, for example, food and PPE.

9. **Clear guidance and continued provision of shielding and the recommendation of strict social distancing of at-risk groups and demographics, including within the workplace**
   - Maintaining continued provision of shielding for high-risk groups with improved protection and support offered.
   - Consistent implementation of the All-Wales risk assessment tool within NHS Wales in order to protect the most 'at risk' staff, and consider further development for application to other sectors.
   - Recommending continued strict social distancing for those at higher risk, including guidance for BAME communities.

Written submission to the Health and Social Care and Sport Committee Inquiry into the Covid-19 outbreak on health and social care in Wales

Introduction and executive summary

1. The Royal College of Surgeons of England is a professional membership organisation and registered charity, which exists to advance patient care. We support nearly 700 members in Wales and 25,000 members in the UK and internationally by improving their skills and knowledge, facilitating research and developing policy and guidance.

2. Throughout the course of the COVID-19 pandemic, we have been determined in our efforts to ensure that surgeons and surgical teams are supported in delivering vital patient care and are not exposed to unnecessary risk.

3. With this in mind, we welcome the opportunity to provide evidence to the Health and Social Care and Sport Committee's inquiry into the Covid-19 outbreak on health and social care in Wales. The key points made in this submission are set out below:

    - A significant elective surgery backlog existed in Wales prior to the COVID-19 pandemic. This will only have increased, due to the necessary postponement of elective surgery. The latest waiting time statistics[1] reflect waiting times in January 2020, before COVID-19. These report a total of 462,358 people waiting to start treatment in Wales, with 76,862 waiting more than 26 weeks. These figures include a wide range of surgery essential to people's mobility, quality of life and ability to work - from hip and knee replacements, to heart and brain operations deemed not to be 'urgent'.

    - The statutory target is for 95 per cent of patients to wait less than 26 weeks and no patients should wait longer than 36 weeks for treatment. This is an ongoing matter of concern. Waiting lists will have increased substantially over the course of the pandemic, due to extensive postponement of elective surgery.

    - While postponing much elective surgery to re-direct resource at COVID-19 has been necessary and something we have supported, the NHS in Wales cannot continue to act solely as a 'COVID service.' Many patients require surgery in a timely fashion if they are not to suffer from worsening symptoms, deterioration in their condition, greater

[1] StatsWales, RTT waiting time statistics: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Referral-to-Treatment/patientpathwayswaitingtostarttreatment-by-month-groupedweeks

disability and (in some cases) a significant risk of death. The delays to surgery already will have resulted in an increased need for complex surgery, as some conditions become more complex to treat if not addressed promptly.

- A recent survey of surgeons in Wales found continued concern around the supply and adequacy of PPE. The survey of over 160 surgeons and surgical trainees in Wales found that over a third of respondents did not have an adequate supply of PPE in their health board. Furthermore, 56.7% of respondents agreed that there had been shortages of PPE within their Health Board in the past 30 days[2]. Before resuming surgical services, hospitals should be satisfied they have adequate PPE and surgical supplies appropriate to the number and type of procedures performed, and clear policies on how and when to use them.

- An expansion of the workforce will be necessary to help recover surgical services and cover the expected reduced productivity from infection control procedures. We strongly recommend that surgeons, nurses and other healthcare workers who have returned to work should be retained to help manage the backlog of work. However, we cannot rely on these individuals alone. Many will have returned solely to help with the immediate crisis, and may not have performed elective operations for a number of years. To rely on them to address the backlog is unrealistic. We need to keep on those who are willing and able to stay, but also expand the surgical workforce as a whole, bolster training and making better use of the range of professionals that form a surgical team.

- It is now imperative that progress is made at pace to establish COVID-19 light sites across Wales so that patients requiring cancer, urgent and planned surgery can be treated safely. It is essential that these COVID-19 light sites are planned strategically and collaboratively across Health Board boundaries to ensure a consistent, transparent approach and equity of access for patients in Wales. The sites need to work alongside a significantly enhanced testing strategy including regular testing for asymptomatic front-line staff and patients.

- To enhance surgical capacity, extending the use of capacity in the independent sector and in field hospitals should be considered, along with scheduling modifications to increase hospital capacity, including extending hours of elective surgery and operating at weekends.

