Strategy & Delivery Committee

14 July 2020, 09:00 to 12:30
Nant Fawr 2 & 3, Woodland House / Via Skype

Agenda

1. Welcome & Introductions

Charles Janczewski

1.1. Apologies for Absence

Steve Curry - Caroline Bird Attending
Abigail Harris - Marie Davies Attending

Charles Janczewski

1.2. Declarations of Interest

Charles Janczewski

1.3. Quorum

Charles Janczewski

1.4. Minutes of the Strategy & Delivery Committee Meeting held on 10th March 2020

Decision

Charles Janczewski

1.4_Minutes _SD0720 -.pdf (9 pages)

1.5. Action Log following the Strategy & Delivery Committee Meeting held on 10th March 2020

Charles Janczewski

1.5_ Action Log - SD0720 -.pdf (3 pages)

1.6. Chairs Action taken following the Strategy & Delivery Committee Meeting held on 10th March 2020

Charles Janczewski

2. Items for Information

2.1. Report outlining deferred agenda items due to the COVID-19 Pandemic

Information

Nicola Foreman

2.1 Report outlining deferred agenda items due to COVID-19 pandemic.pdf (2 pages)

3. Shaping our Future Wellbeing Strategy

No items

4. Integrated Medium Term Plan (IMTP)

4.1. Ensuring that service provision, quality, finance and workforce elements are aligned and integrated - Dragons Heart Hospital Example

Presentation

Jonathon Gray

4.1 DHH_Board June 2020.pdf (28 pages)

4.2. Update on Home First - PCIC

Marie Davies

4.2 Strategy and Delivery Committee July 2020 - Home First Update.pdf (4 pages)

4.2 Paper for Strategy and Delivery Committee (3 pages)

July 2020 - Home First Appendi....pdf

4.3. Service Delivery Plan 2020-21 - Quarter 2 Update

Verbal

Marie Davies

4.3 Q2 Framework Plan Update - Cardiff and Vale UHB v.3 03.07.20 (002) AH.pdf (55 pages)

5. Other Significant Plans

5.1. Research & Development

Stuart Walker

5.1 Research & Development Cover Paper.pdf (2 pages)

5.1 CVUHB R&D Annual Report 2017-2020 (c).pdf (59 pages)

5.2. Tertiary Services Presentation

Presentation

Abigail Harris

5.2 Tertiary Services Presentation (3).pdf (14 pages)

5.3. Primary Care Out of Hours Peer Review - Action Plan

Steve Curry

5.3 Strategy and Delivery Committee July 2020 - OOHs Action Plan Update.pdf (3 pages)

5.3 Peer Review Action Plan Update June 2020.pdf (5 pages)

6. Performance Reports

6.1. Key Organisational Performance Indicators

Caroline Bird

6.1 Key Organisational Performance Indicators.pdf (7 pages)

7. Items for Ratification

7.1. Board Assurance Framework Update - Workforce

Nicola Foreman

BAF Covering Report.pdf (2 pages)

Workforce - BAF Risk updated July 2020 (JC).pdf (5 pages)

7.2. Revised Reserve Forces - Training and Mobilisation Policy

Martin Driscoll

7.2 employment policies report Sept 2020 (reservists).pdf (2 pages)

7.2 Appendix 1 - Reserve Forces - Training and Mobilisation Policy (002).pdf (14 pages)

8. Any Other Business

Charles Janczewski

9. Review of the Meeting

Discussion

Charles Janczewski

10. Date & Time of Next Committee Meeting

Tuesday 15th September 2020
9.00am - 12:30pm
Nant Fawr 2 & 3, Woodland House / Via Skype

Information

Charles Janczewski

Unconfirmed Minutes of the Strategy & Delivery Committee
Tuesday 10th March 2020 – 9:00am – 12:00pm
Nant Fawr 2 & 3, Woodland House

Chair:		
Charles Janczewski	CJ	UHB Interim Chair & Committee Chair
Members:		
Sara Moseley	SM	Committee Vice Chair & Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Capital, Estates & Facilities
In Attendance:		
Robert Chadwick	RC	Executive Director of Finance
Steve Curry	SC	Chief Operating Officer
Martin Driscoll	MD	Deputy CEO / Executive Director of Workforce & Organisational Development
Aaron Fowler	AF	Head of Corporate Governance
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Kinghorn	FK	Executive Director of Public Health
Sian Moynihan	SM	Clinical Director, Children Young People & Families
Shannon O'Callaghan	SO	Graduate Trainee
Stuart Walker	SW	Executive Medical Director
Rose Whittle	RW	Directorate Manager, Children Young People & Families
Keithley Wilkinson	KW	Equality Manager
Secretariat:		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		
Gary Baxter	GB	Independent Member – University
Nicola Foreman	NF	Director of Corporate Governance

S&D 20/03/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in Welsh and English and extended a special welcome to Rhian Thomas – Independent Member - Capital, Estates & Facilities who would form part of the Committee membership going forward.	**Action**
S&D 20/03/002	**Quorum** The CC confirmed that the meeting was quorate.	
S&D 20/03/003	**Apologies for Absence** Apologies for absence were noted.	

S&D 20/03/004	**Declarations of Interest** There were no declarations of interest.	
S&D 20/03/005	**Minutes of the Committee Meeting held on 14th January 2020** The Committee reviewed the minutes of the meeting held on 14th January 2020 **Resolved – that:** (a) the Committee approved the minutes of the meeting held on 14th January 2020 as a true and accurate record.	
S&D 20/03/006	**Action Log following the Meeting held on 14th January 2020** The Committee reviewed the action log and the following comments were made: **20/01/006** - The CC confirmed this action had been superseded by a 'Levers for Change' letter received from Welsh Government which outlined an ambulance handover incentive performance plan, and if needed a future update would be provided by the Chief Operating Officer (COO). The Committee agreed this action was complete. **20/01/014** – The CC confirmed this letter had been received and circulated to Board members, accompanied by a letter of thanks for all staff efforts from the CC. **20/01/016** – The CC confirmed that Developing a Performance Framework would be presented in May, and it was noted that this was a specific area of importance for the Committee. The CC thanked the Head of Corporate Governance (HCG) and the Corporate Governance team for the well documented action log. **Resolved – that:** (a) the Committee reviewed and noted the updated action log following meeting held on 14th January 2020	
S&D 20/03/007	**Chairs Action taken since last meeting** There had been no Chairs actions taken since the last meeting.	
S&D 20/03/008	**Are we Improving the Health of the Population?** ***(Maximising Prevention in the UHB)*** The Executive Director of Public Health (EDPH) explained that the paper had been through Board Development and was well received. The Committee were advised that whilst the overall health of the population of Cardiff and Vale is good, and improving, there were some	

	areas of concern, in particular persisting inequalities in health. A focus on reducing health inequalities and prevention need to remain key objectives of partnership working and the implementation of Shaping our Future Well-being strategy. The EDPH explained that the team regularly monitored a broad suite of indicators in relation to the health of the population, through a variety of mechanisms and they are also reported into the Public Service Board and Regional Partnership Board. The Committee Vice Chair (CVC) asked what was being done on an All Wales Level in relation to weight, diet and physical activity. In response, the EDPH confirmed that a Move More Eat Well plan had been developed which included ten larger pieces of work across the system, in response to a National plan. Part of the plan required local and national delivery and the EDPH confirmed that she was confident that both parts of the plan would be delivered. The CVC queried what parts of the system the UHB could influence to change. The EDPH explained that the Flying Start and Families First programme target areas such as poverty. The CC thanked the EDPH for the presentation and requested a copy be sent electronically after the meeting. **Resolved – that:** (a) The Committee noted the Are we Improving the Health of the Population? *(Maximising Prevention in the UHB)* update.	**LT**
S&D 20/03/009	**Ensuring that service provision, quality, finance and workforce elements are aligned and integrated** The Deputy Chief Executive Officer / Executive Director of Workforce & Organisational Development (DCEO / EDWOD) introduced the paper and explained that it outlined the ongoing work being undertaken for the Major Trauma Network (MTN). The DCEO / EDWOD explained that to achieve the launch date of 1st April 2020, the team needed to attract and employ workforce members from outside of Wales to mitigate the impact on other Welsh Health Boards. It was also highlighted that managing funds not promised from WHSSC presented a challenge, however, the whole programme was managed very well and targets had been achieved. The DCEO / EDWOD commented that the MTN was a very good live example of the UHB working competently and in an integrated way, and due to the success of the programme, the core principles had been adopted to other programmes. The CVC asked where the new workforce uptake had been sourced from. In response, the DCEO/EDWOD confirmed that 50% of posts had been taken from internal vacancies, this was done in the knowledge that further recruitment across the organisation would be required, and an internal assessment had been undertaken to best place individuals. The other 50% had been recruited from outside of Wales and other Health Boards. The CVC also questioned how the Consultant bodies felt about the MTN	

	as previous concerns had been raised at Board level. The DCEO/EDWOD explained that the MTN had been received very positively and that the Executive Medical Director (EMD) had worked very closely with Swansea Bay Health Board to ensure that skills were shared across the profession to fulfil services. The Independent Member - Capital, Estates & Facilities (IM-CEF) questioned the positions that had been backfilled and whether they had come from other Health Boards. In response, the DCEO/EDWOD explained that many had come from the graduate nursing scheme and international recruitment. The IM-CEF asked if there was a risk that other Health Boards would think that Cardiff & Vale had poached staff? In response, the DCEO/EDWOD confirmed he was confident that the message had been well managed. The CC thanked the DCEO/EDWOD for the report and commented that the MTN was a very good example of integrated working. **Resolved – that:** (a) the Committee noted the 'Ensuring that service provision, quality, finance and workforce elements are aligned and integrated' report.	
S&D 20/03/010	**Capital Programme Action Plan – Structure and Governance Update** The Executive Director of Strategic Planning (EDSP) introduced the report and confirmed that it identified reasons why delays within the Capital Programme were experienced, and gave assurance that the Capital Management Group scrutinised all schemes on a monthly basis. The CC thanked the EDSP for the detailed report and commented that it demonstrated how complex the process was and that he hoped in future, the process could become more streamlined. The EDSP explained that interesting learning was being taken from the NHS England approach, where they proceed straight to Business Cases, not business outline cases, and whilst this came with risk, it could prevent the lengthy delays experienced. **Resolved – that:** (a) the Committee noted the Capital Programme Action Plan – Structure and Governance Update.	
S&D 20/03/011 Tolley, Laura 07/13/2020 11:04:12	**Strategic Equality Plan- Caring about Inclusion 2020-2024** The Equality Manager (EM) introduced the paper and confirmed that the Cardiff & Vale Plan built on the success of previous plans and that it also aligned to the UHB's Shaping our Future Wellbeing Strategy, IMTP and the Wellbeing of Future Generations Act requirements. The CVC asked to see more specific links back to Amplify and Apprentice	

	schemes, in addition to identifying links where equality is thought about at the beginning of a process, an example was given of Capital Development Plans. The CVC also suggested that Gender Pay and Welsh Language be included in the report. The IM-CEF commented that it was refreshing to see a multi-organisational approach to the Strategic Equality Plan and queried how confident the team were that current data was available for a baseline assessment to be carried out. In response, the EM confirmed that overall the team were assured that they had the best baseline measure of what was required to deliver the Strategic Equality Plan. The IM-CEF asked what process was in place for the action plan to be monitored. The EM confirmed that the action plan would be closely monitored by the Strategic Equality Group and would report into the Strategy & Delivery Committee on a 6 monthly basis. **Resolved – that:** Subject to the amendments outlined above; (a) the Committee considered and noted the Strategic Equality Plan; (b) the public bodies partnership long term approach to the Strategic Equality Plan be supported; and (c) the Strategic Equality Plan – Caring about Inclusion 2020-2024 be endorsed.	**MD**
S&D 20/03/012	**Update on CAHMS Strategy** The COO introduced the presentation and explained that the update was requested by the Committee as it has been a challenge to deliver and meet targets in Primary Care CAHMS due to the extraordinary demand in the service for the past 2 years. The COO explained that the team had developed and delivered a plan which had seen improvements, however ongoing work was being undertaken to see if the plan would be sustainable. The Directorate Manager, Children Young People & Families (DM–CYPF) explained that a significant amount of work had been undertaken to address demand and capacity in the service and this was monitored on a weekly basis by the Director of Operations. Whilst an improvement had been made, the team had hoped to reach the 80% target by the end of January, however due to unforeseen circumstances, this had not been met. The team had reached 69% of the target to date. The Clinical Director, Children Young People & Families (CD-CYPF) advised the Committee that within Neurodevelopment the target of 80% had not been met due to staffing problems. The team recognised that this needed improvement therefore ongoing work was being carried out in this area. The CD-CYPF explained that work had been undertaken with various IT systems, including PARIS, to identify the Neurodevelopment position on demand and capacity and a new pathway had been developed to broaden access for new patients. The CD-CYPF added that	

	the aim was to work in a more multi-professional way. The CVC asked how the UHB worked with other third sector organisations. In response, the CD-CYPF explained that the team had worked with the Regional Partnership Board and further work was required on how to support schools on neurodiversity. The DM-CYPF advised the Committee that new pathways were being implemented for cross learning, development and integrated working which supported parents by providing one route for families. The CC was encouraged that the team were delivering the strategy but expressed concern with when the team could deliver a fully sustained position to ensure children accessed services that they need. In response the CD-CYPF explained that it was anticipated that a realistic position for neurodevelopment was that the UHB would meet the legal requirement in 12 months' time. The COO added that CAHMS was a very complex area to manage, and demand and capacity work was still ongoing, therefore, the team could not predict accurately when targets would be met, however, work had been undertaken in Primary Mental Health in a more sustainable way and it was hoped that the model could be adopted in other areas. The CC emphasised the ongoing Committee support in this area and encouraged the team to seek further support as and when required. The CC requested a further update be provided in six months' time, to include further understanding in relation to those young people who were currently waiting for more than 52 weeks for a neurodevelopment assessment which was a concern. **Resolved – that:** (a) the Committee noted the Update on CAHMS Strategy.	**SC**
S&D 20/03/013	**Key Organisational Performance Indicators** The COO introduced the report and it was taken as read by the Committee. The following comments were made; • Referral to treatment times had not improved and was not expected to improve by the end of the financial year, this was an All Wales position; • Cancer performance had improved; • Outpatient Follow Up was expected to meet targets by the end of the financial year; • Mental Health Measures had moved on significantly and the UHB were now compliant; and	

	• Unscheduled Care – Winter continued to be extremely challenging and difficult, with the evolving situation of COVID-19 some of the unscheduled care capacity needed to be re-purposed to assist with COVID-19 planning. The CC asked, as the 62 day USC Performance had been achieved in only one month during the current year, how could the UHB could move to a more sustainable approach going forward. In response, the COO explained that moving into a single cancer pathway would improve the position, however the main challenge would be around the Gastrointestinal pathway as this was very complex and required clinical and system redesign. The CC commented that it was pleasing to see improved performance in R1 Ophthalmology Patients. The COO added that the improvement to this service was welcomed by Community staff and the team would assess the capacity it released in due course. **Resolved – that:** (a) the Committee noted the Key Organisational Performance Indicators.	
S&D 20/03/014	**Workforce Key Performance Indicators** The DCEO / EDWOD introduced the report and it was taken as read by the Committee. The DCEO/EDWOD commented that it was pleasing to see absence rates in January decrease, however given the current COVID-19 position, this would be carefully monitored and would bring many challenges. The CVC commented that when conducting patient safety visits, some areas had a very low staffing level. In response the DCEO/EDWOD explained that if there was an area of decreased staff, the team had flexible staffing arrangements which allowed staff to move around clinical boards where appropriate. **Resolved – that:** (a) the Committee discussed and noted the Workforce Key Performance Indicators.	
S&D 20/03/015	**Committee Annual Report 2019/20** The HCG introduced the report and explained that it outlined the work undertaken by the Committee during 2019/20, this would be updated after the meeting and subject to approval from the CC, submitted to the Board for approval in March 2020. **Resolved – that:**	

	(a) the Committee reviewed the Committee Annual Report 2019/20 (b) the Committee recommended the Committee Annual Report 2019/20 to the Board for approval	**AF**
S&D 20/03/016	**Employment Policies** The Committee reviewed the Employment Policies. **Resolved – that:** (a) the Committee adopted the revised NHS Wales Pay Progression Policy (b) the Committee noted that the NHS Wales Employment Break Scheme had been rolled forward	
S&D 20/03/017	**Board Assurance Framework Update** The HCG introduced the paper and it was taken as read by the Committee. The COO confirmed that the Director of Corporate Governance reviewed the scoring prior to being submitted to the Committee. The IM-CEF commented that the format of the report was excellent and requested a copy of the Risk Management Document and Board Assurance Framework be sent to her for information. **Resolved – that:** (a) the Committee reviewed the risk in relation to Sustainable Community and Primary Care to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.	**AF**
S&D 20/03/018	**Any Other Business** The Committee were updated on COVID-19 and were assured that the organisation was working extremely hard to battle COVID-19 and all appropriate measures were being taken to prepare. **Resolved – that:** (a) the Committee noted the any other business raised.	
S&D 20/03/019	**Items to bring to the attention of the Board** **Resolved – that:** (a) the Committee recommended the Committee Annual Report 2019/20 to the Board for approval	
S&D 20/03/020	**Date & Time of next Meeting**	

	Tuesday 12th May 2020, Nant Fawr 1 & 2, Woodland House.	

Action Log

Following Strategy & Delivery Committee
Held on 10th March 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Completed Actions					
S&D 20/01/006	19/10/015 – Regionalisation of Ambulances – New policy for escalation and diverts	The Committee Chair to raise concerns with this at the All Wales Chairs Meeting & question clinical governance sign off for the policy.		S&D 20/01/006	**Complete**
S&D 20/01/014	JET Meeting Letter	The letter from Andrew Goodall be shared with the Committee Chair once received	TBC	Len Richards	**Complete:** Letter has been circulated.
S&D 20/01/021	Terms of Reference	The Committee recommended the changes to the Terms of Reference to the Board for approval	26/03/2020	Nikki Foreman	**Complete:** On Board agenda for March meeting
S&D 20/01/022	Work Plan 2020-21	Subject to further discussion, the Committee recommended the approval to the Board	26/03/2020	Nikki Foreman	**Complete:** On Board agenda for March meeting.
S&D 20/03/008 Tolley, Laura 07/13/2020 11:04:12	Are we Improving the Health of the Population? *(Maximising Prevention in the UHB)*	A copy of the presentation be send electronically to the Committee Chair.	13/03/2020	Laura Tolley	**Complete:** Sent.

S&D 20/03/017	Board Assurance Framework	A copy of the Risk Management Document and Board Assurance Framework be sent to Rhian Thomas for information.	13/03/2020	Aaron Fowler	**Complete:** Sent.
Actions In Progress					
S&D 20/01/008	Primary Care Peer Review – Action Plan	An action plan be developed and brought to the Committee in July 2020	14/07/2020	Steve Curry	On agenda for July meeting.
S&D 20/01/016	Developing a Performance Framework Update	An update report be brought to the Committee meeting in May 2020	15/09/2020	David Thomas	On agenda for September meeting.
S&D 20/03/011	Strategic Equality Plan	6 monthly update report be brought to the Committee	15/09/2020	Martin Driscoll	On agenda for September meeting.
S&D 20/03/012	Update on CAHMS Strategy	An update report be brought to the Committee in six months' time.	15/09/2020	Steve Curry	On agenda for September meeting.
Actions referred to committees of the Board					

Actions deferred due to COVID-19					
S&D 19/10/010	Amplify Outcomes	A paper be brought to the Committee which outlined how development would be monitored to ensure that Amplify outcomes were delivered	TBC	Martin Driscoll	Item deferred due to COVID-19. Will return to Committee at appropriate time.
S&D 20/01/009	Excel at Teaching across the UHB	A paper on nursing and midwifery teaching across the UHB be brought to a Committee meeting.	TBC	Ruth Walker	Item deferred due to COVID-19. Will return to Committee at appropriate time.
S&D 20/01/020	Workforce Key Performance Indicators – Themes and Trends	A 6 monthly report be provided that specifically identified themes and trends.	TBC	Martin Driscoll	Item deferred due to COVID-19. Will return to Committee at appropriate time.

Report Title:	**DEFERRED AGENDA ITEMS DUE TO COVID-19 PANDEMIC**						
Meeting:	Strategy and Delivery Committee				**Meeting Date:**	14 July 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**For Information**	**x**
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Head of Corporate Governance**						

Background and current situation:

The purpose of this paper is to provide the Committee with a status update in relation to agenda items deferred due to the COVID-19 pandemic, and to advise when it is anticipated these items will be brought to Committee.

The May meeting of the Committee was cancelled due to COVID-19 and as a result, the Committee last received reports on standing agenda items at its meeting in March 2020.

The following agenda items have been deferred:

- Amplify Outcomes;
- Workforce KPIs;
- Wellbeing of Future Generations Act;
- Teaching Across Nursing and Midwifery.

Director Opinion / Key Issues to bring to the attention of the Committee:

The below table sets out the Executive Lead for each deferred item, advises the Committee when the item was last received by it (where applicable), and when it is now expected to come to Committee.

Item	Exec Lead	Origin	Last Received	Expected
Amplify Outcomes	Director of WOD	Action Log Oct '19	N/A Expected March 2020	September 2020
Workforce KPIs	Director of WOD	Standing Item as part of work plan	March 2020	September 2020
Wellbeing of Future Generations Act	Director of Public Health	Standing Item as part of work plan	N/A	November 2020
Teaching Across Nursing and Midwifery	Nurse Director	Action Log Jan '20	N/A Expected March 2020	September 2020

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

There of course remains a risk that a second wave of COVID-19 pandemic will further affect resumption of normal business and impact on provision of these items to Committee. Committee can be assured by the following status updates provided:

- Wellbeing of Future Generations (WFG) Act - Due to the COVID-19 response, meetings of the WFG Steering Group were temporarily suspended. Subject to COVID-19 levels remaining low / at manageable levels, a restart of these regular meetings is planned for Q2 2020-21. The actions set out in the WFG action plan will mostly remain high priority for implementation during 2020-21, though will need reviewing for appropriateness in light of COVID-19. Reports to the Committee on progress against the WFG action plan will recommence once the WFG Steering Group has reconvened.
- Amplify Outcomes – Interviews with Senior Leaders around learning and culture are currently taking place and outcomes are to be presented to the Executive Team in July 2020. The Showcase is likely on pause until 2021 and virtual options will also need to be considered.
- Workforce KPIs – Reporting on Workforce KPIs will resume in September 2020.
- Teaching across Nursing and Midwifery – This report will be presented in September and was delayed due to COVID 19.

Recommendation:

The Strategy and Delivery Committee is asked to:

- NOTE the content of this report.

