Agenda - Health, Social Care and Sport Committee

Meeting Venue:
Video Conference via Zoom
Meeting date: 10 July 2020
Meeting time: 09.00

For further information contact:
Sarah Beasley
Committee Clerk
0300 200 6565
SeneddHealth@senedd.wales

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

2 COVID-19: Evidence session with Cwm Taf Morgannwg University Health Board and Hywel Dda University Health Board

(09.30-11.00) (Pages 1 - 60)

Professor Marcus Longley, Chair - Cwm Taf University Health Board
Dr Sharon Hopkins, Interim Chief Executive - Cwm Taf University Health Board
Alan Lawrie, Executive Director of Operations - Cwm Taf University Health Board
Maria Battle, Chair - Hywel Dda University Health Board
Steve Moore, Chief Executive - Hywel Dda University Health Board
Andrew Carruthers, Director of Operations - Hywel Dda University Health Board

Research brief

Paper 1 – Cwm Taf Morgannwg University Health Board

Paper 2 – Hywel Dda University Health Board

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

(11.00)

4 COVID-19: Consideration of evidence

(11.00-11.15)

Break (11.15-11.30)

5 COVID-19: Evidence session with Cardiff and Vale University Health Board and Swansea Bay University Health Board

(11.30-13.00) (Pages 61 - 100)

Charles Janczewski, Chair - Cardiff and Vale University Health Board

Len Richards, Chief Executive – Cardiff and Vale University Health Board

Steve Curry, Chief Operating Officer – Cardiff and Vale University Health Board

Emma Woollett, Chair - Swansea Bay University Health Board

Tracy Myhill, Chief Executive – Swansea Bay University Health Board

Dr Richard Evans, Medical Director – Swansea Bay University Health Board

Paper 3 – Swansea Bay University Health Board

Paper 4 – Cardiff and Vale University Health Board

6 Paper(s) to note

(13.00)

6.1 Additional information from the British Dental Association Cymru Wales following the evidence session on 2 July

(Pages 101 - 107)

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

(13.00)

8 **COVID-19: Consideration of evidence**

(13.00-13.15)

Agenda Item 2

Document is Restricted

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

EVIDENCE TO THE HEALTH, SOCIAL CARE AND SPORT COMMITTEE

10 JULY 2020

1. Introduction

This written submission is made to the Health, Social Care, and Sport Committee prior to the Cwm Taf Morgannwg University Health Board evidence session on the 10th July 2020.

2. The COVID-19 Pandemic in Cwm Taf Morgannwg

2.1 Strategic Response – Command and Control Structure

An emergency planning response was established in March 2020, with a formal Command and Control structure developed within Cwm Taf Morgannwg University Health Board (CTMUHB) in partnership with Local Authority partners, with Gold (Strategic), Silver (Tactical), Bronze (Operational) functions (See Appendix One). A Gold Command Strategic Plan was quickly developed with three strategic objectives to guide the planning response to the COVID-19 pandemic in Cwm Taf Morgannwg (CTM), these strategic objectives were:

1. *To prevent deaths from COVID-19*
2. *To protect the health of people in our community*
3. *To protect the wellbeing of staff in our public services*

The emergency planning response structure was established in the face of the emerging COVID-19 pandemic across the world, in the UK, Wales and within Cwm Taf Morgannwg communities.

It came at a time when Governments were moving from the 'containment' phase of epidemic management to the 'delay' phase. This change in phase brought about a considerable change in policy and in order to be able to respond swiftly and decisively, the emergency response structure was established. It operated over a period of approximately 10 weeks starting from the 13th of March 2020.

The detail of the Gold/Silver/Bronze Command emergency planning response was set out in an Operating Protocol agreed by Gold Command on 23 March 2020. The structure included Health and Local Authority partner representation at each command level. Its purpose was to structure a framework for delivering a strategic, tactical and operational response to the COVID-19 situation. It also allowed processes to be established that facilitated the flow of information and ensured that decisions were swiftly made, communicated effectively and documented.

Strong links were made to the South Wales Local Resilience Forum emergency planning arrangements and weekly stakeholder briefings were held by the Health Board Chair and Chief Executive Officer, with Local Authority Leaders and Chief Executives, MPs, Members of the Senedd (MSs) and staff side representatives.

2.2 Phases of Work

Once the formal emergency planning response was established, three broad phases of work were observed, with further information included as Appendix Three.

- The first phase related to establishing the capacity and workforce to deal with an agreed worst case scenario of COVID-19 cases. This included significant work associated with the bed modelling, and developing capital, estate, equipment, workforce and operational plans required for building additional Intensive Therapy Unit (ITU) and general hospital bed capacity into the system. The former required the potential establishment of 3 field hospitals based in Bridgend, Hensol and Abercynon, to provide additional capacity. This planning work was against a backdrop of a UK-wide 'lockdown' strategy imposed by the UK Government with devolved Governments' support. Following Welsh Government guidance, routine services were subsequently stood down to enable redeployment of capacity and staff to provide COVID-19 care preparation and delivery. Additionally, staff testing units for health and social care staff were established.

- The second phase related to the further roll out of testing, including to further categories of key workers and on testing patients being discharged from hospital into certain community settings such as care homes. The 'discharge to care/residential homes and step down to in designated NHS facility' protocol was agreed with the three Locality Authorities and approved on 30th April, in line with the WG policy position. There was also a major focus on staff resilience and support, including the introduction of several interventions by way of advice and support across the Health Board. Towards the end of the second phase, where the reasonable worst case scenario had thankfully not been realised due to the positive impact of 'lockdown', this saw the planned bed capacity had not been required in full. Work began to focus on enhanced focus on non-COVID-19 work across the Health Board. This resulted in starting to plan for 'resetting to a 'new normal', given that COVID-19 will remain with us for some time to come, so that both care for COVID-19 patients and, in particular, all essential services care for other conditions are provided concurrently.

- The third phase required an understanding of the impact of deferred services on communities and individuals and the commencement of implementing the Public Health Protection and Response Plan. This latter plan was released by the Welsh Government during the week commencing 11th May 2020. The ongoing arrangements for this work are vested in a CTM Regional Oversight Group, led by the Director of Public Health. CTMUHB also prepared its quarter 1 response plan for resetting to a 'new normal' and submitted this to the Welsh Government

on 18 May 2020 (see section 6). This plan recognises that our current health and care system is now significantly out of balance with respect to ability to meet demand for health and wellbeing care. This being a result of necessarily reducing non-essential services across NHW Wales in order to redeploy capacity and staff to prepare for and deliver a COVID-19 emergency response. It set out plans to understand the impact of what has taken place, to evaluate, and to develop plans to begin to restore rebalance to the system as we move into 2020 quarter two.

During the response to COVID-19 Quality Impact Assessments (QIAs) were carried out under the leadership of the Clinical Executives and formed part of the formal decision making framework. Any QIAs with an impact score over 20 were referred to Gold Command for a decision relating to COVID-19 service changes.

Corporate governance arrangements in CTMUHB were adapted during the response to COVID-19, and the detail can be seen as Appendix One. Further governance changes have been made within CTMUHB since moving out of the Command and Control phase, taking learning to support robust, but agile decision-making and these can be seen as Appendix Two.

3. Initial Response and Planning for COVID-19

To accommodate the required focus on responding to the COVID-19 pandemic, decisions and actions were taken to:

- Enable staff time for planning, remodelling pathways and training
- Step down, redesign or divert planned activity in a phased manner (Including use of technology and private facilities)
- Step up discharge of medically fit patients working closely with partners
- Expand critical care capacity
- Create acute care capacity to accommodate predicted oxygen requirements
- Expand step down capacity working with partners (including consideration of field hospitals)
- Creating the required workforce through recruitment (including retired and returning, students, volunteers), redeployment of staff and training and development.
- Adapt our governance arrangements to support effective and timely decision making and assurance.
- Procure the equipment and train CTM staff so that we were prepared and able to maximise the retention of core services through alternative ways of working wherever possible, recognising the working practices and shift patterns to do this would be dependent on COVID-19.

CTMUHB made changes to how some services are delivered, expanded beds available in acute and community settings, made adaptations to current services and in some instances paused services in-line with national guidance. Direction in relation to these actions has been provided by Welsh Government and Royal Colleges.

All changes to CTMUHB services have been logged, with patient information for each service, and included on the Health Board website:

https://cwmtafmorgannwg.wales/latest-information-on-novel-coronavirus-covid-19/service-changes-for-covid19/4

This information has been reviewed by the CTM Community Health Council (CHC) and appropriate links between the CHC and Health Board websites made to keep patients informed of changes.

Ongoing engagement has taken place with the CTM Community Health Council (CHC) via a jointly agreed protocol to ensure that service changes made in respect to COVID-19 are shared with the CHC as appropriate.

A summary of the services (clinics and specialities) that have transferred from one CTM hospital site to another facility, to increase capacity for emergency care can be seen below:

Prince Charles Hospital to Ysbyty Cwm Cynon

- Gynaecology – Outpatient Clinic
- Cardiology – Heart Failure Nurse Outpatient Clinic
- Neurology Outpatient Clinic
- Diabetic Retinopathy Outpatient Clinic
- General Surgery – Surgical Outpatient Clinics
- Dermatology Outpatient Clinic
- Rheumatology Outpatient Clinic
- DMARD Outpatient Clinic
- Biopsy Clinic
- Urology Outpatient Clinic
- Gastroenterology – Outpatient Clinic/ Irritable Bowel Disease – Clinical Nurse Specialist
- Trauma & Orthopaedics – MSK Clinic

Royal Glamorgan Hospital to Ysbyty Cwm Rhondda

- Obstetrics – Antenatal Outpatient Department
- Cardiology – Outpatient Clinics
- Dermatology – Outpatient Clinics
- Respiratory Outpatient Clinics
- ENT Outpatient Clinics
- General Surgery Outpatient Clinics
- Gynaecology Outpatients

Princess of Wales Hospital to Maesteg Hospital

- Ophthalmology
- Biologics, Gastro and Respiratory

Princess of Wales Hospital to New Surgery Pencoed

- Dermatology
- Phlebotomy

Additional detail on the work to plan and respond to COVID-19 can be seen as Appendix Three.

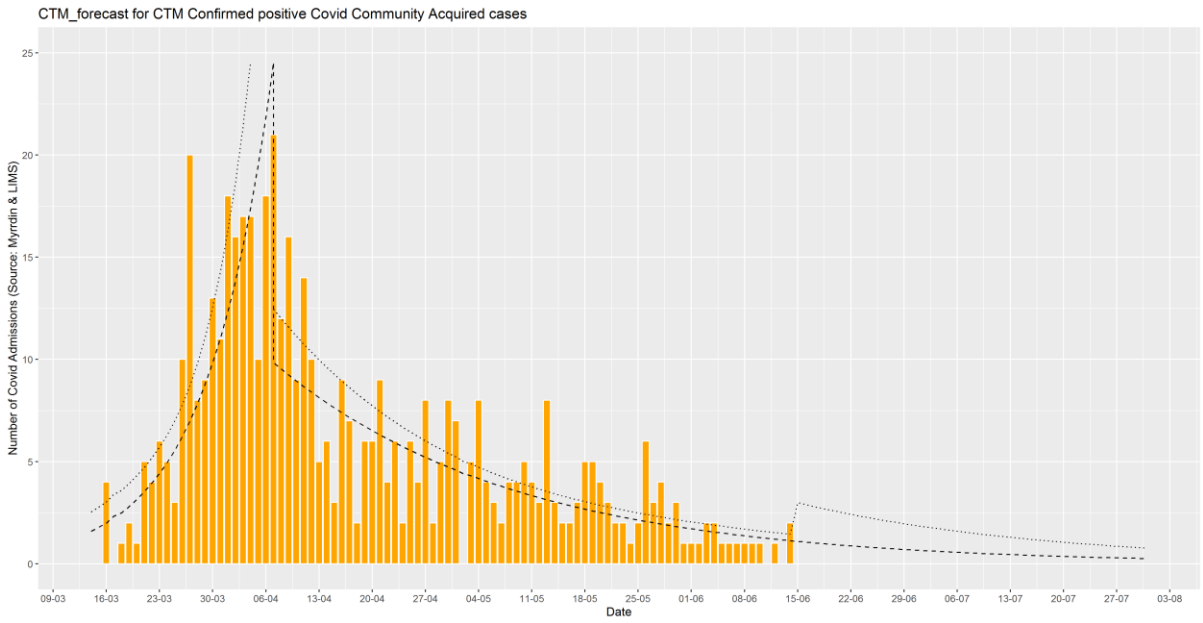
4. COVID-19 Impact on CTMUHB

4.1 Confirmed Cases

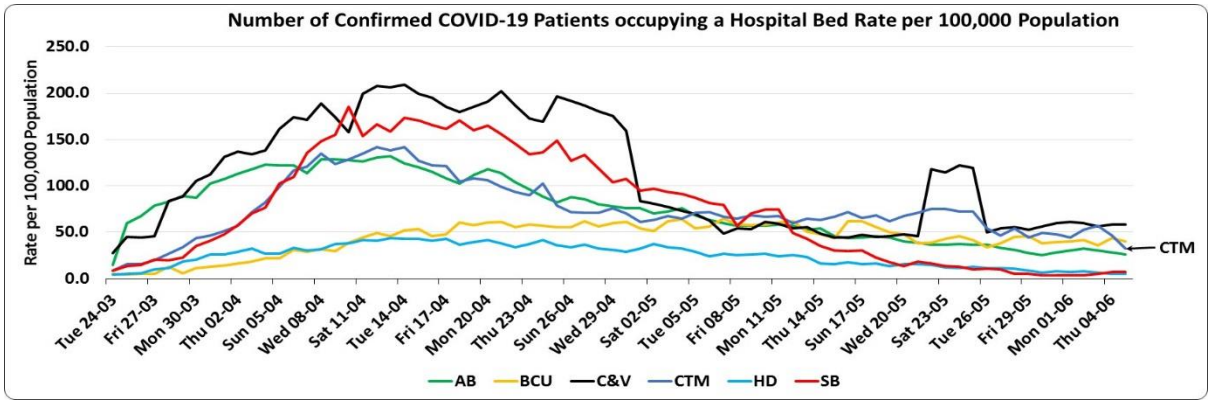
As at the 30th June 2812 CTM residents have tested positive for COVID-19 and 29,136 tests have been undertaken. These include over 5,000 care home staff and residents, 12,000 key workers and 6000 hospital inpatients or Emergency Unit attendees. Of those tested, 185 care home staff and residents, 1,200 key workers and 950 hospital patients have tested positive.

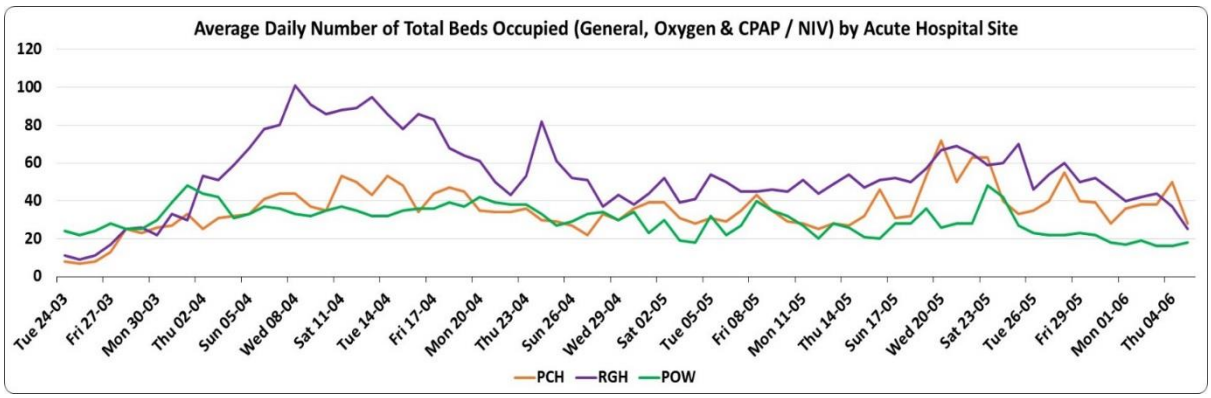
These numbers understate the actual numbers who have had COVID-19, due to community testing being paused in March.

To understand transmission in the community, the UHB monitors community acquired infections who are admitted to hospital, as this tends to be consistent, and not affected by changes in testing approaches. As per the chart below, admissions peaked around the 7th April, 2 weeks after lockdown commenced. As the time from infection to admission is considered to be circa 11 days this would support the theory that lockdown had a significant and immediate impact on suppressing the transmission and thus harm of the virus to CTM communities.



The data shown in the first chart below details the confirmed cases occupying an acute hospital bed since the onset of the pandemic. The second chart highlights that more beds have been occupied by COVID-19 related patients in RGH than any other CTM hospital.





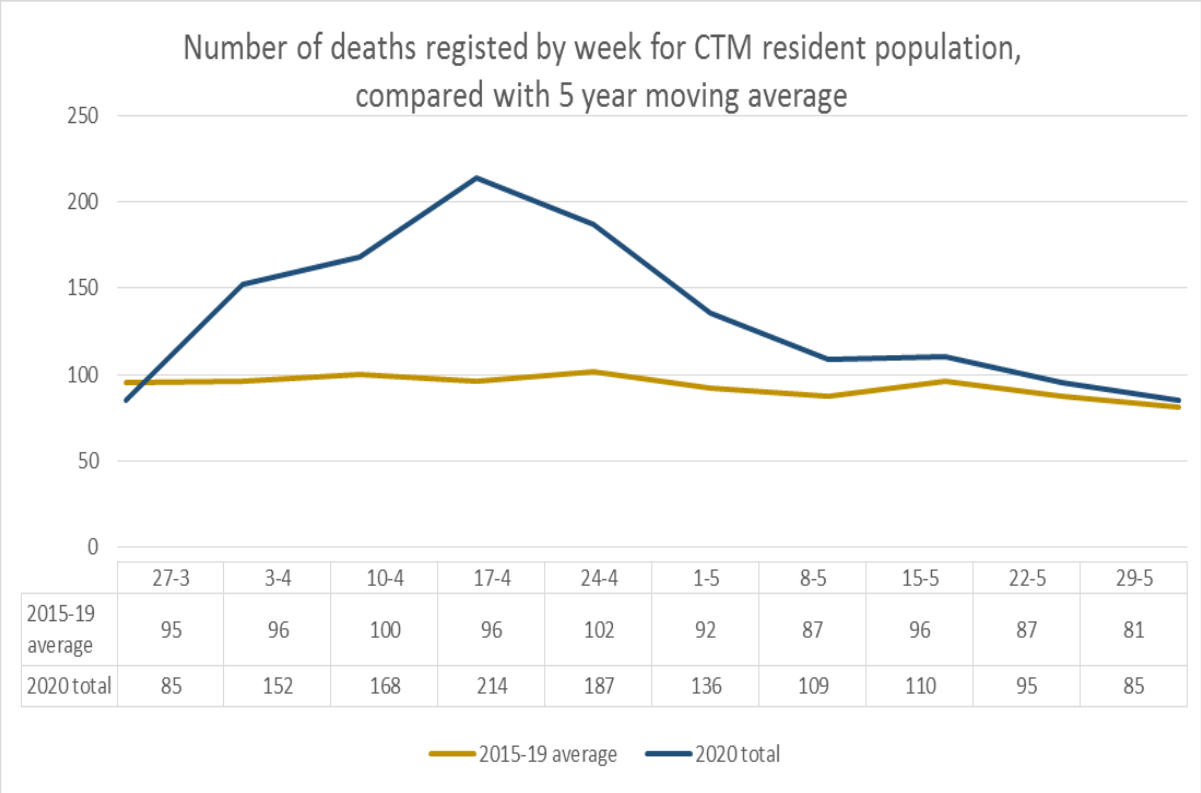
Between 23 March and 10 June, 1,845 COVID-19 related patients have been admitted to CTM hospitals (PCH, POW, RGH), with 2,619 positive tests carried out between 14 March and 10 June.

4.2 COVID-19 Deaths

Tragically, CTMUHB has seen 307 confirmed COVID-19 deaths reported by Public Health Wales between 19 March and 9 June, this number increases to 458 deaths when using ONS (Office of National Statistics) /MPI (Master Patient index) data showing deaths related to COVID-19.

The PHW reported deaths relate to patients who have had a confirmed positive test for COVID-19, whereas other statistics derived either through the ONS, or indeed a combination of ONS and MPI data report a death where there has been any mention of COVID-19, whether it has been recorded as the primary cause of death or a related factor.

The number of deaths registered by week for the CTM resident population compared to the 5 year moving average per week for the period 27th March – 29 May can be seen below.



	27-3	3-4	10-4	17-4	24-4	1-5	8-5	15-5	22-5	29-5
2015-19 average	95	96	100	96	102	92	87	96	87	81
2020 total	85	152	168	214	187	136	109	110	95	85

5. Impact on Non COVID-19 Services

5.1 Referral to Treatment Times (RTT)

Following Welsh Government guidance non-elective surgery has been on hold as a result of the COVID-19 pandemic since the 17th of March 2020. The confirmed position for the end of April 2020 was 7,078 patients waiting over 36 weeks, of whom 2,043 patients were waiting over 52 weeks.

The provisional position for the end of May is 10,385 patients waiting over 36 weeks, of whom 2,600 are waiting over 52 weeks.

It is likely that by the end of June 2020 there will be in excess of 14,500 patients waiting over 36 weeks.

5.2 Diagnostics

The number of patients waiting over 8 weeks for diagnostic services has been impacted by COVID-19. The provisional position for May is 10,301 patients waiting over 8 weeks for diagnostic services. This is a considerable deterioration from the March position of 1810 and 3963 more than April 6,338, with COVID-19 restrictions having a big impact on diagnostic services.

5.3 A&E Attendances

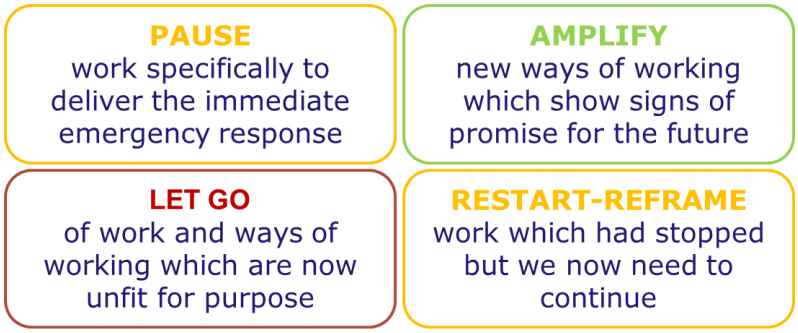
A reduction in attendances has been observed since mid-March 2020 across all CTM Emergency Departments, and continued throughout April. During May attendances have risen, but in comparison to the same period last year total attendances are 30.5% lower.