A backlog of demand

4. Since the beginning of the emergency response to the pandemic, a significant number of elective procedures have been cancelled as part of efforts to free up critical care beds across Wales.

5. We supported this measure and, to ensure that urgent surgery continued, we led on production of guidance[3] to support Health Boards across the country with surgical prioritisation during the pandemic. This classifies patients requiring surgery during the COVID-19 crisis into the following groups:
    - Priority level 1a: Emergency - operation needed within 24 hours
    - Priority level 1b: Urgent - operation needed with 72 hours
    - Priority level 2: Surgery that can be deferred for up to 4 weeks
    - Priority level 3: Surgery that can be delayed for up to 3 months

[2] https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/ppe-findings-from-wales/
[3] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf

- Priority level 4: Surgery that can be delayed for more than 3 months

6. As of 5th May 2020, evidence continues to suggest that the UK has passed the peak of COVID-19 deaths and infections.[4] Although COVID-19 will be around for the foreseeable future, this is encouraging news and indicates that elective surgical services can begin to recover in areas where everything is in place for it safely to recommence.

Measures to address a backlog of demand during and after COVID-19

7. We and the surgical community are under no illusions about the task of recovering surgical services and recommencing elective operations. It will require an enormous effort from a workforce already affected by illness and fatigue, along with continued vigilance to avoid a second wave of the virus.

8. To address the backlog of demand in the system and support surgeons as they prepare to re-open services including elective care, we have developed guidance[5] on the recovery of surgical services. This includes a list of principles, recommendations and key considerations in order to facilitate elective surgery during and after COVID-19. These can be used in combination with national, specialty and local Health Board recovery plans.

9. We believe that the Welsh Government should introduce and support the following key measures in order to effectively recover surgical services and address the backlog of elective surgical procedures:

Personal Protective Equipment (PPE) and testing

10. Before resuming surgical services, hospitals should be satisfied they have adequate PPE and surgical supplies appropriate to the number and type of procedures performed, and clear policies on how and when to use them. This is a vital step, as our recent survey of over 160 surgeons in Wales found widespread concern around the supply and adequacy of PPE. The survey found that:
    - 34.5% of respondents did not have an adequate supply of PPE in their health board.
    - 56.7% of respondents agreed that there had been shortages of PPE within their Health Board in the past 30 days[6].

11. With regard to testing, hospitals should be aware of their diagnostic testing availability and develop clear policies for addressing testing requirements and frequency for staff and patients. We believe that testing capacity in Wales should be dramatically increased and, as in England, should extended to include asymptomatic staff.

Enhancing workforce capacity

12. An expansion of the workforce will be necessary to help recover surgical services. We cannot rely solely on recently retired staff to address the backlog. It will also be important to be prepared for an unstable workforce related to fatigue, illness or social issues.

13. We recommend those surgeons, nurses and other healthcare workers who have returned to work should be retained for the time period necessary to manage the backlog of work, if they are willing and able to stay on. Experienced retired surgeons in particular can also support in

[4] https://www.gov.uk/government/publications/slides-and-datasets-to-accompany-coronavirus-press-conference-28-april-2020
[5] https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/
[6] https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/ppe-findings-from-wales/

key non-patient facing roles such as collecting and quality assuring local data, and monitoring adequate levels of facilities and equipment.

Services to support surgery

14. Steps should be taken to ensure that essential perioperative services (e.g. diagnostic imaging, anaesthesia, critical care, pathology, sterile processing) are also ready to commence operations before resuming elective surgery. Where these are not ready, hospitals may need to consider engaging with external partners, including the independent sector, for temporary support.

Local co-ordination

15. Before the resumption of surgical services, local governance teams should be put together to coordinate the recovery and provide transparent and flexible oversight. The team should have clinical input and be multidisciplinary and multi-professional, with daily meetings to deal with rapidly evolving local and national issues. The local teams should undertake the oversight and clarification of policies and guidance, make real-time governance decisions, manage the whole care pathway, communicate key messages to staff and patients, and liaise with other hospitals and related specialties as needed. Consideration must be given to the prevalence of COVID in the community that patients will return to for their rehabilitation, and availability of supportive community and primary care services to support recovery. If patients are set to be discharged into a setting where there is a high prevalence of COVID in the early post-operative phase, it should be considered, on the balance of risks, whether surgery is appropriate.