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration		Collaboration	x	Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Dragon's Heart Hospital
The Story
1st July 2020

A presentation to the C&V UHB by Professor Jonathon Gray and Victoria LeGrys

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

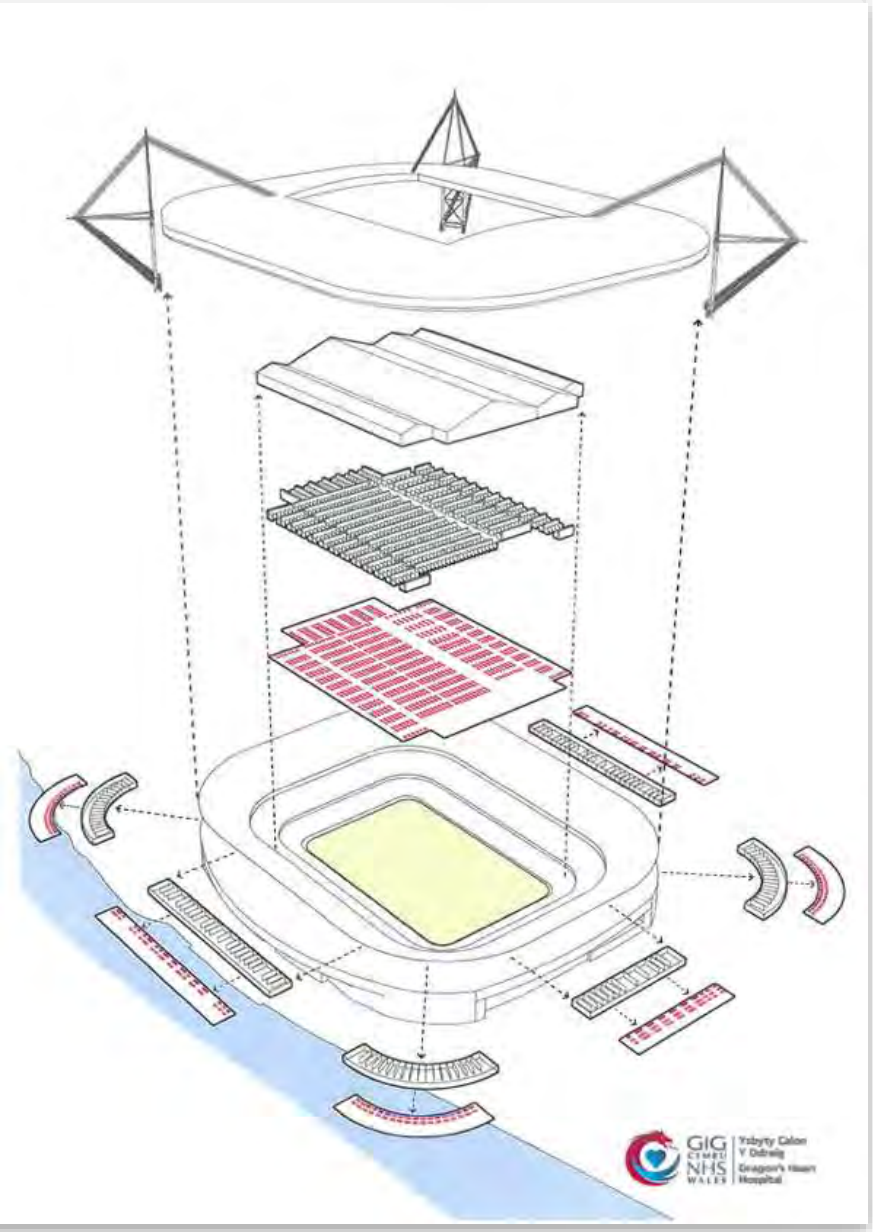
Cardiff and Vale University Health Board

Mission

- Scale - 2000 beds
- Speed - 4 weeks

Execution

- Purpose
- Partnership
- Phasing
- Welsh Government



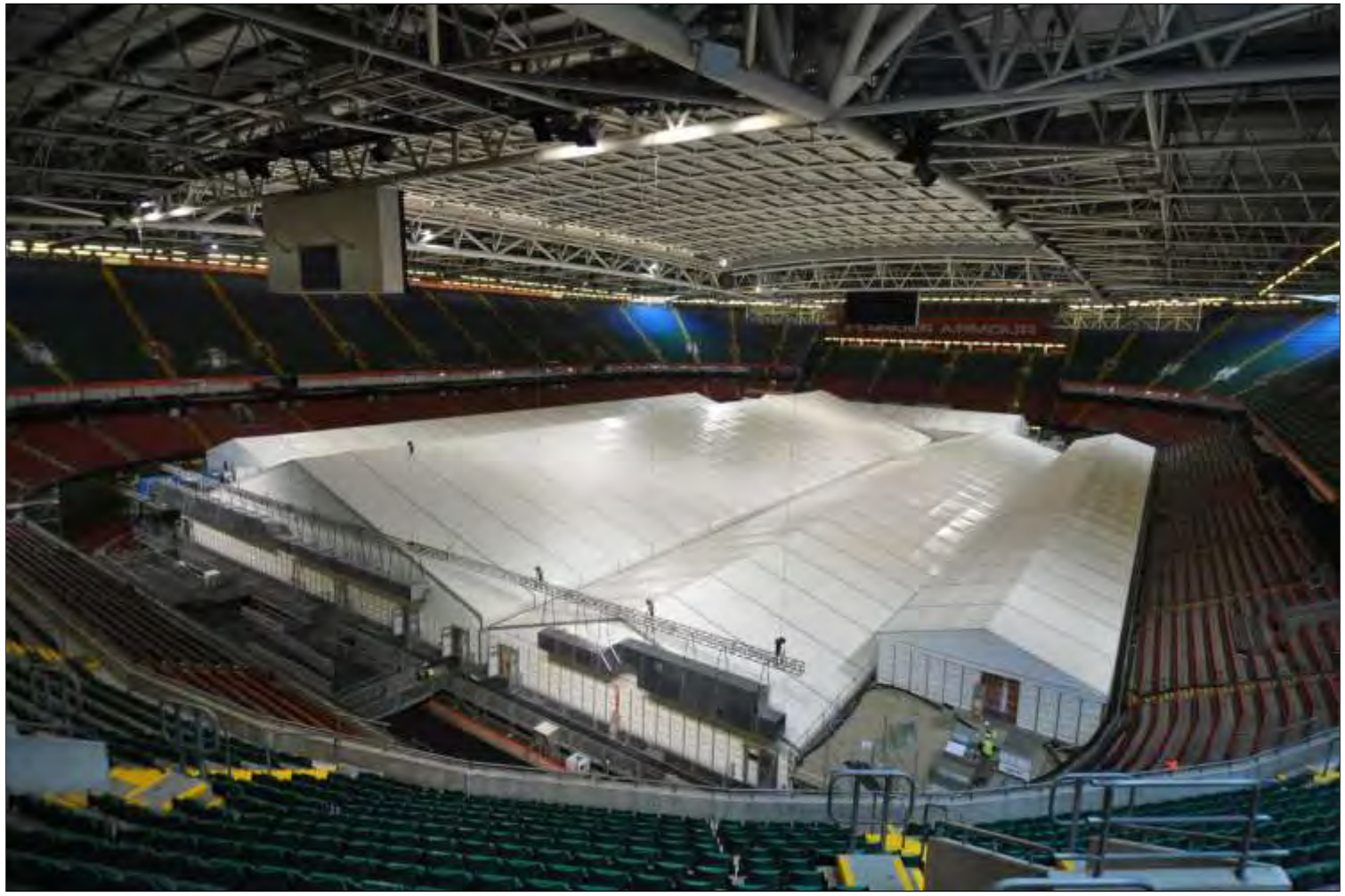
AROUND THE STADIUM IN EIGHTY DAYS

March	18th	First Covid projections received
	28th	Principality Stadium announced as Surge Hospital
	29th	Work begins to transform stadium
	2nd	600 staff are recruited
	5th	Minister for Health and Social Services visits Surge Hospital
April	12th	First ward prepared for 335 patients
	20th	HRH Prince of Wales opens Dragon's Heart Hospital
	28th	First patient is admitted
May	5th	First patient discharged
	8th	Official handover with capacity for 1500 beds
June	4th	Last patient date
	18th	Decommission Levels 4, 5 & 6, partial handover to WRU






THE BOWL

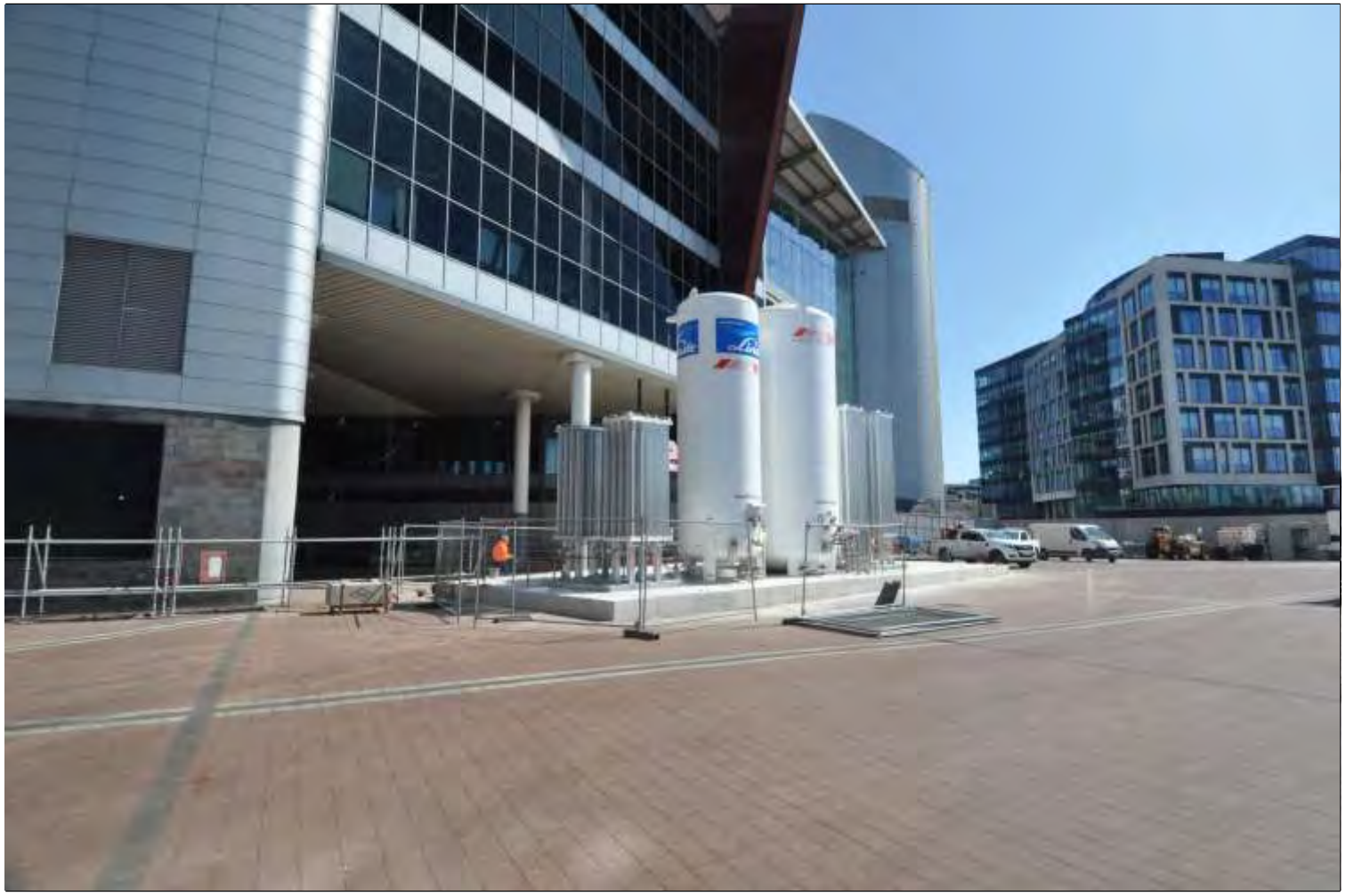


LEVEL 5 HOSPITALITY BOX

LEVEL 5 MILLENNIUM LOUNGE

LEVEL 4 CONCOURSE

THE PLAZA



BODY STORE

THE LAB

GIG CYMRU NHS WALES | Ysbyty Calon Y Ddraig Dragon's Heart Hospital

ESG

Tent area 8 times larger than the Glastonbury main stage

39 days for Phase B completion – 1,200 beds

93 new showers

44 new WCs

300 new sinks

16km of water pipes

50km of electrical cable

Enough generators to power 12,500 homes

3km of ventilation ducting

6,000+ double socket units

675 m² of new signage - enough to cover 2.5 tennis courts

16km of Oxygen pipes, delivering 3 Olympic pools of O_2 a day

61km of internet cables

6km of wall panels

MOTT MACDONALD

GIG CYMRU NHS WALES | Ysbyty Calon Y Ddraig Dragon's Heart Hospital

ESG

50km covered daily by forklift trucks

5 days to design

70+ litres of hand sanitiser

250,000+ manhours

954 articulated lorries of kit delivered

600 workers on site at peak construction

Over 30 different companies involved

1,700+ contractor site inductions

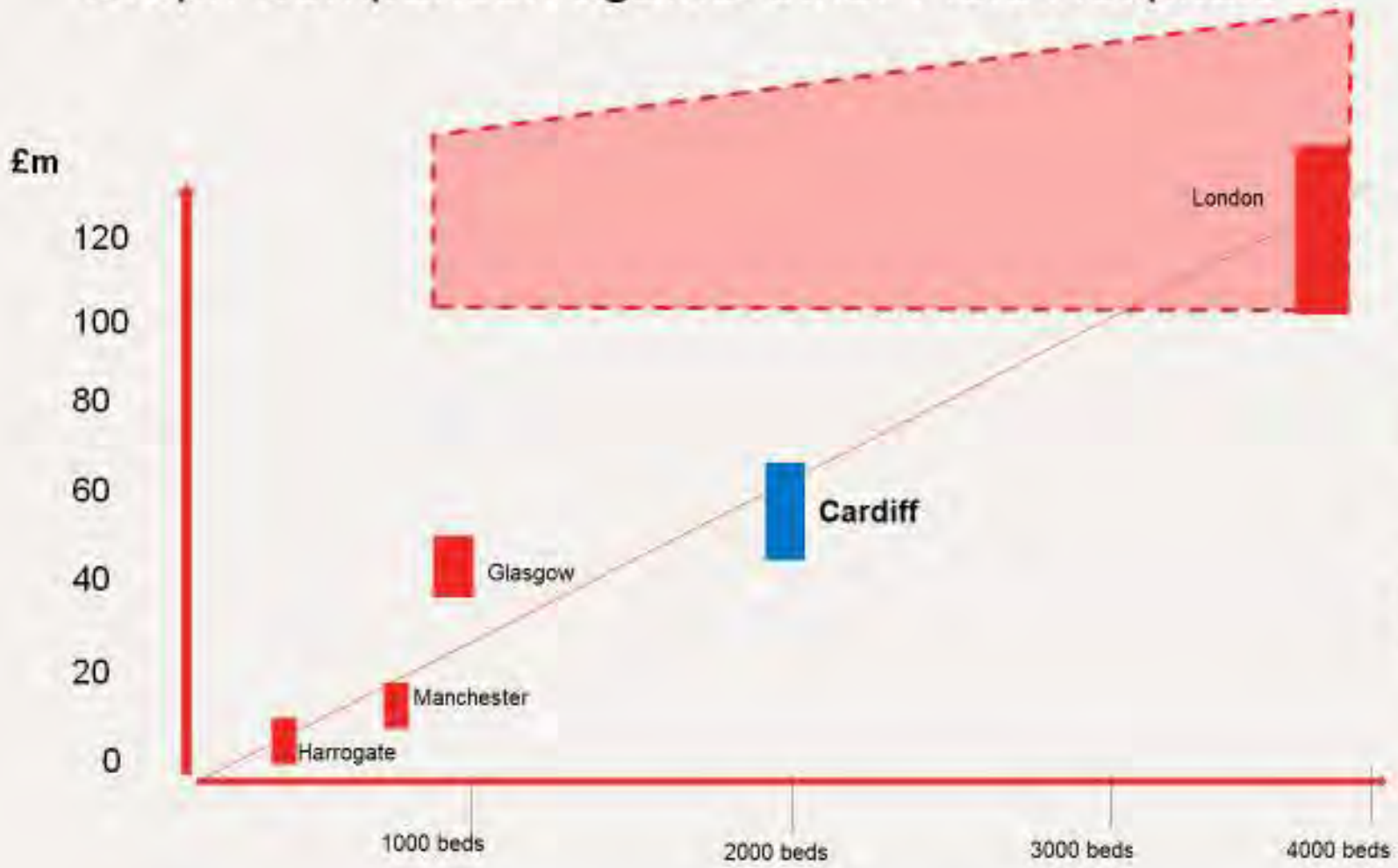
250,000km total distance walked – 6 times around the world!

2,000+ meals prepared daily

4 Hotels and 6500 room nights

20,000 cable ties used

Graph Comparison against other Field Hospitals



Cost Heuristics

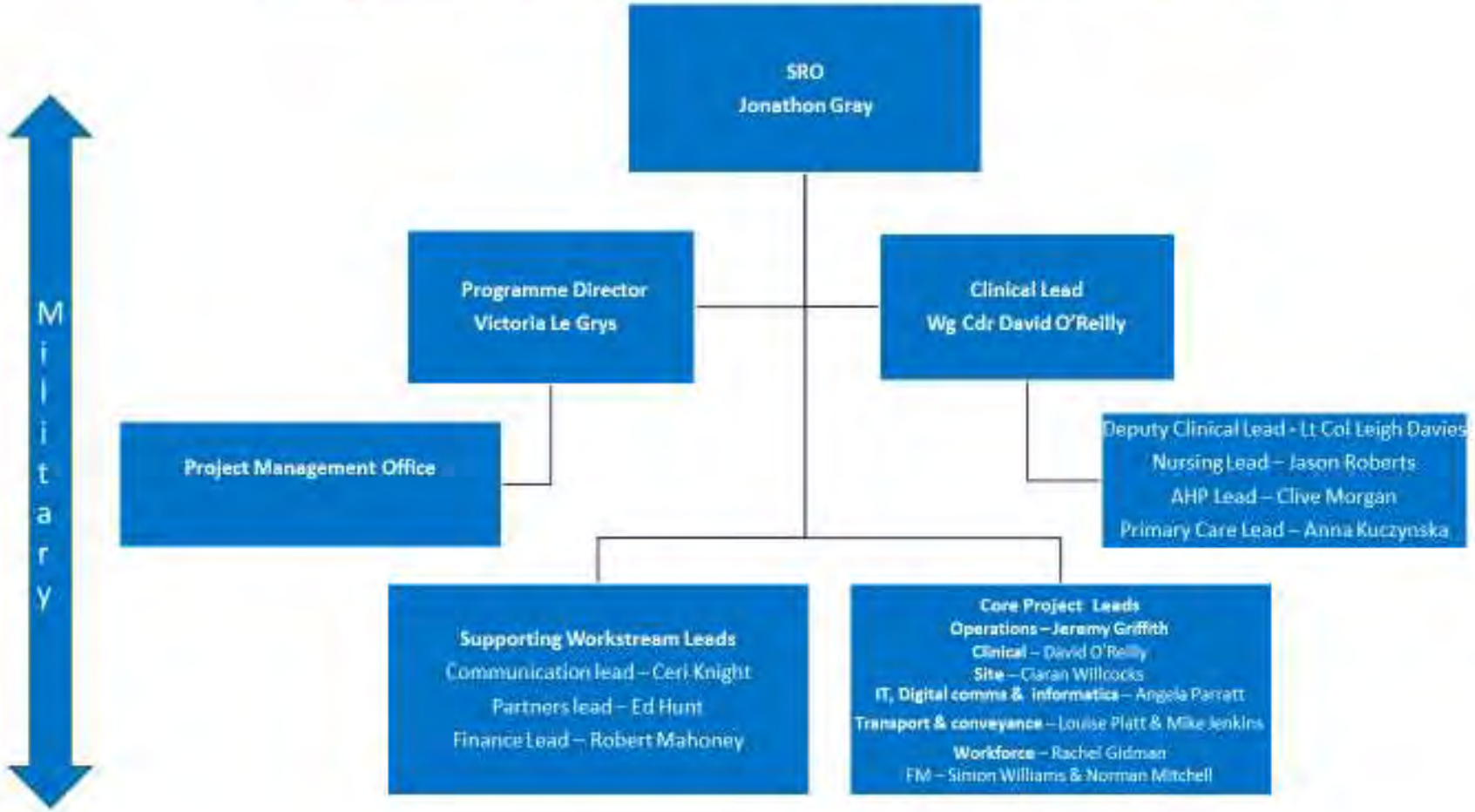
Glasgow - £45m to £50m
1000 beds
Included Medical Gases

Manchester- £10m to £12m
C. 600 low acuity beds
and 150 un serviced beds

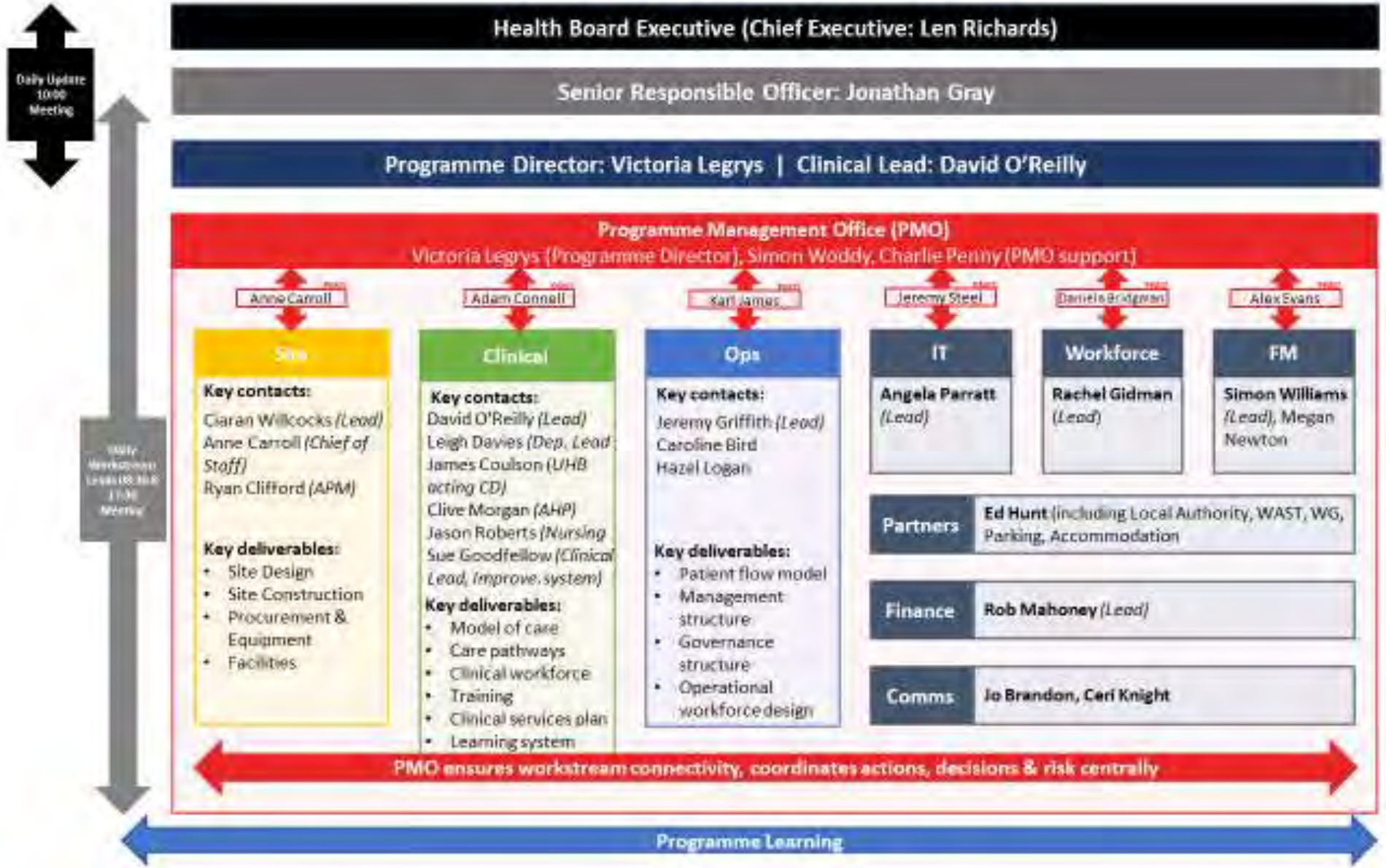
London- £100m to £120m
4,000 beds
Included Medical Gases

Harrogate / NEC £10m - £12m
500 beds
Included Medical Gases

Programme team – management structure



Dragons Heart Hospital Programme Phase 1
Governance Model March – May 20



Learning

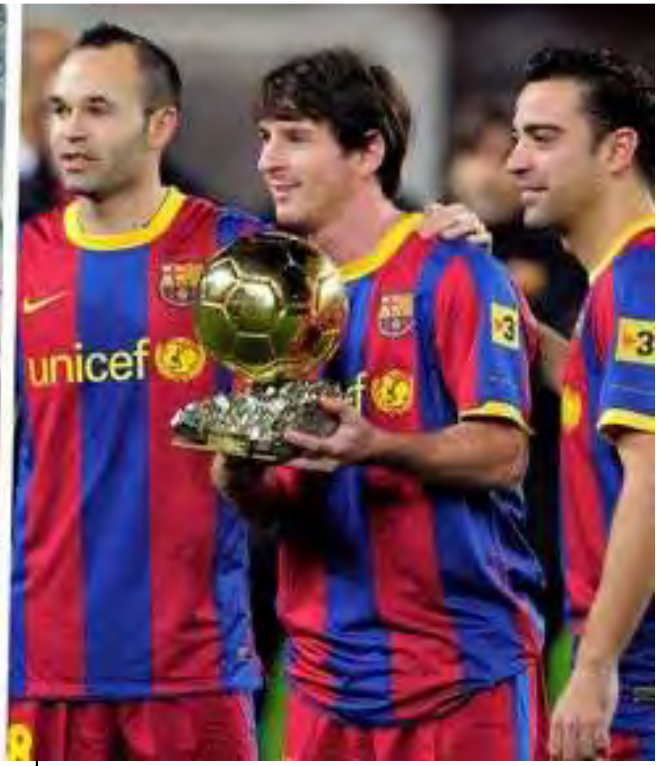
- Governance & Workstreams
- Leadership: clinical/collective
- PMO as Force Multipliers
- Trust
- Purpose & meaning
- Patient outcomes

Application: A Parallel Operating Structure

- Change, innovation & delivery infrastructure
- Replenishable network
- Agile
- Cost-effective
- Integrated

The Opportunity

- Rapid response & catalyst
- Facilitate reciprocal learning and influence
- Multi-perspectival/multi-skilled network of leaders
- Coordinate research and action
- Ensure a sense of relatedness and fellowship amongst CAV staff
- Deployable capability



Football Academies:

- Produce players
- Develop into first team players
- Become a reserve or squad player
- Make money for club as potential transfer

La Masia, "The Farmhouse"

Nov 2012 – all 11 players on pitch from Academy

2010 – 3 nominees Ballon D'Or from Academy

(Messi, Iniesto, Xavi)

Train 2x week – skills & technique

Weekend – competitive game

Assistance from the club

- Homework drills
- Parents guided on nutrition and mental health
- Agility etc.