6. Re-setting Cwm Taf Morgannwg UHB

Since standing down the Command and Control structure, following the final Gold Command meeting on the 21st May 2020, the focus within CTM has been working on how to balance COVID-19 and non-COVID-19 work to enable flexibility and responsiveness given that we do not know how the pandemic curve will behave going forward. We are working on how to achieve a non COVID-19 environment in the absence of a vaccine. We are seeking to maximise the use of all of our resources in providing this important balance.

Resetting CTM Operating Framework sets out how we intend to move out of the current period of COVID-19 emergency response and reset our operating model. In support of this, a set of principles have been developed to guide CTMUHB in letting go of ways of working which are now unfit for

purpose, whilst restarting and reframing the work which urgently needs to continue.



Whist the COVID-19 pandemic has tested the resolve of the Health Board and its staff; our mission, vision, values and strategic well-being objectives remain valid. The CTM Mission being to 'Building healthier communities together'. The CTM Vision: 'Across every community people begin, live and end life well, feeling involved in their health and care choices'.

The remainder of 2020/21 is likely to be characterised by peaks and troughs in COVID-19 demand, balanced with delivery of essential and routine health and care services. Framed by the Resetting CTM Operating Framework 2020/21, short, agile planning cycles, will seek to amplify recent positive working whilst minimising harm to our population and staff; and rebalancing the system.

7. NHS Wales COVID-19 Operating Framework

On the 6th May 2020, Welsh Government issued the 'NHS Wales COVID-19 Operating Framework' which recognised the continued need to respond to COVID-19 and the potential future peaks in COVID-19 demand. Contained within the operating framework was an 'Essential Services Framework' which set out those services deemed as essential that must continue during the COVID-19 pandemic and is designed to support clinical decision making in relation to the assessment and treatment of individual patients, with the ultimate aim that harm is minimised from a reduction in non-COVID-19 activity. CTMUHB has made every effort to minimise the impact on routine service delivery as a result of the outbreak, whilst maintaining essential services, as far as possible.

8. Cwm Taf Morgannwg Essential Services Provision

The Health Board undertook an assessment of the maintenance of essential services during the pandemic in order to understand service availability and equity of access across the Health Board.

Services deemed essential are broadly defined as services that are life-saving or life impacting i.e. where harm would be significant and irreversible, without a timely intervention. Irreversible for purposes of palliative and end of life care includes anything that will not realistically improve within the remaining life span.

A service status has been assigned to each of the service areas in line with the Welsh Government categories:

Service status	**Code**
Do not provide or commission this service	**0**
Essential services unable to be maintained	**1**
Essential services maintained (in line with guidance)	**2**
Intermediate services able to be delivered	**3**
Normal services continuing	**4**

This assessment informed the Health Board Quarter 1 COVID-19 Operating Framework submission to Welsh Government on in May 2020 and detailed the services available, highlighting gaps in essential services that could not be maintained.

The assessment submitted to Welsh Government has been refreshed in to a Quarter 2 submission in line with the guidance and framework supplied by Welsh Government. This was submitted to Welsh Government on the 3rd July 2020.

The Health Board has undertaken an updated assessment of the maintenance of essential services to inform the Health Board Quarter 2 submission in line with the NHS Wales COVID-19 Operating Framework. Further detail is included as Appendix Three.

Many of the essential services have been maintained through a combination of pathway adaptation (for example urgent cancer) and policy adaptation (for example visitor's policy, end of life care).

Essential Services Assessment Score	**Total Number of Services Assessed at that Score**	
	Quarter 1	Quarter 2
0 – do not provide	4	4
1 – Essential services unable to be maintained	5	0

2 – Essential services maintained (in line with guidance)	29	33
3 – Intermediate services able to be delivered	17	18
4 – normal services provided	3	3

Whilst a large proportion of services are running, the Health Board has identified five areas where essential services were unable to be maintained in quarter one:

- Lower GI Cancer
- Upper GI Cancer
- Thyroid Cancer
- Endoscopy
- Pain Services

The Health Board has developed plans to minimise, as far as is practicable, harm from COVID-19 as a result of essential services that have been unable to be maintained during the period of the pandemic. Further detail is provided below on the five areas that were unable to be provided during Quarter 1 2020/21, and changes made to resume service delivering in Quarter 2 2020/21.

Lower GI Cancer

All aspects of the pathway have changed as a result of COVID-19;

- Waiting lists for first appointment/diagnostics and surgery reviewed by Consultants proceeding to telephone review to re-assess priority, advice and possible discharge or attendance at clinic.
- Endoscopy restarted booking of elective USC activity on the 1st June 2020. All patients that were on the USC waiting list have now either had their procedure, have a date in the next two weeks or have been contacted and declined to have the procedure undertaken at this time.
- Virtual clinics and telephone triage in place.
- Plan is in place to re-instate surgery for colorectal scheduled cancer cases from 16th July.
- Rehabilitation – OT, Physiotherapy, dietetics, CNS provision all provided to patients as pre COVID-19.

Quality Impact Assessment including Risk assessment has been completed and an Equality Impact Assessment is in place.

Upper GI Cancer

All aspects of the pathway have changed as a result of COVID-19;

- Virtual clinics are undertaken for both new and follow up. Some USC/complex patients will be seen in YCR/YCC.
- Diagnostics: Endoscopy service now re-instated with regards to all cases.
- Treatment: High risk surgery, patients treated with Chemo/RT as curative modality as alternative to surgery. Palliative Chemotherapy limited due to associated complications during COVID-19 pandemic.
- Rehabilitation - OT, Physiotherapy, dietetics, CNS provision all provided to patients as pre COVID-19.

Quality Impact Assessment including Risk assessment has been completed and an Equality Impact Assessment is in place.

Thyroid Cancer

All aspects of the pathway have changed as a result of COVID-19;

- Any new USC or Urgent referrals are triaged by Consultant
- If any urgent treatment is required patient will be asked to attend a Ward to have a fact to face consultation with Consultant
- In the event of any life threatening surgery needs to be undertaken this will be arranged through the Emergency CEPOD theatre session.
- Cancer follow up patients receive a telephone follow up

Quality Impact Assessment including Risk assessment has been completed and an Equality Impact Assessment is in place.

Endoscopy

Actions to deliver essential services

- A service recovery document has been released by BSG (17/4/2020) to provide a tool kit for endoscopy services during COVID-19. It provides a framework for services to follow in order to plan their recovery.
- The National Endoscopy Programme (NEP) has considered and endorsed this service recovery document & asks Health Boards to use them alongside the guidance in the document to plan the recovery phase of their service.
- A Task and Finish Group was set up to take the recovery plan forward. Endoscopy service now re-instated with regards to all cases in line with BSG guidelines.
- Nursing staff will carry out the pre assessment approximately 14 days before appointment date. COVID-19 screening questions asked and contraindications to procedure identified.

Quality Impact Assessment including Risk assessment has been completed and an Equality Impact Assessment is in place.

Pain

Actions to deliver essential services

- Nurses have been released from COVID-19 roles and are now back seeing acute patients on the wards. All aspects of the acute pain workload is being covered.
- The team (consultants & nurses) will continue to review follow up patients via telephone and attend anywhere video consultation, again there may be need to bring in specific patients for a face to face review.

Quality Impact Assessment including Risk assessment has been completed and an Equality Impact Assessment is in place.

In addition to the essential services set out above being re-started and within the context of the NHS Wales COVID-19 Operating Framework and the 'Resetting CTM Operating Framework 2020/21', the Health Board is undertaking further work to restart the provision of additional services above the essential services in line with clinical need.

9. Future Service Provision

The Health Board is in the process of developing delivery plans to re-start routine services, as part of the Resetting agenda, exploiting opportunities for new ways of working. In developing these plans, a series of design principles have been agreed across the Health Board for the re-start of routine outpatient appointments; diagnostics; cancer and elective surgery from Quarter two.

9.1 Creating Safe COVID-19 Lite Areas

Work has been undertaken on each CTM hospital site to review the guidance and checklists for ensuring COVID-19 guidance to develop a clear action plan to ensure compliance with guidance and Health and Safety measures associated with developing COVID-19 secure environments, taking into account social distancing requirements.

9.2 Urgent Elective Surgery

In Quarter 1 across the Health Board each site had emergency theatre slots for very urgent and life threatening surgical cases on a daily basis. These were only used in very challenging urgent cases.

Over Quarter 1 each CTM hospital site has identified areas within their footprint that could be used to deliver urgent cancer and elective care that cannot be provided in the Vale hospital (Nuffield Health).

Across CTM live capture of the demand for services is broken down by inpatient, day case, outpatient and diagnostics. This demand matrix will be used to help prioritise surgical activity by site, with Outpatient appointments that require face to face appointments to commence imminently.

Access to the Vale Hospital has allowed urgent cancer surgery in Breast, Urology and Gynaecology to progress, this facility will continue to be utilised in the short term.

9.3 Continued use of the Vale Hospital

Given the need to have continued access to a clean site for in patient, day case, outpatient and diagnostics facilities in the short term, and the need for an ability to plan over a continuous 6 to 8 week cycle, the Health Board plan to extend the existing contract by 2 months. This will enable the Health Board to have a clearer view on what the Health Board will be able to deliver in our own hospital sites.

9.4 Primary Care Plans

During the COVID-19 pandemic CTMUHB along with all other Health Boards took action to protect primary care services in line with All Wales guidance. Dental and Optometry services were provided only for urgent emergencies through hubs across the CTM region and Community Pharmacy was supported to be able to provide vital medicines services to local communities under restrictions that had to be applied. GP services continued in the main to be provided by each practice rather than through Hubs and there was cluster support. Contingency planning was also put in place to be able to deal with a worsening scenario and as with much of the rest of Wales the majority of GP consultations took place by virtually and by telephone consultation.

Work has commenced, following Welsh Government guidance to implement a roadmap for recovery or Primary Care services.

The Urgent Primary Care OOHs Service has continued to function well over Q1 and will do so into Q2. They have further maximised the numbers of patients that are dealt with at the triage stage, have delivered the Attend Anywhere platform rapidly and effectively.

9.5 Mental Health Services Plans

Mental health services have continued to be provided. Longer term plans and approaches that CTM intend to take to immediately increase transitional services, as well as enhancing the new innovative ways of working are being developed preparing for the CTM area to ease out of

lockdown, and prepare for potentially increased demand. A raft of exceptional work has already been undertaken by local third sector organisations and will be built upon for future planning and delivery on a partnership basis.

10. Next Steps

The COVID-19 pandemic will demand that we continue to review the emerging evidence and lived experience to inform our direction and will need to remain flexible and responsive as the pandemic progresses.

The Health Board have and will continue to develop service delivery plans to address those areas where essential services are currently unable to be maintained and to re-start routine services with:

- Agreed clinical criteria being consistently applied across the Health Board to ensure that harm to the population we serve is minimised and that we ensure equity of access to services based on clinical need and risk.
- Patients only to attend hospitals where clinically necessary (and who are asymptomatic having isolated 14 days prior to attendance/admission) with services actively pursuing new ways of working.
- Services to be delivered whilst maintaining social distancing requirements.
- Assessment of demand and capacity and impact (e.g. clinical risks and waiting times if demand exceeds capacity).
- Patients requiring surgical intervention to be prioritised according to the Royal College of Surgeons framework and for treatments that are clinically necessary.
- Services planning to offer surgical interventions must detail specific interdependencies (e.g. workforce, equipment, radiology etc.).
- In undertaking any non-COVID-19 and non-essential activity, this should not adversely impact on the ability of the Health Board to respond to COVID-19 with adequate precautions being taken to avoid exposing patients and staff to unnecessary risk.
- Equality Impact Assessment (EQIA) to be completed in accordance with section 149 of the Equality Act 2010.
- Liaison with the Community Health Council (CHC) in accordance with the CHC protocol for dealing with local NHS service changes.

Appendix One: The Cwm Taf Morgannwg UHB Governance Arrangements – During the Command and Control Structure

Corporate governance arrangements in Cwm Taf Morgannwg UHB were adapted during the response to COVID-19.

The Health Board established a governance system to ensure effective governance of Board and committee business, whilst reducing the burden on Health Board officers whose focus was on the response to COVID-19. The governance arrangements were adapted to:

- Stand down all committees, partnership committees, and advisory groups of the Board, with the exception of the Audit and Risk and Quality and Safety Committees, who would continue to meet on a bi-monthly basis to provide scrutiny, operating through quorum arrangements.
- Agree a Command and Control decision making framework for Gold/Silver/Bronze to allow timely decision making, taking into account financial and quality impacts of decisions, agreed on the 26 March Cwm Taf Morgannwg University Health Board meeting.

In addition the CTMUHB Board meeting on the 28th May:

- Approved variation to Standing Orders (reflecting change in approach for Board and Committee meetings)
- Approved approach to revised Corporate Governance Arrangements in light of COVID-19 (reflecting correspondence from the Director General for NHS Wales)
- Approved amendment to Scheme of Delegation and financial approvals process relating to COVID-19.

A session on COVID-19 modelling, planning, and decision making, in relation to use of resources and associated costs took place with the Planning, Performance and Finance Committee on the 19 May 2020 to allow Board committee scrutiny of the COVID-19 financial decision making process. Full details from this session can be seen:

https://cwmtafmorgannwg.wales/Docs/Finance%2C%20Performance%20and%20Workforce%20Committee/014%20May%202020.pdf

Appendix Two: The Cwm Taf Morgannwg Governance Arrangements – Following the Command and Control Structure

The Command and Control structure was formally disbanded following the Gold Command meeting on the 21 May 2020. The focus at this time moved to balance COVID-19 and non-COVID-19 work to enable flexibility and responsiveness given that we do not know how the pandemic curve will behave going forward.

The 'Resetting CTMUHB Operating Framework' for Quarter 1 2020/2021 was received and approved by the CTMUHB Board at its meeting on 28th May 2020 (see section 6 and 7).

The delivery of the Resetting CTMUHB Operating Framework led to proposed changes to governance arrangements to support effective and robust decision-making within Cwm Taf Morgannwg UHB whilst overseeing the Resetting agenda. On the 29 June the CTMUHB approved the revised Governance and Assurance approach in light of the Resetting CTM Operating Framework (replacing the COVID-19 Gold/Silver/Bronze framework), this included the following governance changes set out below:

- Board to meet monthly (moving from bi-monthly) as collective oversight of all aspects of the delivery of the Resetting CTMUHB Operating Framework
- Core business delivered in line with agreed programme for the year, with additional meetings scheduled in the intervening months to focus on Resetting CTM Framework
- Continue to utilise Q&S Committee and Audit & Risk Committee as key forums for scrutiny on behalf of the Board which will continue to meet bi-monthly
- Hold quarterly meetings for all other Committees with the exception of the Charitable Funds Committee which would revert to once a year until we are in a position to re-focus resources on exploring the development of the charity further.

These revised governance arrangements will be reviewed in December 2020 and again in March 2021.

Appendix Three: Additional Detail on CTMUHB Planning and Responding to COVID-19

Creating ITU and General Bed Capacity

In response to COVID-19, the following actions were taken by CTMUHB to create additional bed capacity, informed by modelling information from WG and local modelling and planning:

- Cancellation of non-urgent activities, suspending non-urgent surgical admissions and procedures.
- Introducing hospital/departmental zoning to ensure segregation of COVID-19 and non COVID-19 patients.
- Expediting discharge of vulnerable patients from acute and community hospital settings.
- Freeing up primary care contractors and hospital bed capacity, allowing staff to plan for the urgent COVID-19 response at primary and secondary care levels.
- Huge capital estates programme to ensure facilities were available and could accommodate the oxygen, beds and equipment requirements associated with providing ventilated care. Additional ITU and general bed capacity was created – including:
    - An additional 245 beds in a range of community settings.
    - Additional beds across two field hospitals based at Hensol, in the Vale Resort (255 beds) and Bridgend (220 initial phase ready by 15 June, but with capacity for over 400 beds).
- Proactive use of independent hospital sector agreed for patient categories, linked with provision of cancer services.
- 'After Death' Strategy was agreed on the 2 April 2020, together with additional mortuary capacity (including surge capacity) also created, working successfully in partnership with the South Wales Local Resilience Forum Strategic Co-ordinating Group and its Mass Fatalities Sub-Group.

Innovation, Research and Learning from Elsewhere

- Development and implementation of a Community Respiratory hub to manage COVID-19 patients in the community for those patients not admitted to hospital.
- Use of ICT to support remote working for a range of services.
- Use of ICT to support remote clinical consultations.
- In responding to COVID-19, significant collaboration and learning has taken place with other Health Boards, English Trusts, and internationally as we've learnt and shared learning ourselves with others.

Testing

- The first Staff Testing Unit was operational on the 19th March 2020.
- Five Staff Testing Units were up and running by the 27th March, supporting health and social care, together with a Gold commitment on the 6th April to extend testing to other priority key workers.
- Testing on Hospital Discharge Procedure agreed on the 30th April 2020.
- The Mass Population Testing Unit was operational on the 7th May.
- Welsh Government subsequently released their "Test, Trace, Protect" (TTP) strategy on 13 May 2020.
- The CTM response plan, referred to as the CTM TTP Programme, is being managed on a regional (CTM) footprint.

Staff Testing Units were up and running relatively swiftly. Test result turnaround times could have been swifter initially, but this was significantly improved upon. Further testing developments since, including the introduction of Mass Testing Units and the Test, Trace and Protect programme will take this important work further, into the longer term, with the aim of continuing to protect the health of people in our communities.

Demand and Capacity Planning

Demand and capacity planning for COVID-19 changed throughout the period as a result of central advice and requirements. As did changes in clinical practice (such as use of Continuous Positive Airway Pressure (CPAP) Therapy as an alternative to ventilated care) which were incorporated into the modelling requirements, increasingly as actual data was reflected upon, together with public behavioural change as a result of social distancing. This inevitably resulted in changes to deliverables including:

- ITU and general bed numbers required.
- Mix of bed types (Oxygen/Non Oxygen).
- Community Beds required.
- Number of field hospitals and field hospital beds required
- Staffing

Workforce Planning and Response

The demand and capacity modelling has changed throughout the period, as noted above, which impacts significantly on the workforce model and requires a shift in actual and planned resources each time changes are made.

Significant action was taken to increase the staffing resource to respond to COVID-19, from new staff, to staff being re-deployed to aid the response. An extremely flexible approach to the deployment of the workforce across each site was observed.

In addition significant training and development took place to prepare and equip staff to deal with COVID-19.

Partnership and Public Involvement

The support from the public, CTM communities, local and national businesses has been remarkable, acknowledging that the COVID-19 pandemic affects every aspect of all of our business. We will continue to work hard on engagement, involvement and communication using all of the mechanisms at our disposal and in fact some of the feedback we have had on social media usage during the pandemic has been reassuring in terms of the reach we have achieved.

Appendix Four: Cwm Taf Morgannwg Essential Services

Ref No	Service	Qtr 1		Qtr 2	Score Improvement
		CTM		**CTM**	
1.2	Antenatal Services	**4**		**4**	0
1.2	Maternity Services	**3**		**3**	0
1.3	Neonatal Services	**4**		**4**	0
2.1	Hospital Paediatric Services	**2**		**2**	0
2.2.1	Patients with Neurodevelopment needs	**2**		**2**	0
2.2.2	Vulnerable Children and Families	**2.5**		**2.5**	0
2.2.3	Continuing Healthcare	**2**		**2**	0
2.2.4	Schools Vaccination programme	**3**		**3**	0
2.3	CAMHS	**2**		**2**	0
3.1.1	Breast Cancer	**3**		**3**	0
3.1.2	Lower GI Cancer	**1**		**2**	1
3.1.3	Upper GI Cancer	**1**		**2**	1
3.1.4	Head & Neck cancer	**2**		**2**	0

Ref No	Service	Qtr 1		Qtr 2	Score Improvement
		CTM		**CTM**	
3.1.5	Thyroid Cancer	**2**		**2**	1
3.1.6	Urology Cancers	**2**		**2**	0
3.1.7	Lung Cancer	**2**		**2**	0
3.1.8	Dermatology Cancers	**3**		**3**	0
3.1.9	Gynaecology cancers	**3**		**3**	0
3.2.0	Haematology	**2**		**2**	0
3.2.1	Radiotherapy	**0**		**0**	0
3.2.2	Chemotherapy	**0**		**0**	0
3.3.1	General Surgery	**2**		**2**	0
3.3.2	Vascular Surgery	**2**		**2**	0
3.3.3	Trauma & Orthopaedics	**2**		**2**	0
3.3.4	Urology	**2**		**2**	0
3.3.5	Ophthalmology	**2**		**2**	0
3.3.6	ENT	**2**		**2**	0
3.3.7	Oral & Maxillo Facial	**2**		**3**	1
3.3.8	Pain	**1**		**2**	1

Ref No	Service	Qtr 1		Qtr 2	Score Improvement
		CTM		**CTM**	
3.4.1	Cardiology	**2**		**2**	0
3.4.2	Gastroenterology	**3**		**3**	0
3.4.3	Endoscopy	**2**		**3**	1
3.4.4	Dermatology	**3**		**3**	0
3.4.5	Rheumatology	**2**		**2**	0
3.4.6	General Medicine / Care of the Elderly	**2**		**2**	0
3.4.7	Diabetes	**3**		**3**	0
3.4.8	Respiratory	**3**		**3**	0
3.4.9	Nephrology	**2**		**2**	0
3.4.10	Renal Dialysis	**0**		**0**	0
3.4.11	Blood and Transplantation Services	**0**		**0**	0
3.4.12	Pathology and Histopathology	**0**		**4**	4
3.5.1	Gynaecological Cancers	**3**		**3**	0
3.5.2	Early pregnancy complications	**3**		**3**	0

Ref No	Service	Qtr 1		Qtr 2	Score Improvement
		CTM		**CTM**	
3.5.3	Gynaecology Surgery	**2**		**2**	0
3.5.4	Termination of Pregnancies	**2**		**2**	0
3.6	Substance Misuse	**2**		**2**	0
3.7	Sexual Health	**2**		**2**	0
3.8	Urgent Diagnostics	**2**		**2**	0
4.1	Mental Health	**2**		**2**	0
4.2	Stroke Services	**3**		**3**	0
4.3	Neurological Services	**0**		**0**	0
4.4	Palliative Services	**3**		**3**	0
5.1	General Practice	**3**		**3**	0
5.2	Out of Hours Service	**3**		**2**	1
5.3	Community Pharmacy	**3**		**3**	0
5.4	Emergency and Urgent Dental Care	**2**		**2**	0
5.5	Optometry	**2**		**2**	0

HYWEL DDA UNIVERSITY HEALTH BOARD'S
WRITTEN EVIDENCE
TO THE HEALTH, SOCIAL CARE & SPORT COMMITTEE

Date of Submission: 3 July 2020

1. Hywel Dda University Health Board (the Health Board) welcomes the opportunity to contribute to the Health, Social Care and Sport Committee's inquiry into the impact of COVID-19 on services.