Capacity and COVID-19 light sites

16. The recovery of elective surgery depends on local capacity and availability of clinical and other services necessary for the delivery of surgery. Scheduling modifications may be required to increase hospital capacity. Extending hours of elective surgery later into the evening and operating on the weekends should be considered.

17. As part of plans to re-direct resource towards tackling COVID-19, we have supported postponing elective surgery in Wales. While managing coronavirus has rightly been our focus, as we move to the next phase of the outbreak, it is vital that we help those people who have had their surgery delayed.

    It is now imperative that progress is made at pace to establish COVID-19 light sites across Wales so that patients requiring cancer, urgent and planned surgery can be treated safely. As no site can be considered completely COVID free, by this we mean a site where only patients and staff have self-isolated and been tested negative for COVID-19.

18. It is essential that these COVID-19 light sites are planned strategically and collaboratively across Health Board boundaries to ensure a consistent, transparent approach and equity of access for patients in Wales. The sites need to work alongside a significantly enhanced testing strategy including regular testing for asymptomatic front-line staff and patients.

19. To enhance surgical capacity, extending the use of capacity in the independent sector and in field hospitals should be considered, along with scheduling modifications to increase hospital capacity, including extending hours of elective surgery and operating at weekends.

Virtual services

20. A wider use of virtual clinics as well as virtual patient reviews and consultations should be encouraged as the default option. Integrated system facilities ensure tracking and record keeping, but mobile devices and videoconferencing can also be used as back up. Back up options and administrative support should also be on hand in the early stages of implementation.

Recording deferred cases

21. It is essential that hospitals keep a clear record of all surgery that is being deferred and the criteria used to do so, and regularly review this, so that there is an accurate estimate of deferred surgery and current waiting lists. Numbers of patients should include those who are waiting for elective surgery; on stalled care pathways; and new patients.

22. Patient population data should also be taken into account to assess population needs and potentially larger local community backlogs against available capacity.

Providing healthcare equitably, and for vulnerable groups who are shielding

23. As services recommence, a key consideration will be how to direct resource towards those with the greatest needs, in line with our surgical prioritisation outlined above. The challenge is that, depending on the structure and organisation of local resources, it can be difficult to perform complex but much-needed surgery in some areas, and easier to perform simpler but less vital procedures. A further consideration is how to provide services safely for vulnerable groups who are shielding.

ENDS

AGENDA ITEM
4.1

CTM BOARD

FUTURE OF EMERGENCY DEPARTMENT AT THE ROYAL GLAMORGAN HOSPITAL

Date of meeting	29/06/2020
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Dickinson, Programme Director
Presented by	Dr Nick Lyons, Executive Medical Director (SRO)
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
This specific paper has not been considered by any other committee or group.	N/A	N/A

ACRONYMS	
CHC	Community Health Council
CRG	Clinical Reference Group
ED	Emergency Department
EM	Emergency Medicine
GP	General Practitioner/General Practice

ILG	Integrated Locality Group
MIU	Minor Injuries Unit
PCH	Prince Charles Hospital
POWH	Princess of Wales Hospital
RGH	Royal Glamorgan Hospital
SWP	South Wales Programme

1. SITUATION AND BACKGROUND

In November 2019, the Health Board, building on existing work, formalised a project to develop proposals to ensure a safe, sustainable and effective solution for the provision of emergency medicine (EM) at the Royal Glamorgan Hospital (RGH). This was in the context of significant and long-standing safety concerns and incidents. These related to a high dependency on agency medical staffing due to a shortage of substantive consultant and middle grade doctors within the emergency department (ED) on that site.

The project was also established in the context of earlier recommendations from the South Wales Programme (SWP), which set out the future configuration of EM and other defined acute services within the region, some of which had not been fully implemented within the Health Board.

The Board has subsequently received and considered reports from this project during 2020:

- January: The Board agreed that two options should be prioritised for further development and assessed within the project structure. The Board also tasked the project with continuing to test the viability of retaining a 24/7 consultant led emergency department at RGH, including through enhanced efforts to recruit medical staff.