Youth development 'so important' that when a player reaches 9 years of age, they only play for the Academy

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Sandhurst

- “Serve to lead”

West Point

- “Preeminent leader development institute”
- “Educate Train Inspire”

Military Academies

- Prepare candidates for service in officer corps
- High quality education
- Coursework & Training
- Military tactics & strategy
- Obligation to serve for a number of years

Special Forces Training – an additional level

Toney, Laura
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Hints and Clues from elsewhere?

Dragon's Heart Institute: Tying it all together

- A Parallel Operating System
- A Catalyst for transformation
- A movement led by us the NHS
- A partnership between the hierarchy and the network
- A collection of change-makers
- An accelerator of strategic change

The Dragon's Heart Institute

- an agile, network-like structure

- A 'Think tank'
- A 'Doing-tank'
- A network, a Faculty of 'reservists'
- (young) leaders' network

- Supports & accelerates:
  - design
  - implementation
  - continually assesses the organization & environment
- Complements & strengthens the traditional hierarchy

Empowering existing enterprise

- Recovery
- 5‘I’’s
- RIIC Hub
- Partnerships
- UHW2
- ILA
- Spread & Scale Academy
- Amplify
- CLIMB (leadership programme)

The Proposal

- Linked to OD via a dedicated training wing
- Core staff working with senior faculty
- Secondment to industry partners
- A ‘Reservist’ commitment
- PMO Academy – ‘Energizer battery’ at the heart of C&V
- Young Leaders Academy
- Getting stuff done at pace

With Support from the Board we will:

- Identify structure & funding
- Identify key internal stakeholders
- Form partnerships:Q5,Mott, Archus, Military, WRU
- Identify first priorities
- Timeline – operational in 12 weeks?

What do we have currently?

Improvement - relatively junior, poor capacity & capability for an organization this size. 2 good analysts, 1 excellent QI, 2 good QI

Innovation – 1 experienced, no linkage with clinical innovators, no succession plan, no fellows, no seed fund

PMO – 3 inexperienced band 7, no overview, no strategy/plan

Leaders network – a great opportunity to build on amplify, the TEDx and Pecha Kucha work – but most importantly to build on the lived experience, the leadership experience of the last 12 weeks.

Think tank – scattered expertise, some international links, but not formalized, linked to Bevan Commission or other think tanks

Transformation fund – 500k, but overspent on Pathways (280k), innovation salary, Exec Directors salary

Cheap things cost a lot of money
Spanish proverb

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What will it take to do this?

c£1.5 million

Institute core roles (band 8d & admin)

Think Tank – Bring BC or similar

Doing tank

- Reservists – sessions from key leaders across the organization
- PMO academy
- Young leaders' network

Improvement team -restructure/renew

Innovation team & seed fund – join up clinical & non clinical innovators, innovation fellows & innovation seed fund

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Tolley, Laura 07/13/2020 11:04:12

Report Title:	**Update on Progress against Shaping Our Future Wellbeing and IMTP in respect of 'Home First'**						
Meeting:	**Strategy and Delivery Committee**				**Meeting Date:**	**14 July 2020**	
Status:	**For Discussion**	√	**For Assurance**		**For Approval**		**For Information** √
Lead Executive:	**Executive Director of Strategic Planning**						
Report Author (Title):	**Director of Operations, PCIC**						

Background and current situation: Home First is one of the four Action Areas within the Health Board's Shaping Our Future Wellbeing Strategy 2020-2023. Key components include:

- Strengthening our focus on all forms of prevention - including healthy weight and smoking cessation, working with Regional Partnership and Public Service Board partners.
- Ensuring primary care sustainability and strengthening foundations for transformation through implementing the Primary Care Model for Wales, enhancing cluster and locality working and delivery of the Health and Wellbeing Centres and Wellbeing Hubs.
- Delivering Out of Hours Service redesign to improve timely access to care.
- Supporting people to live well in the community through preventing decline by implementing the frailty pathway and preventing deconditioning.
- Continue to sustain and transform primary and community based services to enable people to remain healthy and independent at home.

This paper provides a high level update on progress against these priorities. It should be noted that CoVid has impacted on the way primary care services have been delivered and in relation to the contractor services this has been directed by Welsh Government (WG). Reporting arrangements have also been stood down during this time.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

There has been a range of work undertaken to develop and deliver increased and new services at community level based on lessons learned from other parts of the country and internationally. The provision of the WG Integrated Care Fund (ICF), Transformation, Cluster and Pacesetter funding has significantly assisted with the development of a range of schemes at pace. Whilst in some cases work has paused due to CoVid, it has also brought opportunities in terms of new ways of working.

1. Increased focus on prevention and promotion of healthy life style. All clusters have been progressing work in respect of the public health priorities identified within their IMTPs. There has been a focus on increasing the rate of childhood immunisation and flu vaccinations, with initiatives including community health promotion days and increased publicity of vaccination campaigns. Other focussed work includes promotion of bowel screening; development of pre-diabetes management programmes in conjunction with Diabetes UK; development of Stay Steady clinics to reduce the incident of falls in the community. Improved referral pathways have been developed to access 'Help Me Quit' Services for those who smoke. A range of initiatives including Healthy Schools and Pre-Schools Schemes are taking a whole

school approach in delivering healthy eating messages.

2. Primary Care Sustainability: The significant investment by the Health Board to support GMS sustainability has enabled the provision of both First Point of Contact Physiotherapy and Mental Health Liaison services at practice/cluster level. The clusters have also invested themselves in new roles such as cluster pharmacists and frailty nurses in support of wider multi-disciplinary team working. The overall aim being to release GP capacity and ensure patients are seen by the correct professional at the first point of contact. In terms of estate infrastructure, there has been progress in respect of capital developments at cluster and locality level. The development of both Penarth, Maelfa and Parkview wellbeing centres, CRI Chapel and CRI main site continue to be progressed, as are development priorities in line with the Primary Care Estates Plan. The merger of two general practices in Penarth and two practices in Cardiff has enabled the continuation of GMS provision in these areas and focused support has been provided to other GP practices to enable them to continue to provide services. The provision of temporary additional accommodation for practices in Whitchurch has again ensured sustainability of services to this population.

3. Out of Hours redesign: Please see separate paper to the Committee (Urgent Primary Care/OOHs Action Plan).

4. Supporting people to live well in the community/transforming primary and community based services: ICF and Transformation funding has facilitated further expansion and development of community services and enabled the introduction and trialling of new models or care and ways of working to enable more care to be delivered at home. Examples include:

4.1 Improved Discharge Pathway/Community Resource Team Developments

Through collaborative working with both Cardiff and the Vale of Glamorgan Council, significant progress has been made to facilitate the earlier discharge of patients from hospital and increase access to reablement programmers in the community to enable people to regain and maintain their independence at home.Through placement of expert staff at ward level (Single Point of Access Team- including CRT and Independent Living Service Staff), 'What Matters to Me' conversations are now being held with patients to plan for their discharge needs and ensure patients are referred to the appropriate community services. There has been an expansion of the existing CRTs in terms of both acceptance criteria, staffing and capacity to facilitate the discharge of more complex patients. Due to the impact of hospital length of stay, this scheme has been continued through use of transformation funding

4.2 Development of Community Reablement Facilities

In conjunction with both Councils, Community Reablement Units have been developed both within residential and nursing homes. These facilities provide an opportunity to provide 2-6 weeks of reablement for patients on transition from hospital to home. Their use in terms of providing an alternative from admission is also developing.

4.3 *New Ways of Working*

Through Transformation Funding, clusters are now looking to remodel the way the way they provide services with more care provided at home, or close to home. In one cluster, MDT meetings have now been established, involving GPs, health staff, council staff and the third sector to review and provide support to the most complex patients in the community. This approach has been further supplemented through additional investment in social prescribing and community development capacity to enable and embed the philosophy of self-care within

the local population. This model also includes the provision of an 'Integrated Care Hub' for use by both patients and GP practices within the cluster. This hub provides users with information/advice and signposting. There is also a project underway in the Vale to provide additional GMS capacity, through a hub model, with the aim of reducing emergency demand on GP practices within the area, releasing their time to focus on chronic disease management.

Different ways of working have been implemented as a consequence of the current Covid situation. These include the use of digital platforms and virtual working to provide services such as telephone/video consultations for patients but also use of skype/Microsoft Teams to enable staff to connect in a different way. There has also been a need to change the way in which estates/premises have been used to ensure they are in line with IP&C requirements including social distancing.

There is ongoing work between primary and secondary care in relation to the outpatients programme. This includes the prioritisation of services and different ways of working, pathways and models. The implementation of Health Care Pathways has continued and will reflect the developments and changes that have been introduced.

Assessment and Risk Implications

Outcome measures are being collected in respect of service developments with support from the Innovation and Improvement Team, Integrated Social Care Partnership and Lightfoot. Appendix 1 provides a summary of the outcome measures for schemes funded via Transformation Funds as at quarter 3 (note reporting for quarter 4 was suspended in line with national guidance). Some highlights from the schemes referenced in this paper include:

- Improvements in screening and immunisation uptake in a number of clusters across Cardiff and the Vale.
- Reduction in emergency admissions from the South West Cardiff Cluster as a result of their MDT and Integrated Hub Work
- The Get Me Home and Get Me Home+ scheme is delivering a reduced length of stay for patients with complex needs, there is an indication that the ongoing care needs of individuals post intervention is reducing
- Outcomes in terms of patient experience and recovery following a stay in the Reablement Units are consistently positive

It is important to note that there is a significant risk to business continuity as a result of Welsh Government short-term grant funding coming to an end on 31 March 2021. The Integrated Care Fund currently funds a number of mainstream services and permanent posts. A detailed risk assessment is being understaken to understand the level of risk this presents to service delivery. Clarity on joint strategic planning, commissioning and exit planning with the two Local Authorities is an important part of mitigating this risk.

Recommendation:

The Strategy and Delivery Committee is asked to:

- Note the progress of against the UHB's Home First Action Plan
- Note the risks associated with continuation of a number of key schemes

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	√	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	√	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	√	Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Paper for Strategy and Delivery Committee July 2020: Update on Home First Appendix 1
Transformation Fund Dashboard Q3 2019-20
Helping people to live the best lives they can in their homes and communities

Funding

Project Descriptor			Description	Indicative Timeline of Funding Availability (Based upon current spend forecasts and subject to ongoing performance monitoring)
No	Title	Total Allocation		
1	**Accelerated Cluster Model (Cardiff area)**	**1 287 463**	A progressive approach to improving population health through a joined up system of communities, third and independent sector partners, primary and community services. It will develop the optimal Cluster, using asset based community development approaches. It will be supported by a workforce model which co-ordinates the well-being workforce at a locality level, including social prescribers, community connectors and importantly a community development resource. A directory will be embedded in Practices enabling professionals to offer information and advice quickly and easily.	okt-20
2	**Seamless Social Prescribing (Cardiff area)**	**801 826**	A single entry point to Cardiff Council's Independence and Well-being Services and Stable and Non-Complex Care Services, bringing together information, advice and assistance services into an easily accessible point for both citizens and professionals working across the whole system. This new enhanced single entry point will be web and telephone based, to enable people to search for relevant well-being services or arrange for a 'What Matters' Assessment to be undertaken. The 'Well-being Matters' service will be a 'front door' to services which can be accessed by people at home, in community settings or by professionals working across the region.	des-20
3	**Single Point of Access GP Triage (Vale area)**	**1 233 959**	This project seeks to address General Medical Sustainability (GMS) issues through the development of an effective General Practitioner (GP) triage service. This builds upon the successful model of the current Vale of Glamorgan Single Point of Access (SPoA) in the Vale of Glamorgan. Patients involved in a pilot practice will call their GP surgery, which would then divert them into the Contact1Vale contact centre where they would be put through to speak with a skilled call handler (care navigator) that can assess the person's presenting issue(s) through a 'What Matters' type conversation. They are also then able to have a clinical consultation with a triage nurse over the phone, this is not a limited session in the same way as a GP appointment but gives the patient an opportunity to talk about their issue in detail. The project will also facilitate patients receiving home visits in order to ascertain their wellbeing situation from a residential setting. Contact centre staff will be able to book appointments for patients in the same way that the practice does.	mar-21
4	**Get Me Home Preventative Services (Cardiff area)**	**614 919**	Known locally as 'the pink army', this project builds on the achievements of the Preventative Services First Point of Contact in Cardiff, with a new Get Me Home Service single access point within the hospital for all community based services. Using a collaborative approach, a new way of working will be developed to improve the patient journey and increase integrated working between Cardiff Council, health and third sector partners to ensure patients have access to the full range of services offered by the Preventative Services programme, as well as community or home based social care services, as required. This will see multi skilled Council operatives working hand in hand with health colleagues in the hospital to facilitate the journey home. The team will be on hand to meet patients using 'What Matters' conversations to provide holistic tailored support that meets the well-being needs of the individual, providing preventative interventions and supporting independent living.	mar-20
5,1	**Get me Home Plus Cardiff**	**1 175 833**	Get Me Homes Plus (GMH+) provides a fast track pathway for at least 8 patients per week who have been assessed as requiring level 2/3 support (Supported /Complex) - often a restart or establishment of a new package of care in order to return home. The project offers a credible and effective option that takes the person's recovery to their usual surroundings, reducing further deconditioning and the risk of hospital-acquired infections. The current delay in discharge can often lead to decompensation, loss of mobility, confidence and independence, potentially resulting in a consideration of residential care. This pathway will also include, where required, support from the Get Me Home Preventative Services in Project 4, to ensure a holistic assessment of needs which will include benefits advice, links to other community services, along with signposting to other third sector support with the aim of preventing further admissions and providing individuals with support to maintain their well-being within their own home.	okt-20
5,2	**Get Me Home Plus Vale**	**445 522**		okt-20
6	**Developing an ACE Aware approach**	**423 560**	A new way of working across health, social care, education and the third sector to increase resilience and awareness in children and young people (CYP) across the region through timely intervention and signposting. The service will be delivered by new Resilience Workers who will be employed by the UHB and supervised by clinical staff, but working alongside the two existing Education teams (Cardiff Specialist Teacher Team and Vale Outreach Team). These teams work into school clusters to support children's emotional wellbeing but the new approach would be bringing the attachment, Adverse Childhood Experiences (ACEs) and mental health perspective to the teams in a holistic service spanning education, health and social care.	mar-21
7	**Developing Place Based Integrated Community Teams**	**423 560**	In line with 'A Healthier Wales', the Cardiff and Vale of Glamorgan Regional Partnership Board is fully committed to a place based approach which enables partners to listen and work with people in need of care or support, to jointly find solutions to meet their needs. Deliverables can be summarised as follows: Year 1: - Work with the third sector to map our community assets and support the contribution of the emerging health and well-being networks in each of the clusters across the region. This will ensure there is a clear focus on early intervention and prevention. - Set in place a foundation on which to develop greater integration between health and social care community teams working within the Cardiff area and to further enhance integrated community team working within the Vale of Glamorgan. - Initiate a mapping exercise to identify requirements for children's community services across the region.	des-20
	Project Management	**237 500**		mar-21
	Evaluation			jan-22
TOTAL		**6 947 984**		

Connection to Strategic Themes

	Homes and Communities First	Starting Well	Living and Ageing Well	Empowering the workforce	Digital Capability
No. of projects with Direct Focus on Theme					
Investment					
No of projects with Indirect Focus					
Curve Turning Indicators					

System Level Outcomes *(further development work required)*

In 2019-20 so far, the Transformation funding has contributed:	People had proactive and preventative care	People led independent lives in their homes and communities.	Cardiff and the Vale are great places to grow up and live	Variation in outcome has reduced	People have more choice and control	People are healthy and safe	Staff have been empowered with the capacity and capability to deliver

Transformation Project Performance

ROF Theme Direct Focus	Project	Annual Total Local Allocation (£)	Actual Spend (£) Q1	Q2	Q3	Q4	Cumulative / RAG
tbc	1 Accelerated Cluster Model	906 087	215 267	73 590	##		398 899
tbc	2 Seamless Social Prescribing	479 707	36 574	34 563	##		130 159
tbc	3 Single Point of Access GP Triage	953 004	115 143	90 289	##		327 039
tbc	4 Get Me Home Preventative Services	388 370	98 533	98 532	##		300 962
tbc	5 Get Me Home Plus (Cardiff and Vale)	1 140 379	168 529	196 549	##		587 559
tbc	6 Developing an ACE Aware Approach	457 658	17 325	70 961	##		201 515
tbc	7 Place-based Integrated Community Teams.	247 978	30 000	0	##		60 064
	Programme Support		3 933	12 803	##		48 744
	TOTAL	4 714 850	685 304	577 287	##	0	2 054 941

How Much / How Well? Measure	Q1	Q2	Q3	Q4	Cum	Baseline
Number of referrals to social prescribing		284			284	n/a
% of people contacted within 1 week of referral.		62%			62%	n/a
% of people reporting they took up at least one intervention.		64%			64%	n/a
Delivery of Partnership agreement						n/a
Development of IT specification and governance						n/a
Completion of asset mapping.						n/a
Development of Project Team						n/a
Staff recruitment.						n/a
Pilot within one GP practice.						n/a
Amount of income maximised for residents.		£164k			£164k	n/a
Number of bed days avoided.		555			555	n/a
Number of patients supported.		1 116			1 116	n/a
Number of Cardiff patient discharges achieved.			57		57	76
Number of Vale patient discharges achieved.			44		44	99
Staff recruitment						n/a
Implementation of training						n/a
Embedding workers within clusters.						n/a
Recruitment of project capacity.						n/a
Workforce Engagement						n/a
Mapping of Third Sector assets.						n/a

Are we better off? Measure	Q1	Q2	Q3	Q4	Cum	Baseline
% of patients showing an improvement in their wellbeing score post contact		77%			77%	n/a
Monitoring of emergency admission and cluster data.		Unavailable				n/a
% people who felt better able to manage their health conditions.		100%			100%	n/a
Development of well-being gateway and chatbot						n/a
Completion of Directors						n/a
Roll-out of phased implementation.						n/a
Review and evaluation						n/a
Roll-out of phased implementation.						n/a
Total number of outcomes provided to patients.		1 119			1 119	n/a
% of health staff feel communication between health and community has improved.		100%			100%	n/a
% of health staff feel service supports faster discharge.		100%			100%	n/a
Data under preparation.						
Identification and maintenance of model.						n/a
Evaluation.						n/a
Mapping of regional and locality cluster assets.						n/a
Agreement of blueprint and governance structures.						n/a

Overall RAG Status	Comment
A	Ongoing meetings to tackle information sharing issues. Funding underspend but agreement to carry forward now in place.
G	Funding underspend but agreement in place to carry forward now in place.
R	Clinical roles partially filled but insuffucient applications for short term role. New date for pilot to be agreed - possibly early Feb.
G	Proposal is being prepared to support prolonged availability of project after Transformation funding ends in March 2020.
G	Activity levels have improved but family choice and late notice discharge cancellations remain issues. Ongoing funding proposal
G	Significant delays in initiation due to staff recruitment. Positive progress now being made.
A	Significant delays in initiation due to staff recruitment. Positive progress now being made.

Forward Work Plan

Performance Management

Task	Lead	Timescale
Quarterly performance monitoring to be co-ordinated with ICF quarterly monitoring via a revised ICF and Transformation Performance Group.	Meredith Gardiner	apr-20
Completion of revised Dashboards following trials in Quarter 3 to inform scrutiny and monitoring for the new Boards emerging as part ongoing work to revise the RPB governance structure.	Meredith Gardiner	apr-20
Workshops are planned to review existing performance measures as one of the key findings from the Midpoint Evaluation Report.	Rebecca Archer	feb-20
Development of a joint business case to extend the 2 Get Me Home projects for consideration by SLG and RPB membership. This will include the piloting of a new process for business planning and exit management which if successful may be rolled out for use across the range of Transformation projects.	Carolyne Palmer / Judith Hill	feb-20
Identification and development of proposals for additional Transformation funding for use in 2020-21.	Cath Doman	mar-20

Risk Log Update

Risk	Rating	Action	Revised Rating
Risk of un-utilised funding in-year being unavailable for following year.	R	Gained agreement from Welsh Government that underspend in 2019-20 can be made available in 2020-21 for use.	G
Transformation Programme Manager vacancy means reduced resource for effective quarterly reporting and ongoing management	R	Risk is currently being managed between the IHSC Programme Manager and the IHSC Data Analyst while recruitment for a new programme manager takes place.	A
Risk of delay in roll-out of key pilots due to absence of business-critical staff.	R	Absence managed locally and timescales revised accordingly but may be subject to further change.	R
Funding for the Get Me Home projects is shortly to cease following the completion of pilot funding, leading to loss of trained, experienced staff should the region agree that the projects should continue.	R	Interim funding is being sought currently to extend the projects as one combined service in line with the timescales of the other projects so that all can be evaluated fairly in line with initially planned timescales.	A
Difficulty in obtaining and sharing key data will impact ability to evaluate the true impact of the project.	R	Ongoing work with further update planned for Q4.	R

Coms / Engagement Actions

Actions undertaken this quarter	Plans for Next Quarter	Lead	Timescale
Initiation of on-line coms log with all SROs invited to add events.	Planned film of Get Me Home and other related ICF projects to raise awareness amongst staff and patients.	Judith Hill / Nimyrah Caesar	mar-20

Case Study Highlight
To be made available in Q4

	Coms plan to be developed for Q1 and Q2 including case study, newsletter items and celebratory event / roadshow to showcase developments and raise awareness.	Nimyrah Caesar	mar-20	

Assurance

Date approved by Performance Management Group:		Date Approved by SLG:		Date Approved by RPB:		

Tolley,Laura
07/13/2020 11:04:12

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.

