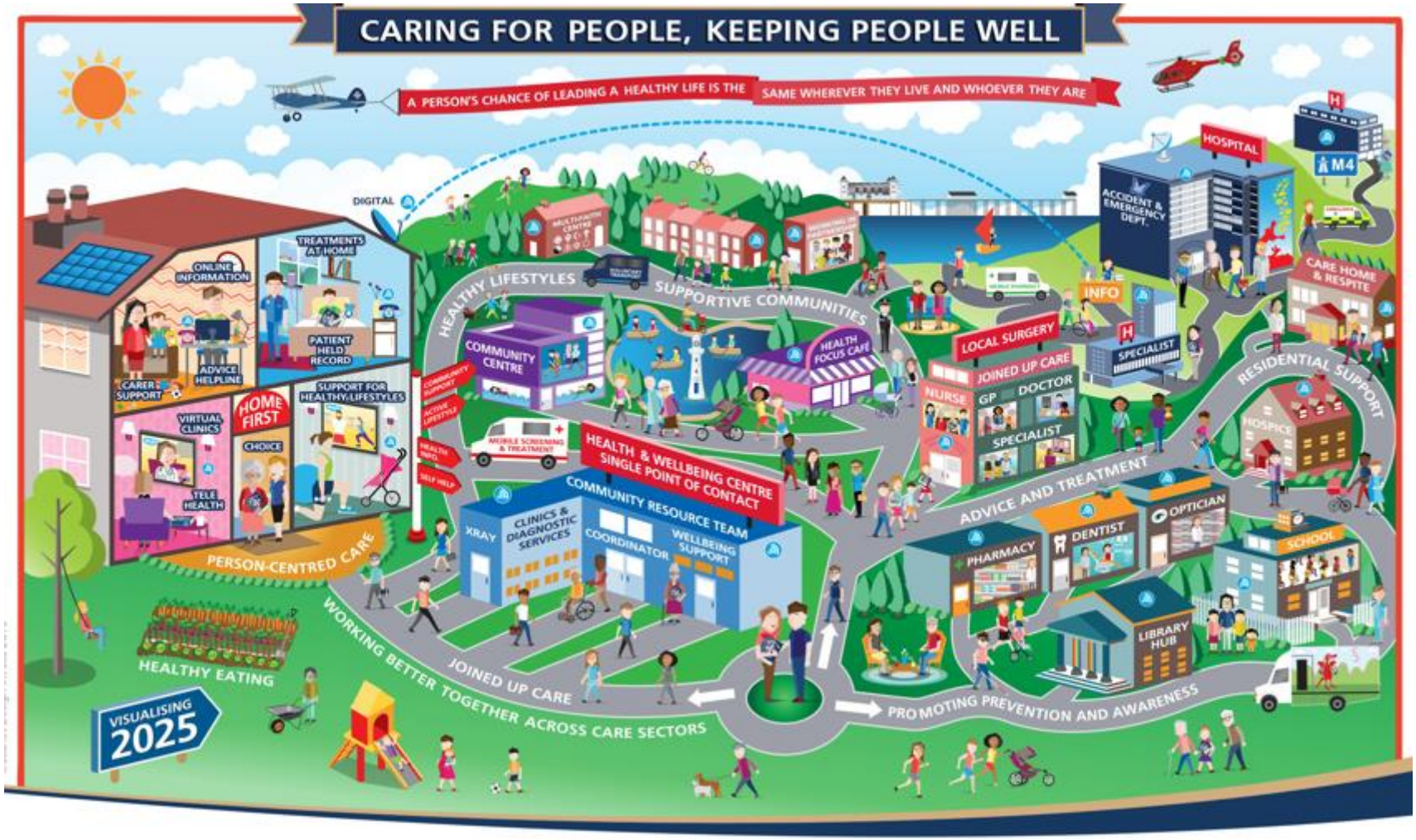


CARDIFF AND VALE UNIVERSITY HEALTH BOARD

SERVICE DELIVERY PLAN 2020-21 – QUARTER 2 UPDATE (FINAL DRAFT)

INDEX

INTRODUCTION

In our quarter 1 submission, our plan set out our framework for how we will deliver services over the course of 2020/2021, with more detail on the actions being taken in the first quarter to develop an operating model that remains COVID-19 ready, whilst enabling us to undertake as much non-COVID-19 activity safely recognising the potential risk of harm caused by delayed access to timely care or treatment. As described in the 2020/2021 plan, the response from our staff during the emergency phase was extraordinary and we are extremely proud of their achievements. People have been innovative in establishing new service models and adapted quickly to new ways of working, new approaches, and redeployment to priority areas.

Following on from the submission of our Service Delivery plan for 2020/21 in May this plan provides further information in a number of specific areas as set out in the Quarter Two Operational Framework and should be read in conjunction with our 2020/21 plan.

As described in our 2020/21 plan, as an immediate acute response to the pandemic, we took a phased approach:

Phase 1: Repurposing capacity and zoning within UHB acute hospitals – e.g. to enable cohorting of suspected and confirmed cases, stepping up critical care capability and capacity, creating dedicated pathways to manage patient flows safely
Phase 2: Commissioning new infrastructure and additional capacity within UHB facilities – i.e. additional ward capacity and a 10 bedded socialist High Consequence Infectious Diseases Unit
Phase 3: 'In Extremis' commissioning short-term surge capacity outside UHB facilities (Dragon's Heart Hospital) – this will be reviewed through Q2 to secure a sustainable, medium-term solution that will meet the likely reduced surge capacity requirement determined by the emerging UK and Welsh Government response to the pandemic over the longer term.

Our **Phase 4** ongoing response described the principles, operating model and gearing approach that we are applying to ensure that the UHB is able to continue to provide a flexible approach to developing and balancing our capacity to deliver essential services, in particular to:

- meet the ongoing undulating emergency, rehabilitation and ongoing care demand arising from COVID-19 across all partners in health and social care, recognising the current relative unpredictability of this need
- meet the returning and growing demand for non-COVID-19 related unscheduled care – in both the acute and primary/community environments
- optimise safe elective care for those priority patients based on clinical need recognising the particular challenges in meeting the demand from out wider South Wales catchment population for complex and tertiary care – both adult and paediatric.

Our organisational culture has emphatically framed the way that we have responded to the challenges of the pandemic. We have strived for a culture of high trust and low bureaucracy, in responding to the need for rapid change we purposefully devolved decision making to our frontline staff, agreeing principles and allowing staff freedom to act within these. We also operated in an open and transparent way, our daily 10am meetings were open to all, clinical teams bought issues and we tasked resolutions. Whilst we move through this next period we want to continue to build on this transformative way of working, enshrining this cultural approach to working which will allow our organisation to grow.

Phase 5 of our response described in our 2020/21 plan outlined our proposed approach to system renewal to ensure that the focus on short term cycles of responsive operational planning did not obscure the partnership lens on working as an outcome-focussed RPB to deliver an integrated system that meets the whole health & care needs of our communities at all stages of their lives i.e. From Birth to 21 (Starting Well), Working Age Adults (Living Well) and Older People (Aging Well). As a component of this system renewal, we will seek to work with our partners to accelerate and embed those service or system changes that have worked well as part of our Phase 4 response with a particular focus in Q2 on Primary Care-led Enhanced Unscheduled Care (CAV 24/7) and Outpatients' transformation

Shaping Our Future Wellbeing and A Healthier Wales continue to provide us with the strategic direction for transforming the services we delivery, and the contribution we make to supporting people in our communities to lead healthy lives, and we will use the crisis presented by COVID-19, and the learning from the last four months as a catalyst to acceleration transformation as we respond to longer term impacts of the pandemic.

This document provides a number of specific updates on our operating plan for 2020/21 and provides further specific information requested by Welsh Government in the 'NHS Wales COVID-19 Operating Framework Guidance Quarter 2 (20/21).

QUARTER TWO UPDATE

1. PRIMARY CARE AND MENTAL HEALTH

During the emergency response phase, our primary care and community mental health teams swiftly adapted their services to meet the needs of those most in need of services and support and have rapidly adopted new virtual approaches to delivering services which have been enabled through investment in digitally technology. During this quarter, our aim is to embed those service changes where the impact has been positive, which will continue to contribute to providing the headroom and appropriate environments to reintroduce more of our routine services.

1.1. Primary Care and Community Services

We are continuing to support GP practices to manage both the COVID-19 and non COVID-19 demand, ensuring the separation of the two patient streams either at practice or cluster level. Hubs have been established at cluster level to ensure timely access for urgent and emergency care. Whilst quarter 1 saw a significant reduction in demand from patients, this is now beginning to rise back towards previous levels. We have seen the transformation in the way that patients are accessing general practice with widespread use of telephone triage, e-consult and video consultations. This has received positive feedback with most patient groups, information received as part of the national programme roll-out. Primary care colleagues have worked with us to provide a proactive media campaign to encourage people to make an appointment to see their GP if they are worried about a change that could require follow-up as a potential suspected cancer in light of the significant drop in attendance for this, and ongoing referrals to secondary care.

We have used our Healthpathways™ system to provide GPs with daily updates on changes to services and pathways, building on the system that we introduced as part of our Transformation Programme. As we come through into the next phase of our renewal and recovery following COVID-19, we will look to embed the positive changes that have been implemented, recognising that the changes that have been achieved are very much in line with the national primary care model and Shaping Our Future Wellbeing.

We have increased our focus on ensuring primary care support to care homes and those on palliative care pathways and this will continue. We are implementing the Directly Enhanced Service to increase specific support to care homes – the new specifications have been sent out to all GP practices and we are awaiting responses. The aims of the DES which has been revised in response to COVID-19, but is time-limited to 31 March 2021, are to:

- Optimise access to primary care for care home residents
- Enable urgent access to primary medical care for care home staff
- Continue provision of pre-emptive proactive and anticipatory care

- Prompt a high quality consistent approach across healthy boards whilst at the same time being flexible enough to be adopted by clusters or individual practices

Particular benefits this will provide for care homes and their residents include:

- Structured clinical consultations to care homes residents on a weekly basis (either face-to face or remote video consultation at the request of the care home)
- Comprehensive review of mental and physical health after admissions and structured patient medication review taken during the year, with regular medication reviews as clinically appropriate
- Required contractors to have a system in place during core hours (8am -6:30pm, Monday to Friday) which ensures care home staff receive an appropriate response to a request for urgent clinical advice, in normal circumstances within 15 minutes of request.

Out of hours, care homes will continue to be supported by the Primary Care Out of Hours services. Practices are also required to engage in and support a death review through significant event analysis of the care of a patient who dies within a care home or within seven days of admission to hospital from a care home.

As we move beyond the emergency response period, general practice is looking to focus on those groups with greatest potential risk of harm from not having accessed routine services – those shielding and with multiple morbidities.

Our community pharmacies have remained open and are providing extensive advice on prescribing and we will continue to promote this over the next period. Working with the voluntary sector, we have successfully introduced an expanded prescription delivery service for patients which has particularly supported people who are shielding.

Now the dental alert has reduced from high amber to amber, we are providing the necessary support to practices to begin to undertake aerosol generated procedures with the appropriate IPC and PPE. On a locality basis, we continue to provide access to services for urgent care through our locality centres, and will continue to provide this service until it is safe to provide a wider range of local services in our dental practices.

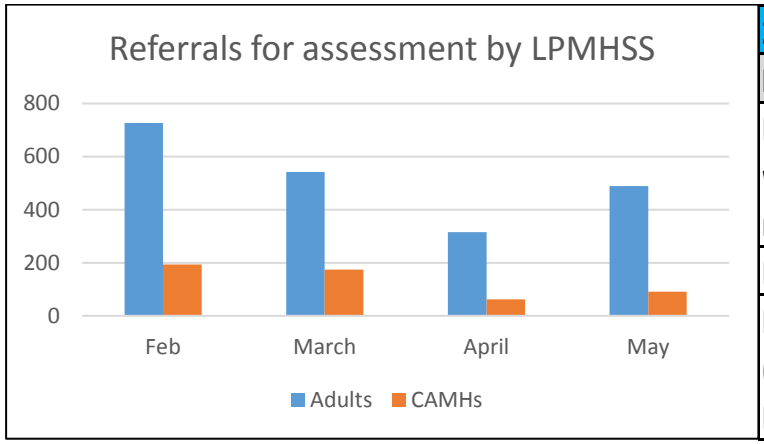
Optometry services reopened at the end June, and with the appropriate IPC are able to provide a near to normal service. This is important in light of the continued suspension of some hospital based eye care. We will be reviewing the pathways for urgent referrals to ensure patients are access the right service in the right place.

During Q2 we will be reviewing and re-prioritising our prevention work within the available capacity, to ensure key priorities including immunisation, tobacco, healthy weight, and health inequalities, are given the focus required, alongside supporting delivery of the regional Test, Trace and Protect (TTP) COVID-19 function.