- February: The Board received a report on progress. The report included a summary of the programme of public, staff and stakeholder engagement that had been conducted in relation to the project, with the support of the Community Health Council (CHC), together with a summary of the key messages received from staff, the public and their elected representatives. The summary reflected the many significant challenges that had been raised in relation to the two options under development within the project and demonstrated the overwhelming strength of local feeling in favour of retaining 24/7 consultant led ED services at three sites within the Health Board, including RGH. The Board listened carefully to the issues raised by the community.

- March: The Board received a report confirming that Clinical Reference Groups (CRGs), made up of clinicians from a variety of disciplines and professions, had made significant progress in developing the detail of the models of care that were required to support the two options, as well as the existing 24/7 service. In view of the need to focus attention on the response to COVID-19, the Board approved a pause to the project, with work continuing on some aspects of the work should capacity allow. Work on medical staff recruitment continued.

- May: The Board received a report on progress that had been made in maintaining the delivery of 24/7 ED services at RGH including the appointment of a full-time consultant as clinical lead for the department. The Board agreed that work on the project should recommence, including work to further consolidate and build on the current recruitment drive, "leaving no stone unturned in enabling delivery of a 24/7 Emergency Department". The Board agreed that a firm recommendation on future service development should be brought to the Board in June 2020.

Since its inception, the focus of the project has been to ensure the delivery of safe and sustainable ED and related services for the Health Board's population. There is clearly substantial public support for maintaining 24/7 consultant led ED services at RGH, but the primary barrier to this has been ensuring patient safety with limited substantive medical staffing and issues stemming from this.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Progress with ensuring the safe delivery of a 24/7 consultant led Emergency Department at RGH

The newly established Rhondda & Taf Ely Integrated Locality Group (ILG), combined with the new medical leadership within the RGH ED, have already had a significant positive impact. There has been a renewed focus on the development of effective multidisciplinary working in the department and supporting teams.

There has also been significant early progress in recruiting further medical staff to the RGH ED. This has, in turn, already had a significant positive impact on the culture within the team.

A renewed focus on governance, joint working with other specialty teams and the ongoing development of a new workforce model is allowing the ED to move into a more sustainable position. There is significant further work to be done, but the direction of travel is highly encouraging.

These developments have enabled considerable progress to be made in addressing historical and recent safety concerns and in laying the groundwork for safe and sustainable service delivery in the future.

Specific recent achievements have included:

- a strengthening of the department's multidisciplinary leadership team
- early success in the recruitment of consultant medical staff

- early success in the recruitment of middle grade medical staff to the department, with further interviews currently planned
- further interest from potential ED consultants in response to ongoing recruitment initiatives, with further interviews currently planned
- early success in developing substantive roles for existing locum staff, encouraging their longer-term employment in the department and providing support and supervision to allow qualification as a consultant
- a significant improvement in medical rostering and shift-fill in the department, with a decreased reliance on single-shift agency doctors
- more consistent and effective team working resulting from consistent medical shift fill
- increased support from the ED at Princess of Wales Hospital (POWH)
- development of plans for expanding the roles of nursing staff within the ED through increasing the potential roles of the nurse practitioner and nurse consultant workforce
- development of other professional roles within the department, including for physiotherapists
- implementation of innovative models to deliver care in the department and new ways of working, implemented at pace, facilitated by the response to COVID
- progress with the development of long discussed models for surgical care and paediatric support for the department, catalysed by the flexible response to COVID
- recruitment of a consultant to lead the development and implementation of a new model for delivering services for minor injuries and minor illness, including in Ysbyty Cwm Rhondda, to help reduce inappropriate ED attendances (thereby reducing pressure on the RGH ED)

Note: Additional information relating to the above points is set out in the appendix.

2.2 Impact of COVID-19

The effect of COVID-!9 has been immediate and this has been widely understood. However, the effects will also be long term. Delivering clinical services safely for patients and staff in the COVID context will continue to have significant implications for services across the Health Board and for the RGH ED.

The pressures and challenges of the COVID response have made clear that the RGH ED department is a core component of the portfolio of acute services delivered at RGH.

As set out in the previous section, significant changes have been facilitated and catalysed by the COVID-19 response. Relationships with other specialty

teams at RGH have been enhanced. Revised patient pathways have been developed alongside significant physical changes in the department to improve safety and reduce the risk of COVID transmission.