2. The Health Board is submitting this written evidence in advance of its attendance at the Committee meeting on 10 July 2020.

3. Maria Battle (Chair), Steve Moore (Chief Executive) and Andrew Carruthers (Chief Operating Officer) will attend the meeting (virtually) to respond to the Committee's questions.

About the Organisation

4. The Health Board is responsible for the health and well-being of its resident population and plans, provides and oversees delivery of NHS healthcare services for people in Carmarthenshire, Ceredigion, Pembrokeshire and its bordering counties. Our 11,000 members of staff provide primary, community, in-hospital, mental health and learning disabilities services for around 384,000 people across a quarter of the landmass of Wales. We do this in partnership with our three Local Authorities and public, private and third sector colleagues, including our volunteers.

An Overview of Our Response to the COVID-19 Pandemic

5. The emergence of the COVID-19 pandemic is a once in a century event which has presented challenges that the NHS has never had to face in its 72 year history. As the Chair and CEO of Hywel Dda we have been inspired, moved and filled with huge pride witnessing how our staff have responded. At every level of the organisation and in every area, we have seen wonderful acts of courage, determination and creativity at a time when many of us faced personal and professional anxiety about what was coming. We all watched the images coming out of Italy and Spain with a mix of trepidation and determination to do our very best for our local populations and our colleagues working alongside us in Hywel Dda University Health Board. We are both also very grateful for the support and leadership provided by our Local Authority partners who have helped us move at remarkable pace to care for our local population. All of this would have been severely tested, however, if our local population had not shown such strong solidarity with their local health and care services. Without their generous offers of help, vocal support and adherence to lockdown guidance we would not have been so successful in rising to the challenge.

6. Since the beginning of March the degree of change implemented across our services has been remarkable – we have implemented changes and introduced new ways of

working in a matter of days and weeks that may have taken months or years in more normal times and many of these changes will be here for the long term. At the earliest stage of planning, our aim has been to stay one step ahead of the curve. We were the first Health Board to establish Coronavirus Testing Units in February 2020, the first to develop specifications for field hospital design in February 2020, the first to develop a care and residential home escalation and support framework in March 2020 and the first to re-establish recording and live-streaming public board meetings from our May 2020 meeting onwards. This was all based on a clear command structure, on-going board and committee oversight and being open and transparent with our population.

7. In that initial stage (March 2020), the Health Board's planning was based on the Reasonable Worst Case (RWC) scenario forecasts for our population of 80% of the population becoming infected, mitigated by 66% (RWC -66%) due to the expected impact on social distancing and other measures. The RWC -66% model was constructed from the Imperial College London model prior to the additional 'lock down' announced on Monday 23rd March 2020. This model predicted a significant peak in demand for both beds and Intensive care units (ICU) demand which would exceed our capacity by a large degree.

8. As a first step, and in line with Welsh Government guidance, the Health Board suspended all non-urgent elective activity on the 13th March, allowing time and space for hospitals to reconfigure themselves, train staff and develop field hospital plans.

9. The Health Board moved at pace to establish a clear command structure, with roles and responsibilities set out for all involved. This established the governance arrangements at an early stage in our response that carried us through the initial crisis and into the current quarterly planning phase. In addition, gold level cells in the key areas of personal protective equipment (PPE) supply and COVID-19 demand modelling were established in March 2020 with additional cells - Public Health/Test Trace and Protect (TPP) Response and Social Distancing - established more recently. The statutory Committees of the Board have continued to meet virtually throughout this period to scrutinise and seek assurance on the Health Board's response to COVID 19. There has been an increased focus and strengthening on quality and safety governance arrangements with additional quality and safety meetings and additional reviews and deep dive activity undertaken.

10. The Health Board has also established an Ethics Panel as part of its command structure to guide our decision-making. This panel has met regularly since March 2020 and provided important guidance and advice to clinicians and the Board on areas such as the risks/benefits of GP visits to Care Homes, managing scarce critical care resources and the supply of equipment to other Health Boards.

11. In this early response phase, we built nine Field Hospitals, opened testing capacity across our area, reconfigured the four existing hospitals into red and green zones,

recruited almost 1000 additional staff in just weeks and rolled out software to enable virtual and home working.

12. Thankfully, our first peak was far below the level initially forecast and we have since been focusing our efforts on embedding the changes necessary to provide services whilst COVID-19 continues to circulate. Due to COVID-19 continuing to circulate in our community, we are taking a cautious approach to restoring/expanding those other services that were curtailed in the initial response phase. As such the Health Board has been developing its plans in accordance with The NHS Wales Operating Framework for Quarters 1 and 2 2020/21, outlining the need to maintain essential services and retain flexibility and adaptability to changes in community transmission rates of COVID-19.

Other Elements of Our Response

13. **PPE and Infection Prevention & Control (IP&C)** - Considerable work has been undertaken to ensure that the Health Board is in a stable position in respect of PPE. A demand management and logistics review has helped to ensure that all Health Board staff have access to the PPE they require in a timely manner, and we have been providing our staff with a weekly status report on stock levels for some time to provide assurance and confidence in supply levels. When necessary we sourced and quality assured PPE from local suppliers. We continue to work closely with Local Authorities, care providers and independent contractors to manage supplies and provide these when needed.

14. The Health Board PPE cell included representatives from across the region including local authority colleagues from all three counties to support a consistent approach to implementation of rapidly changing PPE guidelines. All service areas were represented at the PPE cell including contractor professions through an identified Health Board lead with responsibilities for primary care, community dentistry, community pharmacy and optometry. This approach ensured that issues and concerns voiced by any service area could quickly be understood and responded to. A review of the quality of PPE made available to primary care, following early concerns, which have been resolved, has also been undertaken. The Health Board PPE lead has also engaged in the national PPE cell. The Health Board IPC team has also worked very closely with LA PPE leads to ensure staff in care homes have the necessary advice and training made available to support safe care in all settings.

15. **Test Trace Protect (TTP)** - The Health Board takes its obligation to implement the Welsh Government's Test, Trace, and Protect strategy seriously and has worked in partnership with our three Local Authorities, and Public Health Wales to implement a plan for the population of West Wales. Our contact tracing service, supported by a robust sampling and testing strategy to protect our population became operational from 1st June 2020 Our plan aims to:

- Test symptomatic individuals whilst isolating from family, friends and the community
- Trace individuals who have been in close contact with symptomatic or confirmed cases who then self-isolate
- Protect others, particularly the vulnerable through advice & guidance and provision of rapid test results

16. The Health Board has a dedicated Gold Public Health Cell, as well as task and finish groups, to provide high-level ownership and a command and control structure to co-ordinate this important part of our response. Across the partnership, the Regional Oversight Group supports the co-ordinated efforts of operational Contact Tracing and Advice Teams within Local Authorities and the Health Board's Regional Response Cell to enable a swift response to all new cases however complex, along with system wide surveillance to enable an early warning system to identify potential clusters of infection and employ immediate and appropriate control measures. We have worked effectively at re-deploying our workforce to manage our response across different phases of testing and tracing, as well as with partners in the Local Resilience Forum, particularly our three local authorities.

17. **Community Testing** - The Health Board was the first organisation in Wales to open Coronavirus Testing Units (CTUs) and the first in the UK to establish a drive through phlebotomy antibody testing service at a Population Sampling Centre on 16 June 2020. The Health Board has also allocated some of its CTU capacity for antibody testing, this is available due to the low prevalence of individuals presenting with COVID symptoms currently (and hence lower demand for antigen testing), however it cannot be guaranteed long term. The preferred model going forward for our populations in parts of Pembrokeshire and Ceredigion would be to establish two mobile units to conduct antibody testing for the populations in these areas to improve accessibility and efficiency. We are aware that this model could also provide further efficiencies if the models were to be developed in collaboration with Primary Care.

18. In respect of antigen testing, the Health Board has established 5 Coronavirus Testing Units (CTUs) and coordinates the tests including any symptomatic critical staff, unpaid carers or members of the public, through its Command Centre. We also offer testing to asymptomatic individuals e.g. pre-operative patients and critical workers such as police and ambulance staff on request.

19. **Care for Our Staff** - Supporting the health and well-being of our staff, and maintaining clear communications, has been a key element of our response. From the outset we set up a central hub of information where advice and resources on how to sustain mental wellbeing and resilience during the pandemic could be accessed. Rapid psychological check-in sessions were set up for staff and for managers to share concerns, seek advice and support about team wellbeing, managing staff mental

health or sustaining their own emotional wellbeing as a leaders. Face to face clinical health psychological support was provided for our critical care staff and those working in COVID-19 areas learning from our colleagues in Italy. Based on the experience in China we set up calm rooms or cwtchs in our hospitals and the community for staff to emotionally reconnect, contact family and have a break with refreshments, toiletries and iPads with relaxing apps. Rainbow cards with details of the support available where distributed across the UHB. We enabled staff to access quickly funds generously donated by the public to support their wellbeing. We extended our staff wellbeing support to care and nursing home staff in Hywel Dda.

20. A closed Facebook page has been established to provide a fast means of communication, particularly for those staff working from home. Video-logs by members of the Executive Team have enabled the sharing of more personal and accessible updates on the work of the Health Board which has helped engender a sense of connection between staff and the senior team. These have also been made available on internal staff communication platforms, including daily updates, and a central resource on the Intranet for up-to-date guidance. Regular meetings are in place between the Executive Director of Workforce and OD the Trade Union representatives where feedback, concerns and questions can be responded to on a real time basis.

21. **Communication and Engagement** - We have also prioritised on-going and regular communication with local partners. The Chair and Chief Executive hold weekly virtual update meetings with Local Authority Chief Executives and Leaders, local MPs and MSs, and on alternate weeks with the Community Health Council (CHC) and Independent Members. These meetings have proved invaluable to coordinate our work, share the latest information and address concerns from our local population and partners.

22. **Command Centre** - In early March 2020, a Command Centre was set up to manage all incoming and outgoing communications as well as the local testing process. This has proved to be a highly effective hub which has been popular with staff, Local Authority partners and the general public. A daily dashboard is provided to Board members via the Command Centre, which facilitates near real-time tracking of key indicators to enable visibility up to the Board of the impact of COVID 19 as well as highlighting critical service issues.

Specific Operational Changes Implemented to Date

23. For a number of operational areas, services continued throughout the COVID-19 pandemic with the following impact on routine delivery as a result of the outbreak.

24. **Planned Care, Delayed Outpatients and Diagnostics -** the impact on routine delivery in Planned Care, Outpatients and Diagnostics as a result of the outbreak has been the cancellation of all non-urgent work. This does not include life threatening cancer and

other urgent surgery, urgent sight threatening ophthalmology care, urgent endoscopy and urgent outpatient appointments (such as for fractures and other unscheduled care). In terms of Radiology, whilst urgent and suspected cancer work has been maintained, some aerosol generating procedures (AGPs) have changed to alternative imaging. Imaging capacity has also significantly reduced due to the infection control procedures required and red/green patients on all sites, with changes in service delivery made by altering staffing rotas.

25. The measures that have been put in place to manage the necessary changes made to services during this time include private hospital capacity arrangements, which remain in place to support acute services due to the cancellation of non-urgent clinics. Outpatient and treatment services for Urgent Suspected Cancer and other urgent patients for General Surgery, Colorectal, Breast, Urology, Gynaecology and Ophthalmology have also continued. All outpatient face to face appointments have been clinically reviewed with a view that the majority of the work being delivered virtually in order to minimise face to face contact. All Endoscopy units have returned to function on all sites with a clinically led validation programme supported by Fecal Immunochemical Test (FIT) testing, however capacity will be reduced due to the aerosol generating nature of the procedures.

26. The additional measures we are putting in place to resume normal service delivery include streaming patient flows using patient shielding before elective admission and testing in order that COVID-19-positive and COVID-19-negative pathways are maintained as far as possible. All standard operating procedures for surgical services, operating theatres and critical care have been reviewed and adjusted as necessary to allow for a cautious approach to restarting elective services. Surgical, anaesthetic and theatre rotas are being reorganised in order that those teams undertaking elective work are separate to those undertaking emergency and on call work.

27. Prior to the pandemic, the Health Board was on track to deliver its aim of having no patients waiting for more than 36 weeks for elective care. This would have been the second year this had been achieved. As a result of the cancellation of all routine care, the numbers waiting over 36 weeks has grown significantly over the past 4 months underlining the importance of re-establishing these services albeit cautiously over the coming months.

28. **Therapies -** In terms of the impact on routine delivery within Therapies because of the outbreak, there has been a specific negative impact for Physiotherapy and Podiatry waiting times as these are a physical hands on modality, with clinical activity limited to urgent/high risk patients as per the Welsh Government guidance. Other therapy services have continued with significant elements of their activity delivered remotely using digital interface. Speech & Language referrals have reduced, particularly in relation to education referrals.

29. In terms of the measures put in place to manage the necessary changes made to services during this time, all therapy services have undertaken telephone

consultations to ensure high risk and vulnerable service users are supported remotely, with telephone consultations now being routinely used, where appropriate, in place of a face to face consultation. In addition, the Clinical Musculoskeletal Assessment & Treatment (CMAT) Physiotherapy service has gone live trialing the 'Attend Anywhere' digital platform for consultations, with expansion into Dietetics and Podiatry as part of the CMATs pilot.

30. In terms of the measures put in place to resume normal service delivery, all therapy services are developing plans that outline how to resume prioritised clinical and therapeutic activity in a safe, efficient and sustainable way, taking account of staffing, environment and equipment needs. In addition, services are identifying new ways of working that are currently in place to continue to support reset planning, and ensuring therapy services continue to support scheduled and unscheduled care pathways, together with exploration of digital solutions to address challenging areas e.g. where group therapy classes would be previously delivered, e.g. Pulmonary Rehabilitation.

31. **Cancer Services** In terms of the impact on routine delivery within Cancer services as a result of the outbreak, non-urgent diagnostic investigations have been deferred with urgent and cancer-related diagnostic investigations receiving priority. There has also been a suspension of local surgery for those patients requiring High Dependency Unit (HDU)/ Intensive Care Unit (ITU) support post operatively, with appropriate patients receiving operations in Glangwili General Hospital (GGH) as necessary. As per the Wales Bowel Cancer Initiative, FIT10 screening has been introduced in the management of urgent suspected cancer patients on the colorectal pathway as an alternative, due to the current restrictions on the normal diagnostic pathways. Although urgent and urgent suspected cancer imagining investigations are undertaken, these have been reduced to those within the parameters offered by national clinical guidance for certain aerosol generating procedures, with bronchoscopies limited in line with national guidance.

32. In terms of the measures put in place to manage the necessary changes made to services during this time, new ways of working have been introduced. As per the 6 levels of Systemic Anti-Cancer Therapy (SACT), all levels are still currently being treated across the Health Board. Werndale Hospital has been commissioned to support cancer outpatient and surgical pathways, and joint working has been progressed with regional multi-disciplinary teams for tertiary centre surgeons to provide outreach surgery in Gynaecology and Urology. Major cancer surgery has continued during the whole period at GGH for those patients who have required it.

33. Between March and May 2020, the Health Board has seen a 49% reduction of urgent suspected cancer referrals when compared with the same time period the previous year, with the greatest reduction in both head and neck 64.7% and skin 61.5%. With the exception of haematology and breast, referrals in the majority of pathways have also shown a significant reduction.

34. In recognition of the reduction in referrals, we have looked to proactively engage with the local population and community, using national communication lines reinforcing that our services continue to remain open. This has been supported by direct messaging from our lead Consultant for Cancer services encouraging those with symptoms to come forward as early as possible. Since May 2020, referrals have started to increase.

35. In terms of the measures put in place to resume normal service delivery, plans are in place for the:
    a) Reintroduction of elective cancer care for those patients who do not meet the criteria for Werndale Hospital or require HDU/ITU support in GGH. This commenced on 30 April 2020 with an additional operating list per week reinstated in GGH;
    b) High acuity cancer surgery has commenced in Prince Philip Hospital (PPH), Withybush General Hospital (WGH) and Bronglais General Hospital (BGH);
    c) Recommencement of the bronchoscopy service in PPH on 11 May 2020; and
    d) Endoscopy services have been reinstated for cancer patients across all sites (phased approach commenced on 18 May at PPH with other sites following pending completion of logistical changes to Red/Green zones).

36. **Unscheduled Care** - in order to establish separate Red and Green flows, Emergency Departments (EDs) have been redesigned on all four sites.

37. As a result, unscheduled care provision has continued to be provided on each site for the whole period. We saw a significant decline in attendances and admissions for non-COVID-19 emergencies in the early stages of the pandemic although this is returning to more normal levels.

38. **Mental Health (Adult/Older Adults)**- this service has continued to provide a full range of services throughout the pandemic response, although most face to face sessions have been stood down with telephone and video assessments taking place where required. Admission to inpatient beds are being managed, albeit on reduced bed numbers, due to the need for social distancing and introduction of red/green areas. In terms of impact on referrals to the services, and admissions, comparing average figures between 2019/20 and April/May 2020:

    a) **Adult Mental Health Services** – significant reduction in referrals (49.9% for Adult Community Mental Health Team (CMHT) referrals; 66.4% for Adult Local Primary Mental Health Support Services referrals; 25.2% for Crisis Resolution Home Treatment (CRHT) referrals), together with a significant reduction in admissions (-12% for Adult admissions) with a 38.6% reduction in occupancy.
    b) **Older Adult Mental Health** - significant reduction in referrals of 61.4%, together with a reduction in admissions (3.8%) with a 25.3% reduction in occupancy.

39. In terms of the measures put in place to provide services in new ways during this time, we have:

a) Co-located CMHT and CRHT teams to ensure service continuity over 7 day period and extended operating hours.
b) Developed Emergency Single Point of Contact and Liaison Service to manage assessments, and divert from District General Hospital (DGH) sites.
c) Centralised s.136 suite (The 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act by the police following concerns that they are suffering from a mental disorder) and development of Place of Safety in Pembrokeshire and Ceredigion to reduce conveyancing.
d) Ensured CMHTs are working with pharmacists to provide medication and blood testing effectively.
e) Commissioned third sector services adapted to provide telecare and support virtually to maintain prevention activity.
f) Ensured that discharged patients from Local Primary Mental Health Support Services (LPMHSS) are able to return to service without GP referral.
g) Brought together the Memory Assessment Service with the Older Adult CMHT to ensure service continuity over 7-day period.
h) Developed guidance to support staff and residents to remain safe in Care Homes, with staff working alongside the Long Term Care teams to support staff resilience.

40. **Mental Health (Specialist Child and Mental Health Services Crisis S-CAMHS)** - Again, although face to face sessions have been significantly reduced, telephone and video assessments are taking place where required. Autism Spectrum Disorder services have undertaken telephone assessments on high priority cases i.e. those who are transitioning to secondary school or approaching 18 (circa 40 assessments). Specialist Child and Mental Health Services Crisis teams have continued face to face contact with all cases classified as high risk, and the Early Intervention in Psychosis (EIP) Service moved to 7-day working as it was identified as a high risk/vulnerable group. In terms of impact on referrals to the services, and admissions, comparing average figures between 2019/20 and April/May 2020, referrals have reduced significantly (a difference of -52.4%) with a -14.5% difference in CAMHS ASD admissions together with a 56.3% reduction in Adult ASD occupancy.

41. **Mental Health (Intensive Psychological Therapies Service (IPTS)/Psychology Services) -** In terms of IPTS/Psychology Services, all service users waiting for a psychological assessment have been risk assessed and those high risk have received continued telephone support. There is also continued contact with all clients on the waiting list on a 12-week basis. In terms of the impact, again comparing average figures between 2019/20 and April/May 2020, referrals have reduced significantly with a difference of 57.8%.

42. In terms of the measures put in place to manage the necessary changes to services during this time, Dialectical Behaviour Therapy (DBT) team has continued face-to-face working for high-risk cases where risk assessment indicates they need ongoing support.

43. **Mental Health (Attention Deficit Hyperactivity Disorder ADHD) -** In terms of the impact on Mental Health services as a result of the outbreak, no face-to-face clinics been undertaken since the end of March 2020. Where suitable, assessments have continued by telephone. COVID-19 has had a negative impact on performance for psychological waits.

44. In terms of the measures put in place to manage the necessary changes made to services during this time, Mental Health services have processed new referrals, by sending parents/guardians a position letter highlighting that there are no face-to-face clinics and signposting them to other agencies/resources for support (e.g. Team around the Family, ADHD foundation), with anyone with an urgent concern or emergency advised to contact their GP. New ways of working include increasing the number of telephone assessments undertaken and piloting 'Attend Anywhere' as an alternative platform to deliver services.

45. In terms of the measures put in place to resume normal service delivery, Neurodevelopment ADHD services are trialling virtual platforms to re-commence follow up and new appointments. Psychological services are actively recruiting suitably skilled additional staff and a rolling rota for staff to be in work and work from home has been established. A date to resume face to face activities has also been established and the service will continue to see patients with a mixture of face to face/telephone assessments and therapy interventions. In addition, suitable accommodation is being identified for the delivery of face to face interventions that comply with social distancing.