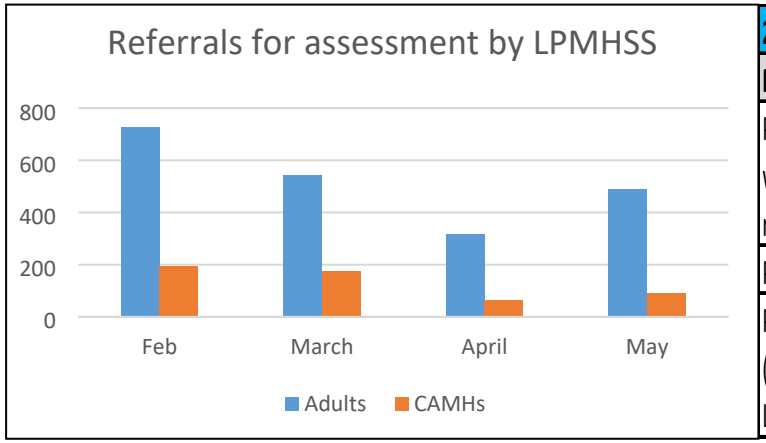
Optometry services reopened at the end June, and with the appropriate IPC are able to provide a near to normal service. This is important in light of the continued suspension of some hospital based eye care. We will be reviewing the pathways for urgent referrals to ensure patients are access the right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

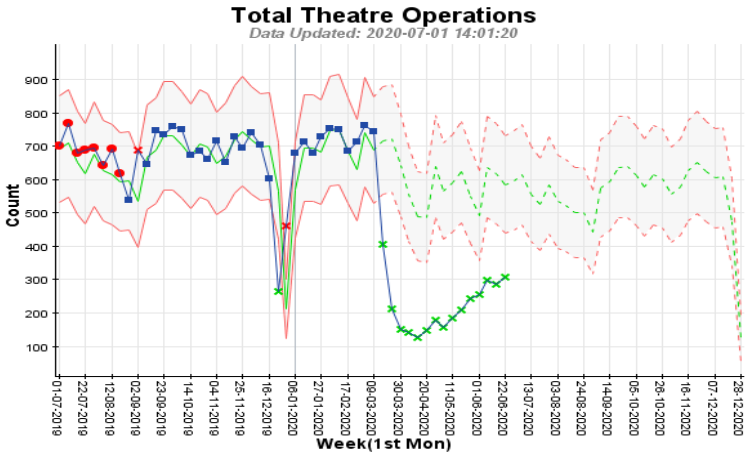
Gynaecological	Urological	Neurological	Colorectal
Gastroenterological	Breast	Haematological	ENT

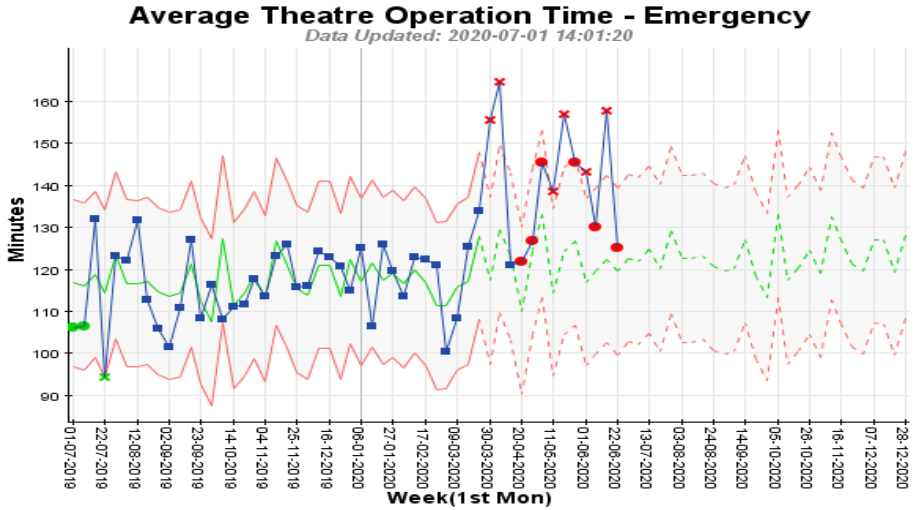
UHB Activity at Spire since 23rd March 2020

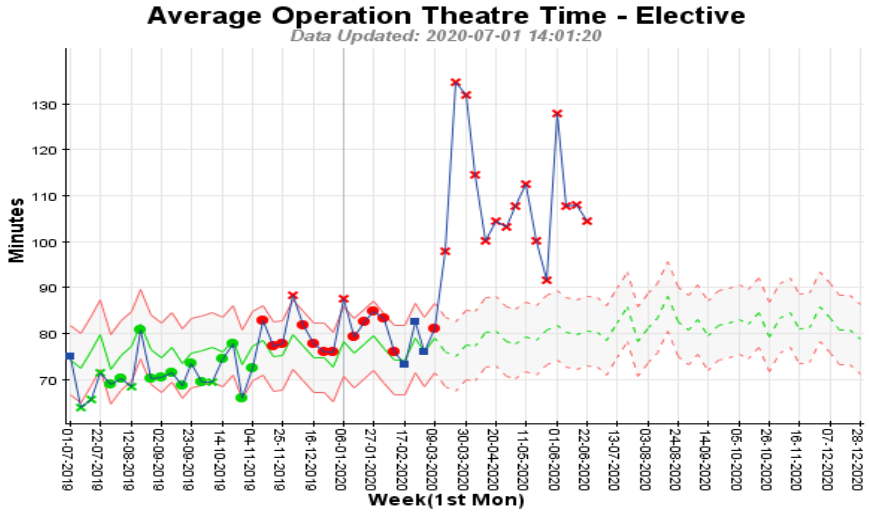
Cancer operations	Other time sensitive Theatre cases (inc 39 eyes)	Outpatients (incl 1,098 eyes)	Endoscopy procedures inc urgent Cancer	Cardiology procedures	Total
262	164	2,023	260	48	2,757

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.

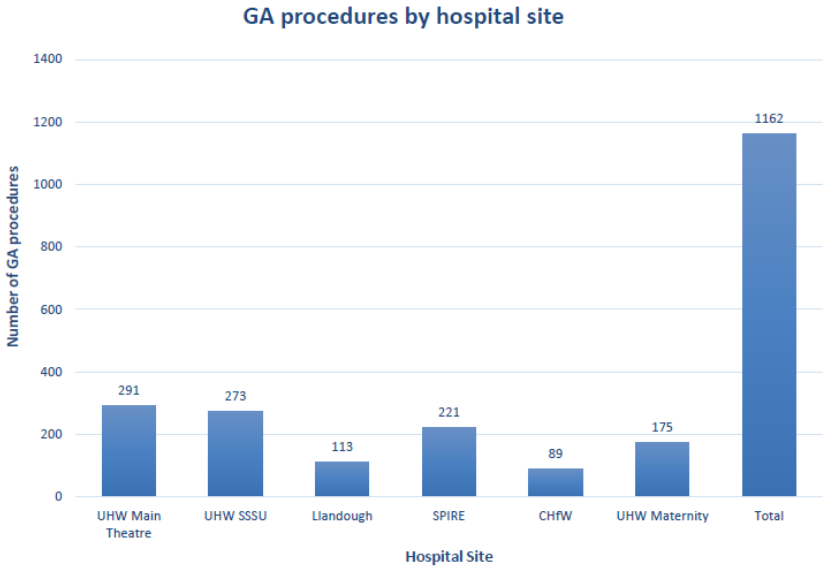
An overview of early Q1 high-level acute demand, activity and performance data can be found at Appendix 6.

3.6 Delivering Compassionate Care Safely

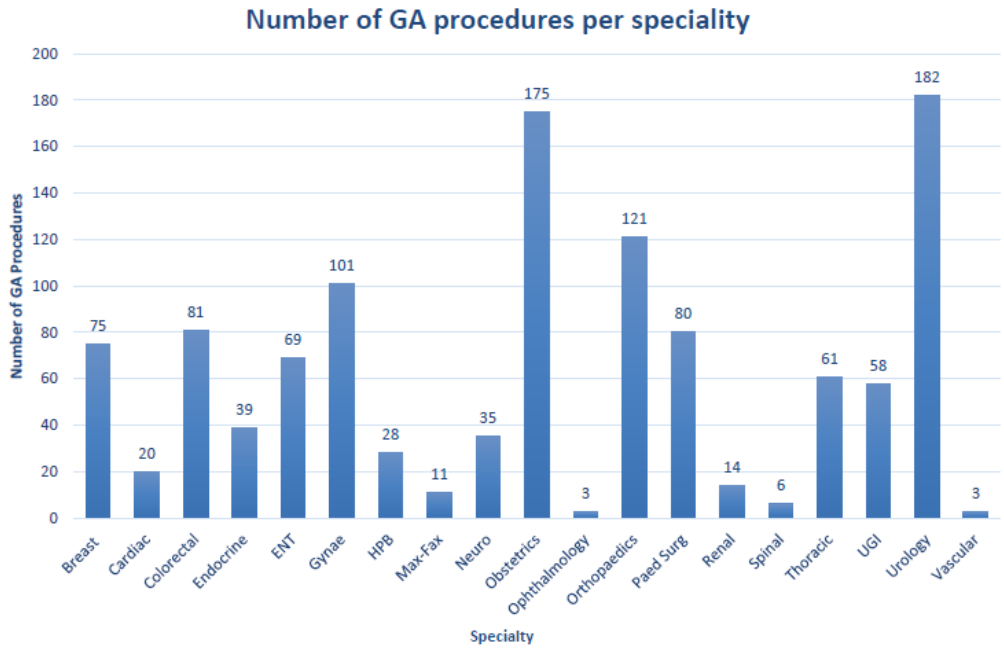
The Nursing and Medical Director's Teams continues to monitor closely the surgical activity that is undertake to enable any issues to be quickly identified an acted upon, and the COVID-19 status of patients in all of our hospitals to identify quickly any issues in respect of hospital acquired infection. 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.



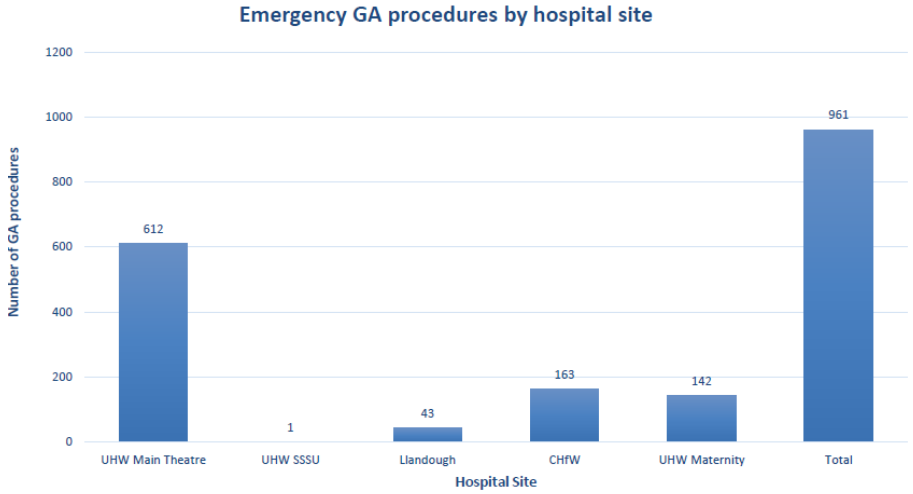
In-patients were swabbed for COVID-19 if they developed possibly COVID-19 symptoms only. Of these, there were around 16 positive swabs (1.4%) for COVID-19 within 30 days of the procedure (the vast majority in March and April). There were about 77 negative swab results over the same period.

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.

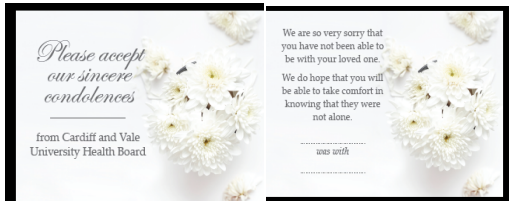
Virtual Visiting

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

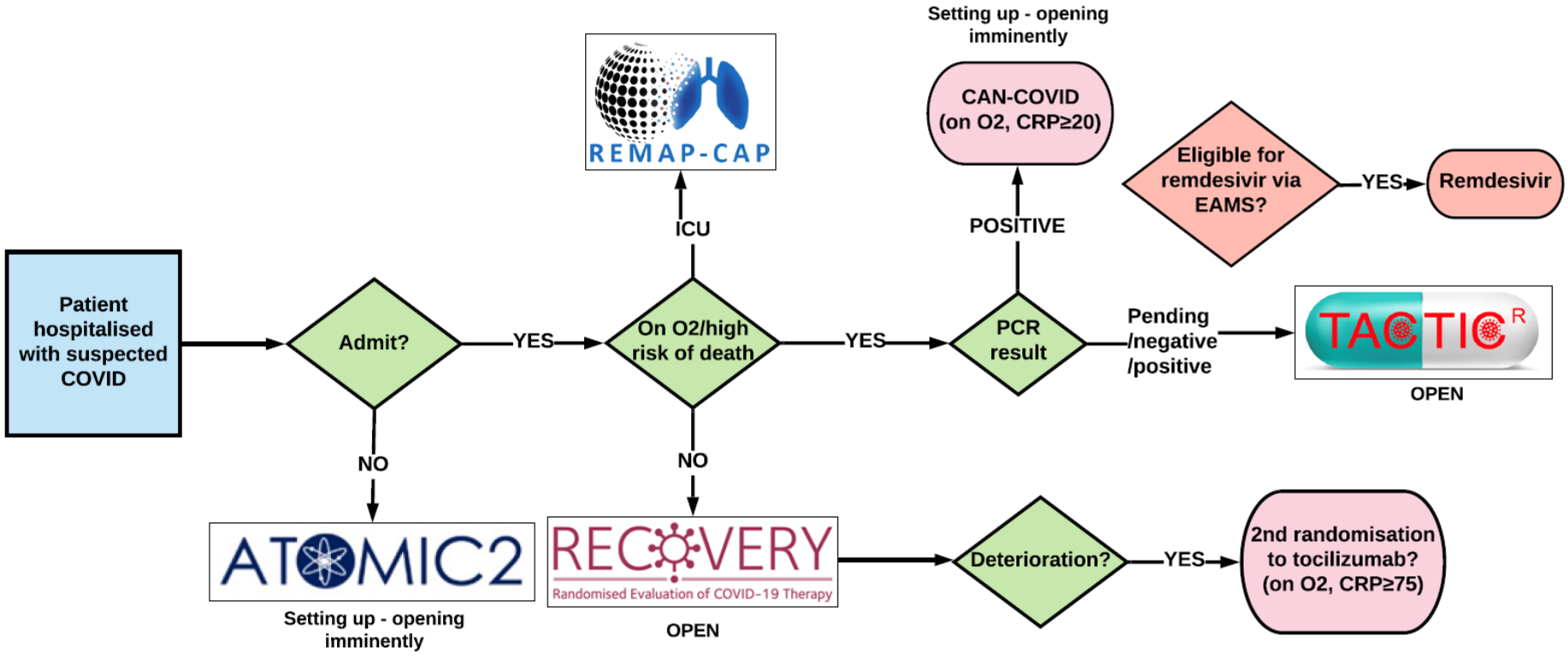
- Teams set up with a coordinated approach for covering UHL, Heulwen/A&E, COVID-19 medical wards and ITU.
- The team, including pharmacist support, had an extensive role in educating the doctors (consultant and juniors), nurses and ward pharmacists who were potentially naïve to research.
- IT solutions 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

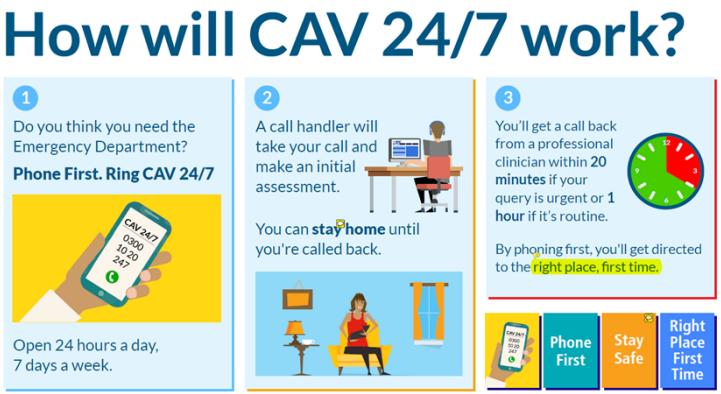


7. PHASE 5 UPDATE - SYSTEM TRANSFORMATION PRIORITIES

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.

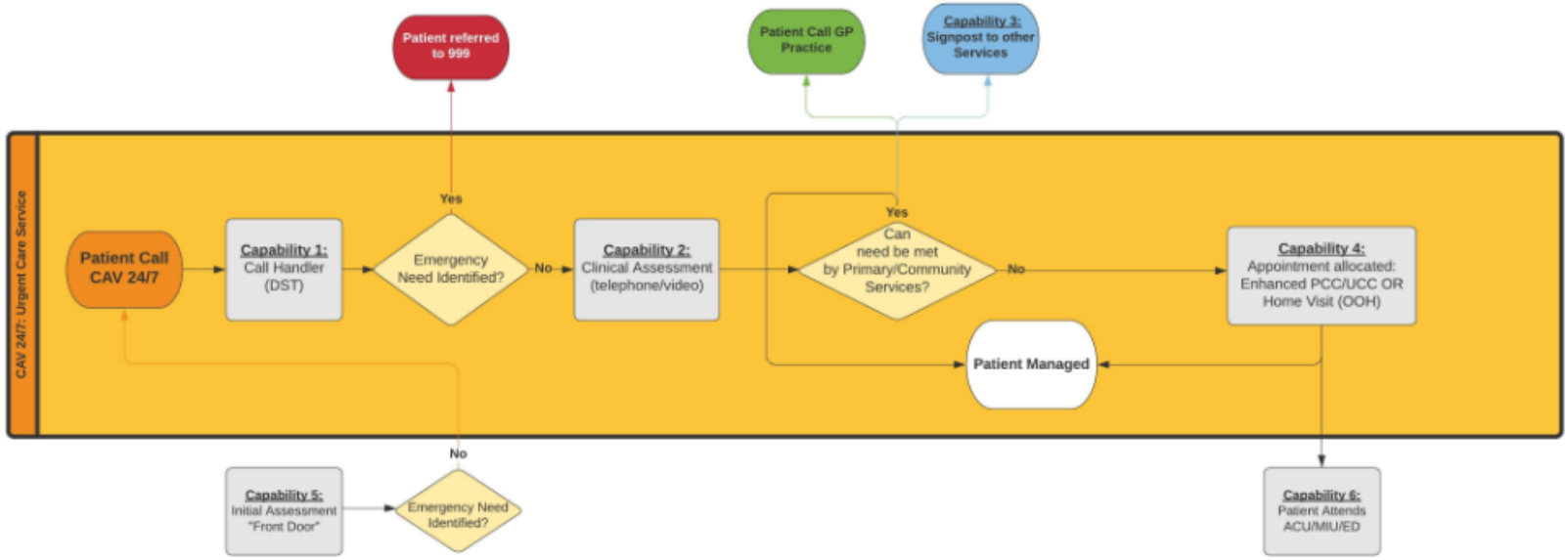
The 24/7 number will:

- 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.



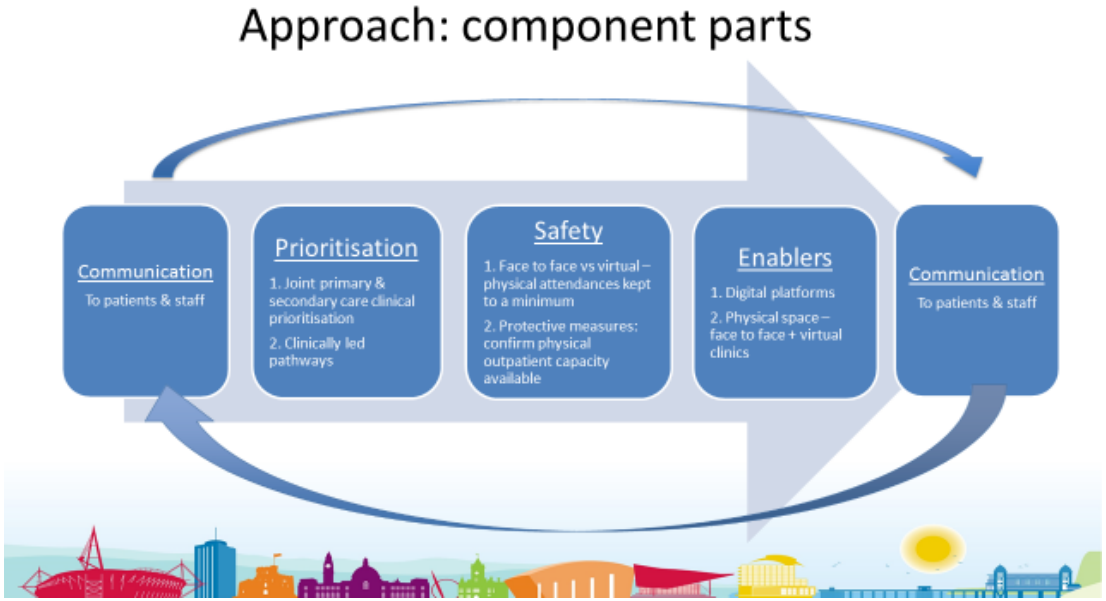
This development is being taken forward as a pathfinder, with action learning built into the approach so that there are key points to pause and learn what changes, if any need, to take place, listening to the feedback from patients and key stakeholders. The methodology will be informed by the learning 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:

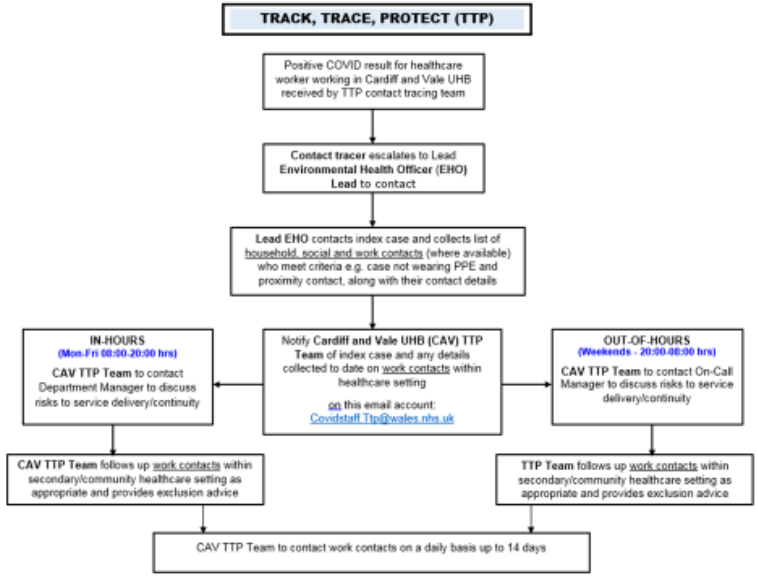
- People Shielding are not off sick
- Managers/Supervisors should fully understand the circumstances of each **individual** in order to establish why they are off and how they can be best supported to undertake work.
    - This is best achieved by completing a risk assessment with the individual
    - 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

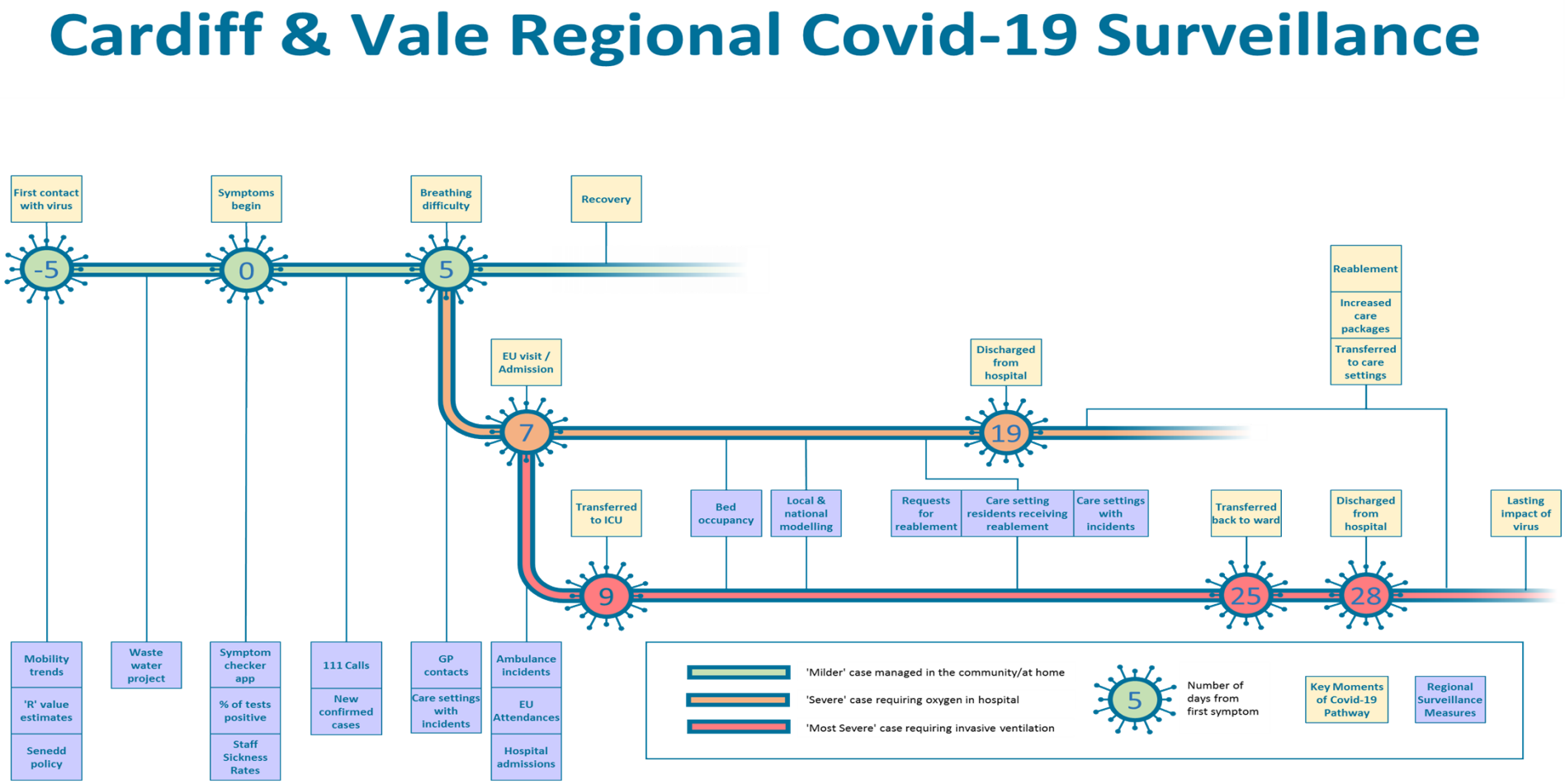
the impact may have been more positive – for example more people taking advantage of exercise outside. Whilst recognising the need to continue to support TTP and manage any localised clusters and incidents, within the Health Board and with our PSB partners we are looking at how we can reprioritise and 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.