We are also assessing how our community services will need to be adjusted to provide support for those patient requiring significant rehabilitation programmes as they recover from COVID-19. In the May submission we outlined out COVID-19 rehabilitation model and this is now being implemented with our MDT operational and health pathway finalised. We have a dedicated COVID-19 website to provide information and advice to individuals, staff and partners.

1.2 Mental Health Services

In our 2020/21 service plan submitted in May, we highlighted the work undertaken to review the expected growth in demand for mental health services as the psychological impacts of the pandemic become apparent, indicating where we envisage needing to expand services. We continue to develop these plans, and embed the new ways of working that have increased and improved access for some service users. The teams are also planning how to safely reintroduce the services delivered through peer groups and we are looking to secure suitable venues, working with partners, to enable these services to recommence safely. The table below sets out how demand for both adult and children and young peoples' mental health services have changed during the emergency response phase.



2020/21		Mar	Apr	May
Mental Health				
Part 1a: % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (Target = 80%)	20/21 Actual	63%	66%	95%
Part 1a: CAMHs only	20/21 Actual	77%	73%	89%
Part 1b: % of therapeutic interventions started within (up to and including) 28 days following assessment by LPMHSS	20/21 Actual	84%	77%	79%

Adults – Referral volumes in April dropped to 34% of previous volumes. Increased in May to 49%
CAMHs - Referral volumes in April dropped to 42% of previous volumes. Increased in May to 48%

We continued to provide services to people referred to the LPMHSS, and face to face consultations replaced with virtual appointments, with other face to face appointments taking place for whom it was assess as being essential. Community Mental Health Services for Older People are also beginning to resume supporting people to remain living at home.

2. SERVICES FOR CHILDREN AND YOUNG PEOPLE

2.1 CAMHS

During the emergency response phase our services switched to virtual sessions, enabling our teams to remain in contact and providing support to children and young people, at a time of increased anxiety and risk of harm for some. The service prioritised those young people deemed most at risk and with greatest needs. For many young people, the move to a virtual setting as a platform for accessing support has been a positive development, and work is being undertake to assess how best to provide services in the future, embedding the positive changes that have been secured over the last four months. We are planning for demand to increase as young people return to school and working through our response to this. Over the next quarter we will be working with local authorities, the third sector and children and young people and their families through the RPB to respond to the challenges set out in the Children's Commissioner's report – No Wrong Door. We will be building on the progress made the Children and Young People's Partnership, with investment from ICF and Transformation Funding. We are also working with Cardiff Council to address the areas of improvement required following inspection of the youth offending service.

2.2. Children with complex needs

As young people return to school this quarter, we are ensuring we are able to provide our input into the schools recognising the significant health input that is provided for some young people with complex needs within the school environment.

2.3 Children's Hospital Services

We have seen a significant drop in unscheduled demand for children's services. We have worked proactively with our primary care colleagues and increased social media communication to encourage parents to bring their children to seek hospital care if they are worried, recognising that we have seen a pattern of late presentation of illness in some children. We have established a separate children's emergency theatre service with dedicated paediatric CEPOD lists.

Our Paediatric Emergency Department (PED) has been temporarily relocated to the Children's Hospital for Wales to be co-located with the Children's Assessment Unit (CAU) and whilst we need to continue to observe strict social distancing measures in our ED department, we will continue to run these from the Children's Hospital for Wales, and plan for where we locate our single point of access service (Adult and Paediatric ED and CAU) adjacent to the main ED department, which remains our plan.

3. ACUTE SERVICES – PHASE 4

3.1 Acute Bed Configuration Plan

In May we set out plans for reintroducing more of our urgent non-COVID-19 demand, the focus in the emergency response phase being on responding to the anticipated COVID-19 demand, and essential non-COVID-19 activity. Remaining vigilant to the threat of COVID-19 and proceeding with appropriate caution to ensure we reduce harm for both COVID-19 and non-COVID-19 patients, we aim to continue to transform at pace and focus on the long term. We continue to operate with strict patient segregation, flexing our bed capacity in response to changes in the demand for different streams. We continue to utilise Spire and SSSU, UHW as our 'Green', COVID-19-protected facilities and are in the process of expanding the Green Zone footprint at UHW and UHL, providing protected elective surgical capacity. This is enabling us to continue to provide essential services and significantly increase the amount of non-COVID-19 activity we can provide safely. Our patient and staff testing regimes have been stepped up in line with national requirements which is assisting with the management of the separate patients groups. We continue to review the position on a daily basis to reflect that the picture can change rapidly and high levels of adaptability are built into our planning.

3.2 Capacity Planning

In common with other Health Boards in Wales, and across the rest of the UK, we have seen a significant decrease in COVID-19 patients since the peak of the first wave in early April. Nonetheless the virus persists in our communities and the potential for subsequent waves remains. Consequently our first design principle in this phase is to be 'COVID-19-ready'.

Early Warning Indicators – System Surveillance: We have worked with regional partners to develop a surveillance system, incorporating early warning indicators, to monitor the prevalence and impact of the virus at a local level. A high-level summary of this is shown in Appendix 1. This is being used to identify early signals of demand changes, particularly in the event of a second wave and, in conjunction with the patient streams and 'gearing' approach, forms our COVID-19 Operating Model.

Planning Principles and Assumptions: To prepare for a potential second wave we have scenario planned the combined bed requirements of COVID-19 demand, non-COVID-19 emergency demand and elective demand. This has been done using the following assumptions:

- Non-COVID-19 activity (including electives) will not exceed 80% of pre-COVID-19 levels at the peak of a second wave
- Bed occupancy rates of 85% for COVID-19 and non-COVID-19 emergencies and 90% for electives
- Additional Winter bed demand of 50 beds, reflecting the typical winter bed planning assumption
- UHW commences as the Major Trauma Centre but no specific provision for any other services to be supported/centralised further (including social care)

- Loss of 22 beds for COVID-19 (red zone) spacing and 27 beds for Green zone spacing but no further provision for increased bed spacing (i.e. does not allow for 2m spacing in all areas)
- Re-purposing of ward areas for the expansion of critical care capacity will remain in place, with resulting loss of non-ITU bed capacity
- Spire remains available to the UHB for elective operating
- Discharge flows into the community and social care are maintained

Potential COVID-19 demand has been considered in two ways. Firstly we have received correspondence from the Director General describing Welsh Government's interpretation of the COVID-19 capacity required in a second peak, based upon the national modelling. Secondly we have access to our own modelling tool allowing various scenarios to be tested, utilising our local data on key variables such as length of stay. This has allowed us to test the sensitivity of our plans to different R_t values, lasting different durations.

The national and the local modelling consider two different scenarios for the spread of the virus in a second wave. For the purposes of contingency planning we have primarily modelled the most recent SAGE Reasonable Worst Case Scenario of R_t increasing to 1.7 and remaining at that level for four weeks before reducing (appendix 2). This gives a sharp increase in demand but is relatively short-lived. Conversely the national modelling is based upon R_t increasing to 1.1 for three months, which gives a slower but longer-lasting second wave. Despite this difference both scenarios reach a similar level for the peak – 796 COVID-19 beds from Welsh Government assessment versus 719 from the local modelling (based upon 85% bed occupancy).

Combining these assessments of potential COVID-19 demand with the earlier assumptions we have calculated a 'worst, worst-case' bed capacity deficit of 470-547 beds (the range relating to which value is used for peak COVID-19 demand). However taking into account the likelihood of a COVID-19 peak coinciding with: the peak of winter, non-COVID-19 demand running at 80% of pre-COVID-19 levels (when it dropped below 40% in the first wave) and elective operating continuing at 80%, we have judged that surge capacity of 400 beds would provide sufficient contingency in the event of a second COVID-19 wave.

This of course reflects an attempt to determine the 'reasonable worst case' scenario for our bed planning. It is not a prediction and by definition we anticipate the most likely bed requirement to be much lower, equally it assumes the government will reinstate lockdown if necessary and therefore does not provide for an unmitigated spread of the virus.

Surge Capacity: The Dragon's Heart Hospital was established to ensure that we were in a position to meet the potential '*in extremis'* demand that could have arisen in the initial phase of the pandemic, responding to the national reasonable worst case scenario modelling. The measures introduced by the Welsh Government to slow the spread of infection were highly effective resulting in much lower levels of demand. In response to the recent modelling work described above, we have assessed that it is not viable to continue to have the Dragon's Heart Hospital on standby beyond October 31st for a number of reasons which have been outlined in separate correspondence with the Chief Executive of NHS Wales. It was designed for a significant peak in short-term demand, rather than as an ongoing facility to provide surge capacity for future peaks in COVID-19 demand should they occur. We have therefore developed

alternative plans which have been shared with Welsh Government to establish a facility for surge capacity on the UHW site. In addition to providing COVID-19 surge capacity, it would provide the surge beds we would need to commission for this winter, recognising that predicting winter demand this year is particularly difficult. Our assessment is that of the 400 beds provided in this proposed facility, 50 would be developed as winter surge beds. The remainder would be kept as surge beds to use if we did see a significant. Our bed capacity plan maintains some of the initial bed expansion created in our GOLD capacity plan (wards in Barry and St David's Hospital as well as the conversion of a physiotherapy area at UHW), but some of the beds originally identified as conversion to COVID-19 beds are required as we bring back on line more non-COVID-19 activity.

3.2 Resuming Non-COVID-19 Activity

Throughout the pandemic the UHB has maintained core essential services. Given the uncertainty brought about by COVID-19 the UHB continues to operate in 4-6 week planning cycles, with prioritisation of need based upon clinical-stratification rather than time-based stratification Given the significant uncertainty in the current operating environment, it is extremely difficult to forecast activity with any degree of certainty - and therefore forecasts beyond the 4 – 6 week current planning horizon are less reliable. Prevailing circumstances mean a range of added activity planning assumptions need to be factored in, including:

- The extent to which current COVID activity changes.
- The Health Board's ability to continue to access independent hospital support (Spire Hospital)
- Activity changes as a result of continuing clinical audit outcomes for the developing 'green zones'.
- No further interruption to specialist PPE requirements for surgery and critical care.
- Theatre throughput being sustained or improved as clinical teams get used to using PPE during procedures.
- Sustaining and improving clinician confidence to undertake clinical activity.
- Sustaining and improving patient confidence in accessing services.
- Avoiding or mitigating staff absence as a result of protection, shielding or TTP related advice.
- Environmental guidance changes and any impact on bed availability.

However, acknowledging patient concern across essential and non-essential services the Health Board has set out an ambition for increasing activity beyond essential services in Q2. The ambition should be seen in the context of the current uncertain circumstances.

A summary of the UHB's ambition against key services is set out in Appendix 3. Further details on the delivery of outpatient services is described in section 7.2)

3.4 Update on Protected Elective Surgical Capacity (Green Zones) and Surgical Activity

Our plan for 2020/21 set out in detail our assessment of surgical demand and backlog for levels 2 and 3 and the capacity we intend to establish in our three green zones – UHW, UHL and Spire. The high level conclusions from this assessment remain extant and are as follows:

- The UHB has throughout the pandemic maintained level 1a and 1b surgery and the majority of level 2 surgery
- The UHB can put in place the theatre, bed and workforce capacity to meet all of the level 2 demand
- The UHB has the physical theatre capacity to also meet all of the level 3 demand but this is likely to present a theatre staffing deficit unless theatre throughout can significantly improve closer to pre-COVID-19 levels; it may also require an expansion of the green zones to allow for more bed provision
- This assessment assumes Spire is available to the UHB for the remainder of the financial year, any reduction in this would lead to a direct reduction in the capacity for urgent and time-sensitive activity
  At this stage, even with the green zones established and the use of Spire, the UHB does not anticipate having the capacity to treat level 4 patients in any significant volumes

At the beginning of the COIVD-19 pandemic, we 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 us extra capacity to care for COVID-19 patients at our 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 include the following specialties, and the table below confirms the activity undertaken there to date:

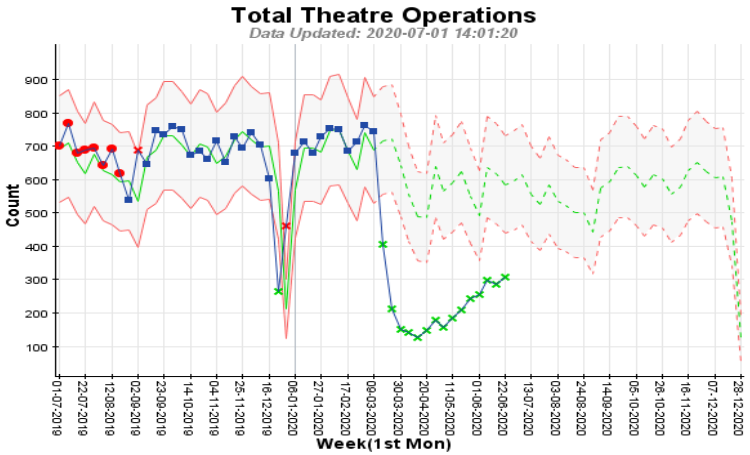
Gynaecological	Urological	Neurological	Colorectal
Gastroenterological	Breast	Haematological	ENT