46. **Mental Health (Community Drug & Alcohol Team) -** Again, although face to face sessions have been significantly reduced, telephone and video assessments are taking place where required and waiting lists have been developed, where appropriate. In terms of the impact, again comparing average figures between 2019/20 and April/May 2020, referrals have reduced significantly with a difference of -36%.

47. Other actions taken to ensure services are maintained include:
    a) The service is working with pharmacists to ensure that prescribing can continue as usual.
    b) A desktop review of cases has been undertaken to maintain support for high-risk patients.
    c) Existing pathways and protocols have been maintained for referrals and assessments, albeit undertaken virtually.

48. **Delayed Transfers of Care** - n the early stages of the pandemic, the Health Board saw a significant reduction in delayed transfers of care due to the huge effort by our Local Authorities and patients' families to help clear beds in readiness for a surge in COVID-19 admissions. Historically patient flow has been compromised by a high number of patients deemed medically optimised by clinicians. These patients are invariably frail and have complex care and support requirements on discharge, requiring assessments by multiple agencies and their associated professionals to determine these requirements and support discharge home. Further, these patients' transfer

home was sometimes delayed due to challenges related to domiciliary and care home (nursing and social care) availability. These high numbers of medically optimised patients was significantly reduced in the early stages of the pandemic due to the following:

- Welsh Government guidance enabling the Health Board to streamline and expedite assessments for formal care and support which includes the 'Home of Choice' policy
- Families choosing to take different decisions in relation to care provision for example families understood the need to facilitate swift discharge from the acute hospital and they were happy to provide care themselves rather than expose their vulnerable family member to the risks of transmission. The latter 'released' care availability for others who needed it to support discharge.
- Local Authorities supported the provision of additional capacity in care homes to support further assessment at home not in hospital

49. **General Medical Services (GMS)** - there has been continued provision of all essential services. National and Local Enhanced Service provision is aligned with national guidance on Directed Enhanced Services, with changes made in terms of access to GP practices.

50. The measures put in place to manage the necessary changes to services during this time include Enhanced Services provided at individual clinical discretion with E-Consult rolled out and in use in 85% of practices. The speed and scale of the roll out of this is a testament to how strongly local practices have risen to the challenges facing them and their desire to ensure Primary Care remained accessible throughout the pandemic.

51. In terms of the measures put in place to resume normal service delivery, plans are in place to support the reset programme, with a checklist developed to assist practices in ensuring the safe delivery of services, including guidance issued to GP Practices to assist in resetting Long Term Condition management safely and to protect vulnerable groups. FAQs are being developed for patients on access and the "new normal" within General Practice. Local Enhanced Services are being reviewed to offer flexibility on service provision e.g. remote consultation. Guidance on the management of long term conditions has also been issued.

52. A revised Care Home Direct Enhanced Service has been issued to Practices to commence from 1 July 2020.

53. **Community Pharmacy -** there has been continued provision of all essential services, albeit with changes in access to manage patient flow. There has however been cessation of certain enhanced services where face to face contact is essential or there is a potential for aerosol generating procedures.

54. In terms of the measures put in place to manage the necessary changes to services during this time, community pharmacies have been supported in amending their

opening hours to manage the increase in work at the peak of the pandemic, and funding made available to support community pharmacies for additional staffing.

55. Capacity to provide Monitored Dosage System (MDS) has been obtained from all pharmacies to support discharge of patients who need care packages from Local Authorities.

56. Provision of Emergency Supply of Medication, Emergency Contraception and Common Ailments Service are still in place with a move towards increased telephone consultations.

57. In terms of the measures put in place to resume normal service delivery, plans are in place to support the reset programme, with a checklist to support this. Supplies of PPE and FFP3 have been provided, as appropriate (to support the flu programme), and frequently asked questions (FAQs) have been developed to support access to Community Pharmacy services whilst recognising the need for social distancing.

58. **Dental Services -** services have been limited to urgent service provision only, with orthodontic services suspended due to concerns over aerosol generating procedures. Child General Anesthesia service has also been suspended due to concerns over aerosol generating procedures.

59. A number of measures were put in place to manage the necessary changes to services during this time, there has been establishment of Urgent Dental Care provision via the Community Dental Service, and Specialist Minor Oral Surgery service has been brought in house to continue to provide care to urgent cases.

60. In terms of the measures put in place to resume normal service delivery, a reset programme is in place, and expressions of interest sought to support the networked development of Urgent Dental Care with three General Dental Practices brought on line at the end of May 2020. A rolling programme of fit testing and supply of FFP3 is in place to support aerosol generating procedures provision. National guidance is currently awaited on orthodontic service re-establishment. There is the potential to provide FFP3 to the Child general anaesthesia service provider to reinstate service provision and FAQs are being developed for patients alongside the provision of appropriate PPE. A checklist is also being developed to assist in managing/assuring on social distancing measures in place.

61. **Optometry Services -**only urgent optometry services have been provided during the pandemic.

62. In terms of the measures put in place to manage the necessary changes to services during this time, red and green sites have been identified and are operational, with a domiciliary service established. Pathways for access to more specialist care in Optometric practices have also been put in place.

63. An all Wales acute eye care telephone advice line has been agreed through the Health Board Low Vision Service.

64. Four acute eye care hubs have been established, treating and managing acute eye care problems which would previously have required a referral into secondary care. 400 patient have been seen during Quarter 1 with 88% managed within the service with no onward referral.

65. In terms of the measures put in place to resume normal service delivery, FAQs are being developed for patients, together with a checklist to assist in managing/assuring on social distancing measures in place. A proposal to extend the continuation of provision of specialist services is to be considered alongside the provision of appropriate PPE.

66. **Care Homes -** the Health Board has built on a strong foundation of integrated working across the region with our social care partners to develop an escalation tool, regarded as best practice for adoption across Wales, for the support and management of the care home sector during the COVID-19 pandemic period which was approved on 20th May 2020, however had been operationalised since April 2020. This enabled partner organisations to identify early, respond to outbreaks within the sector, and put in place appropriate measures according to the level of pressure identified in the care home risk assessment to safeguard residents and staff.

67. The Health Board was well advanced in responding to testing of symptomatic individuals within care homes be this staff or residents. Subsequent to this on 16th May 2020, Welsh Government then issued guidance to test all care homes whether they were symptomatic or asymptomatic in a fast and enhanced way in a short timescale. The Health responded by creating a focused team, who undertook this process in accordance with the guidance by developing a clear plan which was implemented within a four week period. This involved undertaking over 10,000 tests in this four week period, ensuring the ability to actively respond to any indication of an outbreak and support the care home business and identify any need for intervention. During the testing phase, the Health Board team also took the opportunity of providing training and development for care home staff in outbreak preparedness, PPE and infection prevention and control. In addition, weekly skype calls to support resident assessment and review and for Matrons/Home Managers to support training but also importantly a forum for Care Homes to share their experiences and provide peer support were undertaken. A care home daily sitrep and escalation report was developed and multi-disciplinary team working in care management was strengthened.

68. On an ongoing basis however, regardless of whether or not a care home has experienced an outbreak, the Health Board continues to provide a level of support and monitoring across all of our care homes.

69. **Smoking Cessation -** in terms of the impact on smoking cessation as a result of the outbreak, all consultations are now provided via telephone. Smokers are no longer

carbon monoxide validated at 4 weeks post quit date due to the potential risk of COVID-19 transmission in exhaled air. Medical Humanities Research Centre (MHRC) approval was received to supply Nicotine Replacement Therapy via the post in case of any issues with access to community pharmacies and supply; however, this has yet to be fully implemented. Following the transfer of Stop Smoking Wales staff from Public Health Wales to the Health Board, a new integrated smoking cessation service has been created to provide continuity of care across secondary care, primary care and community.

70. In terms of the measures put in place to resume normal service delivery, an evaluation of the telephone support has been undertaken, and the service is currently looking at opportunities to provide group support via a digital platform such as Microsoft Teams and focus on condition specific groups that can provide additional peer support. The service continues to implement the Wellbeing/Health Coach model, and to undertake research to understand the impact of COVID-19 on smoking behaviour.

71. **Workforce - Staff psychological wellbeing service** -traditional staff support services were reviewed and strengthened and a Staff Psychological Wellbeing Plan was developed to respond to COVID-19. As the pandemic progressed we have reassessed the plan following feedback from staff experiences and the plan was further updated to meet need June 2020 This will continue to be adapted to ensure any long term effects on staff are managed to the best of our ability.

72. **Workforce - Learning and Development** - activity within the Learning and Development Department was altered from the delivery of standard training programmes to ones specifically linked to skilling the new and existing workforce for the roles they would need to undertake throughout COVID-19. In addition to a change in education requirements, there was also a need to change practice to reduce the risk of spreading the virus. Further reviews of training provision are being undertaken to support on line learning to sustain provision in line with social distancing guidelines.

73. **Workforce - Staff health - the** Occupational Health team have supported the workforce during this difficult period, in particular supporting individuals with regards to COVID-19 testing, pregnancy risk assessments and risk assessments for the BAME (Black, Asian & Minority Ethnic) workforce. The team have changed service provision to provide virtual clinics, telephone advice and support and have been core to the staff command centre linked to staff testing. Managers have been asked to support staff to continue mandatory training, with online mandatory fire safety training now available on ESR. The Occupational Development (OD) team have issued communications reiterating the need for continued performance conversations and yearly PADRs, and highlighting how these conversations support staff wellbeing.

74. **Workforce - Volunteers –** Some of the Health Boards regular volunteers understandably due to personal circumstances withdrew from service as a result of COVID-19. However, we also received an overwhelming number of individuals expressing an interest to volunteer within the services. Risk assessments were undertaken of roles, which would be suitable for volunteers to be deployed within, and these included transporting equipment/staff, check and chat volunteers, gardeners and community response drivers.

75. **Field Hospitals** – As noted above the original forecast in March 2020 was based on the Imperial College modelling before lockdown, which showed the reasonable worst case scenario of 80% of the population being infected with COVID-19 mitigated by 66% due to impact of social distancing. This showed a need for 1964 COVID-19 beds and 192 Intensive Care Beds at peak and that the peak would occur in around 12 weeks (sometime in May 2020). To respond to this, the Health Board sought to more than double its bed base (with 1,400 field hospital beds) and increase its ICU capacity by a factor of 6. Even working at huge speed, our Field Hospital work resulted in a total of 1,035 beds being established somewhat short of the initial target. As a result of a combination of the accumulation of actual data on the progress of the pandemic in Wales and a developing understanding of the most effective treatment interventions, progress on identifying new sites and ways to address ICU capacity for the shortfall was suspended in April.

76. Thankfully, our Field Hospitals have not, as yet, been brought into full service in response to the pandemic. However, with COVID-19 still in circulation and low levels of immunity in the population, they remain a vital "insurance policy" in the event of significant surges in activity. It is for this reason, to ensure existing hospitals have some capacity "headroom" that we are currently piloting their use with Carmarthen Leisure Centre field hospital, receiving a small number of patients who no longer need Doctor-led support. With the changes in the planning requirements, the table below identifies the status of these field hospitals. Plans for the others will be developed in Quarter 2.

SITE	Current Status	Predicted beds	Actual beds before social distancing	Estimated beds after social distancing
Parc y Scarlets Barn	Hibernation	260	266	212 (TBC)
Parc y Scarlets Stadium	Hibernation	92	80	64 (TBC)
Selwyn Samuel Centre	Hibernation	143	120	101
Llanelli Leisure Centre	Hibernation	154	95	69
Carmarthen Leisure Centre	Commissioned	93	93	74
Bluestone	Hibernation	128	123	74 (TBC)
South Pembs	Hibernation	32	25/27	-
Plas Crug LC	Hibernation	52	52	44
Penweddig School	Decommissioned	51		Decommissioned
Cardigan LC	Hibernation	48	48	37

77. **Value Based Health Care** - The Health Board has a Value Based Health Care (VBHC) programme in place and COVID-19 has provided the Health Board with some associated opportunities such as using patient recorded outcome measures (PROMs) to better understand circumstances of those on waiting lists, increased evidence to support patient and clinical assessment of whether they will still benefit from the proposed intervention/care, the re-introduction of activity based on need and information to inform the management of follow-up activity and administrative benefits associated with the technology that is used.

78. Going forward, the VBHC programme is prioritising the following areas:
    - Cardiac (heart failure and chest pain).
    - Trauma & Orthopaedics (hips, knees, shoulders, and elbows).
    - Ophthalmology (cataracts).
    - Emerging/high risk areas for consideration and prioritisation?
    - Establishing a high quality faculty development and education programme in place.

Learning from the Pandemic – Our Transformation Opportunities

79. At Hywel Dda, we were always looking to emerge from the pandemic as smoothly as possible and ensuring actions to improve organisational sustainability were progressed where appropriate. In March, we established a Recovery, Learning and Innovation Group to capture changes being made to our services that has now become our Transformation Steering Group. Its remit is:

    - To learn from the pandemic and our response to it (both within the Health Board and more widely with partners and our communities).
    - To translate this learning into practical applications and approaches that transform our services today and over the lifetime of our strategy – A Healthy Mid and West Wales.

80. The Transformation Steering Group reports directly to the Board and is led by the Chief Executive. It will provide advice to the Board on changes to be adopted into current services and ways to enhance future plans. It is intended to become a permanent feature of the Health Board arrangements and will be a key driver of our ambition to deliver our social model for health. The advent of COVID-19 and what we have learnt will serve to enhance and accelerate our direction of travel.

81. We have already sought feedback via interview and survey from over 170 Health Board staff and our Local Authority partners on the changes they have made or witnessed in our response to the pandemic. We are also capturing the learning from other parts of Wales, the UK, overseas organisations and previous pandemics in order to cast as wide a net as possible on the opportunities we have to transform our services. We are using this to develop a comprehensive 'Discovery Report' for our public Board meeting and our Local Authority partners in July 2020.

82. In mid-July, we are holding a virtual transformation event involving 75 staff and partners to share this report and agree our next set of priorities to help us drive our existing strategy further and faster.

Conclusions

75. There have been many lessons to learn from this pandemic in both the way we work as an organisation and the way in which we provide services and support to our population. Embedding the changes we have seen will provide fresh impetus to the delivery of our strategic plan – A Healthier Mid and West Wales – enabling us to go further and faster than we envisaged when we published it in November 2018. Over the last few months we have seen the "social model of health" that we aspired to in that plan emerge in front of us as communities and services came together to support each other. With our local partners we want to do everything we can to cement this progress and continue to drive it forward.

76. There are however challenges in the short term that we must continue to overcome. COVID-19 has made people understandably cautious about accessing our services, particularly in hospital settings. Whilst we have seen a return of non- COVID emergency activity to more normal levels, cancer referrals, for example, remain low by historical standards and we need to address this. Access to routine surgery will be a different experience for patients with requirements to self isolate for 14 days, be tested and have additional radiology prior to their procedure. The need for staff to "don & doff" regularly will reduce our capacity as will the need to socially distance our hospital beds.

77. We are also looking ahead into the winter which is traditionally our busiest time of year. Our staff have worked at significant pace for months to prepare for the pandemic, the virus is still in circulation and the risk of further, possibly higher peaks is a constant danger. Added to the potential loss of our newly recruited staff as other areas of the economy and further education reopen and the potential loss of field hospital capacity as sport, fitness, schools and tourism reopen we face the risk of a "perfect storm" as we enter the autumn.

78. Therefore, whilst we are focusing on securing the positive and beneficial changes made in our initial response, we are in a period of careful and cautious planning about the next 6 months. History shows that, eventually, every pandemic ends and life returns to normal but we are very conscious that this pandemic yet ended and normality is still some way off.

Agenda Item 5

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

COVID 19 : EVIDENCE TO THE HEALTH, SOCIAL CARE & SPORTS COMMITTEE

10TH July 2020

1. INTRODUCTION

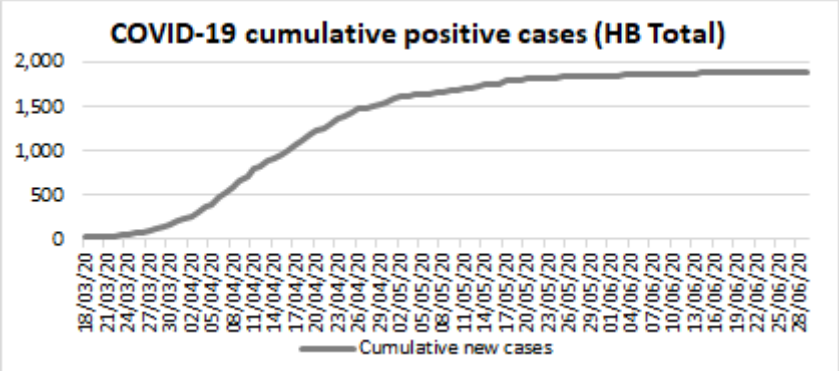
1.1 Swansea Bay University Health Board (SBUHB) welcomes the opportunity to respond to the Health, Social Care and Sport Committee's inquiry into the COVID-19 outbreak.

2. RESPONDING TO THE COVID 19 PANDEMIC

Overview

2.1 The challenges posed by COVID-19 are immense and over the last 4 months the Health Board has needed to adapt its services at an unprecedented scale in order to meet the demand arising out of COVID-19 and to continue to deliver safe care.

2.2 The pandemic is not over. The Health Board remains on a 'response' footing, alert to the very real potential of future surges of transmission of COVID-19 in our community. This continues to have a very significant impact on both the volume and nature of service delivery. Figure 1 below illustrates the cumulative number of confirmed COVID-19 case in the Swansea Bay region since the 18th of March.



2.3 The Health Board established a Pandemic Framework and Tactical Plan as part of a broader suite of local, regional and national emergency response plans and these guided the response to COVID-19. These response arrangements are aligned with the Civil Contingencies Act 2004. A dedicated COVID-19 Coordination Centre was established 16 March 2020.

2.4 A whole system approach to creating flexible capacity within the Health Board was adopted and has allowed for extensive innovation in how we care for patients at home, in the community or in hospital. Working with partners, sufficient capacity was in place to support the first peak of COVID-19 cases during April. This was achieved by remodelling existing capacity; creating surge options on hospital sites and in the community; and developing resilience in our system through working with partners in the development of additional field hospital provision at Llandarcy and the Bay Studios in Swansea.

2.5 The Health Board developed an integrated dashboard providing real-time information on a range of critical measures. A local predictive demand model was also developed, providing short-term (up to 10 days) forecasts to enable rapid adjustment of plans.

Operational Arrangements

2.6 Services have been adapted to manage both the flow of COVID-19 patients (including those who are suspected of being infected) and patients assumed to be non-COVID-19. An initial capacity plan was developed in line with Welsh Government (WG) direction. The modelling received, supported by local clinical judgements, indicated the requirement for significant additional acute and critical care beds within the Health Board to meet reasonable worst-case estimates of COVID-19 demand. Plans for quarter 2 are currently being refined in the light of new national modelling and planning assumptions provided by Welsh Government.

Primary Care

2.7 New ways of working were adopted within Primary Care. New innovative models have been created including Community Hubs for managing COVID-19 in the community, the introduction of new triage systems, and a shift to digital technology and remote consulting. Arrangements for all primary care contractors (General Practice, Dental, Optometry and Pharmacy) are managed in line with Welsh Government guidance.

Community Services

2.8 Core community services have been maintained to support patients to remain in their own homes. Community staff have also been deployed flexibly to support other services such as community testing.

Social Care

2.9 As part of our oversight arrangements, a Community Silver cell, spanning health, social care and the third sector, has supported the accelerated development of new integrated care models. The Health Board has worked very closely with Local Authority colleagues over support to care homes, including on the provision of testing for COVID-19.

Mental Health

2.10 Mental Health services have been adapted so that they could be maintained during the pandemic, including through the use of virtual appointments, where appropriate, streamlined referrals routes and points of contact, and the provision of isolation facilities to manage COVID-19 patients with mental health problems who needed hospital admission.

Hospital Services

2.11 New pathways for COVID-19 patients were created at each of our acute hospital sites - Morriston, Singleton and Neath Port Talbot. Many changes were in line with our Clinical Services Plan but have been able to be enacted quickly through agile and

adaptive clinical and managerial responses. An example of this is the creation of a Single Point of Access for Paediatrics at Morriston that integrates the service offered by Emergency Physicians and Paediatric specialists.

2.12 Additional critical care capacity was created to maintain a separation of known COVID-19 positive patients from others. This enabled us to respond to the first peak and further capacity is now available to support future peaks in demand.

Test, Trace and Protect

2.13 Antigen testing began in February and the first Community Testing Unit (CTU) in Margam opened in March, followed by a second CTU at the Liberty Stadium in May. To date, in excess of 15,500 antigen tests and 11,200 antibody (serology) tests have been undertaken. Data from Public Health Wales confirms that the SBUHB aggregate testing numbers have been consistently high when compared with other Health Boards in Wales. Testing of all care home residents and staff was completed in mid-June. A regional Test, Trace and Protect service is live and there are 14 local contact tracing teams in place across Swansea and Neath Port Talbot.

<u>Key Issues</u>

Workforce

2.14 We pay tribute to the professionalism, commitment and compassion shown by our staff in responding to the pandemic, as well as staff in partner organisations.

2.15 During the pandemic over 1,000 additional staff were recruited and over 900 staff retrained or upskilled in new roles to support the COVID-19 effort. This includes over 150 additional clinical staff trained to provide critical care; nearly 200 non-clinical staff trained to undertake Healthcare Support Worker roles; and significant numbers trained to undertake new roles in our COVID-19 testing units. Staff have been deployed flexibly and there has been positive feedback on the opportunities created to develop new workforce models.

2.16 Supporting staff wellbeing has been a critical feature of the Health Board's response, recognising the enormity of what staff are dealing with. Several wellbeing initiatives and support arrangements are in place. Occupational health and staff well-being services have been expanded and operate 7 days a week. A Trauma Risk Management approach has been adopted to support long term psychological health and well-being. Through collaborative working with Trade Union partners, the Board has undertaken a detailed review of the impact of COVID-19 on local staff and has supported the national development of a risk assessment tool that is currently being used to identify and support staff who may be at disproportionate risk from COVID-19.

Personal Protective Equipment (PPE)

2.17 The Health Board has sufficient supplies of PPE and supply chains are currently stable. Where necessary we have sourced local supplies as well as accessed the national supply chain. Early in our response we developed a stock control system and a PPE model to support stock management and the military provided support to ensure that our systems are robust. There were several changes in guidance during

April, and we continue to manage PPE in line with national guidance. The Health Board has distributed almost 2.5 million items of PPE since 30th March 2020.