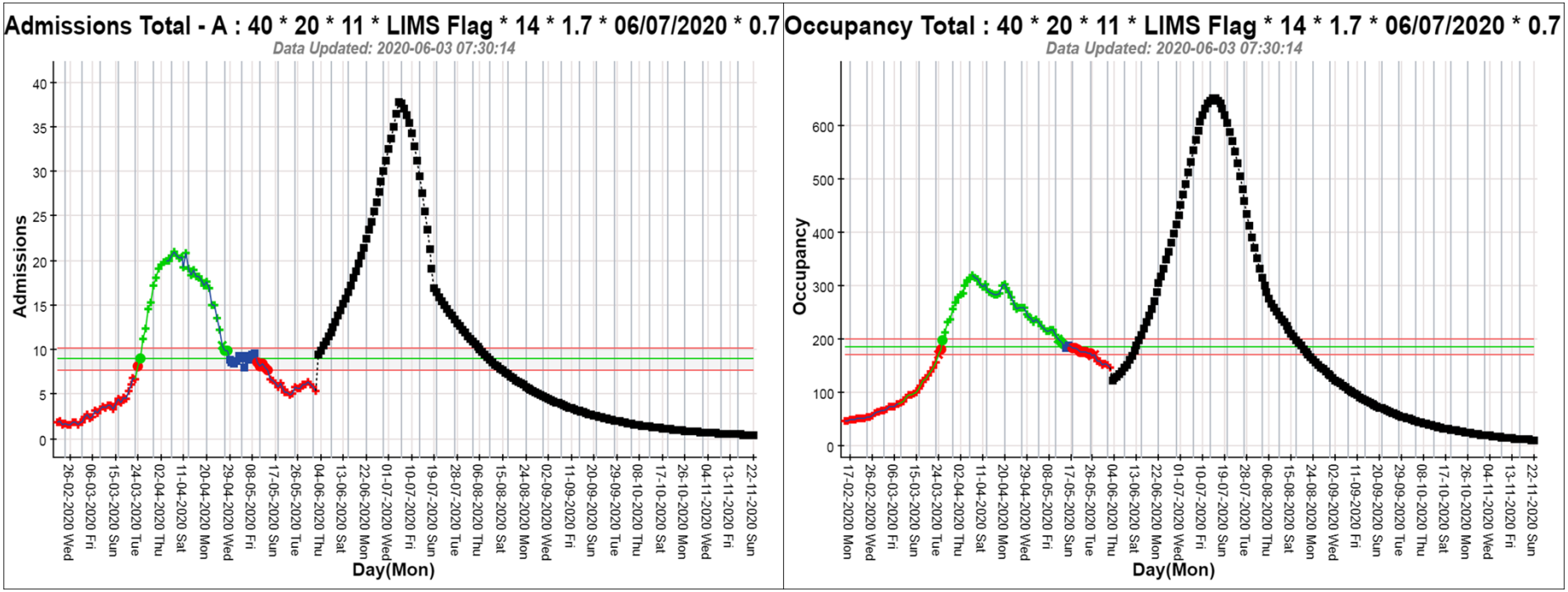
In January our Board signed up to a commitment to tackling climate change and work on developing our sustainability action plan is restarting, recognising the opportunities seen during COVID-19 to work in ways that reduce our carbon footprint. We see this as a key programme of work going forward.

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

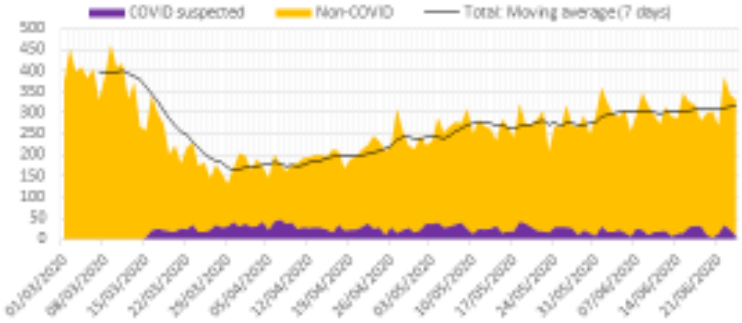
High Level Risk Summary

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*

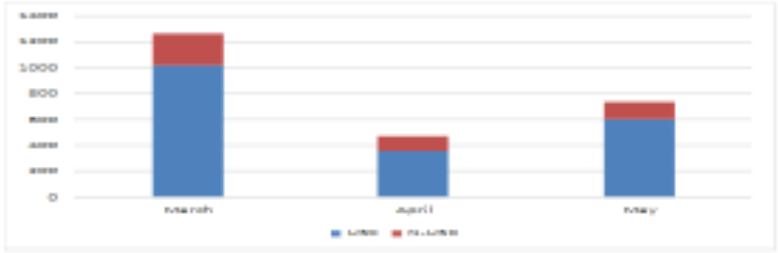
Performance:

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*

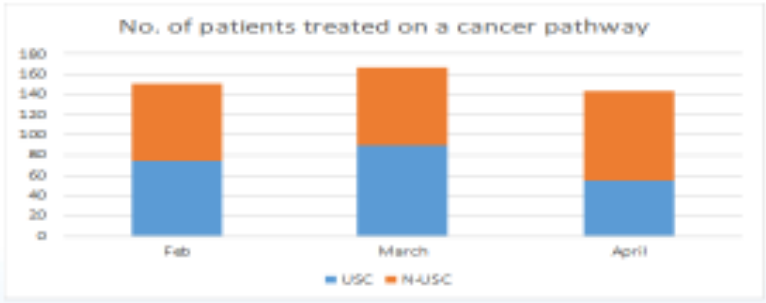
Cancer

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:

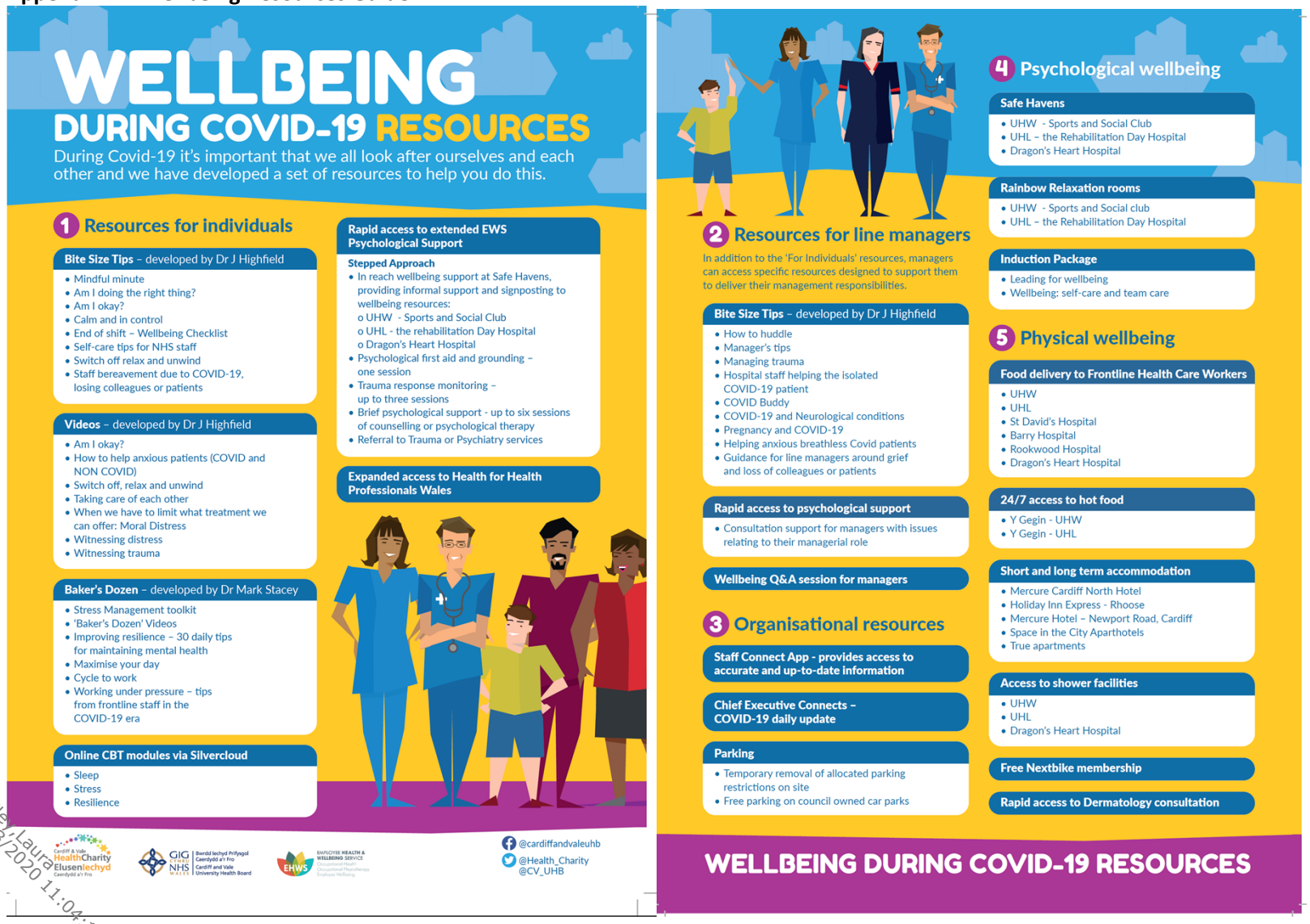
- *Inpatient & daycases fell to 45% of previous levels, now recovering to 50%*
- *Outpatient activity fell to a third of previous levels, now recovering to 50%*

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



Report Title:	Cardiff and Vale University Health Board Research & Development Annual Performance Report 2017-20.						
Meeting:	Strategy & Delivery Committee				**Meeting Date:**	14th July 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**Dr Stuart Walker –Medical Director**						
Report Author (Title):	**Prof Chris Fegan – R&D Director**						

Background and current situation:

As part of CVUHB's R&D Strategy an annual report assessing the R&D performance of Clinical Boards/Directorates and CVUHB as a whole would be provided by the R&D Office. This is the third such report and covers the last 3 years. There have been several major impacts on R&D in the last 12 months notably the passing over of CVUHB's R&D budget to the R&D Director, the establishment of a Research Delivery Management Board (RDMB) to overview the use of the R&D funding, provide strategy and operational oversight of R&D within CVUHB, the ongoing review for changing R&D funding from an Activity Based Funding model to a Needs Based Funding model by Health Care Research Wales and the impact of the Covid pandemic. The overall performance by CVUHB is slightly down on the previous year but there are mitigating circumstances and the overall picture for CVUHB R&D continues to improve.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

1) The establishment of the RDMB has brought about a much more transparent system for knowing where R&D spending occurs which has enabled alignment of strategy and operational delivery in terms of ambition, resources and capability. A new R&D strategy was developed and signed off by CVUHB Executives in December 2019.
2) CVUHB's overall R&D performance in terms of the number of studies open (↓5%) and recruitments (↓14%) is slightly down on the previous year but that is due to 2018-9 being the best recruiting year for 6 years, several very high recruiting studies closed during 2019 and COVID virtually eliminated the month of March in terms of being able to recruit patients to our various studies, virtually all of which had to close to new recruitment. However, across Wales (and the UK) the R&D performance was down almost 30% so relatively CVUHB did well including entering 37% of all patients in Wales into an interventional study.
3) Increased number of commercial studies (up18%) and increased commercial income at £1.7m but we strategically decided to suspend invoicing for commercial work in September 2019 so this figure would have been nearer £2.6m - an increase of almost 50% on the previous year.
4) Although not fully reflected in the R&D Performance Report, CVUHB has been recognized nationally for its performance in Covid trials throughout the pandemic including by being the first in the UK to open the Covid RECOVERY study, making a major contribution to recruitment within that study, being invited to be on the writing group for that study, all of which led the PM to comment on Cardiff's performance at the Downing Street briefing on 16th June.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

Overall the work of the R&D department along with an improving R&D culture within the Clinical Boards/Directorates within CVUHB continues to improve the potential for R&D to play a full and active role in our patient care pathways whenever possible. Obviously there is a lot more to be done but the direction of travel augurs well for the future. Due to the disruption brought by Covid there is a real possibility/probablity that the commercial income generated by R&D in this financial year will be much lower than might otherwise had been but this fall will be off set by the holding back of monies last year by suspending invoicing for commercial work.

Recommendation:
Acceptance of the Report

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	√	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	√
3. All take responsibility for improving our health and wellbeing	√	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	√

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	√	Long term		Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Cardiff and Vale University Health Board

Research & Development Performance Report

2017— 2020

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

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

Contents

Special Acknowledgement from the Medical Director

Professor Christopher Fegan,

In light of Professor Fegan's retirement in December 2020 it is important that this Annual Report acknowledges the significant contribution he has made to Cardiff and Vale University Health Board (CVUHB). It is clear that he has not only made a contribution in his leadership role as Research & Development (R&D) Director but as a researcher in his own right he is highly respected.

He started as R&D Director in 2014. During his time there has been a significant increase in commercial income from research. The total number of research studies increased from 176 in 2016/2017 to 258 in 2018 and over 6,500 participants to research studies in 2018/2019 which was a marked increase from 5,000 in the preceding two years, and the highest for 6 years. Recently he has driven the COVID-19 research agenda tirelessly and worked incredibly long hours to get studies off the ground and been very motivational to those around him.

The Clinical Research Facility has greatly increased its services including overnight stays, development of medical cover and support not only for Phase 1 studies but also Phase 2 and Phase 3 studies. During this time there has also been the development of the Paediatric Clinical Research Facility.

He has driven the transparency of managing the Welsh Government research budget, with the set-up of the Research Delivery Management Board to ensure ownership of the R&D agenda and managed the difficult transition to Activity Based Funding. He successfully managed the integration of the R&D office with the incoming Research Delivery Team following restructure of the R&D Division by Welsh Government, paving the way to develop a vibrant research culture within the UHB.

Finally, he has always ensured patient safety was never compromised by personally overseeing the review of all proposed studies involving UHB patients.

Professor Chris Fegan

Research & Development Director

I started last year's foreword by saying "nothing ever remains the same". What an understatement. Since February 2020, CVUHB and healthcare organisations across the globe have been struggling with the COVID pandemic which has disrupted a lot of what we always took for granted in life; healthcare provision and, of course, research. This is our third annual CVUHB R&D performance report but this year does not contain the individual reports from Clinical Boards/Directorates (such as research income, publications etc.) as preparation of these was completely disrupted by the chaos caused by COVID.

The R&D year started very positively in March 2019 with the CVUHB Executive team passing the responsibility of the management of R&D finances from Clinical Boards/ Directorates to the R&D Director. This was rapidly followed by the setting up of a Research Delivery Management Board (RDMB) whose role was to manage the R&D funding to the maximum benefit of the whole of CVUHB. The RDMB is chaired by the R&D Director with representation from all Clinical Boards through their R&D Leads, alongside the deputy R&D Director and managers from Research Delivery, Performance and R&D Office. The RDMB met monthly for eight months before meeting less frequently and, of course, having its last meeting at the end of February. The RDMB inherited a system where it was very difficult to know exactly what the R&D monies within the various Clinical Boards and Directorates had historically funded and, having identified where the monies were being spent, whether that was the correct and most efficient use of those monies. I would very much like to pass on my personal gratitude to all the members of the RDMB who have always acted most collaboratively and cooperatively in setting about using the R&D budget bestowed upon it, in the most efficient and impactful way. The RDMB embraced the opportunities to move monies across the CVUHB to support active researchers wherever they were, support low recruiting but very specialist areas such as Paediatrics, to undertake more impactful research, employ more staff and ultimately set the agenda for a bigger and stronger research presence at the very core of CVUHB. In total, the RDMB approved the employment of 10 new dedicated research staff across CVUHB. At times these discussions have been difficult but the new transparency within the RDMB has empowered all with a new, more focussed and deliverable R&D strategy being written and subsequently approved by CVUHB Executives at the end of 2019.

Alongside changes within CVUHB, Health and Care Research Wales (HCRW) is itself looking at its funding formula with a move away from the Activity Based Funding model (which CVUHB has always felt discriminated by) to a more needs based approach; albeit very disappointedly CVUHB still received less HCRW R&D funding in 2020 than it did in 2019. However, I remain optimistic that HCRW will support CVUHB in the future through its new funding formula which is being redesigned through 2020-21.

CVUHB's R&D performance, up until the end of February 2020, was overall slightly down on 2018-19 with 5% less non-commercial studies open with recruitment and 14% fewer participants (5389) but that was not a surprise given that 2018-19 had been our best year for recruiting patients for 6 years, several very high recruiting studies closed during 2019 and, of course, COVID virtually eliminated the month of March in terms of being able to recruit patients to our various studies, virtually all of which had to close to new recruitment . In fact, the R&D performance across Wales was down by almost 30% so in relative terms CVUHB performed well. We also still managed to enter 37% of all patients in Wales in to interventional studies and had a record year for commercial income due to opening 18% more commercial studies than the previous year with many studies being more complex with higher remuneration.

However, one has to return to the COVID pandemic. I am very proud of the R&D performance throughout the pandemic; opening 8 CTIMP studies - the first in the UK to open the RECOVERY study to which we are one of the largest UK recruiters with over 180 participants (14th June) - bringing no fewer than 17 therapeutic interventions of potential benefit to patients. The whole of the R&D Office and Delivery staff rose to the challenge of setting up studies in record times and supporting staff – many new to research - in the various COVID areas. I would like to give special praise to the Critical Care team who at the height of the pandemic were entering over 95% of patients into clinical trials, all researchers who had to continue throughout the pandemic to care for all those patients entered into clinical trials and receiving experimental therapies and all the R&D staff who volunteered to be on the COVID front line in, what proved to be, the most difficult of times any researcher will ever have faced.

Key to our success has been collaboration between clinical teams, ward staff and the research team - long may this continue.

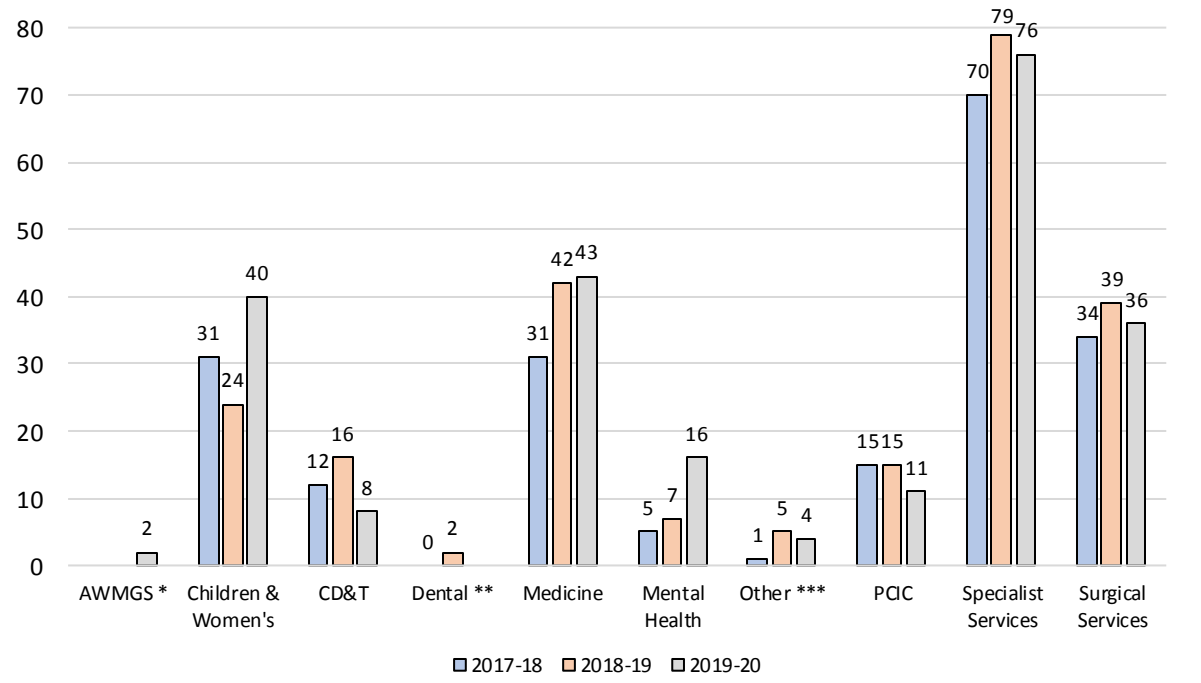
Research and Development Office

The R&D Office is here to provide comprehensive support to the Health Board and is available to all CVUHB researchers and partner organisations. The R&D Office establishment is currently 20.83 whole time equivalents (wte) with 2 wte vacancies. The office is responsible for assessing Capacity and Capability for all research studies, ensuring contractual arrangements are in place, dealing with requests for Health Board sponsorship of research studies and ensuring an adequate level of ongoing governance for all R&D activities involving University Health Board (UHB) resources.