The implications for ED capacity of the physical and operational changes required to operate in the current COVID environment make the consolidation of EM services onto fewer sites an even greater, and probably an unsurmountable, challenge.

The Royal College of Emergency Medicine (RCEM) has emphasised that EDs will need to continue to operate in segregated streams, with an absolute focus on minimising hospital acquired (nosocomial) infections. There will be a 'nosocomial dividend' from this approach, with reduced infections to staff and patients and improved safety and quality of care.

The ED at the RGH is in a positive place to meet these aims and has:

- 'green' and 'red' ED areas
- comprehensive acute physician support at the front door
- 'stay well @home' service provision
- robust links to primary care, community and mental health services

2.3 Development of Minor Injury/Illness Services

In addition to work to improve the safety, quality and sustainability of the RGH ED, further work has commenced to develop services for those with minor injuries and illness who do not require assessment/treatment at an ED.

This is in the context of changes in public behaviour during the COVID pandemic that have decreased attendances at EDs for minor conditions, resulting in greater capacity to respond to more serious emergencies.

The population have received advice and care for minor illness and injury during this period from pharmacy, primary care and community services.

This has demonstrated the real potential for care closer to peoples' homes, thus reducing levels of less appropriate ED attendance and creating timely, appropriate, and accessible models of care.

To lead and support this work, a recently retired EM consultant has been recruited into the team and will be working in the minor injuries unit (MIU) at Ysbyty Cwm Rhondda (YCR) two days a week.

This new role will lead on service re-modelling with a view to increasing local access for local communities to appropriate minor injury and illness provision.

The redesign project aims to:

- improve timely access to services
- develop the provision of accurate advice and direction to appropriate services
- provide greater clarity for patients to guide choices in accessing treatment and advice
- ensure that the public are fully informed of the role and treatments available at their local MIU
- explore how access can be improved for patients in the Rhondda, particularly for those who have difficulty in accessing care on the Health Board's hospital sites

The Health Board is committed to strengthening its relationship with the local community, in order to ensure developments in the service are the right developments for the community and also that they reduce the pressures on the RGH ED, allowing the appropriate focus on more serious accidents and emergencies.

2.4 Consideration of existing options in light of recent developments and experience

2.4.1 Options under consideration

To date, the project has been working to consider the feasibility and safety of two options, whilst providing new impetus and focus in the delivery of 24/7 consultant-led ED services at RGH.

In summary, the two options have been:

- **Option A**: To transition the RGH ED from a consultant-led service to a 24/7 nurse practitioner led Minor Injuries Unit (MIU), the model proposed in 2014,
- **Option B**: To continue a consultant led RGH ED, but with an overnight reduction in service to reduce the pressures on medical staffing

2.4.2 Option A

In the context of work done on the project to date and in light of recent developments, as outlined above, Option A is no longer seen as a viable option that should be further progressed. Specific reasons for this assessment include:

- The reduction in ED access for a significant part of the Health Board's population, with large numbers of people having difficulties in travelling to a 24/7 ED at either PCH or POWH in a timely manner
- The inability of the other hospital sites to manage the increased demand if the RGH ED was to become an MIU.
- The substantial barriers to increasing ED capacity in PCH and/or POWH
- The overall reduction in functional capacity in EDs across the Health Board, due to the need to deliver care in a COVID-19 environment, with the need to ensure social distancing through physical and operational changes
- Safety concerns about 'walk in' emergencies at a site served only by an MIU
- Difficulties in identifying appropriate safe and sustainable models of care through the work of the project to date
- Perceived consequences for the wider sustainability of hospital services (particularly linked to the retention of staff) in the Rhondda & Taff Ely ILG.

Many of the above issues have also been raised by members of the public, their elected representatives and campaign groups during the project, both through formal engagement and consultation mechanisms and by other means.

The project team and the Board have been clear throughout that the views of the community are important, have been actively sought and have informed this assessment.

2.4.3 Option B

The option to provide a consultant led ED service, but with an overnight reduction in service, is also not without challenges in delivering an accessible and safe service.

The service pressures and capacity issues generated in surrounding EDs would be potentially manageable, but, nevertheless, would require capacity building and additional resource in those units.

The ability to access services in a timely fashion, as for Option A, would apply during the hours of closure.