Digital

2.18 One of the key facets of our approach has been the delivery of digital solutions to support the pandemic, both in terms of the delivery of direct patient care as well as back office functions. A number of innovative solutions have been rolled out to support clinicians to provide care in new ways. These include video consulting platforms; applications enabling clinicians from primary and secondary care to engage directly for advice on patient management and patient facing applications that empower patients to manage their own care. New systems that support patient flow; manage electronic prescribing and support day to day business (such as Office 365) have been deployed rapidly.

3. **IMPACT ON ROUTINE SERVICES**

Creating COVID-19 capacity

3.1 The Minister for Health and Social Services announced on 13th March 2020 a number of key COVID-19 related actions NHS Wales should take. These actions included guidance to suspend a range of activity to enable dedicated capacity for COVID-19 to be built up and to protect vulnerable patients.

3.2 As a result of the Minister's announcement, SBUHB took the following action:

- Non-urgent outpatient appointments were suspended with a number of exceptions mainly in the areas of paediatrics, neonatology, ophthalmology, oncology and renal services. Urgent outpatient activity has continued albeit adapted and delivered through different modalities using digital technology.
- Non-urgent surgical admissions and procedures were suspended, and for a 2-week period to allow intensive upskilling of theatre staff in critical care, some urgent procedures, such as cancer surgeries, were postponed. Emergency surgery continued to be prioritised daily.

Accessing Care

3.3 Although access to essential and emergency services has been maintained in common with other parts of the NHS, there was a considerable decrease in the number of patients accessing care during March and April. This was evident through a decrease in the number of patients attending Emergency Departments (see figure 2); as well as a significant decrease in patients being referred for outpatient assessment (see figure 3). The level of emergency demand increased in May and continues to increase (currently averaging around 80% of expected seasonal activity).

Figure 2: Attendance at Emergency Departments within Swansea Bay

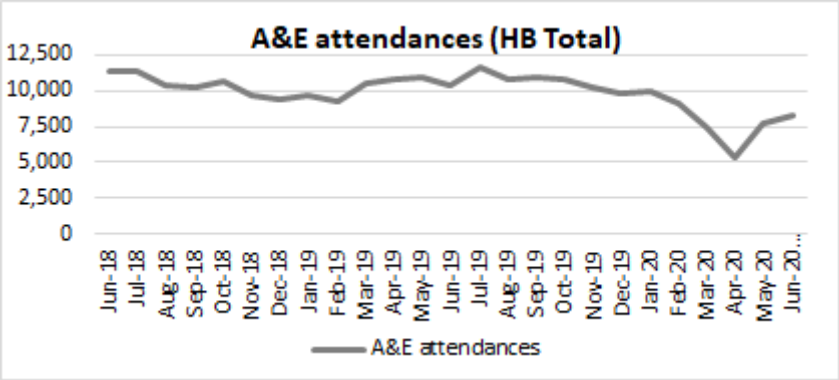
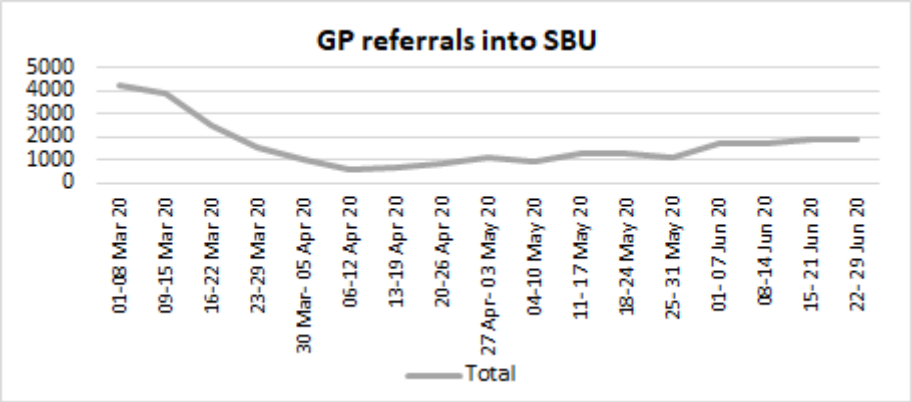


Figure 3: Number of new Outpatient Referrals into Swansea Bay



3.4 Numerous high-profile communications have been delivered nationally and locally to remind patients that the NHS in Wales remains open and emergency or urgent care can be accessed in the community and in hospitals. In the Swansea Bay region this has included the Chair and the Chief Executive publishing an open letter in the local press encouraging the local population to access care appropriately.

<u>Accessing Primary Care</u>

3.5 All GP practices have remained open during the pandemic but have operated "behind closed doors" (that is, no walk-in appointments permitted and only those patients pre-assessed via phone triage being given face-to-face appointments). At the height of the first peak about 60 GPs (about 25%) were absent from work as a result of a need to self-isolate. The number has reduced over recent weeks and currently stands at 2. A national escalation tool has been launched for GP practices.

3.6 There has been rapid deployment of digital platforms to assist virtual working and continuity of services during the pandemic. The *Ask My GP* platform, allowing digital interaction between patients and practices, has been launched and has already been adopted by over half of practices. We continue to support others to take advantage of

the platform. Similarly, *Attend Anywhere (a* video consulting service that enables people to have health and social care appointments from home or wherever is convenient), was also made available to GP Practices nationally on 7th April, and 78% of SBUHB practices to date have utilised the technology.

3.7 *Consultant Connect* is an application enabling primary care clinicians to directly access advice and guidance from secondary care clinicians to support patient. It can potentially reduce referrals between clinicians or delays in accessing advice. It was launched on 8th April and 39 out of 49 practices have utilised the service to date with 255 calls made. In addition, cluster funds have been used extensively to support GP practices to respond to the pandemic and embrace mobile working through the provision of mobile devices.

3.8 Primary Care Cluster COVID assessment hubs were set up in 7 cluster areas covering 32 practices. Currently due to a lack of demand only three are currently operating but the others can be re-established if needed.

Accessing Mental Health Services

3.9 The Health Board continues to provide mental health services with adjustments made to take account of infection prevention and control advice as well as to comply with lockdown restrictions. This has meant a reduction in face-to-face contacts with alternative approaches implemented to undertake assessments or provide support. Where the only means to provide services was by direct contact this has continued to take place with staff taking all appropriate safeguards to maintain their safety as well as that of patients including social distancing and use of PPE

3.10 All referrals for Primary Mental Health assessments under Part 1 of the Mental Health Measure have been received and processed in line with the 28-day target via a telephone assessment/triage model during the pandemic. Community staff risk assessed their caseload to prioritise regular contact and welfare checks. Most of this was undertaken via the phone but some face-to-face patient visits were undertaken where necessary.

3.11 Monitoring clinics for specific treatments have been maintained with suitable social distancing procedures for people attending community teams. This includes Lithium clinics for bipolar disorder, clozapine atypical antipsychotic medication monitoring and depot antipsychotic treatment clinics.

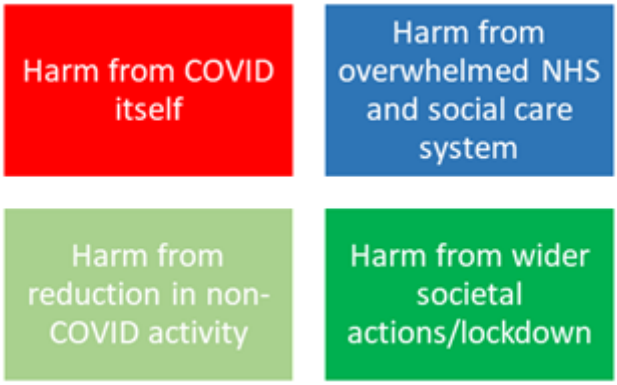
3.12 The crisis/home treatment and inpatients services continued to operate as normal.

3.13 Child and Adolescent Mental Health Services have fast-tracked the implementation of a Single Point of Referral Team (SPORT). SPORT activity has gradually increased over the course of the pandemic and SPORT interventions (consultation, advice, self-help support / resources, signposting, etc.) are likely to be contributing to the ongoing pattern of reduced referrals into both primary and secondary CAMHS services.

4. RESET AND RECVOERY

Essential Services

4.1 Welsh Government is framing the national COVID-19 response and the work of "essential services" against 4 key harms. Underpinning the four harms framework is guidance on essential services which was initially issued as part of a national Quarter 1 Operating Framework and reissued and updated under the Quarter 2 Operating Framework.



4.2 The essential services framework is based on World Health Organisation (WHO) guidance. It is complemented by a suite of additional guidance documents focused on specific services.

4.3 A SBUHB baseline assessment against the Essential Services Framework has been undertaken. Positively, there are no services categorised as essential that have been stopped in their entirety, and we continue to expand services where it is appropriate and safe to do so. We are focusing particularly on surgery, diagnostics and primary care recovery.

Reset and Recovery

4.4 As the NHS in Wales moves towards a new phase in the response to the pandemic, in addition to providing a high standard of care to patients with Covid-19 and maintaining essential services, there is a need to provide a variety of other services, including planned surgery and diagnostic procedures. A Reset and Recovery Programme is underway to focus on the delivery of essential services and to ensure that the benefits of service change evident through the pandemic are maximised.

4.5 The approach to the maintenance or reintroduction of essential services is clinically-led and quality-driven. Features of the approach include:

- An overarching clinical governance framework that ensures a strategic approach to best practice and clinical governance in the context of essential services. This includes references to national guidelines, the national COVID-19 pathway, co-production with patients, informed consent best practice and infection prevention and control requirements;
- Establishment of a Clinical Advisory Group to advise on local policies and processes that align with all-Wales and UK evidence and guidance;

- Deployment of a Quality Impact Assessment (QIA) process, overseen by clinical Executive Directors and supported by a QIA panel to assess the reinstatement of activity to ensure it is structured, controlled and based on effective risk management;
- Use of established quality processes such as incident reporting where delays due to COVID-19 have potentially resulted in harm; and
- Using clinical teams to prioritise patients for treatments.

4.6 Sophisticated demand and capacity models have been developed by the Health Board to aid with the detailed planning. The models illustrate the likely impact of various levels of COVID-19 demand and other factors on the general and critical care bed base. A complex interaction of several factors influences the capacity available, most notably workforce.

4.7 Infection prevention and control is a significant component of this next phase where the need to minimise nosocomial (in-hospital) transmission of Covid-19 is critical. A self-assessment against guidance produced by the NHS Wales Nosocomial Transmission Group is being taken forward; and locally a Social Distancing Cell has been established which focuses on physical distancing requirements as well as behaviour aspects. This is critical as the development of the Test, Track and Protect programme could have a significant impact on NHS services if social distancing is not maintained.

5. **CONCLUSION AND KEY LEARNING POINTS**

5.1 The impact of the COVID-19 pandemic has already been far-reaching for healthcare and wider society. Tragically, there has been the loss of many lives in our hospitals and our communities, including of Health Board staff members. Our condolences go out to the family, friends and colleagues of those who lost their lives to COVID-19.

5.2 While unprecedented in modern times, the scale of the first peak of COVID-19 related demand was nevertheless mitigated to some extent by the sacrifices made by our local populations in abiding by the lockdown measures introduced by the Welsh Government. The Health Board is very grateful. The additional capacity created, in line with appropriate assumptions and modelling of a reasonable worse case scenario, has allowed for COVID-19 demand to date to be met.

5.3 The Health Board has demonstrated an ability to respond and adapt to the demands with pace, energy and purpose. We are grateful to all our staff and partners for the part they have played in that effort to date.

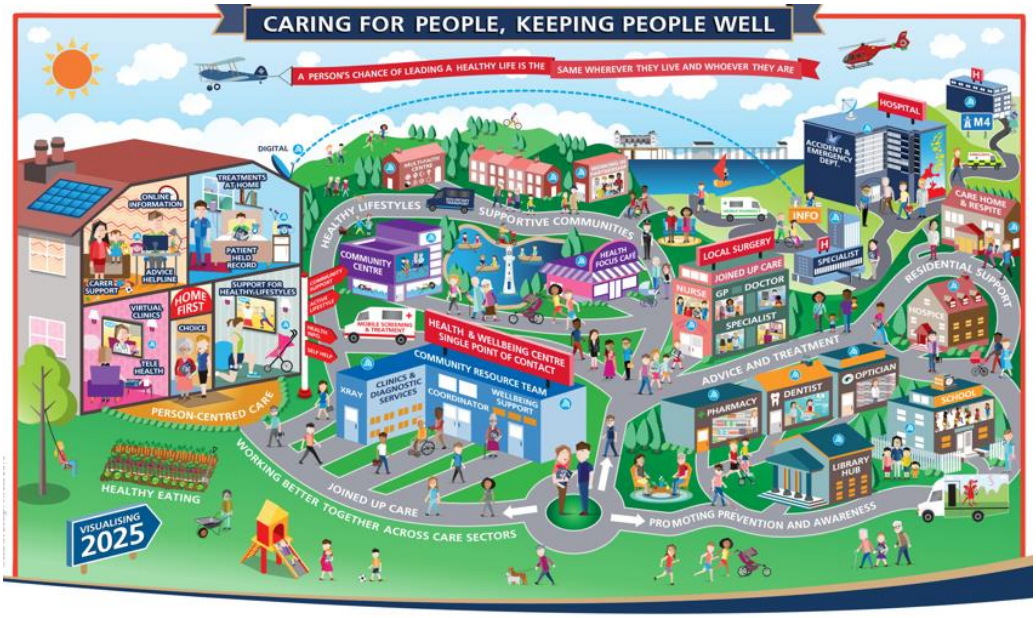
5.4 In several areas the response to the pandemic has required or enabled a transformation in the way services are delivered that the Health Board will be ‘locking in’ as the new normal. This includes the extensive use of digital platforms; the

strengthened integration of health and social care; and new models of care, for instance in outpatients and unscheduled care.

5.5 The pandemic is still with us and its impact will be long-lasting. Recognising this, it is critical that the Health Board takes a cautious and adaptive approach to the delivery and reinstatement of non-COVID-19 services. It is doing so in a way that it patient-centred, clinically-led and quality driven.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

CARDIFF AND VALE UNIVERSITY HEALTH BOARD



COVID 19: EVIDENCE TO THE HEALTH, SOCIAL CARE & SPORTS COMMITTEE

10th July 2020

Cardiff and Vale Submission to the Health, Social Care and Sports Committee

COVID-19

Contents

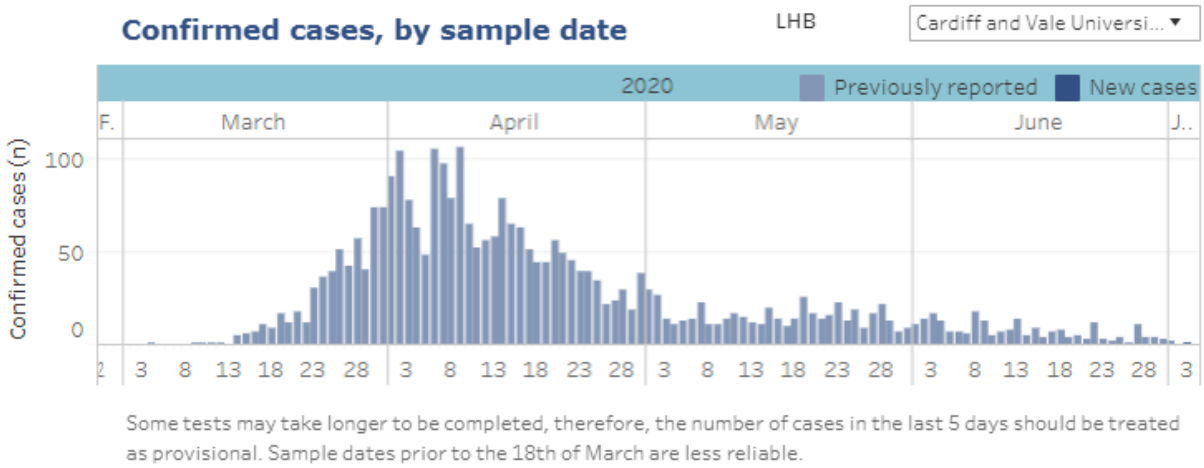
1. INTRODUCTION

1.1 This is Cardiff and Vale's written submission to the Health, Social Care and Sports Committee in advance of the oral evidence session on Friday 10th July.

2. OVERVIEW OF CARDIFF AND VALE UHB'S RESPONSE TO THE PANDEMIC TO DATE

2.1 The coronavirus pandemic reached the UK in February and cases of Covid-19 began to emerge in Cardiff and Vale in early March (see Figure 1). In general the spread of the pandemic in Wales was slightly behind that of the rest of the UK but the virus impacted Cardiff and the Vale of Glamorgan earlier than most other areas of Wales, with the exception of Gwent.

Figure 1: Confirmed Covid-19 cases Cardiff and Vale



2.2 Initial modelling at UK and Wales level identified the potential for an extreme surge event, with a substantial peak in cases, hospitalisation, critical care requirement and deaths. For the Cardiff and Vale population this translated, without mitigation (i.e. behavioural and social interventions), to the potential for 81% of the population to be infected, of which over 30,000 individuals could be hospitalised. With mitigations, *the reasonable worst case* (RWC) *scenario* projected 650-2600 Covid patients in hospital at the peak of the pandemic (Cardiff and Vale population). At this early stage the UHB based its capacity planning on this *mitigated* RWC.

2.3 A three phase plan was rapidly put in place by the Health Board in order to respond to the impact of the anticipated surge in demand:

Phase 1 – Repurposing capacity and zoning
Phase 2 – Commissioning additional capacity within UHB facilities
Phase 3 – 'In extremis', commissioning capacity outside UHB facilities (the Dragon's Heart Hospital)

2.4 The infection in Cardiff and Vale spread rapidly initially, growing from individual cases in early March to over 100 daily confirmed cases on Thursday 2nd April 2020. During

this period the virus had developed earlier in some European countries (e.g. Italy) than the UK and other parts of the UK, particularly London, were ahead of Wales in the spread. Experience from these areas was reinforcing the potential for health services to be overwhelmed.

2.5 In the first week of April the advice from Public Health Wales was that the doubling rate for Cardiff and Vale remained around 4 days, slightly faster than the all-Wales position, and this was the best approach to short-term capacity planning. Extrapolation of the position on the 1st April 2020 utilising this doubling rate suggested the UHB's phase 1 and phase 2 capacity would be exceeded within one week and, without a slowing of the spread, would mean over 1500 Covid patients in hospital by 15th April 2020.

2.6 On 4th April the Director General wrote to the Health Board requesting confirmation of plans for capacity for up to 143 critical care beds and 1592 acute beds.

2.7 By the week commencing the 6th April 2020 there was evidence that the spread of the virus was beginning to slow following the 'lockdown' measures implemented by the UK Government on 23rd March. Analysis on 7th April from PHW identified the Wales doubling rate had slowed to 5.5 days for Wales (however it was still around 4 days for Cardiff and Vale).

2.8 The number of new confirmed cases peaked for both Cardiff and Vale and Wales on 9th April. The number of Covid patients in hospital peaked the week following.

2.9 Key achievements during the first wave of the Covid-19 pandemic include the following:

Table 1: Key achievements during initial wave

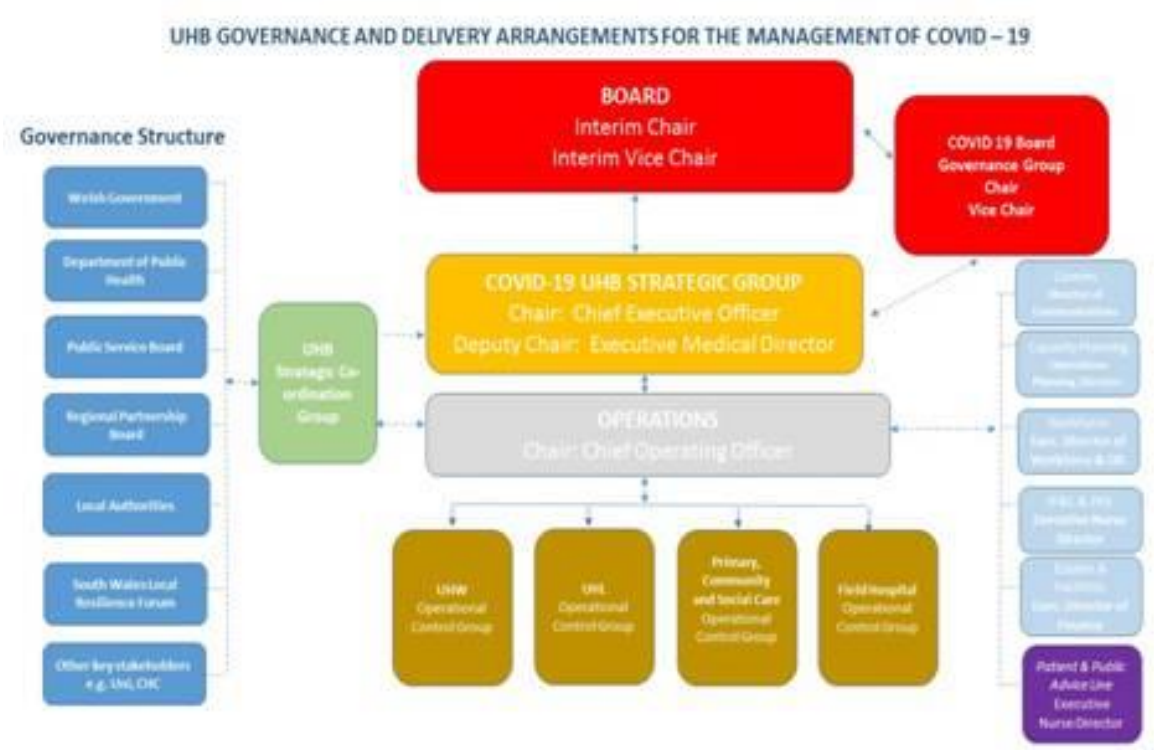
A 1500 bed facility commissioned at the Dragon's Heart Hospital	Over 300 additional beds repurposed on existing sites for cohorting of Covid patients	Expansion of the critical care unit to 85 beds - a 124% increase	2757 cancer and other urgent activity delivered at Spire Hospital	1162 elective and 961 emergency surgical procedures, all with outcomes audited
Conversion of four areas to wards and build of new HCID unit	7996 staff tested and their household contacts	Recruited 1178 additional staff	21,330 Coronavirus tests undertaken	832 Covid patients discharged home
Essential services maintained throughout	Roll out of virtual appointments and digital solutions	TTP service established 1st June and over 300 people followed up in first month	Worked with partners to improve discharge processes and reduce homelessness	Surveyed over 700 patients following discharge from hospital

3. STRATEGIC RESPONSE

3.1 Governance

3.1.1 From the outset of the pandemic the UHB rapidly established the governance structure below to oversee its response to the Covid outbreak:

Figure 2: UHB Governance Arrangements for Covid-19



3.1.2 The Covid-19 Board Governance Group was established in April 2020 to scrutinise the decisions of our Strategic Group and provide support to the Chief Executive and Executive Directors to allow those decisions to progress quickly but within a governance framework with appropriate audit trail. This meeting was developed as a Chair's action group which has the same authority as the Chair has when signing off Chairs actions. The difference is the way the Chairs actions are being executed in that those involved are meeting virtually to enable robust discussion and scrutiny of decision being made. The membership of the group is the Chair, Vice Chair, Audit Committee Chair and Chief Executive. The Group is also attended by the Director of Corporate Governance.