The R&D Office has links with Clinical Boards through the Research Governance Group, Research Delivery Management Board, Directorate R&D Lead meetings, Clinical Board meetings (on request), Clinical Board Performance Review meetings and, through ongoing financial requirements for annual spending plans, financial returns and grant applications. The Capacity and Capability Assessments of individual research projects also require Clinical Board input and liaison.

In 2019-20 the R&D office registered 236 new projects, processed 555 project amendments, dealt with 109 grant applications, executed 401 contracts, reviewed and drafted 67 R&D related controlled documents, undertook 1 audit and coordinated 100 CTIMP self-audits, opened 4 UHB sponsored projects and raised 540 debtor requests to the value of over £1.76 million.

Figure 1 - Number of projects registered with Research & Development by Clinical Board (2017-18, 2018-19 & 2019-20)



Notes

** AWMGS: The All Wales Medical Genomics Service was created as a standalone Clinical Board in 2019/20. Prior to this, Clinical Genetics was a Directorate within Specialist Services.*

*** Dental: Prior to 2019/20 Dental Services was a Clinical Board, but has now been incorporated into Surgical Services. There were no Dental projects in 2019-20 – future projects will be included with Surgical Services.*

**** Other: These projects are organisation-wide or span multiple Clinical Boards.*

Research Education & Training Annual Report

The priorities for the Research Education & Training programme for 2019-2020 were based on staff feedback during the previous year; consultation with Senior Management and reported trends in protocol deviations or breaches of GCP. During Quarters 1-3 in 2019-2020, 108 training sessions were provided for 450 people by research delivery teams. Sessions covered clinical skills, research and trial specific topics, use of systems, student placements, new staff teaching and individual 1:1 sessions with staff. During the year 17 training sessions were cancelled because of low or no bookings, or availability of a presenter. Three sessions in the training programme were cancelled due to COVID-19 restrictions.

During Quarter 4 (January – March 2020) due to the COVID-19 pandemic, training was cancelled and non-COVID research halted to make way for emergency clinical research. Metrics for training were not recorded at this time, however it is recognised that all research delivery staff were involved in providing daily training on clinical research and specific clinical trials to enable fast and efficient delivery of Covid-19 studies. This included clinical skills for research staff to be able to deliver new research protocols; general research training for clinical staff in all areas of CVUHB across 2 hospital sites; and daily teaching on specific research studies to enable clinical staff in COVID areas to identify, consent and treat patients, and to keep up to date with rapid protocol amendments.

Given the ongoing pandemic and social distancing restrictions online training resources including Good Clinical Practice training are available on the Health and Care Research Wales website.

For more information on research training please contact: Researchtraining.CAV@wales.nhs.uk

- Figure 1 shows the number of training events that have taken place between April 2019-March 2020 and the number of attendees per quarter.
- Figure 2 indicates the breakdown of sessions and attendees.
- Figure 3 provides a description of sessions attended.

Figure 1 - Education & Training Metrics (2019-2020)

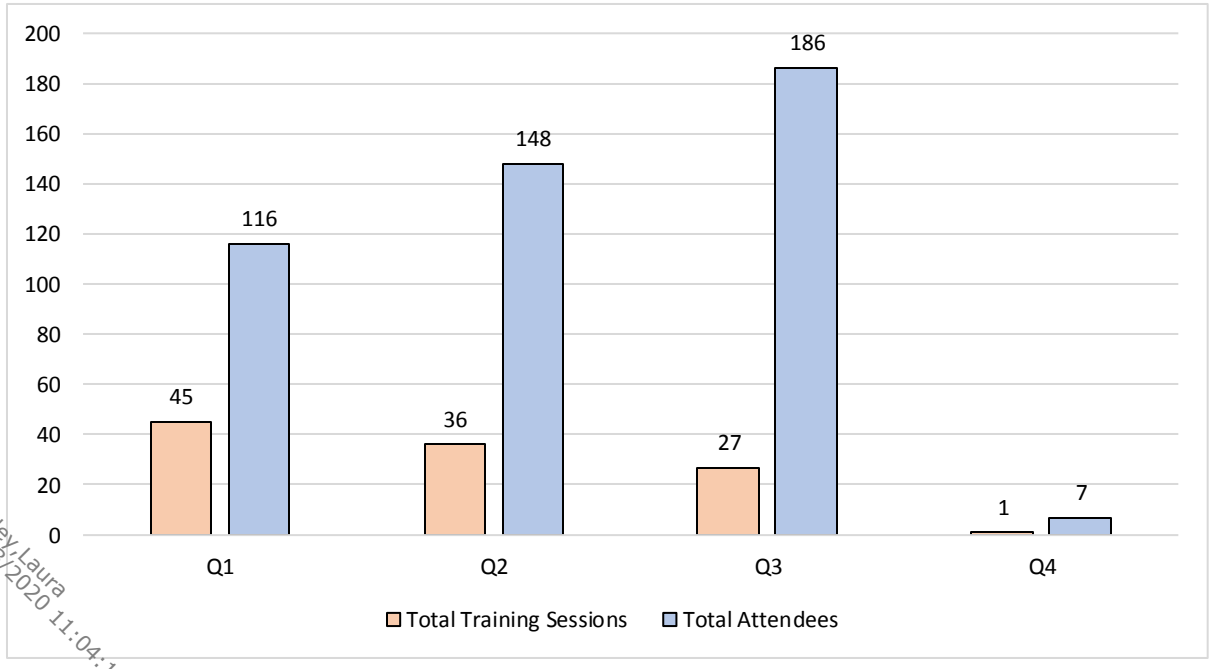


Figure 2 - Breakdown of Sessions and Attendees (2019-2020)

	Q1		Q2		Q3		Q4	
	Sessions	**Attendees**	**Sessions**	**Attendees**	**Sessions**	**Attendees**	**Sessions**	**Attendees**
Clinical Skills	6	12	5	5	1	UNK	-	-
Research Specific	9	74	10	115	14	160	1	7
Trial Specific	-	-	2	9	5	17 +	-	-
1:1	2	2	2	2	-	-	-	-
New Staff	2	2	2	2	1	3	-	-
Systems Specific	20	20	15	15	5	5	-	-
Students	6	6	-	-	1	1	-	-
Total	**45**	**116**	**36**	**148**	**27**	**186**	**1**	**7**

Figure 3 - Description of Sessions

Clinical Skills	BLS, medicines management, venepuncture supervision, assessment and practice sessions.
Research Specific	Lunch & Learn, research processes, abstract writing, conference & external presentations.
Trial Specific	Teaching on new disease areas, care pathways or procedures related to clinical trials
1:1	1:1 informal teaching and coaching sessions.
New Staff	Introduction to R&D and induction sessions.
Systems Specific	Local portfolio management system (LPMS)
Students	Placement week, short visits and teaching sessions for undergraduate students.

The Research & Development Research Delivery Team

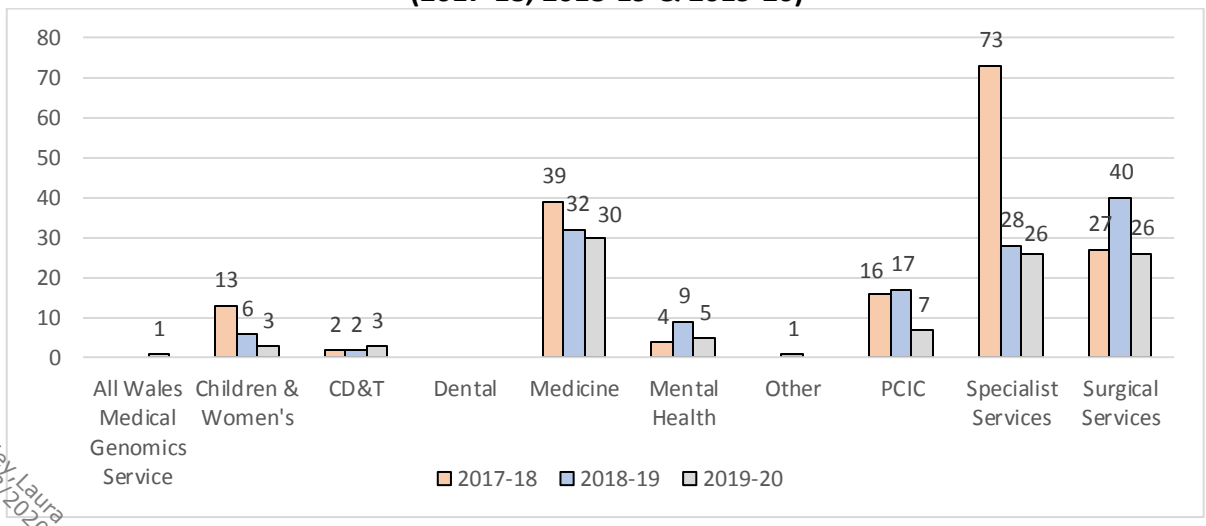
The CVUHB Research Delivery Team (RDT) consists of 53 wte's in a variety of roles including Senior Research Managers, Senior Research Nurses, Research Nurses, Senior Research Officers, Research Officers and Administrators. The team are able to provide expert knowledge in governance as well as regulatory and legal requirements when conducting a study within the UHB. They are able to assist with all elements of a research study from approvals through to screening, recruitment, follow up and archiving. The RDT is able to provide assistance with research specific clinics and clinical space in which to conduct patient visits, assessments or treatments within the Clinical Research Facility (CRF) at UHW. The team has been set up to support a diverse portfolio of studies from intensive Phase 1 studies to large scale 'real world' studies.

At the beginning of March this year, we could not have conceived how many COVID-19 studies would be coming to our door on a daily basis and the speed of study set-up. The RDT found themselves in the unprecedented position of research being at the forefront of all clinical staff within CVUHB, with a united aim to ensure as many patients as possible were offered treatment choices through research. The clinical teams were supported by the RDT and vice versa to achieve this important goal. To enable CVUHB to achieve this and meet the demands of the service the RDT went from a 5 day to a 7 day service virtually overnight. The decision was made by the Senior Management Team to open UHL as an active COVID-19 research location developing a small team based at UHL to enable patients to access research at both locations. Moving forward we are currently seeking office space for a more substantial research presence in UHL.

There will be many lessons learnt from the experience of staff during this period and the research team have risen to the challenge of adapting practices to meet the needs of the service and we would like to thank all for their commitment and hard work during this period.

There are more challenges ahead of us as we become operational, opening to recruitment in other areas with COVID-19 studies still in place, however we are confident that the Research Delivery Team will be able to manage this with a pragmatic approach.

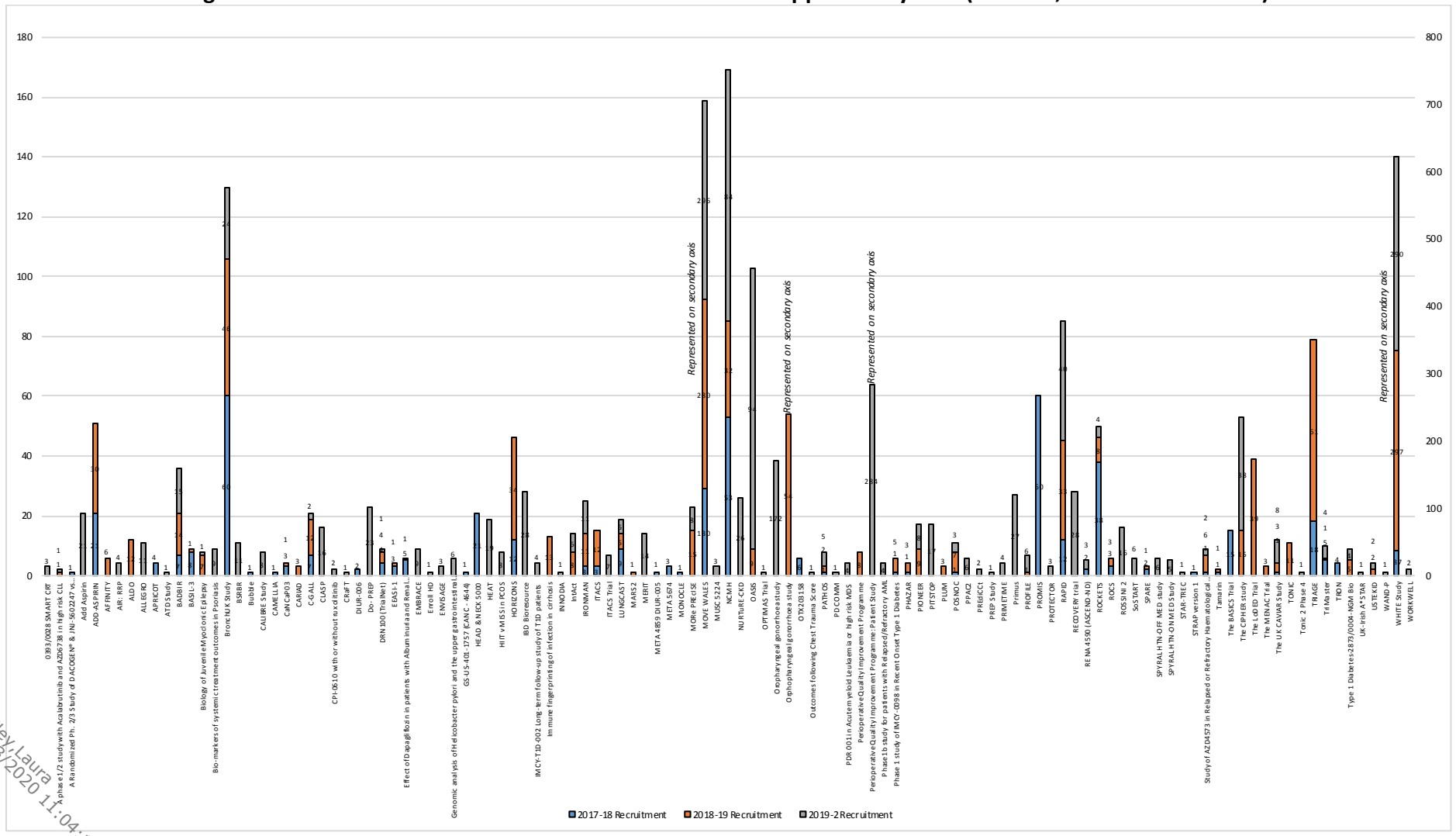
Figure 1 - Number of Non-Commercial & Commercial Studies Supported by the RDT (2017-18, 2018-19 & 2019-20)



Dental Services included under Surgery from 2019-20 onwards. Genetic studies no longer included under Specialist Services from 2019-20 onwards.

Overview of Research and Development

Figure 2 - Non-Commercial & Commercial Recruitment Supported by RDT (2017-18, 2018-19 & 2019-20)



AMAROS, MOVE WALES, NCMH, ADD-ASPIRIN & WHITE recruitment only partly supported/ facilitated by the Research Delivery Team.

Recruitment Trend Line Charts

2018-19 & 2019-20 data includes Commercial as well as Non-Commercial data

Figure 1 - CVUHB Non-Commercial Studies with Recruitment (2017-18)

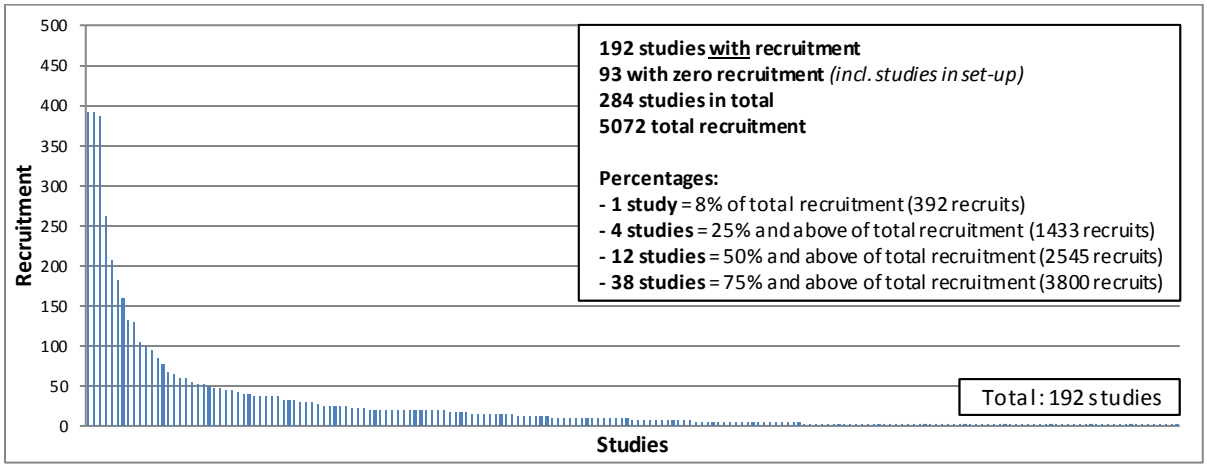


Figure 2 - CVUHB Non-Commercial & Commercial Studies with Recruitment (2018-19)

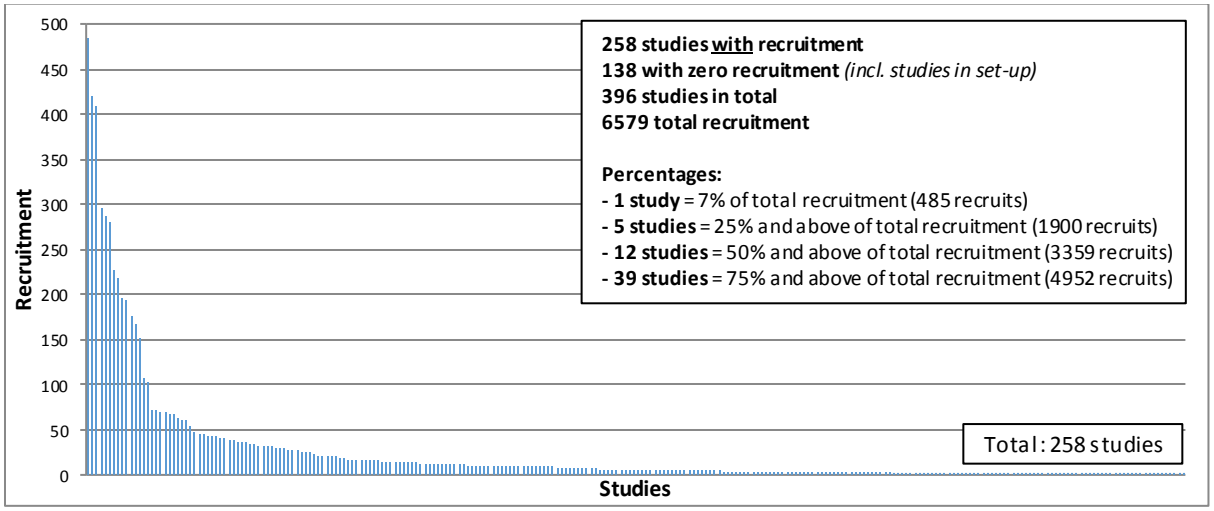
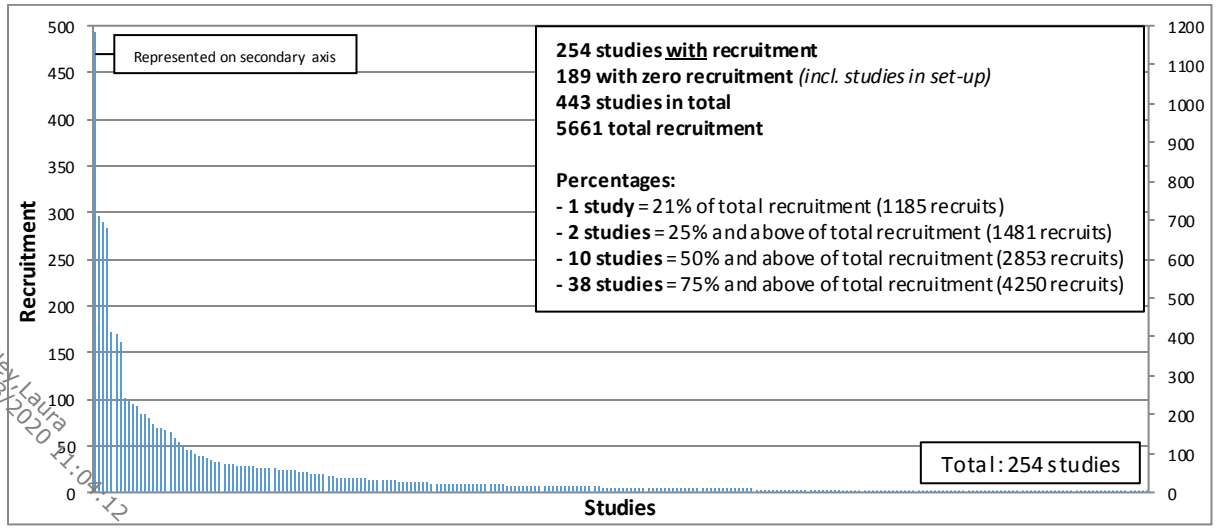


Figure 3 - CVUHB Non-Commercial & Commercial Studies with Recruitment (2019-20)



2017-18

Figure 1 - Non-Commercial Recruitment by Clinical Board **(2017-18)**

Clinical Board	No. of Studies with Recruitment	% of Total CVUHB Studies with Recruitment	Total Recruitment	% of Total CVUHB Recruitment	No. of studies with zero recruits*	Total no. of studies	% of Total CVUHB Studies	*Interventional*		*Observational*	
								No. of Interventional Studies with recruitment	*Total Interventional Recruitment*	*No. of Observational Studies with recruitment*	*Total Observational Recruitment*
Children & Women's	28	15	**1381**	27	13	**41**	15	*20*	*911*	*8*	*470*
Clinical Diagnostics & Therapeutics	6	3	**119**	2	5	**11**	4	*1*	*8*	*5*	*111*
Dental Services	2	1	**411**	8	0	**2**	1	*1*	*392*	*1*	*19*
Medicine	28	15	**357**	7	12	**40**	15	*14*	*146*	*14*	*211*
Mental Health	9	5	**163**	3	6	**15**	5	*3*	*22*	*6*	*141*
Other - Directorate Split	2	1	**16**	0	1	**3**	1	*0*	*0*	*2*	*16*
Primary, Community & Intermediate Care	11	6	**264**	5	5	**15**	5	*8*	*234*	*3*	*30*
Specialist Services	68	35	**1284**	25	31	**99**	36	*35*	*399*	*33*	*885*
Surgical Services	38	20	**1077**	21	10	**48**	18	*20*	*444*	*18*	*633*
	192		**5072**		**83**	**274**		***102***	***2556***	***90***	***2516***

Narrative:
*10 studies with zero recruitment were in set-up during Q4 of this financial year - *these studies are not included above nor in the clinical board charts.*
34 studies with zero recruitment were closed, suspended or abandoned during Q4 of this finanical year.

2018-19

Figure 2 - Non-Commercial and Commercial Recruitment by Clinical Board **(2018-19)**

Clinical Board	No. of Studies with Recruitment	% of Total CVUHB Studies with Recruitment	Total Recruitment	% of Total CVUHB Recruitment	No. of studies with zero recruits*	Total no. of studies	% of Total CVUHB Studies	*Interventional*		*Observational*	
								No. of Interventional Studies with recruitment	*Total Interventional Recruitment*	*No. of Observational Studies with recruitment*	*Total Observational Recruitment*
Children & Women's	26	10	**1327**	20	23	**49**	13	*18*	*893*	*8*	*434*
Clinical Diagnostics & Therapeutics	12	5	**198**	3	6	**18**	5	*3*	*19*	*9*	*179*
Dental Services	1	0	**409**	6	1	**2**	1	*1*	*409*	*0*	*0*
Medicine	41	16	**684**	10	19	**60**	16	*22*	*197*	*19*	*487*
Mental Health	6	2	**89**	1	3	**9**	2	*2*	*38*	*4*	*51*
Other - Directorate Split	4	2	**45**	1	0	**4**	1	*2*	*7*	*2*	*38*
Primary, Community & Intermediate Care	17	7	**258**	4	7	**24**	6	*12*	*177*	*5*	*81*
Specialist Services	105	41	**2076**	32	48	**153**	40	*54*	*326*	*51*	*1750*
Surgical Services	46	18	**1493**	23	16	**62**	16	*30*	*350*	*16*	*1143*
	258		**6579**		**123**	**381**		***144***	***2416***	***114***	***4163***

Narrative:
*15 studies with zero recruitment were in set-up during Q4 of this financial year - *these studies are not included above nor in the clinical board charts.*
62 studies with zero recruitment were closed, suspended or abandoned during Q4 of this finanical year.