Sections 2.1 to 2.3 of this report have described the improvements that have been made to the current 24/7 service at the RGH ED. This enables the project team to make the assessment that there is no requirement to further develop Option B.

It is, however recognised, that staffing levels at all three Health Board EDs remain below levels recommended by professional bodies and will remain so in the short to medium term.

In view of this ongoing fragility, it is prudent to further develop existing contingency plans.

These plans could include temporary overnight closure to ambulance admissions of a specific ED in defined circumstances; where patient safety could not be assured in that department, but with the department remaining open to patients attending as "walk-ins".

These plans will include clear thresholds and trigger points and detailed operating procedures. They will build on existing plans that were previously implemented at RGH during the Christmas period in 2019, and be informed by the work to develop Option B.

2.5 Conclusions and proposed next steps

Much progress has been made in a short period of time, partly facilitated by the flexible response to the COVID pandemic and the resulting changes to working arrangements pathways and facilities.

More importantly, new clinical leadership has resulted in changes in culture and attitude that are continuing to facilitate successful recruitment to the RGH ED. Historical and recent safety concerns have been significantly addressed and the quality of service continues to improve.

Progress in the RGH ED is being supported by the commencement of focused work on the design and delivery of local services for those with minor injuries or illness who do not require assessment or treatment at an ED. The continuation of this work will be critical to a future sustainable 24/7 ED and will rely on communities utilising services differently.

As a result of the progress described in this report, and with the support of the local community, it is concluded that the most appropriate way forward is for the Health Board to commit to the progressing of the further work needed to ensure the safe and sustainable delivery of 24/7 consultant led ED services at RGH, PCH and POWH.

Such a commitment will give the certainty and confidence necessary to facilitate further successful recruitment and service change.

In the light of progress to date, the leadership of the project has concluded that a safe 24/7 consultant led ED can be sustainably delivered at RGH, as one of 3 EDs within the Health Board area.

Further work, in partnership with the community through a Partnership Panel for Cwm Taf Morgannwg, is now needed to:

1. develop appropriate models of care, in meaningful partnership with the community, for the RGH ED, supporting services at RGH and local services for those with minor injuries and illness
2. develop plans to mitigate the risks stemming from the ongoing fragility of medical staffing

In the meantime, efforts will continue to recruit to EM consultant, middle grade doctor and nursing posts.

Note: Further detail in relation to some of the specific underpinning actions is contained in the appendix.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD

The following remain key risks and issues relating to the project:

- There remain risks to ongoing ED medical workforce sustainability across the health board, which will be mitigated through actions set out in this paper, including ongoing recruitment efforts, the development of multidisciplinary approaches and through contingency arrangement at times of exceptional pressure.
- There is an ongoing need, exacerbated by the impact of COVID-19, to take action to ensure continuity of service provision prior to the implementation of future project recommendations.
- There is a risk that a return to pre-COVID patterns of attendance at the RGH ED could compromise the sustainability of that department. This risk will be mitigated by the action described to work in partnership with the community on the design and appropriate utilisation of local services for those with minor injuries and illness.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	To be considered within the scope of the project.
Related Health and Care standard(s)	Safe Care
	All standards applicable
Equality impact assessment completed	No (Include further detail below)
	To be addressed as part of the project.
Legal implications / impact	Yes (Include further detail below)

	To be considered within the scope of the project.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	To be considered within the scope of the project.
Link to Main Strategic Objective	To Improve Quality, Safety & Patient Experience
Link to Main WBFG Act Objective	Provide high quality care as locally as possible wherever it is safe and sustainable

5. RECOMMENDATION

The Board is asked to **NOTE** the content of this report.

The Board is asked to **NOTE** the progress in addressing the medical staffing shortages in the Royal Glamorgan Hospital Emergency Department and the further work needed to ensure long term sustainability.

The Board is asked to **APPROVE**

- a commitment to the ongoing, long-term, delivery of emergency medicine services through a 24/7 consultant-led Emergency Department at the Royal Glamorgan alongside those at Prince Charles and Princess of Wales Hospitals

- the rejection of any further development of **Option A** (a 24/7 MIU at the Royal Glamorgan Hospital)

- the rejection of any further development of **Option B** (reducing the operational hours of the Royal Glamorgan Emergency Department)

- the continuance of work to develop the detailed underpinning service and staffing models for emergency medicine, minor injury and illness services and relevant elements of supporting specialities

- the establishment of a Partnership Panel, with active community and staff involvement, to support development and implementation of models of care

- the development of contingency plans in response to any short-term staffing pressures in the Health Board's Emergency Departments which preserve access to safe and high-quality care.