Decisions are formally recorded and reported to the next meeting of the Board for consideration and ratification.

Its remit is as follows:

- Decisions reserved for the Board in line with Standing Orders;
- Decisions with a financial value over £500k;
- Legal documents and contracts of significance either in value or content;
- Decisions with the potential for reputational damage;

- Strategic decisions beyond the authority of the UHB Strategic Group;
- Any other decisions requiring approval of the Group.

3.2 Local Resilience Forum

3.2.1 The UHB has actively engaged with partners throughout the response to Covid-19, in particular as a Category One responder under the Civil Contingencies Act through the South Wales Local Resilience Forum (SWLRF). SWLRF established its command and control structures in early March to coordinate the partnership response to emerging issues across South Wales; and the UHB has attended and contributed to twice weekly meetings of the Strategic and Tactical Coordination Groups ever since.

3.2.2 As part of the process, each organisation has been submitting daily situation reports, collated by SWLRF to provide situational awareness for all, and to inform Welsh Government on emerging issues such as mortuary capacity, PPE, sickness absence, field hospitals, testing and medical / pharmaceutical supply challenges.

3.2.3 Of the emerging issues, early on SWLRF identified a need to establish additional storage capacity for deceased patients across South Wales. Through rapid effective partnership working, multi-agency plans were initiated under Operation CAMWOOD; the South Wales response to establishing and operating a temporary storage facility in Cardiff Bay.

3.2.4 Access to sufficient suitable PPE has been an ongoing challenge for all organisations. The UHB has had a full system in place for PPE, controlled by our Deputy Exec Nurse Director and Head of Procurement. We continue to assist with PPE supply for partners who are caring for NHS patients on a case by case basis, and set up a contact point early to assist with urgent requests.

3.3 Financial Governance

3.3.1 The Welsh Government wrote to the UHB on 19th March 2020 to inform it whilst it had an approvable plan, it had paused the IMTP process for an indefinite period so that organisations could focus on the challenges of Covid-19. The main focus of the UHB is managing the impact of Covid, which will inevitably come with a significant cost.

3.3.2 The UHB is incurring significant additional expenditure as a result of Covid. The costs of the Dragon's Heart Hospital are significant, especially the set up costs which allow for significant expansion. In addition, the UHB is incurring additional costs to cover sickness and absence and to resource the additional Covid hospital capacity that has been been generated.

3.3.3 Covid-19 is also adversley impacting on the UHB savings programme with substantial underachievment against the annual savings plan. It is not anticipated that this will improve until the Covid pandemic passes. Elective work has been significantly curtailed during this period as part of the UHB response to Covid and this has seen a reduction in planned expenditure.

3.4 Demand modelling

3.4.1 The initial Health Board level modelling was issued by Welsh Government on 9th March 2020. It projected the potential scale of the peak by Health Board, the *Reasonable Worst Case Scenario* (RWC), in two forms: without mitigations and with social distancing measures in place. Social distancing measures were predicted to reduce the size of the peak by 66%. Given the uncertainty these two scenarios were also scaled at 100%, 75%, 50% and 25% to produce a range of possible outcomes. The modelling did not provide an indication of when the peak might occur.

3.4.2 Without mitigations the virus was projected to infect 81% of the population and the (100%) RWC peak for Cardiff and Vale was calculated to exceed 1000 daily Covid hospital admissions and exceed 7000 patients in hospital. This is set against the UHB's total adult hospital bed capacity of c.1300 beds (excluding mental health and maternity). With social distancing measures in place the predictions ranged from 87-349 daily admissions and 654-2618 hospital beds occupied by Covid patients, of which 63-252 would be critical care.

3.4.3 These scenarios were presented to the Strategic Group on 19th March 2020 and were combined with non-Covid demand projections and bed capacity plans to identify the potential bed deficits facing the UHB. The UHB adopted the planning assumption that the social distancing measures (lockdown) would be introduced and this would have the effect of reducing the peak as predicted by the modelling. In addition it was assumed elective surgery would cease entirely at the peak and non-Covid demand would reduce to 80% of normal levels. Nonetheless this left the UHB with a bed deficit of 200-2100 beds at the peak (the range relating to 25%-100% of the mitigated RWC).

3.4.4 A series of revised models were subsequently produced nationally, taking into account the effects of lockdown at different levels of public compliance. These models were anticipated to better reflect actual expected numbers but with a degree of uncertainty on compliance and timing. PHW advice remained for planning to be based upon the earlier mitigated RWC estimates and short-term estimation based on real-world local data combined with doubling-rates of 3-5 days.

3.4.5 Up to the 2nd April 2020 the bed occupancy profile of the UHB was closely tracking the 100% mitigated RWC, i.e. the scenario which peaked at a bed deficit of 2100 beds. The advice from Public Health Wales was that the doubling rate for Cardiff and Vale remained around 4 days, slightly faster than the all-Wales position, and this was the best approach to short-term capacity planning. Extrapolation of the position on the 2nd April 2020 utilising this doubling rate suggested the UHB's phase 1 and phase 2 capacity would be exceeded within one week and, without a slowing of the spread,

would mean over 1500 Covid patients in hospital by 15th April 2020. In other words, if the doubling rate continued, the DHH would be required to open on the 8th April and could have up to 1000 Covid patients by the end of its first week.

3.4.6 The Health Board received a letter from the Director General on the 4th April 2020 advising that the Welsh Government view was Cardiff and Vale UHB required Covid capacity of up to 143 critical care beds and 1592 acute beds.

3.4.7 During the week commencing the 6th April there was evidence that the social distancing measures were taking effect and demand was beginning to flatten both across Wales and in Cardiff and Vale. PHW advised on 7th April that at an all-Wales level it was anticipated the peak would be reached within one week. An update on demand went to the UHB's Strategic Group on 9th April predicting that the UHB was reaching an inflection point and the bed requirement might increase by up to a further 50 beds over the forthcoming week, i.e. not see the exponential increase in demand considered possible one week earlier.

3.4.8 The peak in new cases occurred on the 9th April for Cardiff and Vale and hospital bed occupancy peaked the following week.

3.4.9 During the pandemic the UHB has developed, through its partnership with Lightfoot Solutions, its own local demand models to project admissions and bed requirements at different infection rates and utilising local data on length of stay. This continues to be utilised to scenario plan the capacity implications of a second wave of Covid infections.

3.5 Testing

3.5.1 Across Cardiff and the Vale of Glamorgan, the approach to testing has been aligned to the UK-wide Coronavirus action plan:

1. **Containment -** Prior and up to the announcement of the global pandemic on 11th March 2020, the aim was to identify and test all early cases in the local general population, using the RT-PCR throat swab. Working jointly with Public Health Wales, Community Resource Teams in the UHB enabled testing to take place promptly where people resided. Only a relatively small number of cases were identified during this time, 27 positive out of a total of 165 tests.

2. **Delay -** Following on from the pandemic announcement, and in order to 'flatten the curve', we followed UK Government advice and testing was reserved for those admitted to hospital and a small number of priority front line staff only. RT-PCR testing was conducted by hospital staff, and Primary, Community and Intermediate Care (PCIC) staff, respectively.

3. **Research –** Local research aligned to testing includes the use of near patient testing in Emergency Units (EU), to test the ability of EU staff to take the test and to see how the test performed against the RT-PCR test.

The trial of an Antibody testing service for healthcare workers began on 19th June 2020, utilising a venepuncture pathway on 400 pathology service staff, who received their results via the NHS Wales Text Service. Work is ongoing to expand this service to Clinical Boards and Corporate Departments.

The UHB began phased testing utilising Point of Care Testing (POCT), for teachers and other school staff on Monday 29th June 2020. Of the 187 schools in Cardiff (130) and the Vale of Glamorgan (57); 15.7% or 9 schools have been completed in the Vale, with a further six booked in for 2-3rd July 2020. The programme for Cardiff schools is currently being finalising, with testing anticipated to start early next week.

4. **Mitigation –** the current testing regime continues to focus on symptomatic individuals, including inpatients, key workers or members of the community. However, following government policy aimed at maximising reassurance to the care home community specifically, the UHB now also tests hospital inpatients prior to discharge to care homes and asymptomatic staff and residents in a 'whole home' testing programme.

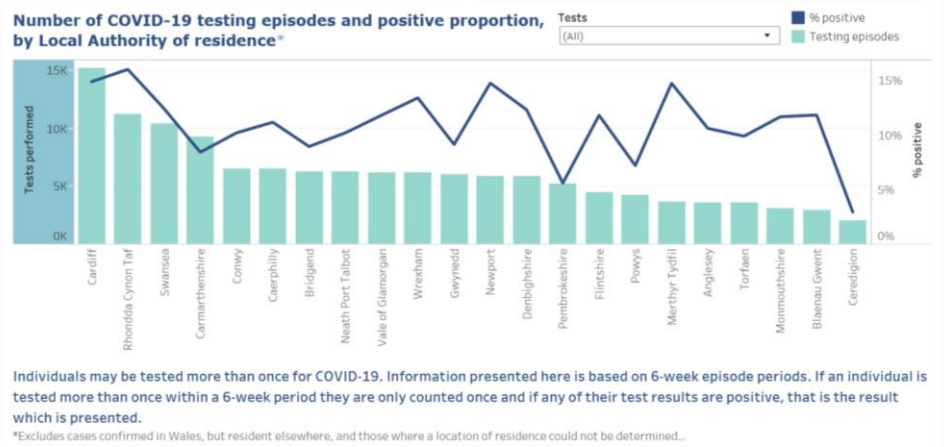
3.5.2 There are now five routes open to individuals outside of hospital, for RT-PCR testing. The first three are coordinated by Cardiff and Vale UHB, tests are analysed in NHS Wales laboratories, and data are therefore available.

- **The Community Testing Units** (CTUs): drive-through facilities based on the Whitchurch Hospital site and in STAR Hub, Splott). These serve Health Board, Welsh Ambulance Service and Velindre NHS Trust staff who are symptomatic, and their symptomatic household contacts (Cardiff & Vale of Glamorgan resident) with 7,996 tests carried out as of 30th June 2020. In exceptional circumstances, staff without access to a car will be visited in their own homes to be tested.
- **The Population Testing Unit** in Cardiff City Stadium. This service facilitates 240 tests/day and is a drive-through facility for other (non-health) key workers. Originally run by Public Health Wales, since 10 June 2020 this is run by the UHB. Since 10th June 2020, up to and including tests on 30th June 2020, the UHB has tested 2176 people via this pathway - averaging 109 daily.
- **Our CTU teams** also visit Cardiff and Vale care homes to test. Up to 30th June 2020, 7,326 tests had been carried out by our CTU in such closed settings, resulting in positive results for 183 staff or residents. Of 151 care and residential homes in Cardiff and the Vale of Glamorgan registered with Care Inspectorate Wales, all large homes (21) have been completed and 85.4% or 129 'whole' homes have been tested. Of those yet to complete 'whole home' testing, three have arranged tests, seven have so far declined and six are yet to submit the relevant data (NB. six homes are actually closed).
- **Care home portal**: since Monday 15th June 2020, all asymptomatic care home staff have been offered a weekly test for a four week period. These involve the use of self-administered swabs. All symptomatic care home staff are still being offered tests via the UHB testing service.

- Via the **nhs.uk/ask-for-a-coronavirus-test portal** for symptomatic members of public.

3.5.3 Overall within the first three services above, 15,132 tests have been carried out in Cardiff residents (15% positive) and 6,198 tests have been carried out in Vale of Glamorgan residents (12% positive), in the period up to 30 June 2020[1]. Comparative data are shown in the graph below.

Figure 3: Tests performed by Local Authorities



Source: Public Health Wales Confirmed case data (NHW Wales laboratories only) daily surveillance dashboard

3.5.4 Comparing timeliness of test results returns for CTUs across Health Boards, Cardiff and Vale UHB has the highest percentage of tests returned within one day (71%, Wales average 41%) and two days (92%, Wales average 76%)[2]. The Ministry of Defence (MOD) team has also been deployed in the Cardiff and Vale area since 15th May 2020, and continue to support health board teams undertake testing in care and residential homes.

[1] Public Health Wales: Confirmed case data (NHW Wales laboratories only) daily surveillance dashboard
[2] Public Health Wales 28.6.20, from Welsh Government internal briefing

3.6 Staff Wellbeing

3.6.1 The health and wellbeing of our staff is of upmost importance especially at this unprecedented time. The Health Board has been actively listening and proactively enabling facilities and resources to support staff and teams[3]. This includes staff havens, hotel accommodation and additional psychological support. The UHB is fortunate to have enlisted the support of our Occupational Health and Employee Well-being Team and a number of senior Clinical Psychologists within service areas.

3.6.2 The safety of our workforce is fundamental to our organisation. A risk assessment process is in place for all staff to ensure staff are not placed at greater risks through their deployment in the organisation.

3.6.3 Absence levels are being monitored within the organisation and the UHB continues to work with staff to ensure they are supported when they are sick; able to return to work after a period of illness and supported to undertake homeworking if they require Shielding and are able to do so. The latest data shows in excess of 550 individuals shielding on any given day. Daily Covid-19 sickness levels are reporting at around 2% in addition to the non-covid absence.

3.6.4 The UHB has robust staff testing processes in place through our Community Testing Units, which have already provided testing for around a third of the total workforce.

3.7 Communications and Engagement

3.7.1 The UHB looked at new ways to increase communications and engagement throughout the Covid period. A new staff app called Staff Connects which all employees of Cardiff and Vale UHB could sign up to and access on their mobile devices. This has a dedicated Covid-19 section which includes regular updates and links back to key documents such as the case definition and Public Health Wales information and guidance. This means that more staff can access information 'on the move' and do not need to be at their desks.

3.7.2 The UHB also implemented a daily "CEO Connects" for Covid. This daily briefing is sent as an email to all staff, available on the intranet and on Staff Connects to update staff on the current position. This included the latest information on Covid admissions and positive cases across the sites, updates on staff testing, operational issues, PPE, and a collection of good news stories to boost morale.

[3]Link below to UHB staff resources:
http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,172024171,253_172024187&_dad=portal&_schema=PORTAL

3.7.3 Daily CEO connects was also sent to key partners, the local authorities and CHC. A weekly C-19 briefing was also implemented to send to key stakeholders including local government to update them on our response to Covid. The briefing was from the CEO and Chair of the UHB and was completed by virtual meetings to answer any questions or concerns.

3.7.4 The UHB increased its video team to capture footage of the response to Covid, including documenting the development of Principality Stadium to Dragon's Heart Hospital, capturing stories of how the UHB mobilised quickly to respond to the demand, as well as educational videos and information around the guidance, such as social distancing. These videos are published on the UHB's You Tube Channel and have been shared on social media channels and with the media.

3.7.5 The UHB developed a new web resource 'Keeping me well' with our therapies teams to provide online support and guidance for patients who had been affected by Covid 19 understanding the long recovery journeys patients may have. This included input from Physiotherapy, Occupational Therapy, Dietetic, Speech and Language Therapy. The website has been expanded to include prehab to support patients while they are waiting for surgery so they can keep themselves well.

3.7.6 A dedicated website was developed for Dragon's Heart Hospital which included a timeline of the build of DHH, key information for staff and videos relating to the project. Similarly the intranet page hosted a Covid-19 section which included key information and updates from PHW, daily CEO connects, staff wellbeing information and support and sections for different areas to host their information.

4. OPERATIONAL RESPONSE

4.1 Primary care

4.1.1 In Primary Care contracted providers in General Medical Services, Dental and Ophthalmology have moved to cluster models, with 'red' practices and single cluster sites open. Rapid expansion of virtual appointments has taken place, with all GPs moving to a telephone triage first model and practices buddying to provide support. Contractors have adhered to social distancing requirements through both physical measures but, significantly, rapid roll-out of remote consultation working. Pharmacy services also delivered rapid transformation, maintaining continuity of care through effective medicines management as well as maintaining common ailment services and working collaboratively to ensure effective supplies of palliative medicine in the community. The establishment of Community testing centres initially for patients and then for staff has enabled significant number of staff to return to work.

4.2 Mental Health

4.2.1 The impact of the pandemic on mental health is expected to differ from physical health and demand for services is anticipated to occur later than the peaks for physical health. From early surveys and existing knowledge it is a reasonable assumption that the NHS will need to expand certain elements of Mental Health services. In the main, this is likely to be around the lower tier services model to allow the minimum and earliest intervention possible. This response should include a wide population based approach as well some more targeted and specialist services, with a particular focus on primary care. As a starting point, the following services are being considered for early expansion:

Table 2: Patient Streams in Covid Environment

Tier 0	Mental Health and Well Being General Advice and Support / On Line Low Level Interventions / Book Prescriptions / Debt and Benefits Advice / CALL enhancement / step towards support move to single triage for OOHs / Population mental health and wellbeing on line guidance and products via PHW and CALL
Tier 1	Mental Health and Well Being Targeted Advice and Support / Primary Care Support and Assessments / On Line Low Level Interventions / Debt and Business Advice
Tier 2	Psychological Interventions Including on line suicide prevention / Support for Schools
Tier 3	Trauma Services / Specialist Psychological Interventions
Tier 4	Detox

4.2.2 The UHB has developed a more detailed Mental Health services plan, to guide the development of the service over the next period, in line with *Together for Mental Health*.

4.3 Hospital Capacity Planning for Covid-19

4.3.1 <u>Phase 1 – Repurposing and Zoning</u>

Within a two week period the Health Board repurposed and reconfigured a large proportion of its facilities in order to maximise the bed capacity available for Covid-19 patients:

- a receiving ward for 'suspected' Covid-19 patients was put in place on both hospital sites
- a zoning plan was established to provide segregated ward capacity for confirmed Covid-19 patients on floors 5-7 at UHW and the East wing of UHL
- the critical care footprint at UHW was extended to the fourth floor, to allow the existing unit on the third floor to be dedicated for Covid-19 patients

These changes meant the Health Board had a total of 85 critical care beds available plus over 300 ward beds dedicated for cohorting/zoning of non-ventilated Covid-19 patients. In addition a number of service moves were made to allow expansion of essential services, for example the fracture clinic at UHW was transferred to UHL, and a single-unit model for paediatric emergencies put in place at the Children's Hospital for Wales in order to allow the expansion of the Emergency Unit footprint.

4.3.2 Phase 2 – Additional capacity

In the second phase the UHB identified suitable areas outside of its normal adult bed capacity to expand the available bed base. This included vacating Owl ward in the Children's Hospital for Wales, re-commissioning one ward at Barry and one at St David's, converting the physiotherapy outpatients in UHW and an area alongside East 4 and 6 in UHL into additional ward areas. In total this additional capacity provided for a further 200 inpatient beds, with the option to utilise Owl ward for further critical care expansion.

4.3.3 Phase 3 – In extremis

Dragon's Heart Hospital (DHH) was commissioned in response to the Covid demand modelling to enhance the UHB's ability to care for all its patients during the pandemic by increasing bed capacity, optimising patient flow and providing active treatment. Establishing DHH provided the system with an 'insurance policy" ensuring that the UHB, and potentially the region, had the capacity needed for its population and was ready (if needed) to:

- deliver the most appropriate care to those in most need and thereby save more lives
- rehabilitate and discharge patients as quickly as possible
- provide appropriate care for those at the end of life and for their loved ones

After a consultation with a wide range of clinical colleagues, it was identified that a Covid field hospital should meet the following criteria:

- a single site capable of expanding to 2,000 beds to mitigate the fragmentation of an already stretched workforce
- be as close to UHW as possible
- if possible, a fixed structure rather than build something temporary

The setting up of field facilities was being practiced in Italy, Spain and France and overnight on the 24th March, it was also announced that the Excel Conference Centre in London was to be used.

A series of site visits and reviews took place on 25/3 to assess options. The Principality Stadium was deemed to have the most infrastructure in place in a venue built for accommodating large numbers of people. 2,000 beds could be accommodated and catering facilities, toilets, power, access, security, rooms & suites were all readily available.

The Executive team made the decision to proceed with the Principality stadium following a site visit alongside military doctors from Cardiff and Vale UHB.

It was specified that the DHH was intended to provide non-critical care surge capacity for C&V UHB patients. To achieve its mission, through stakeholder engagement and good clinical leadership, the Dragon's Heart developed the following clinical capabilities:

- A step-down, rehabilitation and discharge pathway
- A supportive care pathway providing active management of Covid -19 in those with a Ceiling of Treatment and end of life care for those who deteriorate
- A low acuity active management pathway for patients with no Ceiling of Treatment receiving level 1 care including provision for those who deteriorate and may require level 2/3 care
- A "Front Door" providing a GP-referral-based medical emergency admissions unit

DHH delivered its first 335 beds on time on the 12th April with the remaining beds just 16 days later. The official opening took place on the 20th April with the first patients being admitted on the 28th.