2019-20

Figure 3 - Non-Commercial and Commercial Recruitment by Clinical Board **(2019-20)**

Clinical Board	No. of Studies with Recruitment	% of Total CVUHB Studies with Recruitment	Total Recruitment	% of Total CVUHB Recruitment	No. of studies with zero recruits*	Total no. of studies	% of Total CVUHB Studies	*Interventional*		*Observational*	
								No. of Interventional Studies with recruitment	*Total Interventional Recruitment*	*No. of Observational Studies with recruitment*	*Total Observational Recruitment*
All Wales Medical Genomics Service	7	3	**69**	1	18	**25**	6	*0*	*0*	*7*	*69*
Children & Women's	29	11	**1608**	28	30	**59**	14	*19*	*369*	*10*	*1239*
Clinical Diagnostics & Therapeutics	8	3	**154**	3	7	**15**	4	*3*	*65*	*5*	*89*
Medicine	48	19	**542**	10	23	**71**	17	*19*	*139*	*29*	*403*
Mental Health	8	3	**172**	3	2	**10**	2	*2*	*50*	*6*	*122*
Other - Directorate Split	1	0	**5**	0	2	**3**	1	*1*	*5*	*0*	*0*
Primary, Community & Intermediate Care	11	4	**295**	5	9	**20**	5	*6*	*79*	*5*	*216*
Specialist Services	95	37	**1383**	24	57	**152**	36	*58*	*349*	*37*	*1034*
Surgical Services	47	19	**1433**	25	25	**72**	17	*31*	*520*	*16*	*913*
	254		**5661**		**173**	**427**		***139***	***1576***	***115***	***4085***

Narrative:
16 studies with zero recruitment were in set-up during Q4 of this financial year - *these studies are not included above nor in the clinical board charts.
71 studies with zero recruitment were closed, suspended or abandoned during Q4 of this finanical year.

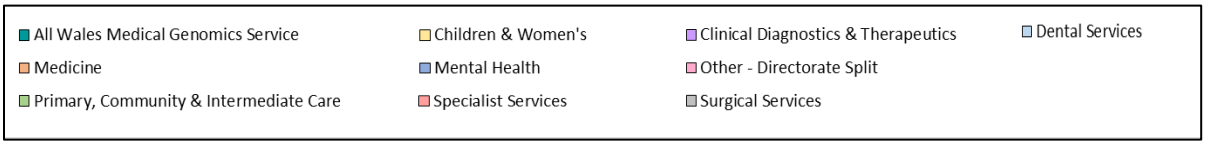


Figure 4-Number of Non-Commercial Studies with Recruitment by Clinical Board (2017-18)

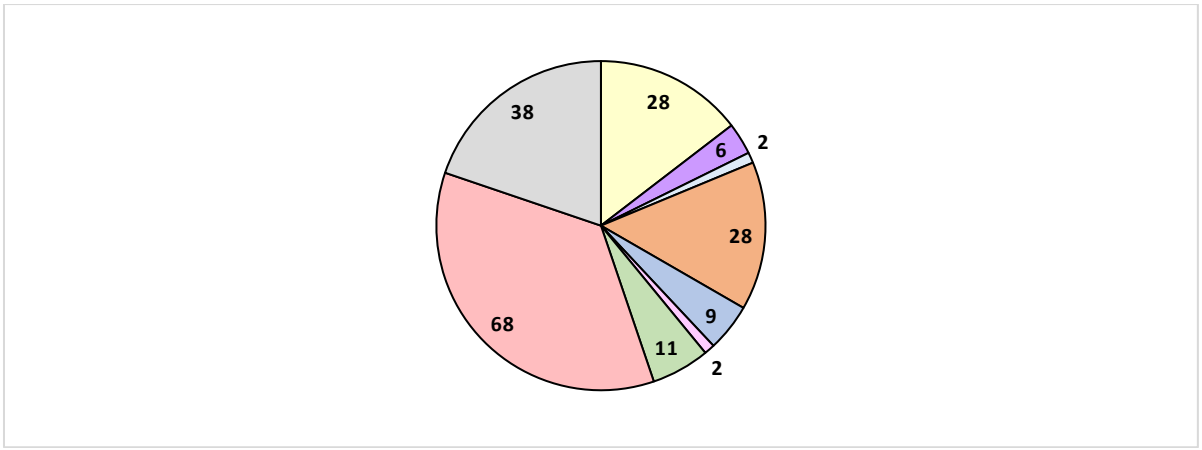


Figure 5 -Number of Non-Commercial and Commercial Studies with Recruitment by Clinical Board (2018-19)

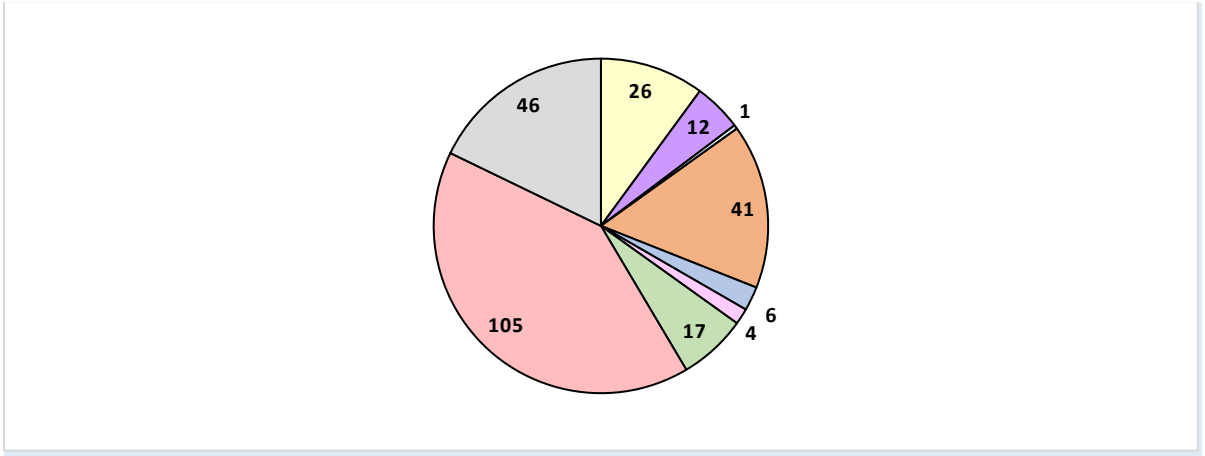


Figure 6 -Number of Non-Commercial and Commercial Studies with Recruitment by Clinical Board (2019-20)

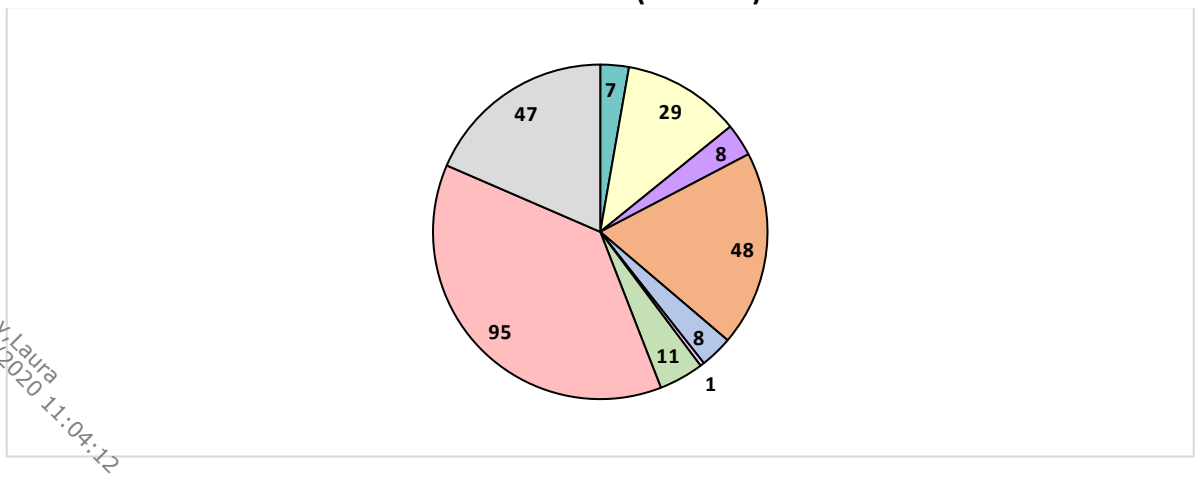


Figure 7 - Number of Non-Commercial Interventional and Observational Studies with Recruitment by Clinical Board (2017-18)

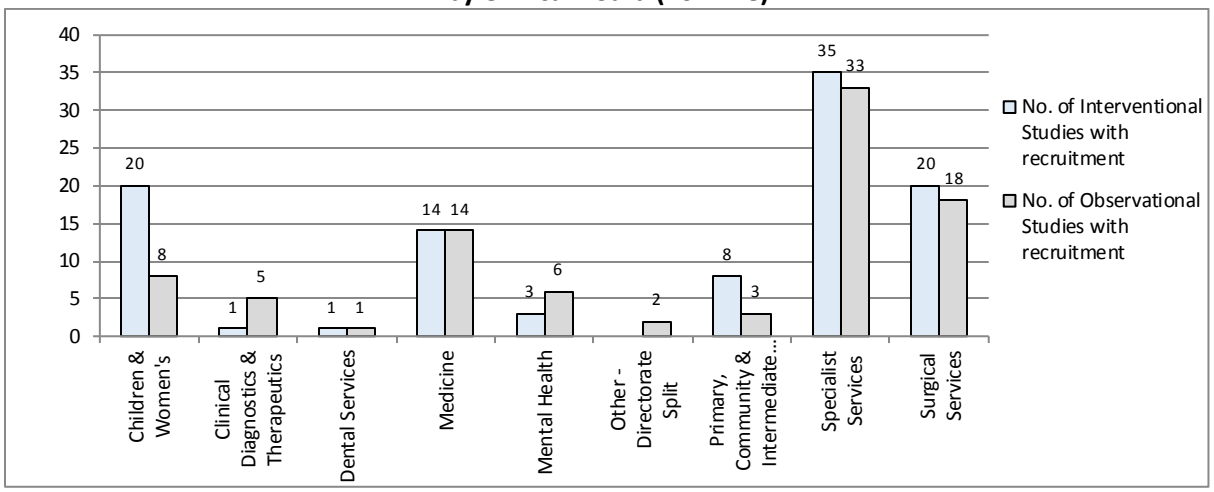


Figure 8 - Number of Non-Commercial and Commercial Interventional and Observational Studies with Recruitment by Clinical Board (2018-19)

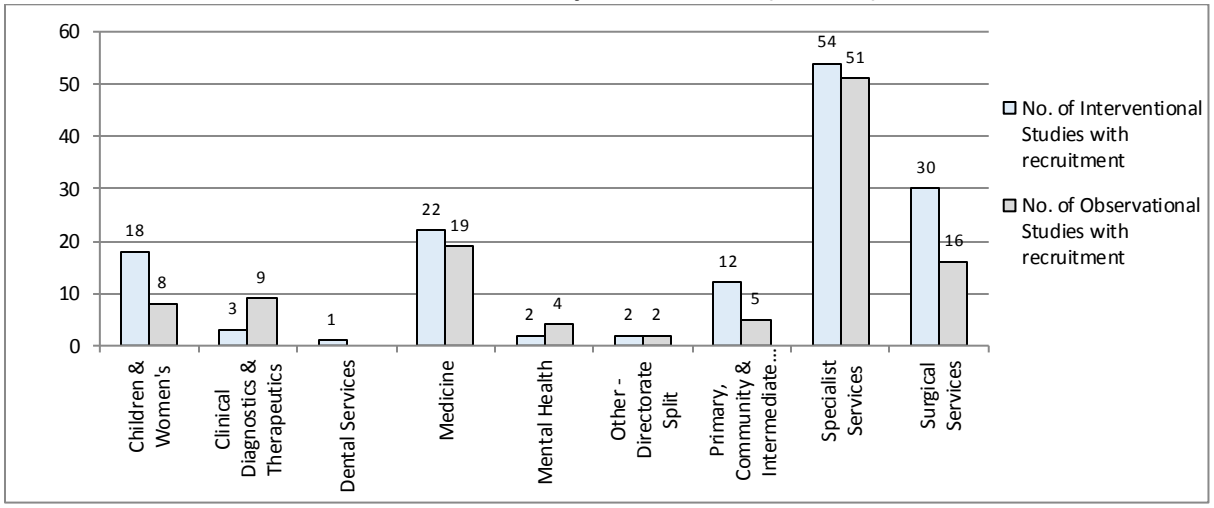
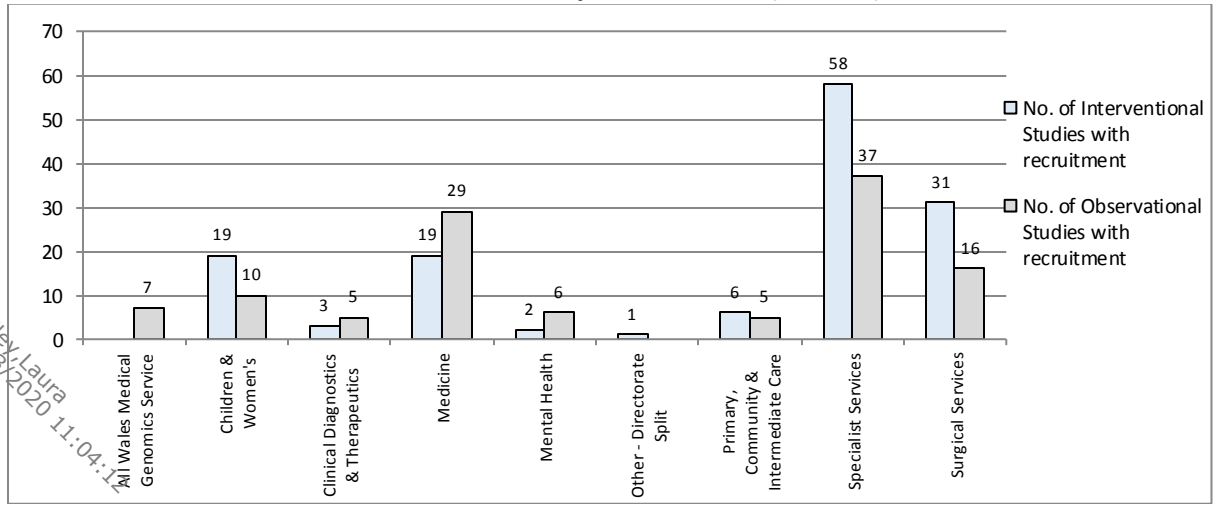


Figure 9 - Number of Non-Commercial and Commercial Interventional and Observational Studies with Recruitment by Clinical Board (2019-20)



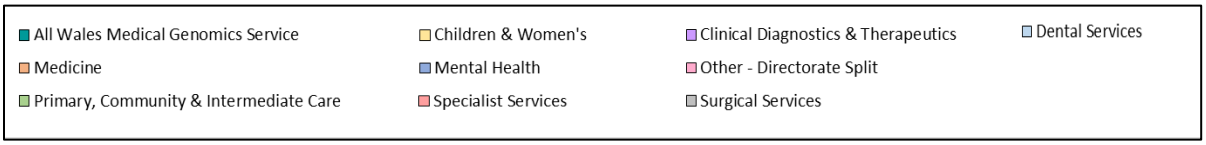


Figure 10 - Total Non-Commercial Recruitment by Clinical Board (2017-18)

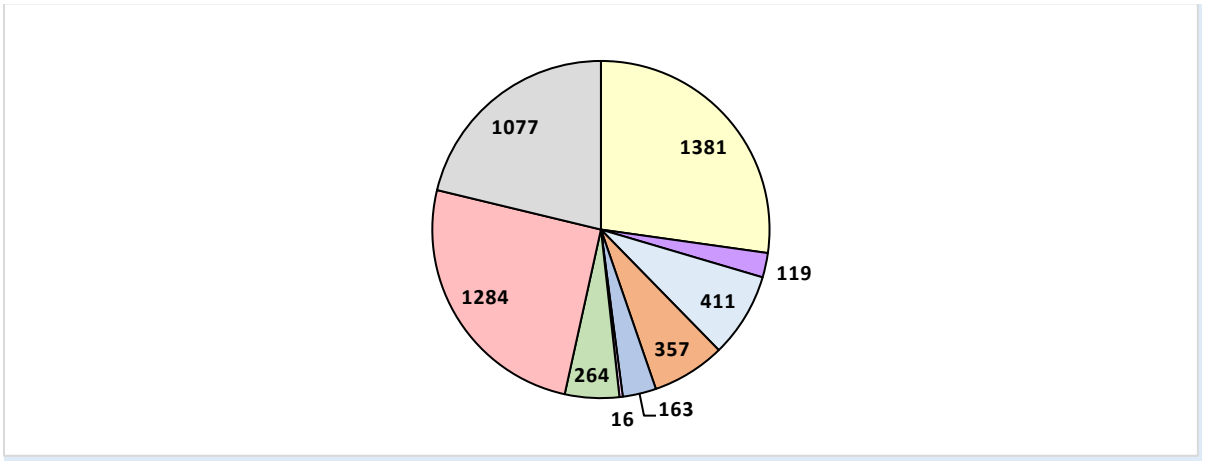


Figure 11 -Total Non-Commercial and Commercial Recruitment by Clinical Board (2018-19)

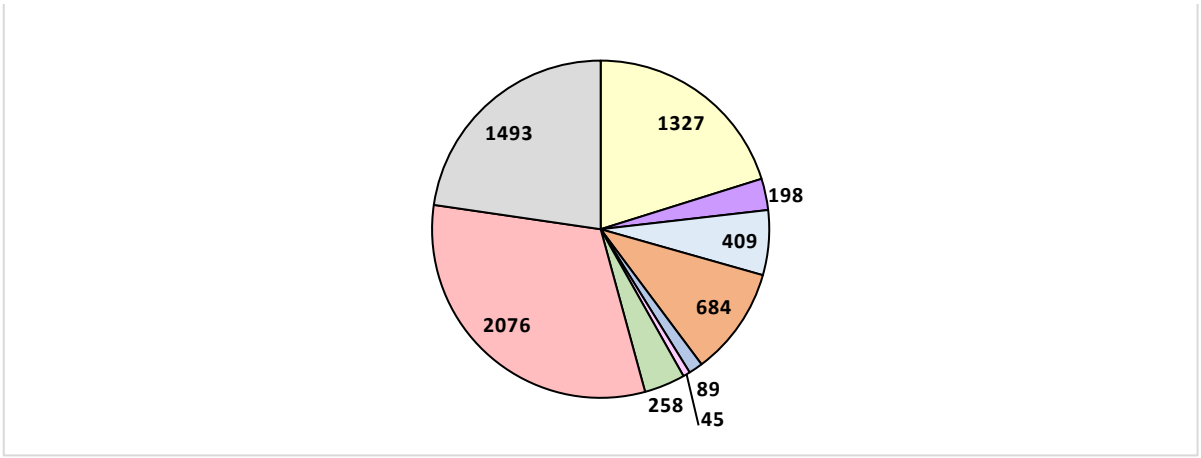


Figure 12 -Total Non-Commercial and Commercial Recruitment by Clinical Board (2019-20)

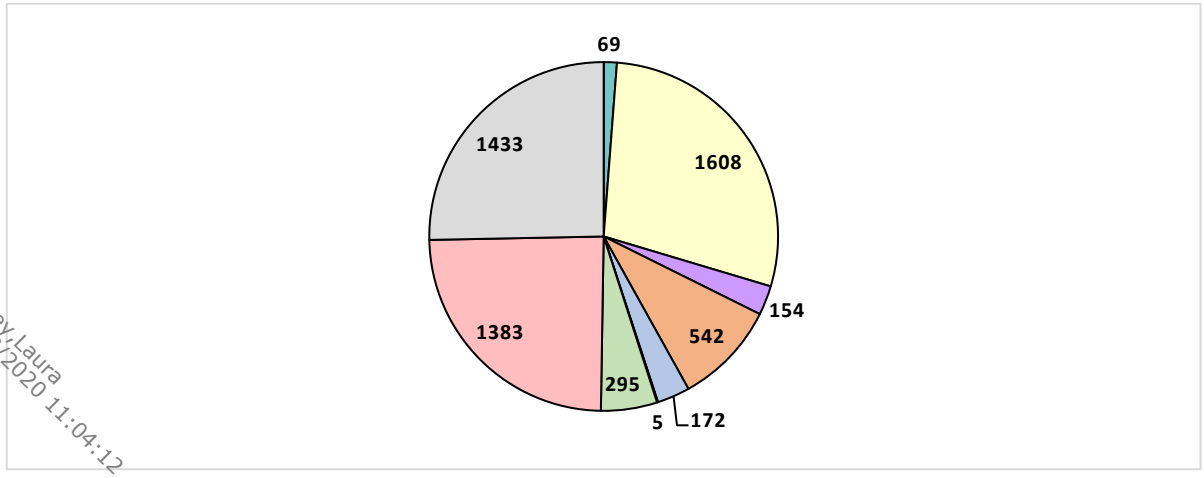


Figure 13 - Total Non-Commercial Interventional and Observational Recruitment by Clinical Board (2017-18)

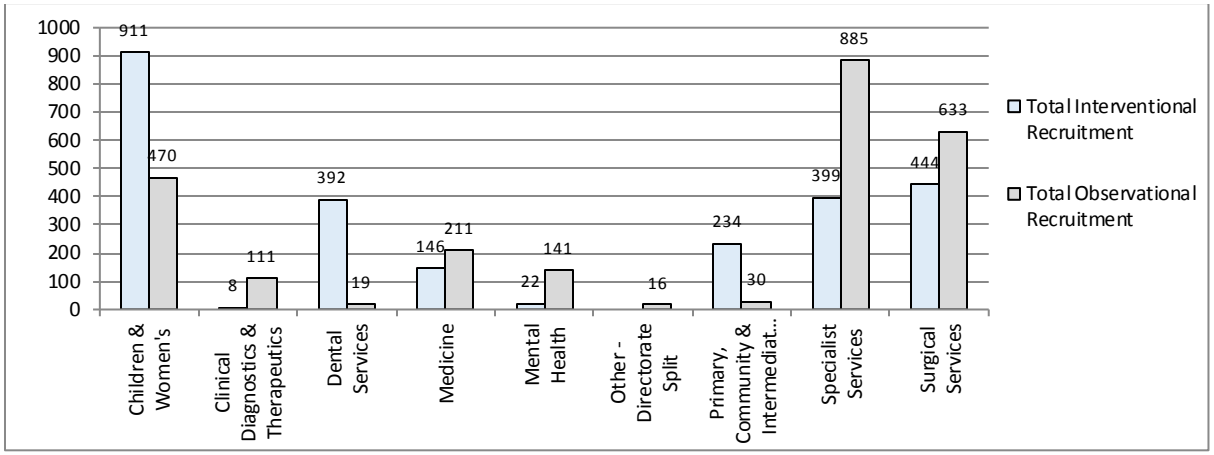


Figure 14 - Total Non-Commercial and Commercial Interventional and Observational Recruitment by Clinical Board (2018-19)