APPENDIX - Safe and sustainable delivery of a 24/7 consultant ED at RGH – Additional Information

Medical Workforce – Substantive and Locum Staff	
Progress to date	*Next steps*
The RGH ED now has seven-day consultant cover, provided by: • 2.0 WTE consultants (including the clinical lead) • Two long term locum consultants • 0.4 WTE share of a full-time consultant working across RGH and POWH This has also allowed a consultant to undertaking key administrative duties, Monday to Friday, including reviewing: • radiology reports • all paediatric attendances to highlight safe-guarding issues • "did not wait" cases • complaints • coroners' statements Substantive middle grade staffing has increased to 7 WTE (from 1.8 WTE in March 2020) through: • developing and agreeing substantive roles for four existing locum middle grade staff • recruiting a further full-time middle grade doctor Ad hoc internal locum doctors have been recruited, making the department less reliant on agency doctors and improving patient safety and continuity of care.	Consultant recruitment is continuing. Currently there are approximately 80 EM trainees in Wales. This number has increased substantially over the last 10 years. Welsh trainees usually take up consultant posts in Wales, increasing the chances of successful recruitment. To sustain the 24/7 medical rota the department requires a total of 20 middle grade doctors and posts are currently being advertised. The department is looking to recruit 10 Junior Clinical Fellows and an advert is currently being finalised. The posts are portfolio jobs to be attractive and sustainable and also give time for non-clinical duties that will benefit the department There has already been interest in the posts and the department aims to have five employed by the end of August 2020. Some of the department's middle grade doctors wish to complete a Certificate of Eligibility of Specialist Registration (CESR). By supporting the doctors through CESR programmes it is hoped that they will subsequently apply for consultant posts. Once the department is fully staffed, it is planned to apply for recognition for Emergency Medicine Training. Initial discussions have already taken place with the Foundation Programme Director at the RGH and the Dean for HEIW.

Medical Workforce – Agency Staff	
Progress to date	*Next steps*
All agency doctors' CVs have been reviewed by the clinical lead and a core group of doctors who provide high clinical standards of care is now being used.	There remains a need to utilise agency doctors whilst recruitment is ongoing, but this should continue to reduce over time. Any new agency doctors will only be used subject to: • their CV being approved by the clinical lead. • meet with the clinical lead and having a specific induction process prior to undertaking any shifts • 'buddying up' with a substantive doctor at the start of each shift
Developing the Multi-disciplinary Team	
Progress to date	*Next steps*
Currently, there are four highly experienced Advanced Clinical Practitioners (ACPs) working in the RGH ED, who work autonomously across a wide case mix. The role of the Advanced Clinical Practitioner (ACP) in EDs is relatively new. Working as part of the multidisciplinary team they make an important contribution to EM. ACPs in Emergency Care may work only in the adult area, in the children's area or throughout the department. Emergency Care ACPs (EC-ACPs) are able to: • look after patients with a wide range of pathologies • identify the critically ill and injured, providing safe and effective immediate care • use expertise in resuscitation • establish the diagnosis and differential diagnosis rapidly and initiate or plan for definitive care • work with all the in-patient and supporting specialties as well as primary care and pre- hospital services • identify who needs admission and who can be safely discharged	The future vision is to expand this group in the ED workforce. This is in part to provide a sustainable skilled workforce but also to introduce some career progression for the dedicated nursing staff. The current plan is the creation of a trainee ACP post to train a future ACP, expansion of trained ACP workforce with additional posts plus senior ACP posts. These posts will supplement the middle grade medical rota, but also provide additional workforce to support the senior ED team with education, quality improvement, undergraduate education, research and governance. We are also planning to appoint two Nurse Consultants. These posts are usually 50% clinical with dedicated management time for leadership and service development roles. Nurse Consultants would be responsible for the nurse practitioner workforce leading on development, training, support and education. There is local interest in all the above roles.