4.4 Partnership Working

4.4.1 Since the start of the pandemic, the Executive Team has met jointly with the Directors of Social Services and Cardiff Council's Corporate Director of Communities. This has supported timely and open communication, the sharing of issues and risks and joint problem solving. There was early recognition of the need to support care homes jointly with our social services colleagues. The weekly joint executive meetings have enabled a number of issues to be unblocked including:

- PPE supply and protocols
- Testing
- Care home support
- Discharge flow

4.4.2 Enclosed settings such as care homes, residential schools and prisons pose particular risks for the causes and transmission of infection. This is due to the nature of the physical environments and the vulnerability of those living within them. The most effective way to prevent illness and death in the current pandemic within closed settings is to prevent the virus that causes Covid-19 entering. In addition to testing, the evidence suggests that there are five further areas for action:

- Hand hygiene
- Environmental decontamination
- Staff rotation
- Visitors restricted to only emergency/critical cases

- Resident and Staff Wellbeing

4.4.3 In Cardiff and the Vale of Glamorgan, a strong multi-agency approach, including Cardiff and Vale University Health Board, Local Authorities (Commissioning, Safeguarding) and Shared Regulatory Services, Public Health Wales closed setting cell/regional health protection and local Public Health teams, Care Inspectorate Wales, cluster GPs and individual care home providers, is being employed to support each of these evidence-based practices.

4.4.4 The UHB continues to work closely with commissioners and partner Health Boards to ensure that together we are protecting and strengthening fragile regional and tertiary services where we have the greatest challenges.

4.5 Maintaining Essential Services

4.5.1 The UHB has been able to maintain all essential services through the pandemic and is now resuming more intermediate services and, where safe, returning to normal service provision in some areas.

4.5.2 At the beginning of the pandemic, the UHB reached an early agreement with Spire Healthcare to enable patients with non-complex cancer and other urgent conditions to receive treatment at Spire's Cardiff hospital. This allowed the UHB to protect this important activity whilst providing additional capacity to care for Covid-19 patients at the UHB's main sites, in particular to enable space for regional services. The majority of the Health Board's patients at Spire Cardiff are being treated for cancer or for time critical/urgent health conditions and table 3 confirms the activity undertaken there to date:

Table 3: UHB Activity at Spire since 23rd March 2020

Cancer operations	**Other time sensitive theatre cases**	**Outpatients**	**Endoscopy procedures** (incl urgent Cancer)	**Cardiology procedures**	**Total**
262	164	2,023	260	48	**2,757**

4.5.3 One of the major successes of the UHB during the pandemic is we have been able to safely maintain a large volume of surgery, both urgent scheduled and urgent. This has been undertaken with a high degree of safety and underpinned by a robust clinical audit process. Between 16th March and 12th June the UHB undertook 1162 elective surgical procedures and 961 emergency procedures.

4.6 Personal Protective Equipment

4.6.1 The provision of Personal Protective Equipment (PPE) for our staff has been one of our top priorities from the outset. Ruth Walker, the Executive Nurse Director, is the nominated Executive Lead in the Health Board.

4.6.2 The Health Board has established a multi-disciplinary PPE Cell that has met on a weekly basis for many weeks. This has proved to be a very effective decision making group and has representation from clinical staff (including surgeons and anaesthetic staff) and also from a staff side representative. At each meeting a range of issues is discussed including:

- procurement issues, current stock levels and future requirements
- health and safety issues including the provision of Fit testing and the assessment of the suitability of PPE
- infection prevention and control issues
- all reported incidents and the actions being taken to address them

4.6.3 An operational lead has been identified, whose role it is to work with Clinical Boards to ensure on-going supply of the appropriate PPE to all clinical areas. This person reports in to the PPE cell and has direct access to the Executive Nurse Director, if any issues require escalation.

4.6.4 CEO connects is a daily briefing that is produced for staff and has regularly contained updates on the provision of PPE. In the last few weeks the UHB has started to issue a regular PPE Safety Briefing to keep staff as up to date as possible with the situation. An intranet site on PPE has also been developed as a useful resource for staff. This contains latest national guidance, information in relation to training and Fit testing, instructions for ordering PPE, guides on how to 'Don and Doff' as well as FAQs.

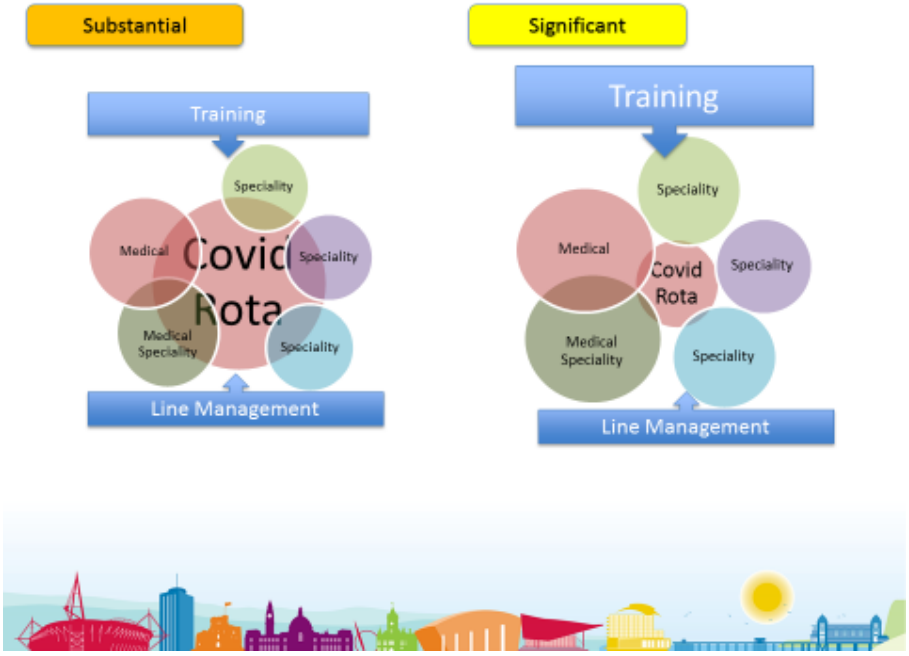
4.6.5 The UHB has now secured continuity and sustainability of both gown and mask supply. The **1863** is now the primary pandemic mask and currently within the UHB there are sufficient stocks and additional stock in Wales if needed. An All-Wales order for 1.8 million 8833 masks has also been placed. While these are currently being held in Turkey we are hopeful that they will soon be available and will provide approximately 6 months' supply.

4.6.6 A £500k order for additional gowns to secure a medium-term supply, has also recently been placed. The Health Board has also invested in 1000 powered hoods and an order submitted. This follows some joint working with medical colleagues in critical care and in theatres. This provides a long term solution for colleagues in these areas. The Health and Safety Department are currently deploying available powered hoods to identified staff who have failed qualitative and quantitative Fit testing on all available half masks.

4.6.7 The Health Board will continue to place significant emphasis on the provision of appropriate PPE to staff. The UHB recognises that this can be a constant source of stress to our staff and we are making every effort to work with clinical staff to ensure good communication and to resolve problems as they emerge. To ensure we hear the views of staff and patients we have undertaken a number of audits and surveys from staff and patients to help inform our decision making and communication. This process has been very beneficial.

4.7 Workforce

4.7.1 The UHB's workforce plans overlay with our zoning and gearing plans. Our medical workforce has redesigned its rotas to reflect our operating approach, building from a core Covid 'red' rota to understand how staff can be freed to return to core specialties. Importantly training requirements have been fundamental to building this model, prioritising those who need to complete core competencies to progress their medical training and ensuring clear oversite and supervision of trainees. The UHB has successfully appointed 57 Year 5 medical students and 80 Year 3-4 students.



4.7.2 Similarly nursing rotas have been adjusted to ensure the UHB meets Safe Staff Nursing requirements across our plans. Staff have responded extremely positively to the need to be flexible and have been deployed across zones and sites as required. The UHB's nursing numbers have been considerably bolstered by effective recruitment through the UHB Workforce Hub. We have recruited over 100 registered nurses to the Bank as well as 290 Health Care Support Workers. In addition, we have appointed over 400 student nurses on fixed contracts since April and a number of retired nurses who have positively responded to the Welsh Government advertisements and call to action. Our Therapy staff have also been flexible in their rotas and have developed 7 day working to support clinical areas; specifically to support rehabilitation models and Dragons Heart Hospital. Therapy students will come on stream in September 2020 as planned. The early recruitment of medical and nursing students will help bolster and back-fill for non Covid activity.

4.7.3 Significant recruitment has also taken place across a range of essential roles in order to enable the effective operating of our plans.

Table 4: Additional Temporary Staff Recruited

Roles	No. Offered Temporary Contracts
Administrators	14
Facilities Staff	614

Drivers	15
Pharmacy Porters	8
Runners Pharmacy & Labs	5
HCSW	345
Allied Health Professionals	45
Pharmacy	15
Laboratories	8
Registered Nurses	109
Total	**1,178**

4.7.4 The ability to flexibly redeploy staff and recruit at pace has only been possible though effective partnership working with our Trade Union partners.

4.8 Patient experience

4.8.1 The Patient Experience Team diversified in function to meet the needs of patients in the pandemic. The team moved to a 7 day service to provide an enquiry line for patients, carers and families. This was commenced in March 2020 and receives approximately 40-50 contacts per week.

4.8.2 Virtual Visiting

Due to the restrictions on visiting 400 tablets have been set up by our IT department to ensure that the tablets are safe for patients to use and comply with data protection guidelines. Each tablet has been set up with Zoom for virtual visiting, Radio Glamorgan, free magazines from Wi-Fi Spark and a feedback survey. IT have added a range of game and activity apps to help alleviate boredom on the wards. We trained medical and nursing students to support the Virtual Visiting,

Feedback from the virtual visiting has been very positive from both staff and patients, some of whom had not seen family/friends in weeks. In April a messages from Loved ones e-mail and phone line was set up to ensure that patients and families had a way to communicate during these difficult times. The message was then printed and any photos laminated and sent to the patient on the ward.

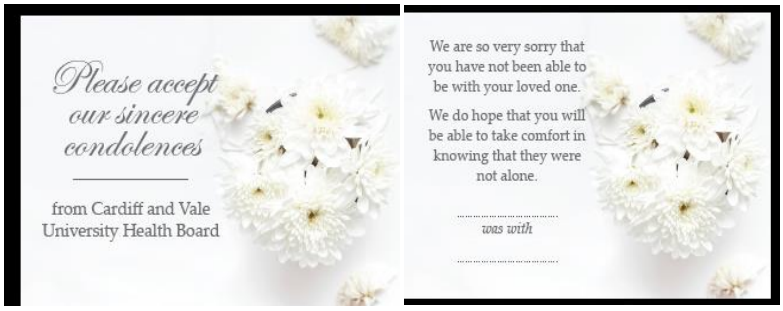
Understanding that many people in the community are shielding and not able to socialise as they used to, the UHB launched a volunteer led Chatter Line. From the 31st March those who were feeling isolated and lonely, through the pandemic, could contact us and request a call from one of our volunteers as a one off or as a regular call. Volunteers were provided with information on services to support in the community should they identify that the person they are calling has further needs to just a ‘chat’.

4.8.3 Bereavement

In April a bereavement helpline was implemented, members of the Patient Experience team contacted all people who had suffered a bereavement. The aim was

to provide someone to listen, signpost to other organisations and initiatives, such as our Chatter Line, and address any queries where possible around the death of their loved one. To date the team has supported over 280 bereaved families. We have also established a system to return property to bereaved families.

Whilst the UHB has a condolence card, with a message form the Executive Nurse Director, it was recognised that during these difficult times one of the key issues for families, who cannot be with their loved ones, is who was with them when they died. The condolence card, which was adapted from one developed by staff on C7, stated who was with the patient when they died. The knowledge that their loved one was not alone when they died will hopefully be of some comfort to the family.



4.8.4 Feedback

Due to Covid-19 the infection, prevention and control advice was to withdraw the monthly paper feedback surveys and feedback kiosks across the UHB. This led us to adapt the way we receive patient/service user feedback.

In relation to Covid-19 specific feedback, we have undertaken:

- ***PPE current inpatient survey***.
  This study involved in patients completing an online survey of their experiences of staff wearing PPE and their stay. In total, **102** patients were surveyed.
- ***PPE discharged inpatient survey***. This study involved recently discharged inpatients completing an online survey of their experiences of staff wearing PPE and their stay. To facilitate this, a message/survey link was texted to those for whom we had a mobile phone number. We had over 700 responses, with a completion rate of **87%**.
- ***Prehab booklet feedback survey.*** This is a study into the wellbeing of patients currently on the waiting list, which due to Covid-19, may/will have had their procedure delayed. The concept is to promote preparation rather than waiting lists and promoting well-being and health optimisation.
- ***Boredom and isolation survey***. This is a study looking into aspects of patients' wellbeing, while currently admitted. The survey centres on being bored and the feeling of isolation, due to visiting restrictions/limited activities. The online survey is available to patients via the tablets

All of the survey work undertaken has informed and influenced our work during the Covid-19 position and as we are planning services for the future.

4.8.5 The Patient Experience team has also provided patients with toiletries, nightwear and clothes as required across all UHB sites. There have been many generous donations from business and communities to enable this work.

5. RESTART & RECOVERY

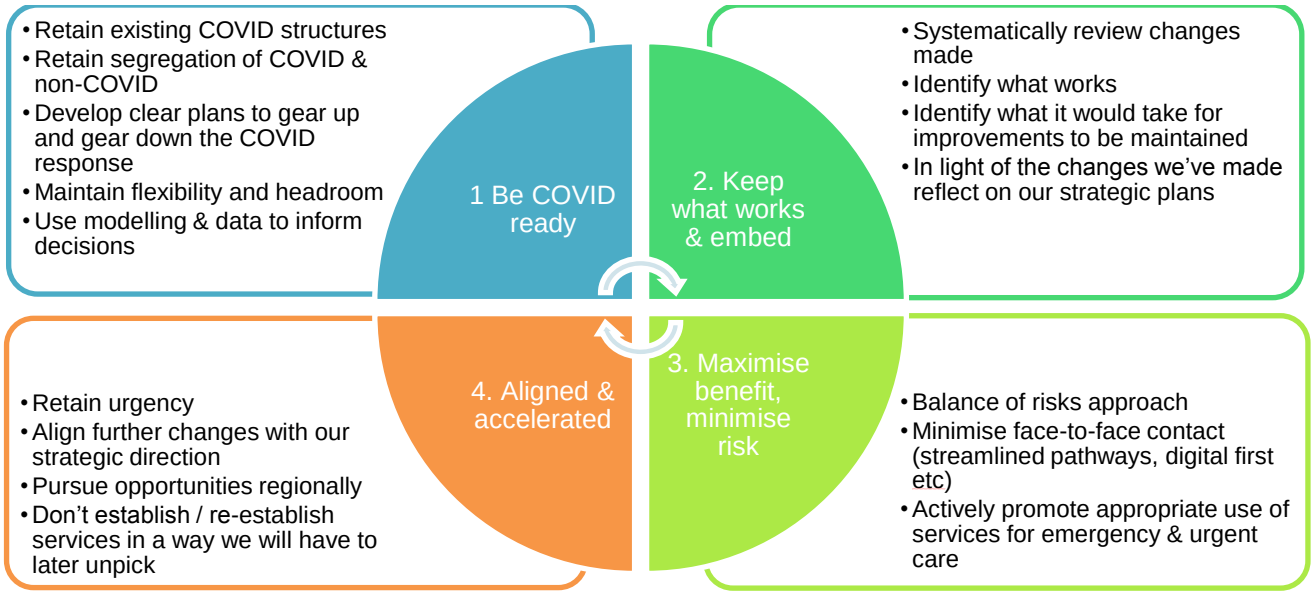
5.1 Design Principles

5.1.1 The effectiveness of lockdown in halting the spread of the disease has altered our planning assumption from a single surge event to a longer-term, undulating model. In this scenario coronavirus remains prevalent in the community for many months with periods of higher Covid demand. Further, given we believe the majority of the public remains susceptible, the potential still exists for substantial surges in demand. In the next phase, it is therefore necessary for the UHB to both plan for varying levels of Covid demand and restore a wider range of non-Covid service delivery in order to prevent broader harm to our population.

5.1.2 *Shaping Our Future Wellbeing* remains our strategy and has guided the approach through the first three phases. Indeed we have seen an acceleration in the delivery of the strategy over the few months, e.g. virtual appointments, rapid discharge, single points of entry, enhanced cluster working, greater community integration, enhanced partnership with social care and perhaps most importantly a culture that has empowered front line staff to act with confidence at pace.

5.1.3 As part of this fourth phase the UHB has established some clear principles which allow us to remain vigilant to the threat of Covid-19, ensure we reduce harm for both Covid-19 and non-Covid patients, continue to transform at pace and focus on the long term.

Figure 4: Design Principles



5.2 Operating Model

5.2.1 The situation NHS Wales now faces is uniquely challenging. Not only is demand expected to be highly volatile but the delivery of services will need to significantly alter to account for the risk of transmission. In response to this the UHB has developed an operating model designed to be highly adaptable and provide for both Covid and non-Covid patient groups. It is anticipated that, even with the earliest warning system, it will only be possible to plan up to 4-6 weeks ahead. The UHB will therefore need to operate within rolling six-week planning cycles, informed by data and modelling, and 'gear' the service provision to appropriately respond to the changing levels of demand.

Figure 5: Operating Model

5.2.2 The UHB has established a suite of information to monitor trends and predict demand levels in different scenarios. In addition the UHB has worked with the Regional Partnership Board to develop a Covid Surveillance System, incorporating early warning indicators to identify changes in the prevalence of the virus.

5.3 Streams

5.3.1 In recognition of the risk the virus presents it is necessary to separate patient groups and provide appropriate levels of protection to these individuals and the staff who care for them. This is important both to reduce actual risks and to provide greater confidence for patients accessing services and clinicians working within them. The UHB has identified five distinct patient streams based upon their Covid status:

Table 5: Patient Streams in Covid Environment

Stream		Definition
RED stream	Confirmed C19+	Has had +ve test in past 14 days
PURPLE stream	Suspected C19	Clinically suspected, not confirmed
ORANGE stream	Non-COVID	Asymptomatic, does not meet green stream criteria, e.g. emergency
GREEN stream	COVID-free	Planned activity, meets green stream criteria

BLUE stream	C19 Recovered	>14 days post confirmed +ve

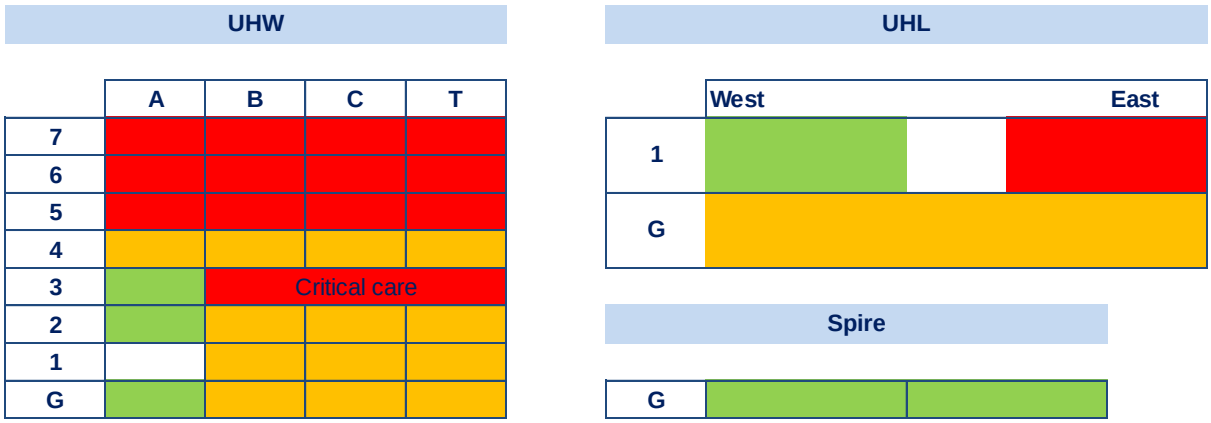
5.3.2 Aligned to this approach the UHB is zoning its facilities in order to safely provide services to both Covid and non-Covid patients.

5.4 Green Zones

5.4.1 Throughout the pandemic the UHB has been segragating Covid confirmed, Covid suspected and non-Covid patients. In addition the Spire hospital and the Short Stay Surgical Unit (SSSU) at UHW have been used as 'Covid-free' facilities to provide essential and urgent operating. Local audit data, international evidence and national guidance all strongly indicate that, in order to provide safe surgery, it is necessary to provide dedicated, 'Covid-free' environments with strict admission criteria. The UHB is therefore in the process of re-configuring the UHW and UHL sites in order to provide such facilities, in addition to that available at Spire.

5.4.2 These green zones are intended to operate as a 'hospital within a hospital', including separate access, facilities, processes and staffing. The UHB has moved quickly to respond to this and has agreed the revised configuration below for the two main sites. However the implications of enhanced theatre cleaning between cases and the requirement to increase the spacing of ward beds is expected to mean significant reductions in effective capacity relative to the pre-Covid baseline.

Figure 6: Simplified schematic of site zoning



5.4.3 The fundamental objective of establishing these green zones is to protect patients whilst re-commencing core services. To support this the UHB has a systematic clinical audit process in place to capture the outcomes of all surgical procedures.

5.5 Gearing

5.5.1 The UHB anticipates periods of undulating Covid demand over many months, with the potential for extreme surges. It is likely this will mean different responses are required at different times. To support this the UHB has defined three levels of Covid escalation – Significant (Yellow), Substantial (Amber) and Severe (Red). The UHB is

currently at Yellow escalation. The intention is to report the status daily at the operational group meetings and, using the early warning system described earlier, project the forecast for the next six weeks. The strategic group will use these forecasts to trigger an escalation / de-escalation. This will provide a common basis for planning services (Covid and non-Covid) and help the UHB get into an operational rhythm.

Table 6: Covid escalation levels

	Post-COVID	Significant *(current level)*	Substantial	Severe	In extremis
COVID daily attendances	0	0 – 50	50 – 100	100 – 200	> 200
COVID daily admissions	0	0 – 25	25 – 50	50 – 100	>100
COVID patients in hospital	0	0 – 250	250 – 500	500 – 1000	>1000
COVID critical care	0	0 – 35	35 – 75	75 – 150	>150

5.5.2 The necessary segregation of Covid, non-Covid and Covid-free, combined with unpredictable and undulating demand means, not only will overall bed demand be higher, but it will also be necessary to reserve significantly more headroom and adaptability into the system than would previously have been the case, in addition to the reduced effective capacity within the green zones. To mitigate this it will be essential to provide alternatives to hospital admission, step-down patients at the earliest opportunity and maintain resilience in primary, community and social care.