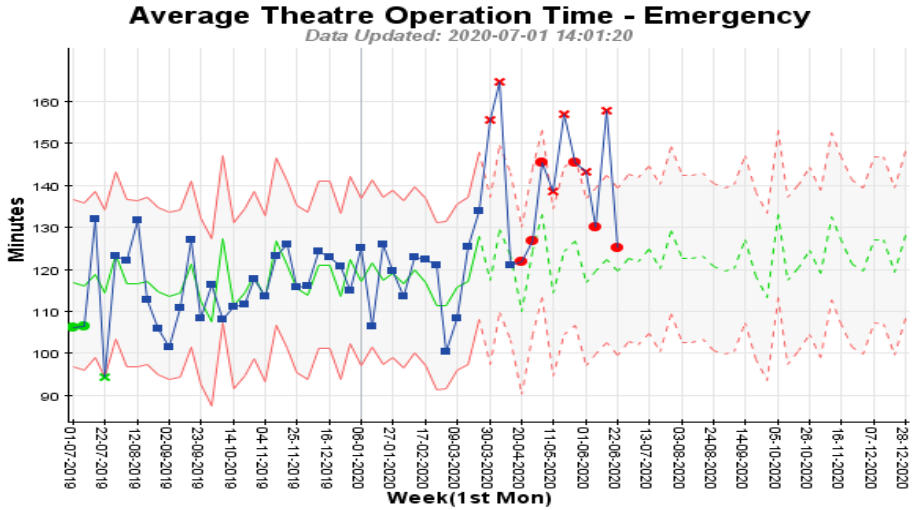
UHB Activity at Spire since 23rd March 2020

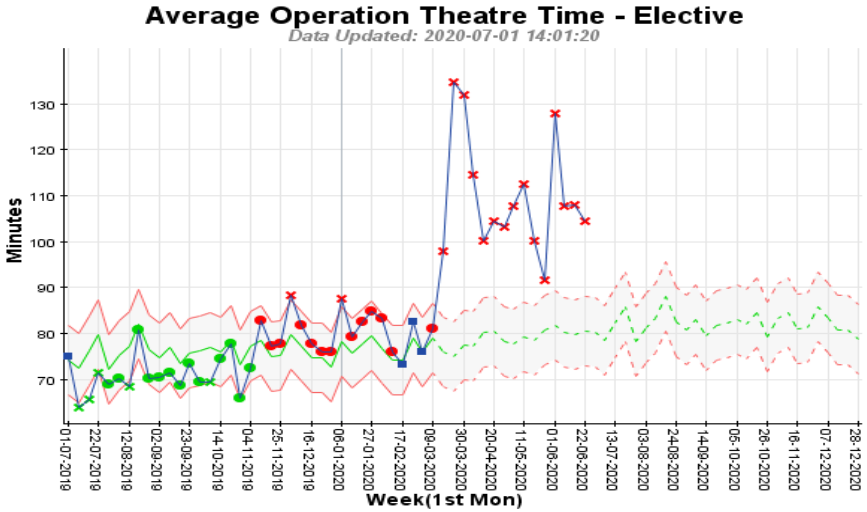
Cancer operations	Other time sensitive Theatre cases (inc 39 eyes)	Outpatients (incl 1,098 eyes)	Endoscopy procedures inc urgent Cancer	Cardiology procedures	Total
262	164	2,023	260	48	2,757

In line with the intentions described in our 2020/21 plan the UHB has, since the height of the pandemic, been steadily increasing its core theatre activity (see below). This is within the context of theatre cases taking approximately 50% longer post-COVID-19. The full establishment of the current planned green zones through July and August will allow further stepped increases in capacity during quarter 2, supporting the service plans set out in Appendices 3 and 4.

Continued exclusive use of Spire Hospital Cardiff is a key dependency in the delivery of the activity described in Appendix 3. We continue to use data extracted through Signals from Noise to plan our activity, using it on a daily basis to adjust our operational plan as necessary, as illustrated in the graphs below.







3.5 Regional Collaboration for the Provision of Acute Services

We continue to work closely with commissioners and partner UHB providers to ensure that together we are protecting and strengthening fragile regional and tertiary services where we have the biggest challenges – focussed work is taking place in a number of specialities including interventional radiology, upper GI cancer surgery, paediatric gastroenterology and paediatric neurology.

We have re-established our specialist and tertiary provider partnership with Swansea Bay UHB, and are also recommending discussions with CTM UHB regarding a number of fragile services were a collaborative/networked service will deliver a more sustainable service model. We are also keen to progress regional discussions about high volume ophthalmology surgery – in particular cataract surgery where there will be a significant backlog post COVID-19.

Working with the Major Trauma Network, we are committed to establishing the Major Trauma Centre at UHW in line with the go-live plans that were put on hold in light of the emergency response to the pandemic. We reviewed our implementation plans, and will need to make minor adjustments to our original plan and have discussed these with the Major Trauma Network team. There is agreement that we should aim to establish the Major Trauma Centre from early September, exact date yet to be agreed, in line with the EMRTs flight based service coming on lien 24/7. The Major Trauma Network will need to remain 'COVID-19-ready' with the ability to quickly instigate surge management plans.

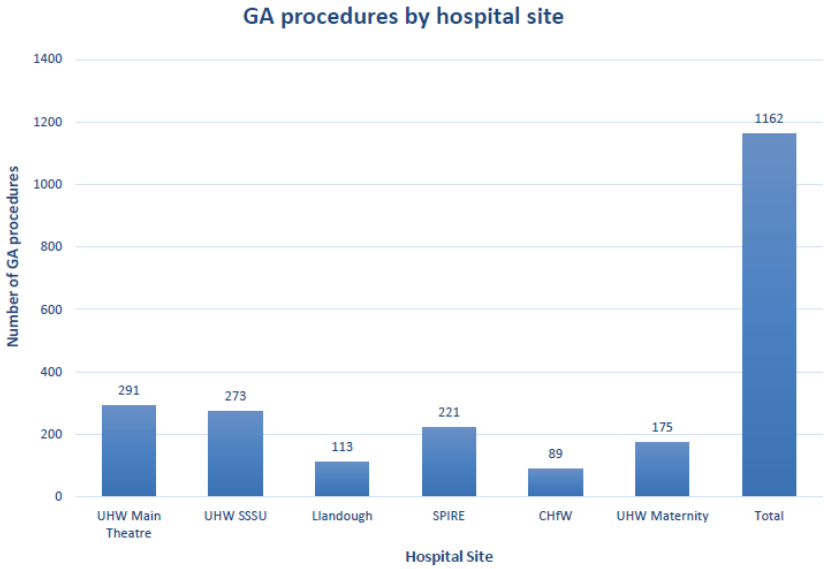
An overview of early Q1 high-level acute demand, activity and performance data can be found at Appendix 6.

3.6 Delivering Compassionate Care Safely

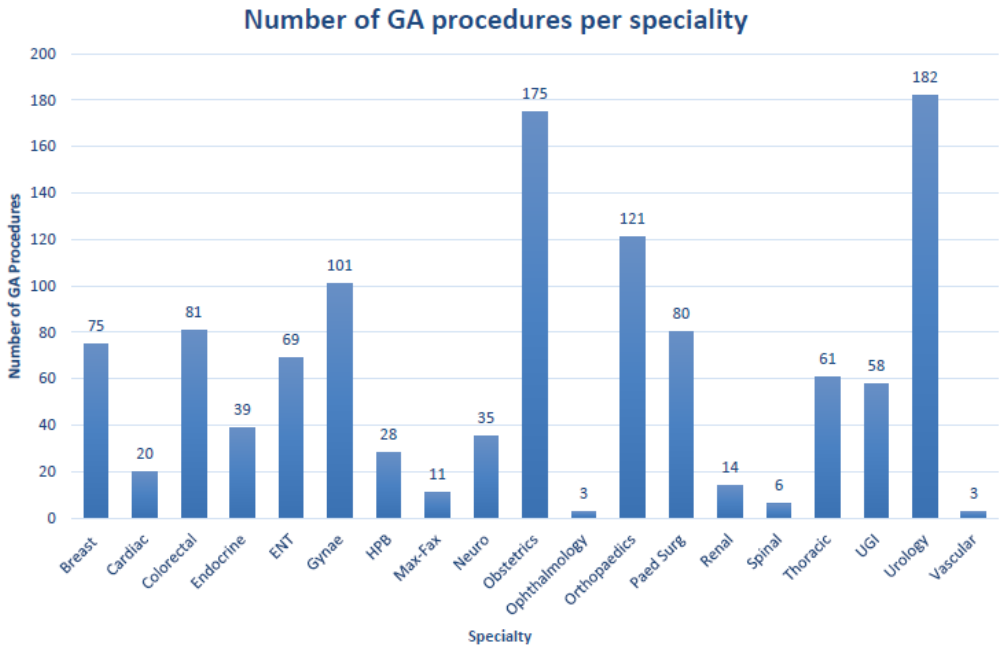
The Nursing and Medical Director's Teams continues to monitor closely the surgical activity that is undertake to enable any issues to be quickly identified an acted upon, and the COVID-19 status of patients in all of our hospitals to identify quickly any issues in respect of hospital acquired infection. Below sets out the findings of our initial review of the non-COVID19 activity we have undertaken to date.

Elective Care

Between 16.3.20 and 12.6.20 we have undertaken 1125 surgical procedures under GA or spinal/epidural. This number excludes all LA or endoscopy procedures. Cases were undertaken on a number of sites, with a key cohort managed at the Spire Hospital in Cardiff:



The case mix was highly varied, with work undertaken from a number of clinical areas, with a majority of work undertaken for cancer diagnoses – but with a significant minority for non-cancer concerns. This highlights the importance of not confusing essential surgery in a COVID-19 pandemic with just cancer work.



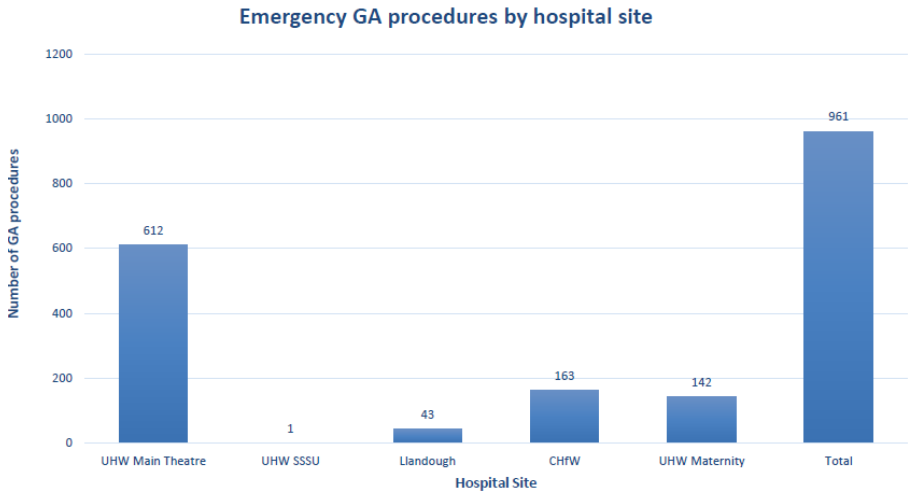
In-patients were swabbed for COVID-19 if they developed possibly COVID-19 symptoms only. Of these, there were around 16 positive swabs (1.4%) for COVID-19 within 30 days of the procedure (the vast majority in March and April). There were about 77 negative swab results over the same period.

There were five deaths within 30 days of the operation but another two within 32 days. Of these 5 deaths (0.4% overall but about 30 % of positive swab cases), all appeared to be from COVID-19.

The conclusion therefore, in scheduled care, is that the risk of COVID-19 in elective setting, with all IPC controls, is in fact very small – especially now, due to reducing COVID-19 burden in the community and mitigation by the pre-op pathway, which include PPE guidance, isolation and pre-admission testing. However it remains the case that contracting COVID-19 peri-operatively carries a high risk of mortality.

Emergency Care

Our initial review results for emergency care show a slightly different picture. We have undertaken 1367 procedures, under GA or Spinal/Epidural, between 16.3.20 and 12.6.20 (again excludes all LA procedures/ endoscopy etc). Again work was undertaken in a number of sites (but not Spire).



Of these, again tested for COVID-19 type symptoms only, we identified approximately 51 positive swabs (3.7%) – these were mainly post-op. There were 186 negative swab results over the same period.

Our review to date has identified 14 deaths (1% overall but about 30% of positive swab cases) which appear to be from COVID-19 within 30 days of procedure: About half the deaths were in trauma – which is of course often a frail, elderly cohort post hip fracture.