Clinical Governance	
Progress to date	*Next steps*
The clinical lead, with the full involvement of the nursing and management team members, has put into place improved and robust clinical governance arrangements: • Weekly meetings have been introduced to discuss all incidents, complaints and risks related to the ED • There has been a reduction in incidents, although it is not yet clear if this is caused by reduced attendances due to the COVID-19 situation Specific improvements to date include development of: • new ED nursing documentation • a new doctor clinical assessment proforma • flow chart for review of radiology reports • a database of all missed x-rays, complaints and incidents, which are fed back to the relevant individual with suggested further learning.	Patient feedback forms will be implemented, and any informal concerns will be responded to within 24 hours. The GP discharge letter is being reviewed in liaison with cluster Leads and IT.
Service Improvement and Pathway Redesign	
Progress to date	*Next steps*
Many pathways have changed due to the COVID-19 response and there has been considerable support from other departments in RGH. Specific recent actions include: • development of an RGH ED handbook (based on POW version), available on the SharePoint site, with clinical information, local pathways and patient advice leaflets • development of pathways for a number of fractures that do not need any Trauma and Orthopaedics follow-up • a review of ENT equipment, with the ENT team, led by a regular locum who is planning a career in ENT • a review of CT requesting with the Radiology team	Specific planned actions include: • implementation of new pathways for ambulatory management for Urology Emergencies • development of patient information leaflets for conditions referred to AECU • development of new mental health pathways • a 'frequent attender' project led by a Specialty Doctors with previous experience in substance misuse and mental health • an electronic database of all activity evidencing learning and action plans • clinical governance days for the multi-disciplinary team

Changes to respond to COVID – 'Red' and 'Green' services	
Progress to date	*Next steps*
As part of the COVID-19 response, significant changes have been made to the physical environment within the ED and a second green ED area has been commissioned. Pathways for navigation from triage to reduce the number of patients whose healthcare needs could be met better by another service.	An extension to the department will be required in order to maintain social distancing within the waiting area and clinical areas. Plans for this are being developed. Pathways are being explored with primary care and the GP Out of Hours service, as well as specialties at RGH.
Redesign of Minor Injury Services	
Progress to date	*Next steps*
It has been agreed that a retired consultant will return to the team and will: • provide consultant support to ensure effective clinical governance and patient safety within the MIU at YCR • lead on service re-modelling with a view to increasing access for local communities to minor injury and illness provision as part of the UHB plans for the post COVID-19 pandemic period.	The redesign project will aim to: • reduce waiting times for NHS Direct call back • ensure the provision of accurate advice and redirection, when required • avoid patient confusion • reduce reliance on EDs • address communication issues The directorate team is happy to work alongside the CHC and local pressure groups as part of the redesign programme.

Prisons & Probation Ombudsman
Independent Investigations

Sue McAllister CB
Prisons and Probation Ombudsman

Health, Social Care and Sport Committee
Welsh Parliament
BY EMAIL

23 June 2020

Dear Health, Social Care and Sport Committee

I have recently been contacted by the Commons Justice Select Committee at the UK Parliament to provide written evidence for their inquiry into the ageing prison population. In my evidence about end of life care in prisons, I referred to an investigation we carried out into a death in custody at HMP Parc. As we have provided this evidence to the Commons Justice Select Committee I thought that it was also appropriate to share the same evidence with you.

Following an investigation into a death in custody at HMP Parc in August 2019 we raised some concerns about the care provided. The individual suffered from dementia and was referred for assessment, however there was disagreement with the Local Health Board as to who was funded to assess and provide support. The Local Health Board failed over a period of years to reach a solution to enable the individual to access appropriate specialist care for dementia. We recommended that discussions took place with the Local Health Board to ensure that patients with suspected dementia at HMP Parc have access to full service provisions. We are waiting for confirmation as to whether these discussions have taken place.

We would also like to take this opportunity to raise our concerns about the length of time it takes for inquests to be held in Wales. As an example, there was a death in a Secure Children's Home in Wales in February 2017 and we are still waiting for notification of an inquest date. There was also a death in custody that occurred at HMP Swansea in March 2014 and the inquest only concluded in February 2020. These are quite significant delays that are causing upset to bereaved families.

Please get in touch if you require any additional information.

Yours sincerely

Sue McAllister CB
Prisons and Probation Ombudsman

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