5.6 Test, Trace, Protect Programme

5.6.1 Background

The Welsh Government published its Test, Trace, Protect (TTP) Strategy https://gov.wales/test-trace-protect-html on the 13th May 2020, signalling the intention to introduce enhanced health surveillance in the community and an effective and extensive contact tracing system. This, along with support to self-isolate, is intended to contain the spread of the coronavirus in Wales and is a key mechanism to allowing lockdown restrictions to be relaxed, keeping 'R' under 1, and starting the process of moving to a 'new normal' of living alongside the virus.

5.6.2 Cardiff and Vale partnership approach

In Cardiff and the Vale of Glamorgan, the two local councils, Shared Regulatory Services and the University Health Board (UHB) have worked in partnership to establish a contact tracing service. Cardiff Council is hosting the contact tracing service, which is operated to nationally agreed procedures, with local partner organisations contributing staff through secondment arrangements. National data sharing and information governance arrangements are in place.

The Chief Executives of the three partner organisations agreed a governance framework to establish both a strategic and an operational board. This framework identifies four key functions requiring direction and coordination at the regional level:

1. Management of the contact tracing and advice service
2. Testing
3. Surveillance and performance
4. A public health response team

The Operational Board meets weekly to monitor progress, problem solve, and share learning from local, regional and national sources. The Strategic Board meets fortnightly to provide oversight.

5.6.3 Contact tracing process

A national digital Microsoft Dynamics contact tracing software was procured by NWIS, and has been in use in Cardiff and the Vale since 10th June 2020. The system automatically routes positive test results to the relevant area of residence from NHS Wales laboratories, which process tests taken in local testing units and hospitals, as well as those processed in England via the on-line testing portal. People with positive tests are phoned by contact tracers who, after reiterating 7 day self-isolation advice, work with the person to identify their significant contacts in the 48 hours before and 7 days after they became symptomatic. Contact advisors then call the identified contacts to advise them to self-isolate for 14 days. A significant contact includes not only those they live with during that time period, but also anyone they have had a face to face contact with, or have touched, coughed on, or been within one metre of in any other way for over a minute. It also includes those who have shared a car or who have had contact within two metres for over 15 minutes; this can be in smaller but repeated time periods that add up to over 15 minutes in total. NB This excludes situations where appropriate PPE has been worn, for example in health and social care settings.

5.6.4 Operational delivery

The contact tracing service ran in shadow form from 28th May 2020 and was fully operational from 1st June 2020, coinciding with the national launch. Staff numbers were increased in a phased way to move rapidly to cover seven days per week. To meet current levels of demand, operating hours are 8am – 8pm Monday to Friday, and 9am to 5pm on weekends. The service operates bilingually, with translation services available for other languages as necessary.

The public health response team is a multidisciplinary and multiagency team responsible for responding to Covid-19 related cases and incidents within Cardiff and the Vale of Glamorgan, including closed settings such as care homes, as well as providing advice on risk reduction and infections control to a variety of settings and sectors. A multi-agency, multi-professional regional team meets daily during the week to review issues and queries that arise from contact tracing teams. As a result, the team has provide targeted infection control and preventative advice in a variety of settings.

Cross partner resource is being deployed to develop and deliver the surveillance and monitoring function, linking both local and national data sources and teams. A dashboard is being developed which will allow regional data to be reviewed in a timely way and to guide local action.

Key supporting functions such as finance and human resources are also being provided by the partnership. Importantly communications teams from the three partner organisations, led by the Vale of Glamorgan Council, are also working collaboratively to develop resources and messaging to support contact tracing in the region. Their work initially focussed on what to do if you become unwell and how to access testing, particularly for critical workers, as well as what to expect if you are phoned by the contact tracing team. However, subsequent content has been guided by the experience of incidents in the first few weeks, and has increasingly addressed the importance of maintaining physical distance of 2 metres, as well as handwashing and respiratory hygiene. There will also be a focus on how to reach those who do not access the most commonly used media.

5.6.5 Current position

In its first month of operation the TTP programme in Cardiff and Vale processed over 300 positive results, and identified and followed up the significant contacts. Experience of using the national digital platform is growing and we are working collaboratively with NWIS to influence system updates and improvements. Partnership collaboration is strengthening continually and a standard operating procedure has been agreed which outlines the agreed response to the most commonly encountered scenarios. This complements existing guidance agreed for settings such as care homes, and will be continually developed to ensure a consistent approach across the region. Advice is being provided to a range of settings, including within health care, and intelligence from experiences across Wales is being used to guide local action. Proactive engagement has already taken place with schools ahead of their reopening this week and with local food processing firms in light of the incidents elsewhere in Wales.

6. REBUILDING & RENEWAL

6.1.1 There will be no hard stop to our response to Covid-19 but a transition to a renewed and refreshed Cardiff and Vale health and care system. Therefore it is important we maintain a focus on our long term ambition through this year. We have built a platform of sustained delivery, there has been continued improvement in the performance of our health system and we have demonstrated operational grip. We now need to move from this foundation of delivery to tangible transformation of services for our communities, focused on delivering improved outcomes for people and better value for the system. This can only be achieved by working in partnership to common objectives.

6.1.2 The predominant focus of phases 1-4 has been the delivery of health services to our population. We know that to transform our services we need to work at a system level. Therefore the fundamental principle for phase 5 of our plan is to Think System. Our system is complex with intricate relationships between the Health Board and other NHS providers, locally, regionally and nationally; between Regional Partnership Board organisations and across the wider Public Services Boards arena. Therefore phase 5 will be a Cardiff and Vale Plan to articulate the outcomes we need to achieve and the partnerships required to deliver them. Central to this will be the Regional Partnership Board Area Plan which will be refreshed to capitalise on our experiences of the last few months which have shown we can deliver at pace. There have been some key elements to our ability to deliver successful transformation:

- Urgency
- Clarity of purpose
- Clear operating principles
- Freedom for frontline staff to act and the time to do it
- Removal of constraints
- The ability to act and sense make
- No pilots- make the change, if it doesn't work- stop

6.1.3 The challenge is also there to be bold. Whilst we have clear narrative in our Regional Partnership Board Area Plan and the Health Board's Shaping Our Future Wellbeing this is an opportunity to reshape our approach to delivery, rethink how we use the collective grant and transformation funding and our wider Cardiff and Vale pound to focus on population outcomes, regardless of where they are delivered in the system. We can galvanise partners around a common vision for a truly integrated whole health and care system which is focused on the needs of our communities and outcomes that matter to people at different stages of their lives:

- Starting well: from birth to 21
- Living well: working age adults
- Ageing well: older people

6.1.4 This approach recognises that there are many determinants to health and wellbeing and health services alone won't enable people and communities to thrive.

Figure 7: Regional Outcomes Framework (draft)

7. CONCLUSIONS

7.1 The UHB has, with the rest of the World, faced the most significant pandemic in a century. It is highly contagious, with over 11 million confirmed cases worldwide to date and half a million deaths. The early modelling predicted that, without mitigations, the virus would infect the majority of the population of Cardiff and Vale and, even with social distancing, the impact could be of a scale that would overwhelm the health system.

7.2 Throughout the first wave of the pandemic the UHB managed to stay ahead of the demand curve. Services were not overwhelmed at any point and the UHB had further contingencies in place should demand have continued to increase. However the scale and speed of the spread of the virus meant there were still comparatively small margins before this point could have been reached, perhaps only 7-10 days.

7.3 Social distancing measures were highly successful in reducing the infection rates but it was not known how effective they would be in advance and it was not until early April that there was clear evidence that the spread of the virus was slowing. The peak of new confirmed cases occurred the following week and the peak of hospital inpatients the week after that.

7.4 In preparing for and responding to the pandemic the UHB has transformed the way it delivers many services and will need to continue to do as we adjust to the implications of living with coronavirus. Throughout our staff have shown, and continue to show, extraordinary flexibility and professionalism in the face of an unprecedented public health crisis.

7.5 Our objective at this point is to minimise overall harm to our population, both directly from Covid and indirectly. The UHB has maintained essential services throughout the pandemic and is steadily reintroducing other services in a safe manner. In many cases this will require new, innovative models of care. It is also essential we look beyond this to the future of our system and set in place conditions which allow clinical teams to transform our system in line with our strategy and the national approach set out in *A Healthier Wales*.

BDA Cymru's evidence to the Senedd Cymru's Health, Social Care & Sports Committee 2 July 2020

Following the presentation of our oral evidence on 2 July, BDA Cymru submits this written evidence in support. The panel wishes to thank the Health Committee for the opportunity to discuss these very pressing and important issues in dentistry. The Key points are expanded upon later in this document.

Key points

Impacting the state of dentistry currently are three key areas which we explored with the Health Committee. These are:

1. **The changes to treatment measurement within the existing general dental services contract in this the pandemic recovery year and the sustainability of NHS dentistry in the mid and long term.**

2. **Private Dentistry has been unsupported by Government business support schemes during the pandemic and faces an existential crisis. If wholly private practices go under, NHS dentistry will not cope with increased patient demand. Mixed contract practices are also at risk of failing.**

3. **The Community Dental Service (CDS) has been manning almost all of the Urgent dental care centres (UDCs) for the last three months. But the CDS needs to step down the UDCs work to treat their special need patients who are in urgent need now.**

Underlying Issues

In addressing these three key areas we looked at the underlying issues:

a. **The patient journey - How Government can better support the GDS to get care back in own practices. Authorities need to understand the GDS and CDS are intimately linked and cannot be treated in isolation from each other.**

b. **The current and future impact of the pandemic on the oral health of patients and the disease burden in the population, including oral cancers.**

c. **The future impact of the pandemic on the dental teams and the loss of dentists, hygienists and therapists to the system through redundancies, retirements and career changes.**

We have attempted to provide solutions and timelines to be clear what are we asking from Government, with the Health Committee's important help, rather than just stating the problems. Our asks are summarised below:

ASKS

Following our evidence session we have articulated our asks below and trust these will be useful in eventually formulating the Health Committee's recommendations to the Government.

IMMEDIATE ACTION

Allow all practices to undertake more routine work now

This is essential for all NHS, private and mixed contract practices. SOPs are currently overly restrictive and limit the range of treatment available and to whom. By undertaking routine work including mouth checks, practices would be able to reduce the risk of missed mouth cancers and subsequently reduce the impact on the wider health service.

Guarantee PPE supplies

The government must take all available steps to ensure PPE is supplied to dental practices across Wales. This must include any essential fit testing. They should also provide grants for reusable PPE to help reduce practice waste and the impact of COVID-19 on the environment.

Instigate full reinstatement of contract value for GDS NHS practices without delay

The government must bridge the funding gap which has arisen in GDS practices by reinstating 100% contract values now so dentists can provide full levels of treatment. This will enable the Community Dental Service to step down their work in the urgent dental centres and allow community dentists to concentrate on their vitally important role, including the management of special needs.

Lift the business rates ceiling to be accessible for all individual practices

The majority of practices missed out on rates relief due to the ceiling being so low. Practice owners are currently operating at significant losses, a rebate on rates for the rest of the financial year might make the difference and help practices to survive.

Identify all dental team members as key workers

We need all practice staff, including private contractors, to be able to work and to provide care during the de-escalation period of lockdown. Without key worker status, many dentists are not eligible for childcare, especially as we head towards the summer holidays. Extending key worker status to the whole dental team is vital.

Reassure the public via a wider health campaign

The government must undertake a campaign to help practices communicate their message that dental teams are experts in cross infection control. They need to reassure the public that dental practices are controlled and safe environments to which they can return without fear or concern.

ELEVATE PATIENT NEEDS

Reintegrate services to ensure children and vulnerable adults are not at risk

At risk groups have become a ticking bomb since the outbreak of the pandemic. Children and vulnerable adults are still the forgotten group. Designed to Smile, our

free and successful preventative programme to improve oral health in children, is now on hold. As is Gwen am byth, our programme for improving oral health in older citizens living in care homes. The young, old, susceptible, and disadvantaged will suffer poorer oral health as a result. We must ensure that children and vulnerable adults do not become the lost group from this pandemic. Reintegration of existing services will be key.

Allow eligible patients an extension on payment exemptions

Patients whose eligibility for treatment and exemption from NHS fees has elapsed during the pandemic should be granted an extension. This includes:

a) Mothers of babies under 12 months who would normally receive free NHS care where available.

b) Orthodontic assessment made possible for those who would ordinarily have been referred before their 18th birthday. We note that in England, provision has been made for orthodontic referrals.

REVIEW AND REFINE

Review evidence into infection risk and fallow time

We need further evidence into infection risk in the dental surgery and fallow times. This particularly applies to the decision of the Welsh Government to differ from the FGDP guidelines in terms of 60 minutes of fallow time from an aerosol generating procedure. Reductions in fallow time is key to being able to improve the oral health for more patients.

Investigate why fit testing is only required in the UK

Fit testing is not a requirement in other countries. In fact, there is discrepancy in much PPE guidance. In many countries dental teams are only using level 2 PPE for the vast majority of procedures. We need to investigate this further and ensure Welsh dental teams are not disadvantaged as they try to recover.

PLAN AND CONSULT

Plan for a piloting year for NHS GDS and contract negotiations could follow

The recovery year and the support for NHS contracts is welcomed by the profession. We must not use this as the piloting year, although we recognize the valuable learning from using the units of dental assessment (UDAS) and the assessment of patient needs and risks (ACORN). Full piloting and testing must be done in normal times with full consultation with the profession. Any new GDS contract requires a full negotiation process. Negotiation and consultation could start from April 2021. Well before then we need clarity around the government's time table for contract negotiation.

Support and retain the workforce

Ensure LHBs do not reduce the staffing levels of the CDS as a cost saving exercise (ie not replacing staff who have recently left or retired).

There may be other opportunities for the LHBs to offer salaried roles to dentists who might otherwise be lost, for example foundation dentists plus one year posts.

EXPANSION ON KEY POINTS

1. The variation to the NHS GDS contract is a welcome port in the storm

Key message: Removal of the Units of Dental Activity and introduction of Units of Dental Assessment and Assessment of Clinical Needs and Risks in the recovery year ahead of a full pilot is welcomed by the the WGDPC.

The new UDAS - Unit of Dental Assessment
This is intended to reflect the new measure of completing the needs and risk assessment (ACORN) and any associated preventive treatment for each patient within a 12 month period. Some patients will still need AGPs in addition. All of this is captured in the revised FP17W the NHS dental activity monitoring form.

The number of UDAS reflect the number of patients seen. This year there will be no target as such, just a reasonable demonstration of patient throughput, which is obviously going to be much reduced.

Eventually, once things have stabilized, the intention is to assign a number of patients (1 patient is equiv to 1 UDAS) against the contract value - and the calculation should take into account the percentage of high needs patients ... assuming this scheme continues into next Financial Year.

ACORN - Assessment of Clinical Risks and Needs
The ACORN has been extensively developed during the last three years of contract reform in consultation with all stakeholders. The BDA supports this as a valuable clinical tool. Now it is being used by all practices with NHS contracts in the recovery year. Some of the information can be obtained via remote patient consultation. The results from the ACORN are recorded in the NHS Business Services Authority System. Urgent patients will also have a certain amount of information recorded.

Numbers of NHS patients and future targets
Although the earlier CDO communications gave the impression that practices would be expected to see all their patients by end of March 2021 as a target, the CDO has since clarified that there will only be a target for patient numbers in 2021-22. There will be monitoring of activity in 2020-21 via the FP17W and there will be ghosting of UDAs in the system for comparison purposes. Any practice following the new scheme of units of dental assessment and doing a reasonable patient throughput will not suffer clawback this financial year. However, should a practice retain their UDAs, which they are liberty to do, they will most likely suffer clawback - the clock will be ticking from 1 July on prorated UDAs.

Financial constraints and pressures
There is a recognition by Government that in this recovery year continued payment to dental practices for NHS work will help the sustainability of many. However, the contract value has been depressed at 80% between April and June. This has meant

for three months practices have been paying 100% of NHS staff salaries but with practice owners having to make up the shortfall of approx 7%. Some practices which have previously relied on private income are already on the brink of permanent closure.

Many dentists are worried about how they are going to balance the books when they start to provide Aerosol Generating procedures (AGPs) to their NHS patients. Currently with the Annual Contract Value (ACV) now at 90% there is still a fear about the financial risk.

The new mandated way of working with risk in the Government's SOPs is hobbling patient care and patient throughput
Now and longer term the **patient throughput** is a significant concern. This is substantially impeded by a lengthy **fallow period** following AGPs before decontamination procedures which require a further period. Even a simple examination requires a **rest time** of 15 minutes plus swabbing between patients. The BDA would like to see more robust science on the efficacy of the SOPs and also of air handling mechanisms.

Before Corona virus there was a great dal of **unmet need** and **access for new NHS patients** was at record lows - only 15% of practices across Wales could see new adult patients. Now with COVID-19 pandemic measures that unmet need has been welling up and will continue to accumulate for some time to come. As a rough estimate it will take at least the next six months to see all the patients in need who have been waiting for the last three months. Meantime patients with new needs now will be waiting in a queue that could last until the winter and beyond on current alert levels. Dentistry is a vital part of bigger picture- doctors and A&E do not want overspill.

Infection control and patient safety
Dentists and their teams are experts in infection control - necessarily so - and there should be a high level of trust by government officials, LHBs and patients that the deescalation stringent measures are attainable. However, we do question the strength of the science base for some aspects of the SOP that are more cautious and stringent than other UK countries require or the Faculty of General Dental Practice recommends. As a result these create a difficulty with patient throughput times.

The costs of PPE have rocketed sky high in the last few months. While the provision of PPE to practices during the amber phase is very helpful this needs a concerted Once for Wales procurement by the NHS for dental practices to maintain quality and consistency of PPE beyond the amber phase.

Impact of pandemic conditions on staffing and the workforce
As a result of the increasingly stressful working conditions many dentists are considering taking early retirement or even retraining for another career which could impact dentist numbers. Any impacts on dentists may be less severe in some cases than on hygienists and therapists - there are many currently who are not re-registering with GDC.

2. Private Dentistry has gone unsupported by Government business support schemes

Key message: Private dentistry supports NHS dentistry - if it collapses the NHS system will be overwhelmed

Impact of the pandemic
Dental practices are independent businesses and are exposed to many of the same financial conditions that other types of businesses have faced with lockdown, but without the same eligibility for government support.

Government support was not available
The Economic Resilience Fund in Wales was unlikely to help many practices because the scheme is aimed at businesses with employees rather than contractors. Most dentists, dental therapists and hygienists in General Dentistry are contractors not employees. We asked Welsh Government ministers Rebecca Evans SM and Ken Skates SM to act rapidly to put in place a raft of remedies, including changing the Welsh Economic Resilience Fund by counting dental contractors as employees.

While some dental practices may have received the £10K business rate grant, many practices across Wales have been deemed ineligible because premises exceed the £12K business rates valuation. We asked the ministers for lifting of the business rates ceiling to provide relief to practice owners. We also said that banks must be held accountable and required to offer practices loans through the government Coronavirus Business Interruption Loan Scheme, which had been denied to virtually all practices in Wales.

BDA campaigned for private dentistry
The BDA centrally has written repeatedly to the Chancellor to improve the financial security for dentists throughout this crisis. The measures included raising the ceiling on self-employed earnings from £50K. We have yet to receive a reply.

Across the UK, 101 MPs wrote to the Chancellor demanding new financial support packages for dentists and dental practices. To date he has not replied to his Parliamentary colleagues. We wrote to all 40 MPs in Wales about the lack of support for private dentistry and more than a quarter of MPs replied to convey their concern and some requested new measures from the Chancellor. Ben Lake, MP for Ceredigion, was particularly supportive and tabled early day motion #338.

Prospects for private dentistry
Expansion of face-to-face care will not solve all the issues that have arisen since the outbreak of the pandemic. The costs of PPE for treatment of a single patient have multiplied from pence to many pounds. Some estimates obtained by the BDA are as high as 6,000%. The severely reduced throughput of patients will inevitably lead to redundancies for private practice staff once furlough is lifted.

3. Urgent dental care centres need to be stepped down soon to enable special need patients to be treated

Key message: The CDS now, more than ever needs to be fully staffed to deal with the backlog in existing treatment and assessments of new complex referrals.

UDCs in response to red alert
At the beginning of the emerging Coronavirus pandemic in Wales, the Community Dental Service took the lead to initially convert 15 clinics throughout Wales into Urgent Dental Care Clinics. Their primary role was for the urgent dental treatment of patients with COVID symptoms or those requiring urgent treatment involving an Aerosol Generating Procedure (AGP). The number of Urgent Dental Care clinics has now risen to around 25 and in a few areas they are supported by the GDS and in Cardiff by the Dental Hospital. Greater travel distances for patients with urgent treatment needs have resulted but this is not good for reducing COVID spread and not good for patients' confidence.

Impact of pandemic on CDS staff and staffing levels
Working long hours in full enhanced PPE, especially in warm weather, has had a significant impact on CDS staff's health and well-being. Many feel taken for granted given how constant the work demands have been. Community dental teams have done a great job for many patient emergencies.

Very recently some CDS staff have retired and now is not the time for LHBs to leave these positions unfilled. If this is not addressed, it will raise work-related stress, decrease morale and thus increase work related sickness and staff leaving the profession or early retirement, Which in turn will leave even fewer staff to deal with a rapidly growing caseload. The CDS now, more than ever needs to be fully staffed to deal with the backlog in existing treatment and assessments of new complex referrals.

UDCs in response to deescalation amber alert
Patients want to be treated by their own dentists. Patients are frequently reluctant to come in to the UDCs unless they are in extreme need. As we emerge from this first peak of infections, the Urgent Dental Clinics need to transfer the urgent work to the GDS so that the CDS can return to their primary role and patient group, treating special needs children and adults, the most vulnerable groups of society.

Funding for the UDCs needs to moved into the GDS - the funding of GDS doesn't work presently - practices are operating at a loss already and doing AGPs will increase the level of loss unless the annual contract value is fully reinstated. Government must respect that GDS practices are businesses with the clock ticking.

For further correspondence please contact:
Dr Caroline Seddon
National Director, BDA Wales [redacted]