In comparing elective versus emergency cases: Emergency cases presented a higher risk of COVID-19 (3.7% versus 1.4%) overall, emergency cases presented higher risk of death from COVID-19 (1% versus 0.4%) overall and emergency and elective cases have similar death rates if COVID-19 infection present of around 30%.

Of course the key issue in emergency care is a comparison of operating or not in a COVID-19 era. It can be seen from our hip fracture data that there is a genuine chance that despite the risks of COVID-19 the overall mortality risk from intervention may be decreased in the current situation rather than increased – due to the other service changes that have been essentially delivered due to the pandemic.

PPE

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. We 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

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.

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 we have 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. We have now secured continuity and sustainability of both gown and mask supply. The 1863 is now the primary pandemic mask and currently within C&V 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 also give us about a 6 months' supply. A £500k order for additional gowns to secure a medium terms supply, has also recently been placed. The Health Board has also invested in a 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.

We will continue to place significant emphasis on the provision of appropriate PPE to staff. We recognise 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.

Patient Experience

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.

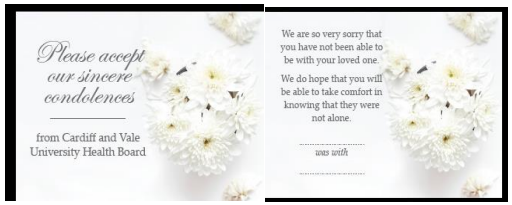
Virtual Visiting

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 socialize as they used to, we 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'.

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 have supported over 280 bereaved families. We have also established a system to return property to bereaved families. Whilst we have 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.



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 COVID19 specific feedback, we have undertaken a PPE 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 COVID19, 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.

The team have 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.

4. HEALTH AND SOCIAL CARE PARTNERSHIP WORKING

4.1 Social Care Interface

Since the start of the pandemic, the Executive Team has met jointly with the two 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. Our primary care and local public health teams will continue to provide extended support to care homes in Q2 to reflect the additional needs of residents with COVID-19 symptoms, and the additional operational consequences on staff, supplies and occupancy levels. The weekly joint executive meetings have enabled us to execute strategy and unblock issues including:

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

Q2 actions build on those put in place in Q1 and include:

- Ongoing support with infection prevention and control
- The continuation of the support provided by the UHB IP&C team and microbiologists for care home providers building on the success of the series of webinars that were put on for care homes at the start of the pandemic
- A multi-agency support protocol is in place to support independent sector providers where COVID-19 cases have been identified. Remote meetings are held when an incident is initially identified with representation from the UHB, GP practice and Community Directors, social services, environmental health, CIW and public health Wales so support and response to any queries the provider may have is provided quickly and comprehensively. Regular follow up meetings are arranged. Where ongoing concerns are highlighted the regional multiagency escalating concerns protocol is enacted
- As part of the protocol providers are contacted 3 x weekly by environmental health officers who complete a regular assessment of policies and procedures and provide advice and support with respect to IP&C policies and procedures
- UHB staff have supported care homes with fit testing of staff where residents have Aerosol Generating Care needs and the UHB is providing enhanced PPE for those providers where required
- Where concerns have been raised UHB staff are visiting the setting to monitor and provide direct advice and support
- Assistance with training and support for example in relation to basic parameters and observations, signs of the deteriorating patient, pulse oximetry, rehabilitation, advanced care planning:
- As part of a multiagency response all care homes have been provided with infrared thermometers to assist in monitoring staff and residents baseline observations as part of daily management

- Prior to the pandemic Macmillan funded staff working within the clinical Board have been promoting the use of advanced care planning for individuals in care home settings and this was identified a key priority within our LES. Since lockdown this has been further encouraged and promoted within all Clusters
- The nursing home sector have been encouraged and supported to access Verification of Death training to support more timely verification of death and to minimise footfall within closed settings
- Care Homes are part of a programme to roll out NEWS across the UHB primary care footprint. Pilot homes have already being supported by the 1000 lives plus campaign to implement NEWS
- COVID-19 recovery and rehabilitation programme
- Training and provision of soft set kits for administration of end of life drugs was offered to all nursing home providers to mitigate any issues with access to syringe drivers should demand be high
- We have signed off a Standard Operating Protocol for the repurposing of end of life drugs to mitigate any issues with supply

4.2 Discharge support

Building on the integrated services established through ICF and Transformation Funding, and led by our integrated health and social care teams, we are working with both social services departments to continue to strengthen integrated discharge arrangements, including

- First Point of Contact 'pink army' council staff embedded within hospital teams which have been expanded utilising the Transformation Funding diverted to support the COVID-19 response.
- Daily ward multi-agency coordination meetings to review care home status and availability for discharge
- Principle of home first where COVID-19 self-isolation arrangements can be met
- Additional care home isolation bed capacity commissioned for when COVID-19 self-isolation arrangements cannot be met
- Common discharge risk assessment and discharge COVID-19 testing algorithm
- Additional intermediate care capacity in CRT/VCRS, including care, nursing and therapies

We have introduced the Red Bag scheme, which is a new initiative introduced to improve communication on transfer of patients to a care home. The bag will include all relevant documentation, recent test COVID-19 results and take home medication in one place. It is intended that should the patient be readmitted at any time the bag would be utilised by the care home thus enabling the admitting team to have accurate, relevant information immediately on admission.

Work is currently ongoing with the Care Home Liaison team to improve the support provided to care homes when managing patients with complex challenging needs, for whom isolation is proving difficult to maintain.

4.3 Homelessness

We continue to work in close partnership with our local authorities and other statutory and not-for-profit services to meet the needs of our homeless and roofless population. These individuals generally have high levels of need, frequently with multiple physical and mental health conditions combined with substance misuse and have often experienced previous trauma. Street sleepers tend to have chaotic lifestyles and chronic co-occurring mental health and substance misuse issues.

Cardiff city centre previously had a high prevalence of rough sleepers, with proactive partnership work reducing these numbers from 84 in March 2019 to around 30 at the start of the pandemic. Cardiff Council had undertaken a strategic review of homelessness services and preparations were underway for change, supported by partners including CAV UHB. During the pandemic 182 units of supported accommodation were established to support rough sleepers and individuals in emergency accommodation. Most of this was across two hotels and residents were supported by council support staff on site 24/7 with additional health input provided to the residents at the hotels including nursing, mental health and substance misuse. Residents were supported to self-isolate and be tested for COVID-19 if they developed symptoms. Public health input has been provided at multi-disciplinary homelessness conference calls in Cardiff and the Vale of Glamorgan, and an ongoing model for discussion of complex cases at a daily regional public health call is now in place.

There were specific provisions around substance misuse, such as a mobile needle and syringe programme, harm reduction guidance and advice on wound care and blood borne viruses. A pilot rapid access prescribing service for opiate substitutes was expedited and rolled out more widely and the move to a long acting injectable form of buprenorphine (Buvidal) was accelerated and expanded with financial support from Welsh Government. The effectiveness of these schemes will be monitored and evaluated over the coming months, but initial response has been positive, with the long acting effects of Buvidal enabling individuals to engage with services to address previous trauma.

The changes to the provision of homelessness services have offered a window of opportunity to redesign services to provide good quality initial accommodation with a clear pathway into more permanent solutions. The hotel model is not sustainable in the long term and Cardiff Council has outlined its future vision. This vision has a focus on preventing homelessness, but where this is not possible, offering an easy access assessment and triage approach with the aim of providing good quality, self-contained accommodation in a supported setting and providing rapid rehousing using Housing First principles and providing intensive support in the community. This will initially involve an expansion to the existing multi-disciplinary team and we are committed to supporting this model of care and is assessing the ability of existing services to adapt to meet the needs of this population group, recognising the opportunity that exists to have secured a complete transformation in service provision for this community as a result of the immediate requirements necessitated by COVID-19.

4.4 Accommodation with care

Experience of the last four months has confirmed the frailty of some of our care provision in the community, with difficulties experienced in securing appropriate care placements for people with dementia or other complex needs that require a more specialist care plan. Working with Cardiff Council we have commenced work to look at options for developing a joint care provision.

4.5. Regional Partnership Board

Whilst the RPB did not meet during the initial emergency response, it approved the proposals for the use of the COVID-19 transformation funding which was targeted to supporting hospital discharge and the prevention of unnecessary admissions. The Strategic Leadership Group which supports the RPB has commenced work to refresh the Area Plan, taking the learning from our joint working across social care and the independent and third sectors who have played a key role. The work of the Research Innovation and Improvement Coordinating Hub is being targeted to support the health, social care and housing partnership from COVID-19. Our ongoing preparations for winter will be taken forward through the Strategic Leadership Group and the RPB.

5. TEST, TRACE, PROTECT

Working with our local authority partners we have established our TTP service as one of the key pillars to the safe releasing of lockdown measures. The contact tracing service is hosted by Cardiff Council on behalf of the three organisations; Contact Tracers and Contact Advisors are managed in teams by the Council, with Environmental Health Officer oversight. A Regional Team provides oversight of the public health response across Cardiff and the Vale of Glamorgan, and provides advice on the management of incidents as they arise. The core regional team has representation from Shared Regulatory Services, Local Public Health Team, UHB IP & C and Occupational Health, as well as specialist health protection provided by the national Public Health Wales Health Protection team. A range of other partners are invited to participate as necessary, including Councils' H&S teams, and there is therefore close working with Local Authority led social care oversight groups.

The TTP service went live on 1st June 2020 and by the end of the fourth week of operation had followed up over 300 people who had received positive results. After using an interim solution for the first week, the bespoke national digital platform was adopted, which supports contact tracing at scale and facilitates the necessary transfer of data between partners and other regions of Wales.

Delivery of nationally developed protocols combined with this cross-organisation approach has enabled a number of clusters to be identified and targeted infection control and prevention advice provided, along with the advice to contacts to self-isolate. A number of these clusters have been within the UHB and healthcare settings.

Contact tracing aims to identify those who have had significant contact with someone who has tested positive for COVID-19 in the 48hrs before and 7 days after they became symptomatic, and asking them to self-isolate for 14 days with the objective of halting the onward chain of transmission. 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 meter 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.

A clear lesson from the experience of TTP so far has been the need to maintain physical distancing at all times, particularly when not in the clinical settings where appropriate PPE is used. This is particularly important at break and meal times, and at hand over. To this end, the three partner organisations will be further enhancing their communication campaigns to focus on physical distancing, sharing ideas and tips on how to do this most effectively. This will complement existing 'catch it, bin it, kill it' and hand washing messaging, as well as information on what to do if symptomatic and how to access testing.

Continuing to develop and implement a comprehensive contact tracing system will be key to reducing the risks of infection as lock down restrictions are lifted and we head into the winter months.

6. RESEARCH COLLABORATION

Our research activity has been significantly enhanced, and successfully delivered, during the COVID-19 pandemic. This required a significant change in how our research team functioned, but at the same time built upon the systemic improvements that have been made in our 'Research and Development' service function and processes over the past few years, working closely with Cardiff University.

The successful implementation of a COVID-19 research programme was associated with a number of key enablers – these include: one organisational patient-centred objective, excellent goal-oriented team work, agility and flexibility in our research processes, empowered staff with local decision making, high level Executive support, and timely high quality communications, all with staff wellbeing support.

A number of key changes to our processes were rapidly implemented at the onset of the pandemic. Highlights include:

<u>R&D Preparedness</u>

- In line with the NIHR suggestions we closed down the majority of non-essential trials allowing us to concentrate on COVID-19 Studies with potential treatments for our patients
- Operational COVID-19 meetings were set up at 8am, 3 times/week. This allowed rapid changes to protocols, introduction of new protocols on a daily basis, agile problem solving and staff support.
- All patients were given the opportunity of being offered a clinical trial, as such the Research Delivery Team needed to change from a 5 day working week to 7 days cover.

- Access to senior R&D staff was made available 24/7
- We opened studies in 5-10 days (previous average 210 days). Priorities looked at daily with concentration on treatment studies.

Communication

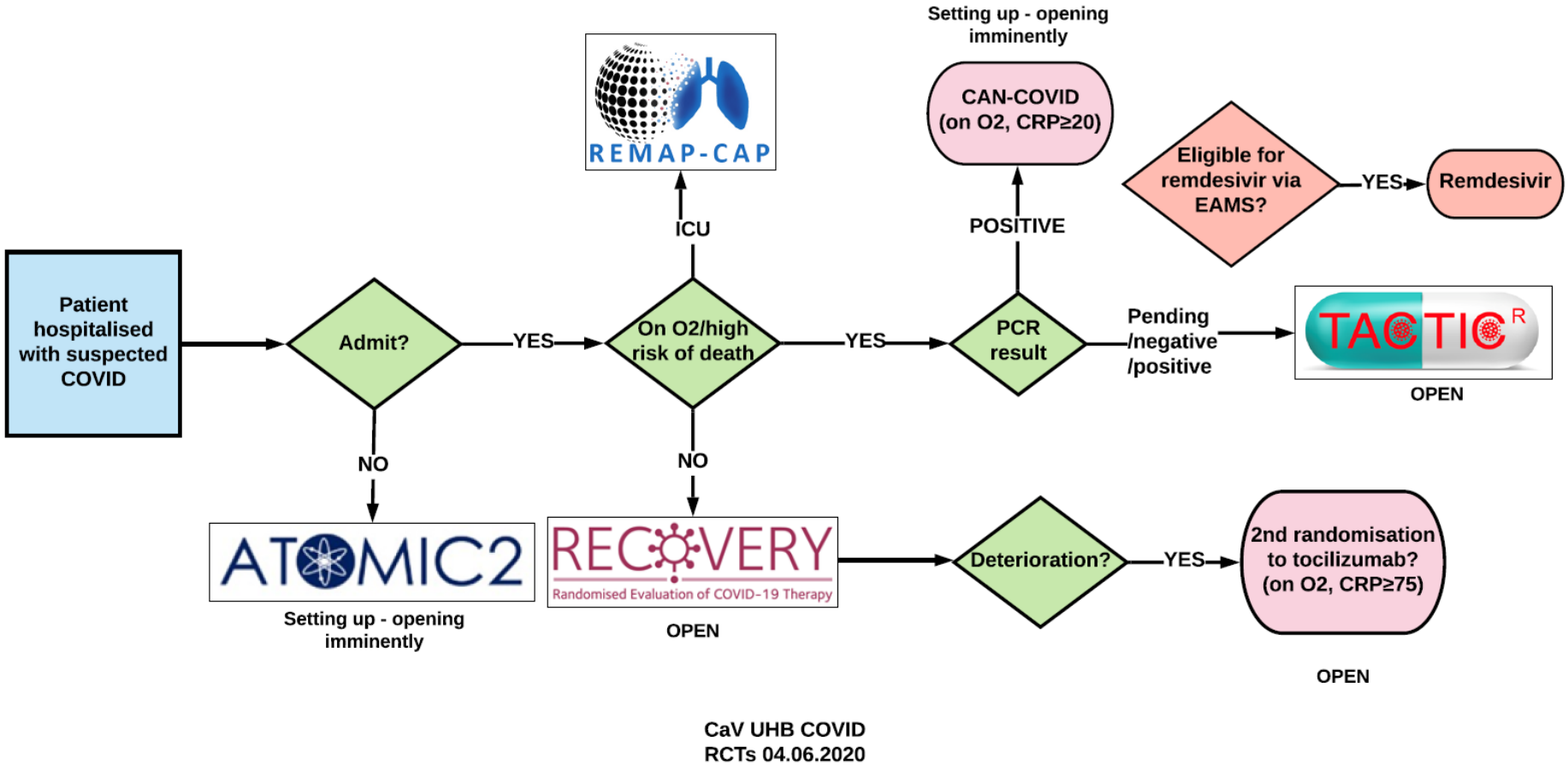
- Teams set up with a coordinated approach for covering UHL, Heulwen/A&E, COVID-19 medical wards and ITU.
- The team, including pharmacist support, had an extensive role in educating the doctors (consultant and juniors), nurses and ward pharmacists who were potentially naïve to research.
- IT solutions were put in place to support our processes – such as with ward and CRF Zoom meetings, WhatApp and similar groups were set up between R&D staff, medics and senior nurses etc. This ensured research staff unable to join 8am meetings were supported e.g. teams in Critical Care.

Ward interaction

- R&D staff attended thrice daily board rounds on COVID-19 wards.
- Team building was undertaken (Research Delivery Team and ward staff) - almost immediate relationships were built with frontline ward staff - both teams felt supported by each other. It helped that we had one disease to deal with and one goal for all – "To find effective treatments".
- Staff took responsibility/ownership for overcoming hurdles and for making sure patients had the opportunity to access trial drugs.
- Pharmacy reduced set up time to 3-5 days (typically 3-6 months) and joined the thrice weekly COVID-19 meetings at 8am to aid communication.

All of this enabled us to be a UK-leader in COVID-19 trial recruitment and delivery – including in the International RECOVERY study. We attach an infographic explaining the trial research availability in June. Overall we have recruited ~200 patients into CTIMPS (Clinical Trial of an Investigational Medicinal Product) and over 300 into additional observational studies. Our RECOVERY trial performance was specifically highlighted as an exemplar by the UK Prime Minister in a Daily COVID-19 briefing. Our research performance continues, with access to an internationally novel Compliment system inhibitor our next major new study planned.

COVID RCTs for hospitalised patieints in Cardiff and Vale Univeristy Health Board

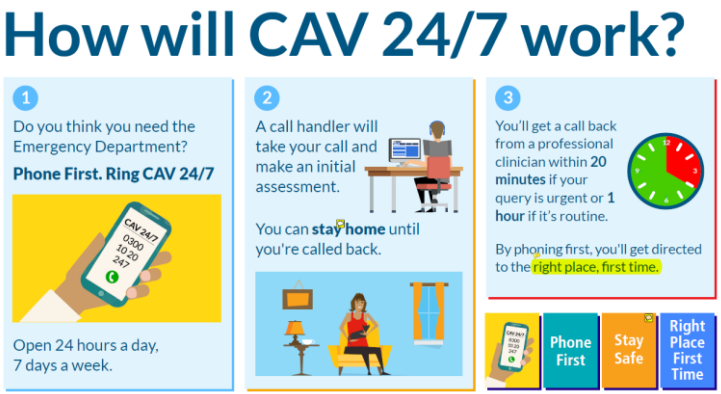


7. PHASE 5 UPDATE - SYSTEM TRANSFORMATION PRIORITIES

As set out in the 2020/21 plan we are developing a number of pieces of work to support the transformation of our system. These developments whilst critical to our successful response in the early phases of COVID-19 are very much in line with direction of travel set out in A Healthier Wales and Shaping Our Future Wellbeing. As we plan our emergence from the initial phases, we will take action to embed the positive changes we have secured, and accelerate our service transformation in a number of areas.

7.1 Unscheduled Care – CAV 24/7

We will be establishing a 24/7 phone first triage approach, targeting citizens who would traditionally have walked up to the Emergency Department. The focus will be on reducing footfall through the Emergency Department, social distancing has significantly reduced the capacity in the waiting area and we do not want to create queues around UHW where we are not safely able to protect and prioritise patients.



All Patients who need believe they need urgent care will be required to ring first, either 999 for immediate emergencies, their own GP for appropriate in-hours urgent care or a single 24/7 number for all other urgent care.

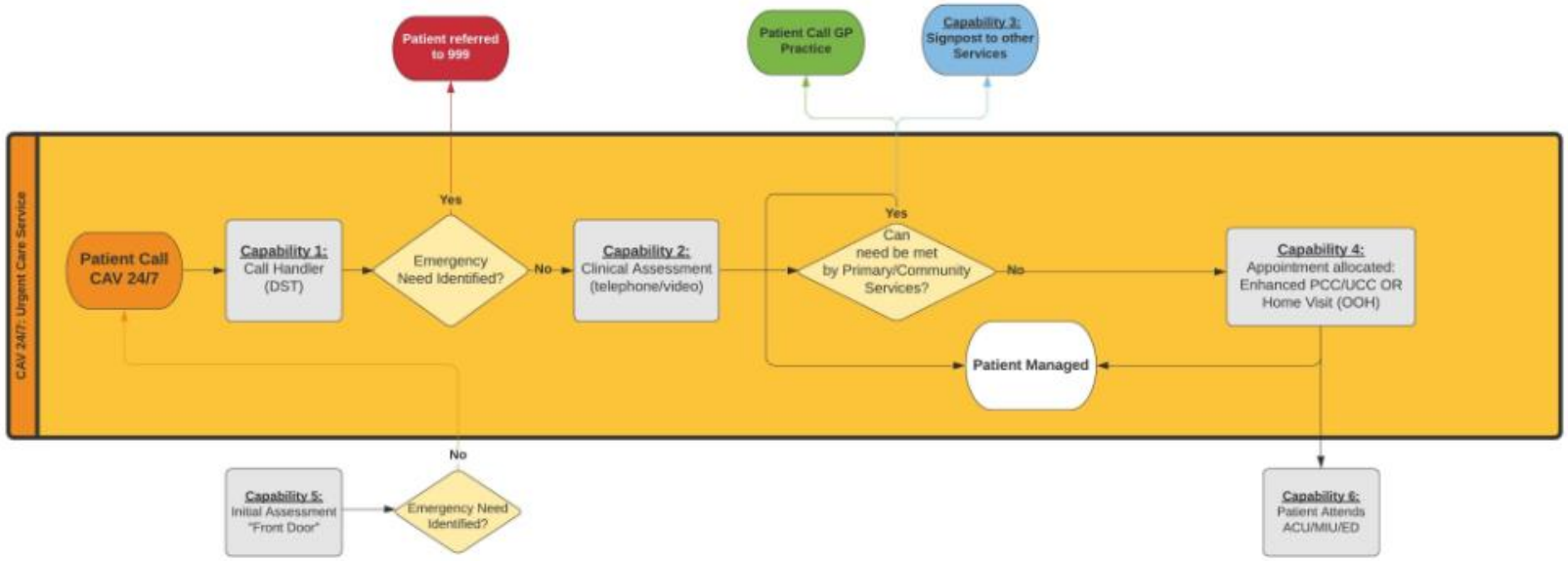
The 24/7 number will:

- Answer 95% calls within 1 minute
- Clinical triage/assess callers – urgent response call back within 20 mins
- If need to be seen at ED will be directly booked in to a timed slot
- If need to be seen at Minor Injuries Unit will be directly booked in to a timed slot

- Signpost to other services as appropriate

The 24/7 number for Cardiff number will clinically triage the patient and sign post them to most appropriate service for their needs, for example direct access physiotherapy or mental health support services. Patients who are assessed and advised to attend the Emergency Department will either be identified as needing to attend immediately or booked into a timed attendance, so they can wait in a place of safety.

Citizens who attend the Emergency Department without telephoning will be assessed for immediate support, if their requirement is not immediate they will be directed to the 24/7 number. Ensuring consistency and equity across our systems. The service will also incorporate our Out of Hours Service, so there is a single number and consistency of process for our citizens 24/7. The service will not involve the 999 ambulance service or GP referrals, these processes will remain unchanged.



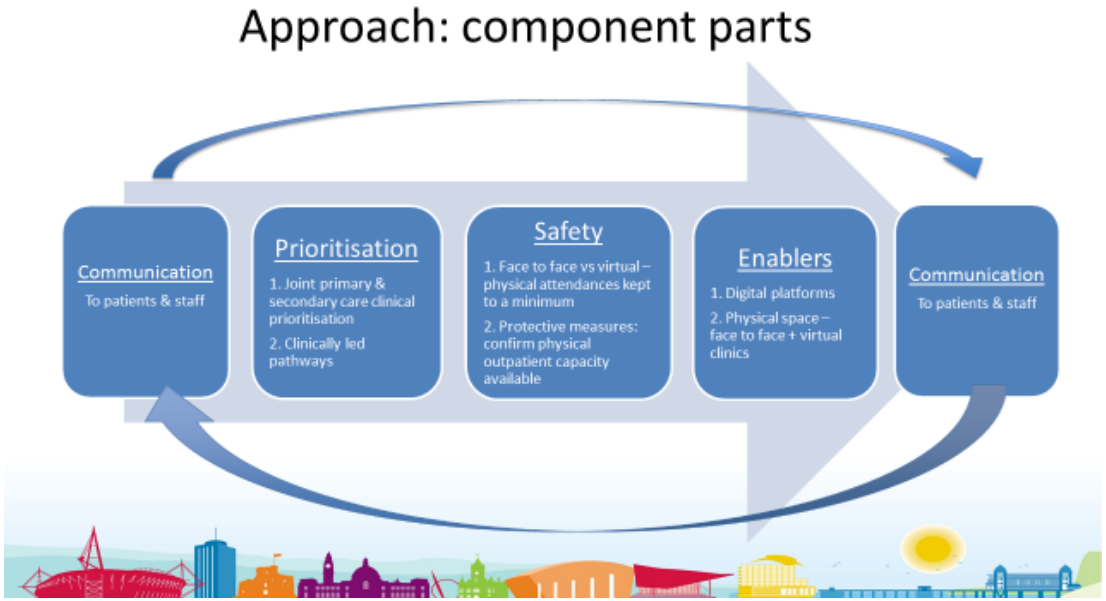
This development is being taken forward as a pathfinder, with action learning built into the approach so that there are key points to pause and learn what changes, if any need, to take place, listening to the feedback from patients and key stakeholders. The methodology will be informed by the learning we have taken from the Canterbury District Health Board's use of 'alliances' to bring together people to develop service solutions to challenges.

7.2 Outpatients Transformation Programme

The delivery of outpatient services has been significantly affected by the demands brought about by COVID-19. We are moving a significant proportion of our appointments onto virtual platforms, with urgent face to face appointments taking place with appropriate social distancing and IPC measures when a physical examination is required or where it is not possible for someone to participate through a virtual appointment.

We have developed an organisation wide outpatient services transformation programme which is being developed and delivered jointly between with Primary and Secondary Care. We are utilising an alliancing approach embedding where possible sustainable and long term changes to outpatient delivery models in line with our Outpatients 2025 vision. We will not return to the same model of outpatient provision post COVID-19 in line with our home first principle and the benefits of delivering a mixed model with a significant proportion of appointments taking place virtually, resulting in reduced travel for patients.

It is taking a clinical risk based approach to prioritisation as we seek to restart services. The work will initially focus on seven areas – Medicine; Surgery; Children; Radiology; Palliative; MSK; and Mental Health and CAMHS. Prioritisation is informed by guidance already in existence from NHS England alongside waiting list information, linking with Healthpathways™, and with a Digital first approach. For each service area, we are setting clear goals for the number of appointments and clinics being delivered virtually. This transformation will be progressed at pace, and will form a key part of enabling more activity to return as we start to assess how to address the backlog in demand that has accumulated in the last four months.



8. WORKFORCE

8.1 Overview

During the emergency response phase of the pandemic, we saw our staff adapt quickly to the challenges we face adopting new working patterns, new ways of working, redeployment to priority areas, rapid on-boarding new recruits and responding to the IPC requirements. During the quarter we are working though the next phase of our plan prioritising the ongoing support to shielding staff, including working arrangements when shielding ends, our BAME staff groups and continuing our proactive approach to staff wellbeing.

8.2 Shielding Staff

We have undertaken a detailed analysis of shielding staff. We have 637 staff (517.64 wte) who are Shielding. The largest proportion staff group Shielding are Additional Clinical Services (148), followed by Registered Nursing and Midwifery (147), Administrative and Clerical (145). Additional Clinical Services are primarily Healthcare Support Workers, but also includes other supporting roles such as Technicians and Laboratory Assistants.

- Of the 637, 318 state a risk assessment has been undertaken, 141 have answered no to a risk assessment being undertaken and 178 not applicable. Further risk assessment work needs to be undertaken to gain a better understanding (conversational and written).
- Of the 637, 248 are undertaking work from home, whether that be their own job or alternative work. 63 of these are working on the Track and Trace.

We have established a group, in partnership with our Unions to develop clear principles for shielding staff

Emerging Principles:

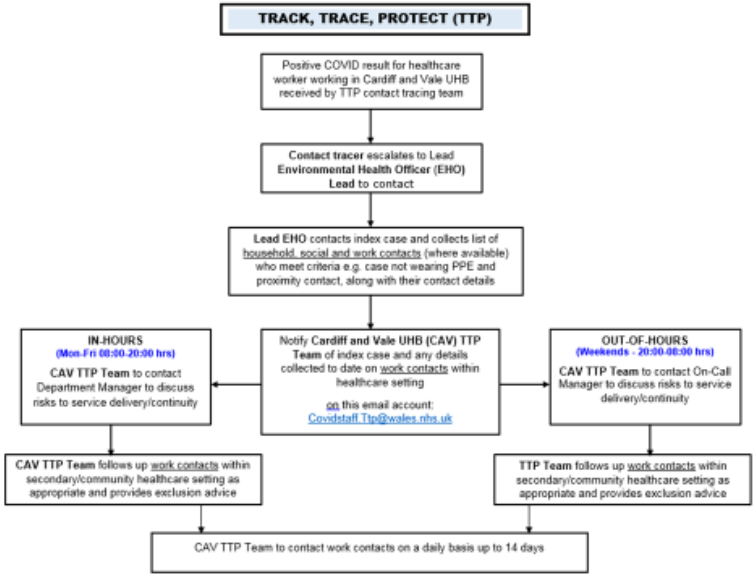
- People Shielding are not off sick
- Managers/Supervisors should fully understand the circumstances of each **individual** in order to establish why they are off and how they can be best supported to undertake work.
    - This is best achieved by completing a risk assessment with the individual
    - This is about helping staff undertake work remotely and to support their well-being
    - Managers and individuals should have regular conversations and keep in touch
    - The risk assessment and/or outcomes should be reviewed regularly
- Don't assume people can't work or do things when seeking alternative opportunities– ask individuals for their ideas. Be open minded – it may be they can help in other departments and important functions e.g., Track and Trace. On the other hand don't assume everyone has access to IT or a permanent base they can work from
- Both parties should understand any "blockers" to undertaking work and try to get support to work them through – e.g., IT, role not able to be undertaken at home, confidence around performing different duties

- Encourage cross working with Directorates and Clinical Boards to maximise opportunities
- Contact the Workforce Hub for help with alternative work
- When considering alternative work, don't let banding or job titles get in the way. Just have the conversation about meaningful work (the alternative is to do no work and that's not good for anyone)

- Seek trade union support and be open to gaining their support as they will be able to help broker conversations if you need that whether you are a staff member or manager
- Understand everyone's perspective. Very often the individual feels alone, whilst the Manager may well be juggling a lot of issues and shielding will be only one element of what's going on. Their capacity is a real issue at the moment.
- Try to help yourself and take personal responsibility and encourage your staff to do the same

8.2 Test Trace Protect- Staff

We have established a clear process for the identification of staff through TTP and protocols are in place.



8.3 Supporting our BAME workforce

We have been actively involved in working with the national BAME Group in developing an accessible toolkit that will be rolled out to ensure that we are taking all appropriate precautions in the risk assessment and management of this particularly vulnerable group.

8.4 Continued Staff Wellbeing Support

The UHB had developed and rolled out a range of resources to support our workforce including Safe Havens, Relaxation Rooms, self-help guidance, access to psychological support as well as a range of other services and support arrangements – many of these are signposted through our COVID-19 Wellbeing Resources Pack – see Appendix 7

8.4 Supporting Positive Culture Change

We are in the process of completing a rapid feedback exercise with the leaders across the organisation to understand the impact of COVID-19 on our leadership capability and capacity, identifying what has really worked well, and ensuring this is embedded within the organisation and what we need to learn from going forward. The last four months have presented many with the greatest challenges of their career and people have responded with extraordinary resilience and innovation, and it is important that the achievements of the last quarter are appropriately acknowledged and celebrated – and that the sense of pride that there is for many working across the organisation is captured.

9. INFRASTRUCTURE AND ESTATES

9.1 COVID-19 Infrastructure and capital enabling works*

During Q1 and Q2 estates development work is ongoing to support the COVID-19-related accommodation and infrastructure:

Scheme	Key Deliverables	Est Capital £m
Emergency Additional Bed Capacity	• Community Hospital beds – 46 beds • Conversion of space at UHW & UHL – 51 beds	3.159
High Consequence Infectious Diseases Unit	10 bedded self-contained isolation unit at UHW – modular build	7.250
Digital infrastructure and major equipment	E.g. oxygen plant, digital devices, radiology equipment	3.709
Creation of Green (COVID-19-free) capacity	Protected Elective Surgical Capacity at UHW & UHL	2.236
TOTAL		16.618

**Excl Dragon's Heart Hospital*

Further enabling schemes are being developed to support ongoing COVID-19 response and recovery which include the additional 400 medium term surge facility and additional body storage capacity needed in light of the anticipated closure of the LRF led regional body storage provision at the end of the summer. We have been the only health board in the region requiring use of this regional facility and it is unlikely that it will remain a viable option going forward, therefore alternative provision is required.

These schemes are in addition to the UHB's existing major capital programme plan which is currently under review with the WG Capital Team as the UHB recognises that there is a need to reprioritise our proposed investment programme. This is a significant challenge as the COVID-19 experience has highlighted and further exposed our poor physical environment at UHW and the urgency to accelerate replacement plans. Infection prevention and control has always been a weakness with mainly nightingale wards and bays but COVID-19 saw this weakness exposed where patients were infecting one another. For example, our critical care facility had just one isolation room. This resulted in the need to zone according to COVID-19 positive, negative and uncertain. An already undersized unit was being used inefficiently where some zones were full while others under-utilised. Further safety protocols depleted available space further with corridors, relative rooms and staff rooms being used for PPE storage. It has proven difficult for staff once out of PPE to effectively socially distance causing infection and associated absences. Work is ongoing during Q2 to produce accommodation solutions to optimise delivery of essential services in response to continuously updated guidance.

9.2 Strategic Capital Investment Planning

Our 2018 Estates Strategy set out the need for replacement of UHW2 as an urgent priority. The increasing levels of significant major capital required by the UHB to risk manage the high levels of backlog maintenance and increasingly non-compliant infrastructure which does not meet critical 21st century clinical standards is both unaffordable and non-strategic. The Health Board has to make progress on UHW2 replacement planning during Q2. At present we are concluding a tender to receive advice on what we should be specifying out of a strategic partner to write a Programme Business Case (PBC). By the end of Q2 we are aiming to be in a position to have concluded or approaching conclusion of a tender for a strategic partner so that a PBC can be produced rapidly. The challenges of responding to COVID-19 have further exposed some of the inadequacies of the infrastructure at UHW, particularly the ward environments and lack of adequate single room accommodation, the critical care environment and our theatres where there are challenges in terms of the additional measures required from a IPC perspective. We welcome the opportunity to discuss and scope with Welsh Government colleagues pragmatic approaches to making effective progress. We will know what output we are aiming for at the end of the quarter including the fleshing out of our Clinical Services Plan, understanding the opportunities for Cardiff, the Vale and the S Wales region that arise from an academic life sciences quarter and a view of the overall benefits that UHW2 could bring to bear.

10. ENGAGEMENT

Focusing our resources on the emergency response to COVID-19 and the measures introduced by the Welsh Government to contain and reduce the spread of the virus have impacted significantly on our engagement activity during the first quarter for both the UHB and the CHC. We have focused our efforts on engaging with key partners to share with them the impact of COVID-19 on our services and our plans for managing the changing picture so that we continue to expand the range of services we can safely provide to patients.

Engagement with stakeholders has taken on particular significance during this period of face paced change and challenge. We have maintained regular engagement with the South Glamorgan Community Health Council including meetings at chief executive and chair level, meetings to discuss specific issues including the Service Delivery Plan, sharing of a weekly log of operational service changes implemented as part of our emergency response to COVID-19 and most recently a meeting with all CHC members to discuss proposals for transforming urgent care.

The Public Services Boards have continued to meet during pandemic, with a focus in the first quarter of coming together across the region to share intelligence and ensure a co-ordinated public service response as well as joint leadership communications with staff and the public. Discussions have now turned to recovery and renewal planning. A joint Management Executive with local authority partners has been held on a weekly basis and regular meetings of key groups under the Regional Partnership Board have continued to oversee the collaborative emergency response across the health and social care arena.

A set of additional communications tools have been developed during Quarter 1, to ensure staff and key stakeholders are kept up to date with developments. A daily operational CEO Connects newsletter has been sent to staff, drawing together timely data and updates from Operational hub meetings and a Staff Connect app was launched, allowing staff to access the latest COVID-19 information and guidance from any portable device. A weekly COVID-19 Key Stakeholder Brief has been shared in confidence with trusted partners including the CHC, MSs and MPs, local councillors, LMC, PSBs, the Local Partnership Forum and Stakeholder Reference Group. In addition, the UHB chair and chief executive have held fortnightly briefing sessions with local MSs and MPs.

We will continue to liaise weekly with the Community Health Council with updated schedules on the changes we have made to services as we continue to respond to the changing requirements to remain COVID-19 ready as we bring more of our activity back on line. We held a special engagement session with the CHC to discuss the plans for the 24/7 urgent care service, including the communication and implementation plans.

We will review arrangements going forward, adapting as necessary to keep them timely and relevant.

11. FINANCE

The Welsh Government wrote to us 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-19, which will inevitably come with a significant cost.

The UHB is incurring significant additional expenditure as a result of COVID-19. The costs of the Dragon's Heart Hospital are significant, specifically in relation to set up costs. In addition, the UHB is incurring additional costs to cover sickness and absence and to resource the additional in COVID-19 hospital capacity that has been been generated.

COVID-19 is also adversley impacting on the UHB savings programme with substantial underachievment against the annual savings plan. Given that a number of our high impact schemes were based on reducing bed capacity, improving flow and workforce modernisation, it is not anticipated that this will improve until the COVID-19 pandemic passes. However, the UHB continues to identify and maximise all potential savings opportunities avaialble.

Elective work has significantly been curtailed during quarter 1 as part of the UHB response to COVID-19 and this has seen a reduction in planned expenditure. Plans are being developed to reintroduce some of this work in quarter 2 supported by the establishment of Green zones at both UHW and UHL at a capital cost of £2.236m.

The net expenditure due to COVID-19 is being captured in revisions that have been made to the monthly financial monitoring returns. The full year forecast position included within the month 2 monitoring returns totalled £165.864m. Quraters 1 and 2 of this forecast is shown below:

	Forecast Q1 £'000	**Forecast Q2 £'000**
TOTAL ADDITIONAL OPERATIONAL EXPENDITURE	66,797	33,593
TOTAL NON DELIVERY OF PLANNED SAVINGS	6,354	6,221
TOTAL EXPENDITURE REDUCTION	(10,042)	(981)
TOTAL RELEASE/REPURPOSING OF PLANNED INVESTMENTS/DEVELOPMENT INITIATIVES	(250)	0
NET EXPENDITURE DUE TO COVID-19	**62,859**	**38,833**

Key financial planning assumptions:

- It is assumed that COVID-19 will impact throughout 2020/21
- Within this forecast the Dragon's Heart Hospital costs are assessed at £72.721m with a further £2.822m capital costs. This is based upon the DHH going on standby from 5th June and retention until 31st October 2020.
- TTP with 3 testing Hubs including Cardiff City Stadium full year forecast cost of £4.4m running to 31st March 2020.
- The cost of theatres, outpatients and diagnostics utilisation at Spire is include in the forecast up until 6th September at a cost of £2.6m. Any extension to this date costs are assumed to be picked up by the UHB and will need to be added to the forecast.
- The reductions in non-pay costs due to reduced elective capacity is assessed to be £10.042m in quarter1. As the planned care workstream comes back on line it is not anticipated that there will be any planned care savings from July onwards. This position will be reviewed and updated as activity comes back on line.

Additional workforce costs included in the month 2 monitoring returns forecast total £21.780m for quarters 1 and 2. £11.016m related to quarter 1 for which WG funding has now been received.

The full year forecast does not include any additional revenue costs in relation to potential surge capacity requirements post 31st October 2020. The UHB has judged that provision of a 400-bedded facility would provide sufficient contingency in the event of a second COVID-19 wave. Additional workforce requirements would need to be reviewed looking at utilisation of staff already in post and the availability of bank and agency staff if this additional surge capacity was required.

What is key for the Board is how it recovers from this period. It needs to avoid adding recurrent expenditure to its underlying position and to embed the many transformation changes that have been delivered at pace due to neccesity. This is a period of both significant financial risk and opportunity for the UHB.

12. GOVERNANCE AND RISK

We have a clear approach for maintaining robust governance through the course of the pandemic with regular Board and Committee meetings taking place virtually to enable appropriate strategic oversight and scrutiny of the plans being developed and implemented. The organisation is beginning to transition back to some of the previous arrangements, but taking the opportunity to conduct Board business in the most efficient and appropriate manner in light of the ongoing impact of COVID-19. The Board will continue to receive regular reports on progress with delivering the key elements of plan recognising it will continue to evolve and develop with each quarter refresh and update.

Our full Board Assurance Framework can be found as published with our Board Papers are the end of May:
http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/FINAL-Boardbook%20published.pdf
See Appendix 5 for key corporate high-level risk summary

13. PLANNING AHEAD

Our ability to respond quickly to any changes in the progression of COVID-19 will dominate the planning framework for the remainder of this year, and will be reflected in our 4 – 6 operational planning cycles and will continue to feed into our quarterly plan refresh and updates. We will continue to work collaboratively with Health Board partners and, where appropriate, WHSSC to together strengthen the fragile regional and tertiary services – some services are likely to require the implementation of urgent, interim arrangements whereas others will be progressed, with the full engagement of our wider stakeholders, as part of our wider redesign agenda as we develop the detailed clinical services redesign plan which will underpin our proposals for the replacement of UHW.

During this quarter, a stocktake of Shaping Our Future Wellbeing will be undertaken in light of the learning from our approach to responding to COVID-19 so that our plan going forward will focus on the opportunity to accelerate delivery of the strategy and respond to the wider societal impacts of COVID-19 which are likekly to worsen health inequalities, with our PSB partners.

In the last four months much of our important work on wider prevention and tackling inequalities in health, led by our Local Public Health Team, has been put on hold as the resources and expertise have had to be repurposed to responding to the pandemic – working with PCIC, local authorities and PHW to support care homes, the system of testing, managing local clusters and incidents and establishing the TTP programme of work. We know that the impact of lockdown measures will have impacted negatively on the health of our local population, including a widening of health inequalities, although for some areas

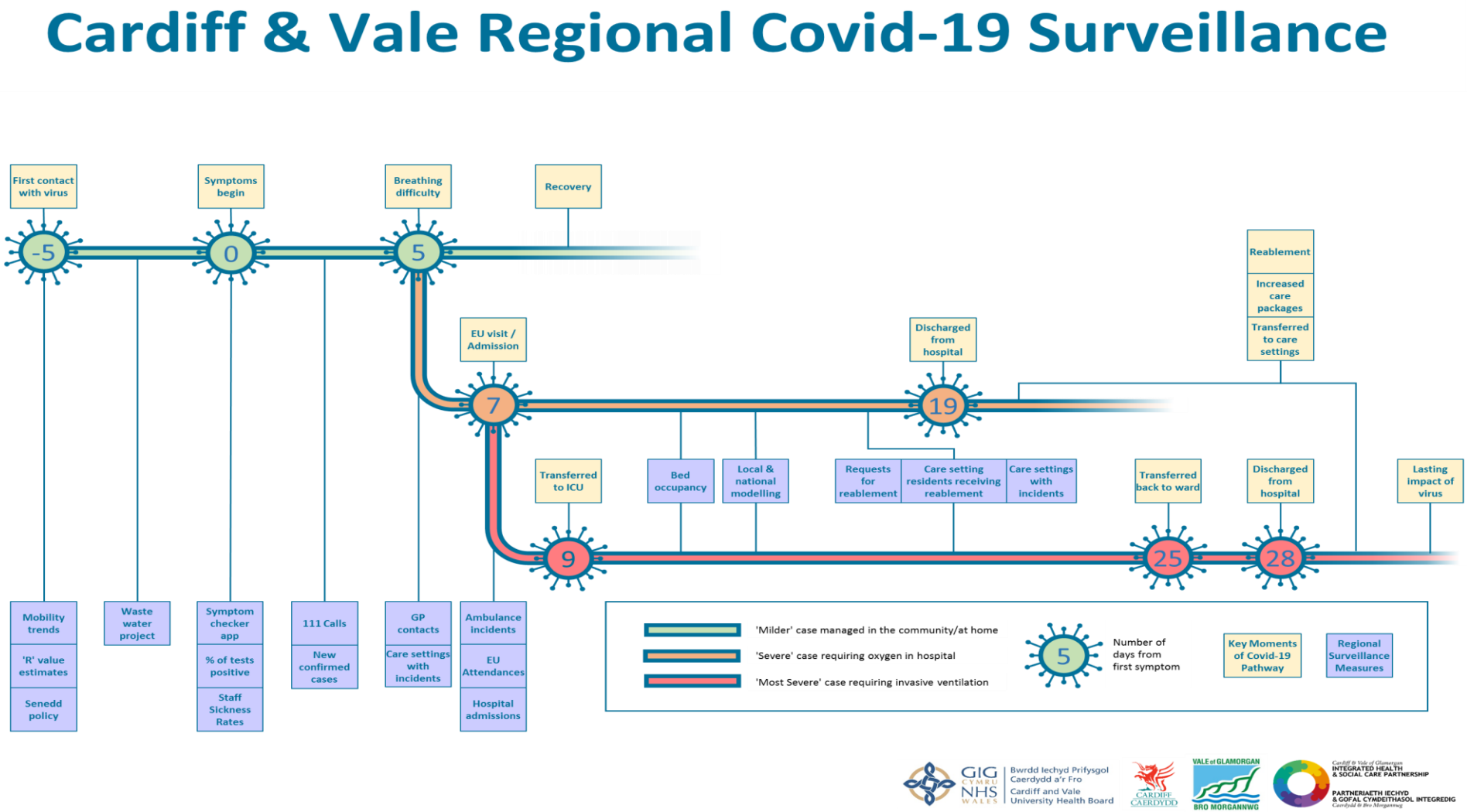
the impact may have been more positive – for example more people taking advantage of exercise outside. Whilst recognising the need to continue to support TTP and manage any localised clusters and incidents, within the Health Board and with our PSB partners we are looking at how we can reprioritise and recover our work on prevention, including immunisation, tobacco, healthy weight, and focused health inequality work.

We are accelerating our plan to establish an Institute of Improvement and Innovation to support the rapid implementation of improvements and innovation at pace and scale. We are keen for this exciting development to be progressed in collaboration with a number of stakeholders including the Life Science Hub, academic partners, other health boards, and Canterbury District Health Board and Tan Tock Seng Hospital in Singapore. We are also undertaking an on-going review with Cardiff University to glean learning from the pandemic from across the globe.

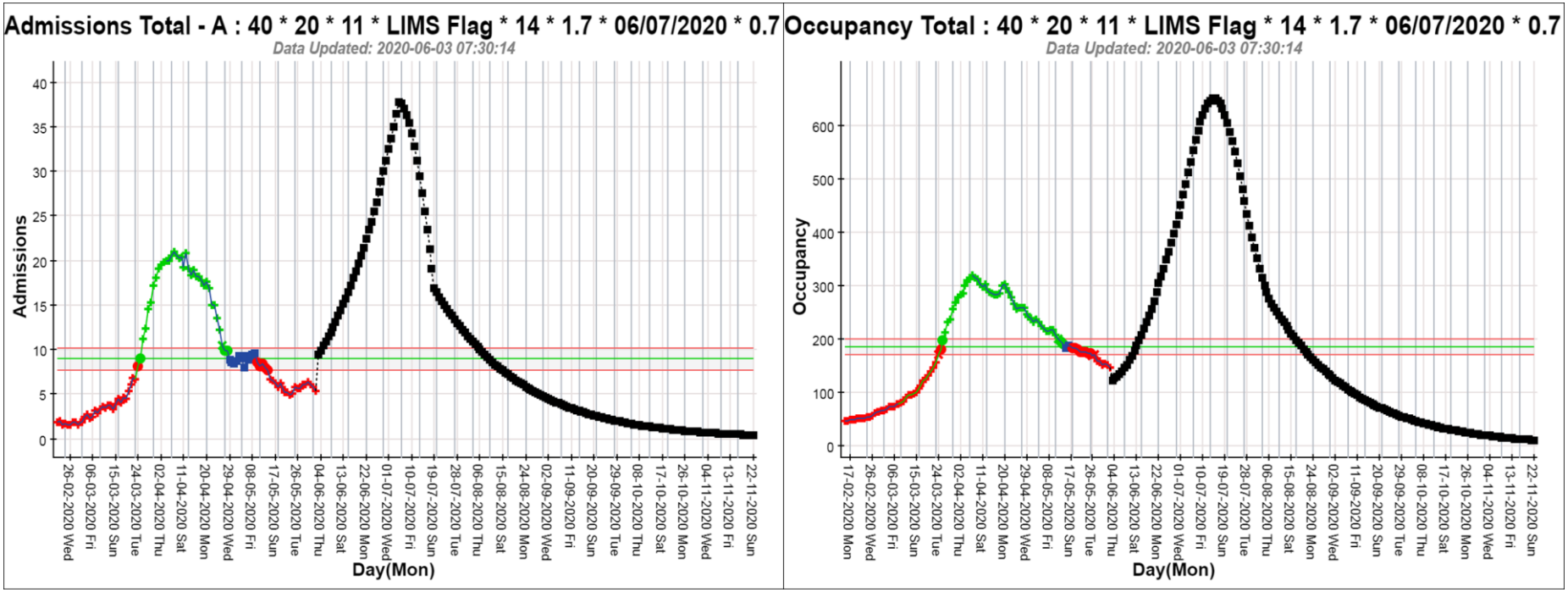
In January our Board signed up to a commitment to tackling climate change and work on developing our sustainability action plan is restarting, recognising the opportunities seen during COVID-19 to work in ways that reduce our carbon footprint. We see this as a key programme of work going forward.

We are capturing all of these workstreams in our COVID-19 'recover/renewal' programme which outlines the likely impact of the pandemic, and the opportunities to be capitalised on and risks to be managed. The programme sets out the key milestones for rising out from COVID-19 over the next 12 – 18 months.

Appendix 1: Schematic of Regional Surveillance System



Appendix 2: Local Modelling of a Potential Second Wave (SAGE RWC, R=1.7 for 4 weeks)



Appendix 3: Overview of Essential Services

Essential Services	Anticipated delivery status in quarter 2 compared to pre-COVID-19	Current Status	Anticipated capacity in quarter 2
Intensive Care			All commissioned beds are staffed and available – and a surge plan to 92 beds in place
Renal Dialysis			Home dialysis Programme will restart 6th July
Solid Organ Transplantation		Service resumed on 29th of June for deceased donors. Live donation programme anticipated to commence in August	1 offer anticipated per week. Current waiting list of 69 patients.
Cardiac Surgery		Service moved to UHL as recovery plan	>36 week waits doubled (34>36 weeks qtr 1 -98>36 weeks qtr2) phased approach to growth over quarter 2 –ambition up to 85%
Thoracic Surgery			No delays. Demand and Capacity in balance
Haematology			No delays. Demand and Capacity in balance 1 car-T patient per month as per pre-COVID-19
Neurosciences		Tumour and Lifesaving surgery	No delays. Demand and Capacity in balance 35 cases – 20% pre COVID-19 activity Neurology -80% virtual and Rookwood
Major Trauma Centre			Additional 24 cases per month. Demand and capacity projected to be in balance at go live

Essential Services	Anticipated delivery status in quarter 2 compared to pre-COVID-19	Current Status	Anticipated capacity in quarter 2
Stroke		From 1st of June a Stroke Consultant will be based at front door and MDT clinical lead appointed to support pathway	Service can meet demand – on average there are 150 confirmed strokes per quarter
Gastroenterology		Capacity constraints due to IP&C restrictions, staffing and no insourcing	<50% of pre-COVID-19 activity will be delivered (Q1 – 3941 procedures compared to Q2 – 1362 procedures)
Acute Oncology		Currently no backlog of referrals	Service can meet demand – on average 300 referrals received per quarter
Lung Cancer		Oncology clinics and SACT delivery transferred to Velindre during COVID-19 where it currently remains	Service can meet demand – current waiting list 40 (3 USC and 37 non USC)
Skin cancer		MOHS Surgery re-commenced	Service can meet demand
Paediatric Inpatients			Significant pressure in Radiology and Theatres & Anaesthetics cover for Paediatric Endoscopy and Paediatric GA MRIs
Paediatric Community			Majority of services remained functional and delivered services virtually Some services (eg. Neurodevelopment and School Nursing) offered welfare support and safeguarding only
Obstetrics and Gynaecology		All activity proceeding as pre-COVID-19	As pre-COVID-19

Essential Services	Anticipated delivery status in quarter 2 compared to pre-COVID-19	Current Status	Anticipated capacity in quarter 2
HPB Cancer & Urgent		Level 2 & 3 surgery already commenced but increased in Qtr 2 as part of PESU – start date 6th July 2020	Service can meet current demand with increase of lists and access to PACU start date 6th July 2020
GI Cancer & Urgent		Capacity Constraints and a reliance on Private Facility (Spire) to deliver activity required. Diagnostic pressures and BSW recommencing will mean additional capacity will be required to meet demand	Increased capacity from July as above however absolute need to maintain private facilities to deliver essential services for remainder of the year
Head & Neck Cancer & Urgent		Currently no backlog of referrals	Service can meet demand – on average 300 referrals received per quarter
Breast Cancer		Effective service runs out of spire with 80% of all work delivered. Additional sessions created in Llandough for Qtr 2 to support more complex cases	
Spinal Urgent		Minimal access to theatres given pressures with workforce – Team are triaging patients carefully and also utilising Spire. Alternative care plans are being developed, scoliosis surgery is being undertaken in Quarter 2	Paediatric theatre plan in place to support essential services in Spines and orthopaedics

Essential Services	Anticipated delivery status in quarter 2 compared to pre-COVID-19	Current Status	Anticipated capacity in quarter 2
Urology Cancer		Robotic surgery constraints due to limited workforce.	Service can meet demand but robotic surgery demand and backlog has created a pressure. We are working through this with neighbouring health boards
Ophthalmology R1 & R2		We are delivering Glaucoma, AMD, VR and urgent cataract activity to ensure patients are do not come to harm	
Emergency Surgery		We have increased capacity for CEPOD to mitigate the IPC constraints relating to COVID-19	Additional theatre capacity in children's hospital and main theatre to maintain essential emergency services
Trauma		Trauma & Spinal Emergencies is currently delivered in Llandough and UHW successfully. Additional capacity in place to mitigate increased demand and IPC / COVID-19 constraints	Increase capacity available in UHW and Llandough to deliver safe emergency care for Q2
Emergency Ophthalmology		Joint working with optometric practises has reduced demand by 50% ensuring we can safely manage patients virtually	Continue to deliver eye care clinic via electronic triaging with optometrists

Appendix 4: Non-"Essential", High Volume Specialties

Service	Anticipated delivery status in quarter 2 compared to pre-COVID-19	Current Status	Anticipated capacity in quarter 2
Dermatology		Clinics have reduced from 12 patient to 6 due to IP&C issues and social distancing	IP - 75% of pre-COVID-19 activity will be delivered (50 cases per week in Q2 compared to 65 cases per week pre-COVID-19) OP – 45% of pre-COVID-19 activity will be delivered (60 face to face + 250 virtual in Q2 compared to 728 OP pre-COVID-19)
Rheumatology		Clinics have reduced from 12 patient to 6 due to IP&C issues and social distancing	50% of pre-COVID-19 new patient clinics will be delivered (face to face) 100% of pre-COVID-19 follow up clinics will be delivered (virtual clinics)
Ophthalmology		Virtual Clinics / Clinical Validation and links with Eye Sustainability Plan. Non-essential work started for cataracts	50% of capacity (4 theatre sessions) delivered from last week of June '20. Outpatient clinical triage in conjunction with optometrist and PCIC
Orthopaedics		Cardiac & Thoracic surgery delivered in CAVOC and workforce constraints mean that routine orthopaedic work is not being undertaken. However there is a plan to begin surgery mid-August '20	3 all day lists (20%) of pre COVID-19 activity to start mid-August in Llandough for treatments Outpatient plan to deliver 6 clinics per day in CAVOC (2.30pm – 7.30pm) delivering 30% of pre-COVID-19 activity

Orthopaedics		Cardiac & Thoracic surgery delivered in CAVOC and workforce constraints mean that routine orthopaedic work is not being undertaken. However there is a plan to begin surgery mid-August '20	3 all day lists (35%) of pre COVID-19 activity to start mid-August in Llandough for treatments Outpatient plan to deliver 6 clinics per day in CAVOC (2.30pm – 7.30pm) delivering 30% of pre-COVID-19 activity
General Day Case		Moves to create safe treatment areas for our essential services have meant that we have lost day case facilities in both SSSU and Llandough	Currently minimal level 4 for outside of ophthalmology running due to capacity constraints
Dental		Dental service are running essential service predominantly however plans are being put in place to increase capacity in Quarter 2	Increase capacity to 65% of pre-COVID-19 through Q2 to include all oral outpatient services resuming

APPENDIX 5

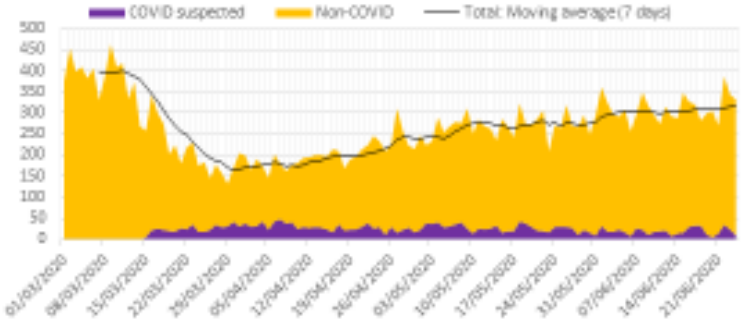
High Level Risk Summary

Risk	Gross Risk	Net Risk	Target Risk	Executive Lead	Committee
1. Staff safety and welfare	**25**	**15**	**10**	Executive Director of Nursing, Executive Director of Workforce and OD	Strategy and Delivery Committee
2. Patient Safety	**25**	**15**	**10**	Executive Medical Director, Executive Director of Nursing, Executive Director of Therapies and Health Sciences	Quality, Safety and Experience Committee
3. Decision-Making, Financial Control and Governance	**20**	**12**	**8**	Director of Finance, Director of Corporate Governance	Audit Committee, Finance Committee
4. Workforce	**25**	**20**	**10**	Executive Director of Workforce and OD	COVID-19 19 Strategic Group, Strategy and Delivery Committee
5. Risk to delivery of Cardiff and Vale IMTP	**20**	**20**	**10**	Executive Director of Strategic Planning	COVID-19 19 Strategic Group, Strategy and Delivery Committee
6. Reputational damage	**16**	**12**	**8**	Chief Executive and Director of Communications	COVID-19 19 Strategic Group
7. Test, Trace and Protect (TPP)	**20**	**15**	**10**	Executive Director of Public Health	COVID-19 19 Strategic Group, Strategy and Delivery Committee

APPENDIX 6 – DEMAND, ACTIVITY AND PERFORMANCE - Q1 HIGH LEVEL OVERVIEW

Unscheduled Care

EU activity:



- *Attendances reduced to daily average of 191 in the last two weeks of March, with lowest daily attendances of 132 on 29/03*
- *Increased attendances since the end of April – with last 3 weeks up to daily average of over 300*

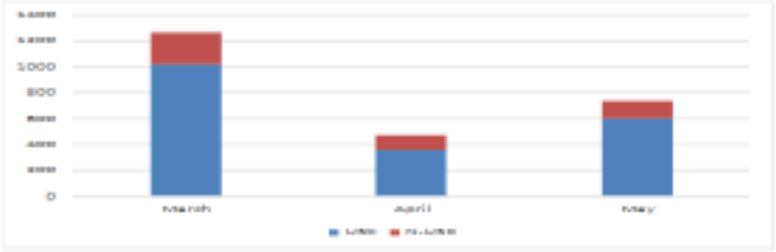
Performance:

2020/21		Mar	Apr	May
Unscheduled Care				
EU waits - 4 hours (95% target)	20/21 Actual - Monthly	84.8%	91.3%	91.4%
EU waits - > 12 hours (0 target)	20/21 Actual - Monthly	70	13	14
Ambulance handover > 1 hour (number)	20/21 Actual	255	97	45
Ambulance - 8 mins red call (65% target)	20/21 Actual	67%	75%	81%

- *Over the last two months, performance has improved across all unscheduled care measures*

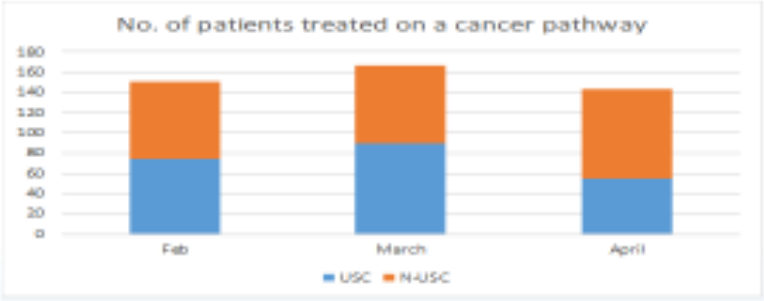
Cancer

Demand:



- Referrals volumes in April only 27% of expected level. Increased in May - to 39% of expected levels

Activity:



- *Patients expedited for treatment in March*
- *Treatments in April 94% of previous levels*

Performance:

2020/21		Mar	Apr
Cancer			
31 day NUSC cancer (Target = 98%)	20/21 Actual	97.5%	96.7%
62 day USC cancer (Target = 95%)	20/21 Actual	81.1%	75.3%
SCP - with suspensions (NB: Shadow Reporting Data)	20/21 Actual	79.0%	76.8%

- *N-USC performance remained close to target in April but USC performance decreased*
- *81% of patients on an open cancer pathway are < 62 days*

RTT & Diagnostics

Demand:

- *Primary care referrals into secondary care fell to 20% in April but now recovering to 50%*
- *D&T referrals into secondary care fell to 27% of previous levels – now recovering to 45%*

Activity:

- *Inpatient & daycases fell to 45% of previous levels, now recovering to 50%*
- *Outpatient activity fell to a third of previous levels, now recovering to 50%*

Performance:

2020/21		Mar	Apr	May
Planned Care				
RTT - 36 weeks (Target = 0)	20/21 Actual	3515	7330	11814
RTT - 26 weeks (Target = 95%)	20/21 Actual	81.7%	74.1%	66.3%
Total Waiting list	20/21 Actual	87579	85287	85611
Diagnostics > 8 weeks (Target = 0)	20/21 Actual	780	5,948	10,476
Eye Care				
% R1 opthalmology patients waiting within target date or within 25% beyond target date for OP appointment	20/21 Actual	66%	59%	54%
98% of patients to have an allocated HRF	20/21 Actual	98%	98%	98%

- *RTT – Whilst the overall waiting list volume has reduced, waiting times have deteriorated. 56% of patients waiting > 36 weeks at the end of May were at new outpatients stage*
- *Diagnostics – Patients waiting > 8 weeks has increased, with largest volumes in radiology and endoscopy*
- *Eye Care – We continue to meet the HRF target but compliance against R1 has reduced to 54%*

Appendix 7 – Wellbeing Resources Guide