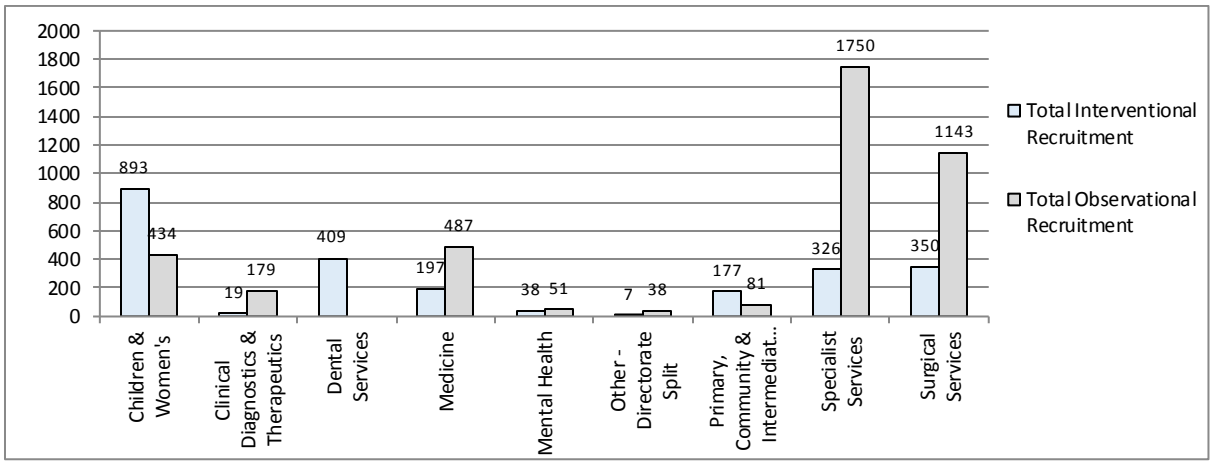
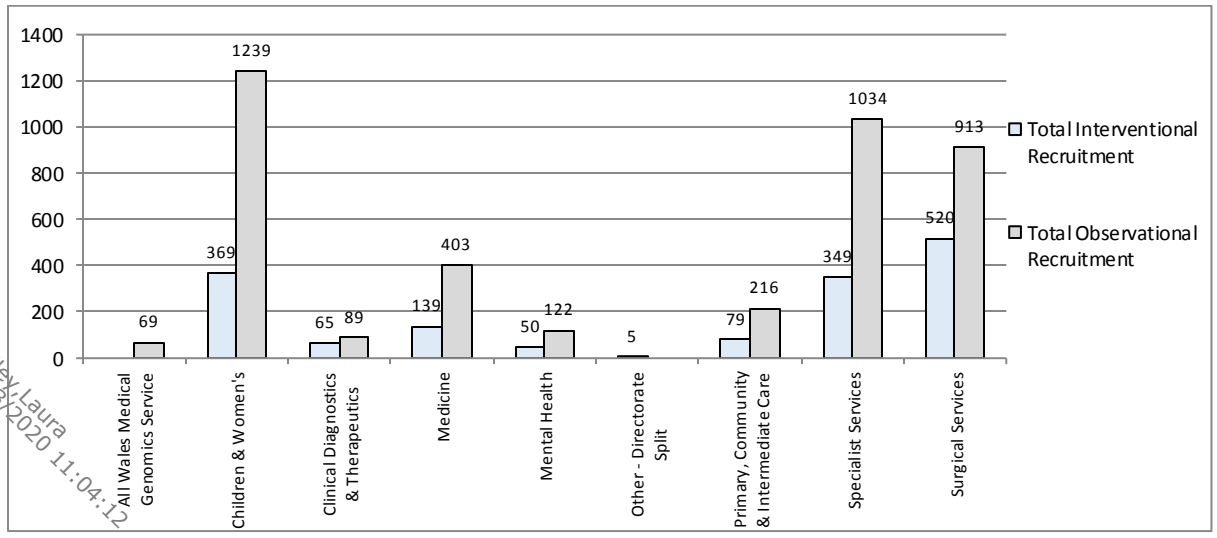


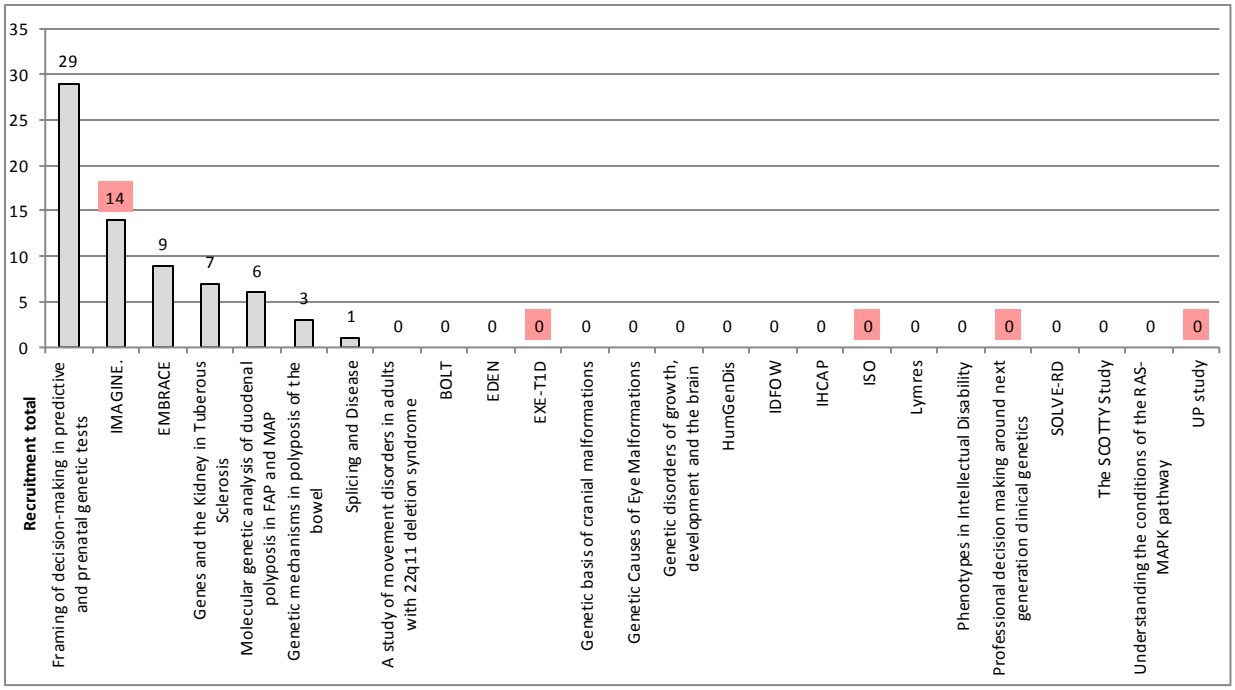
Figure 15 - Total Non-Commercial and Commercial Interventional and Observational Recruitment by Clinical Board (2019-20)



: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

All Previous* Medical Genomics Service *data (pre. fy 2019-20) is represented under Specialist Services Clinical Board

Figure 1 – All Wales Medical Genomics Service Clinical Board Non-Commercial Recruitment (2019-20)



No All Wales Medical Genomics Service 2019-20 Commercial Studies

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Children & Women's Clinical Board Non-Commercial Recruitment (2017-18)

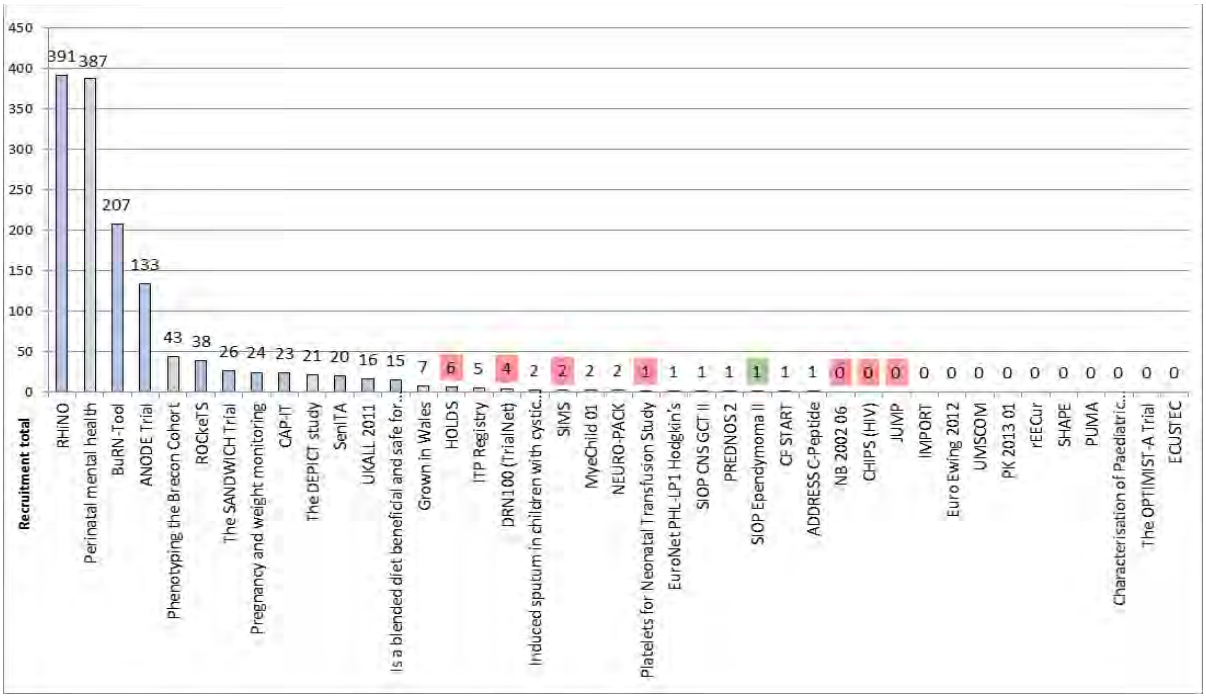


Figure 2 - Children & Women's Clinical Board Non-Commercial Recruitment (2018-19)

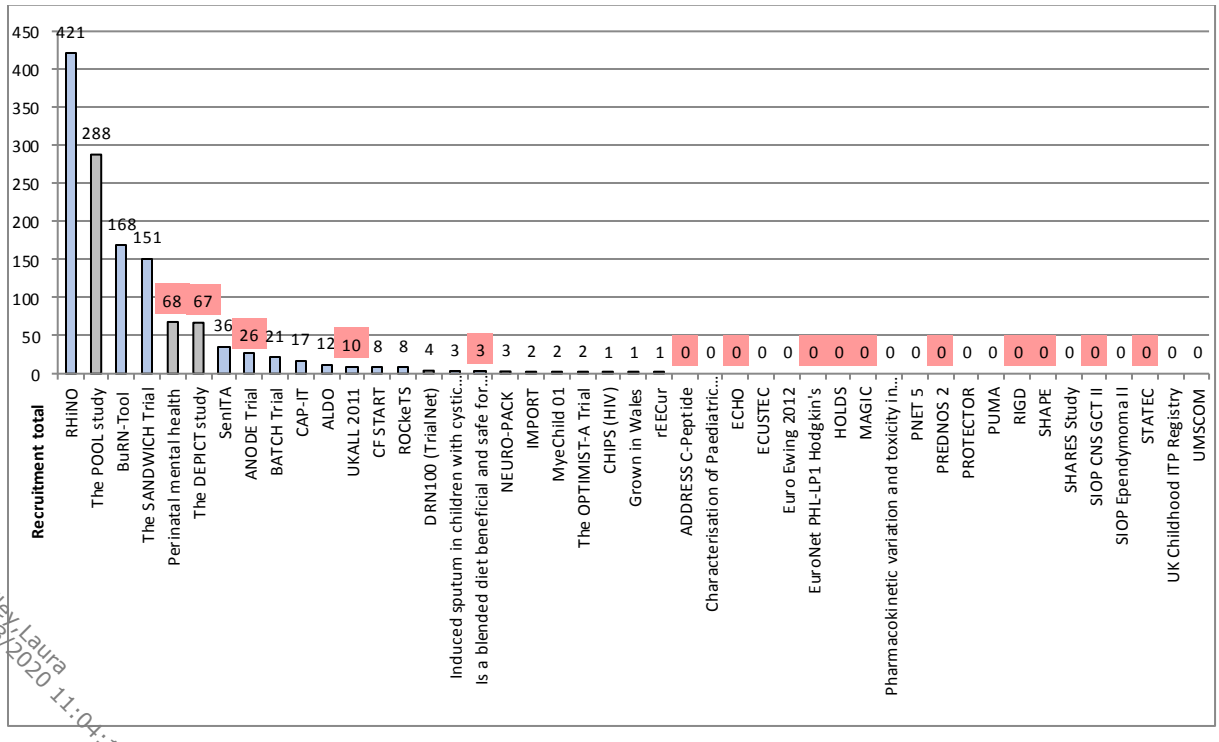


Figure 3 - Children & Women's Clinical Board Non-Commercial Recruitment (2019-20)

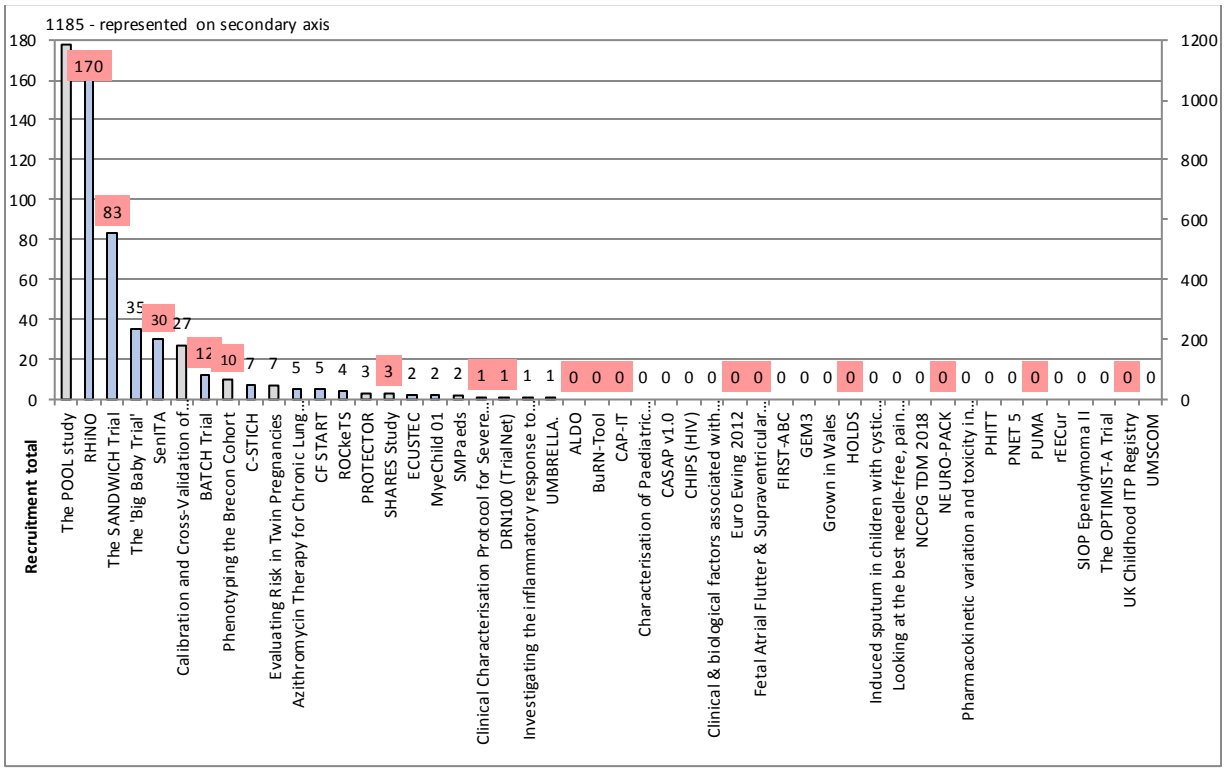


Figure 4 - Children & Women's Clinical Board Commercial Recruitment (2018-19)

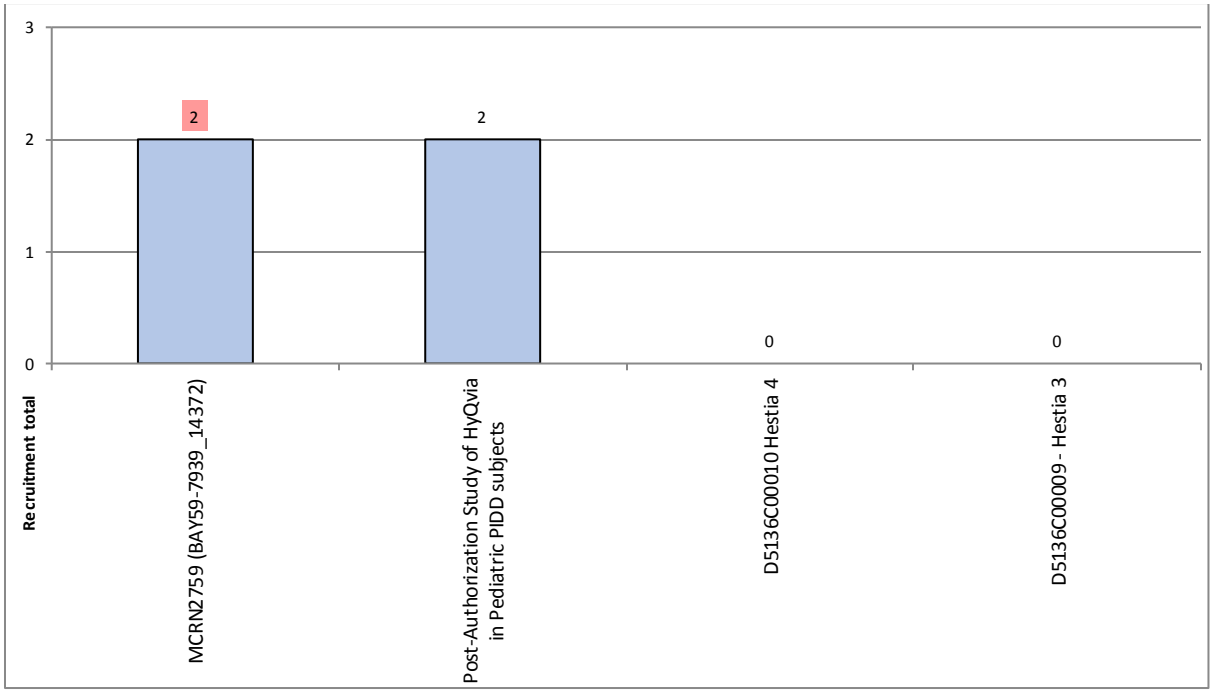
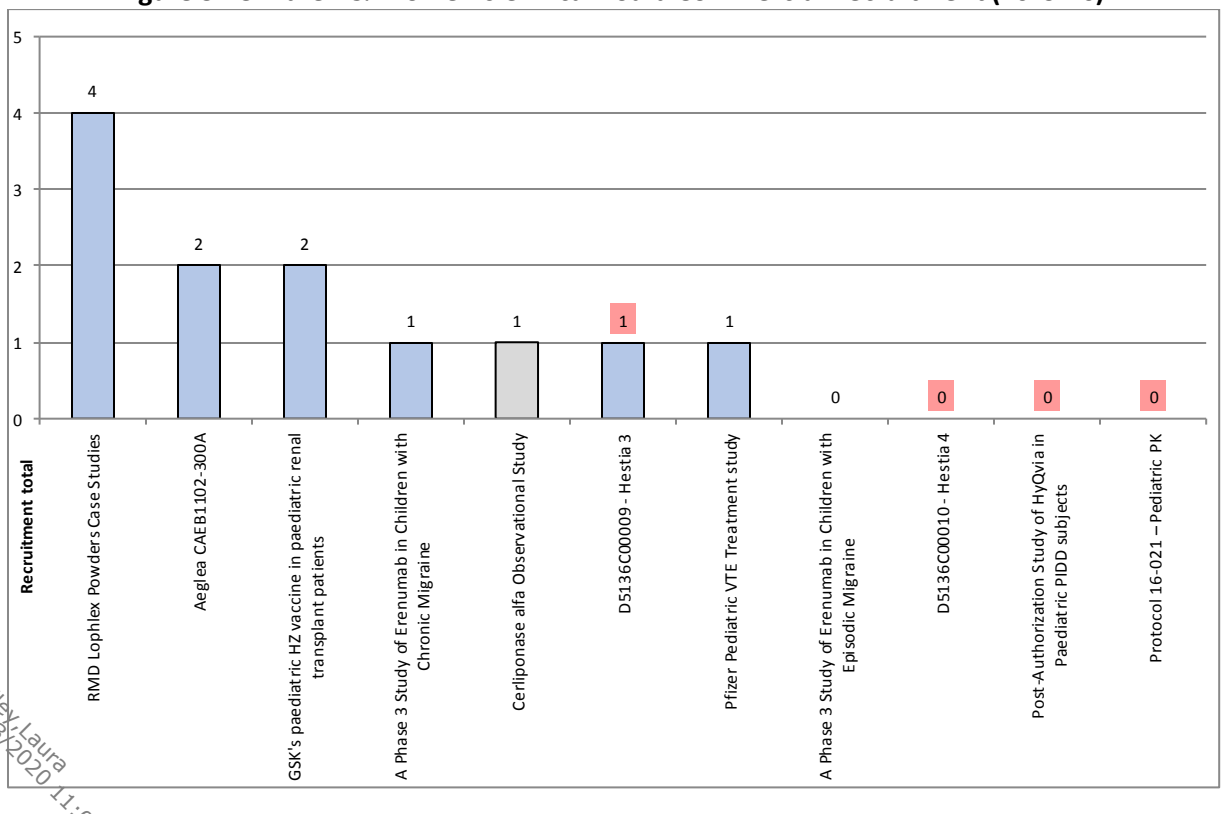


Figure 5 - Children & Women's Clinical Board Commercial Recruitment (2019-20)



: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - CD&T Clinical Board Non-Commercial Recruitment (2017-18)

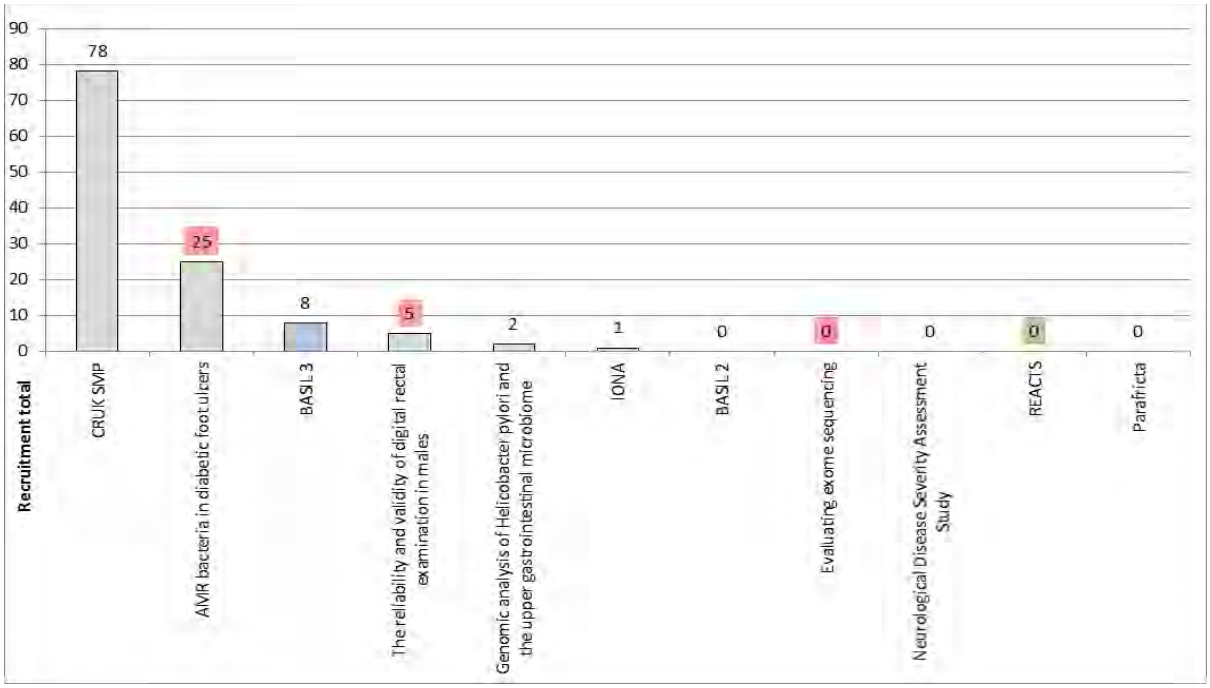
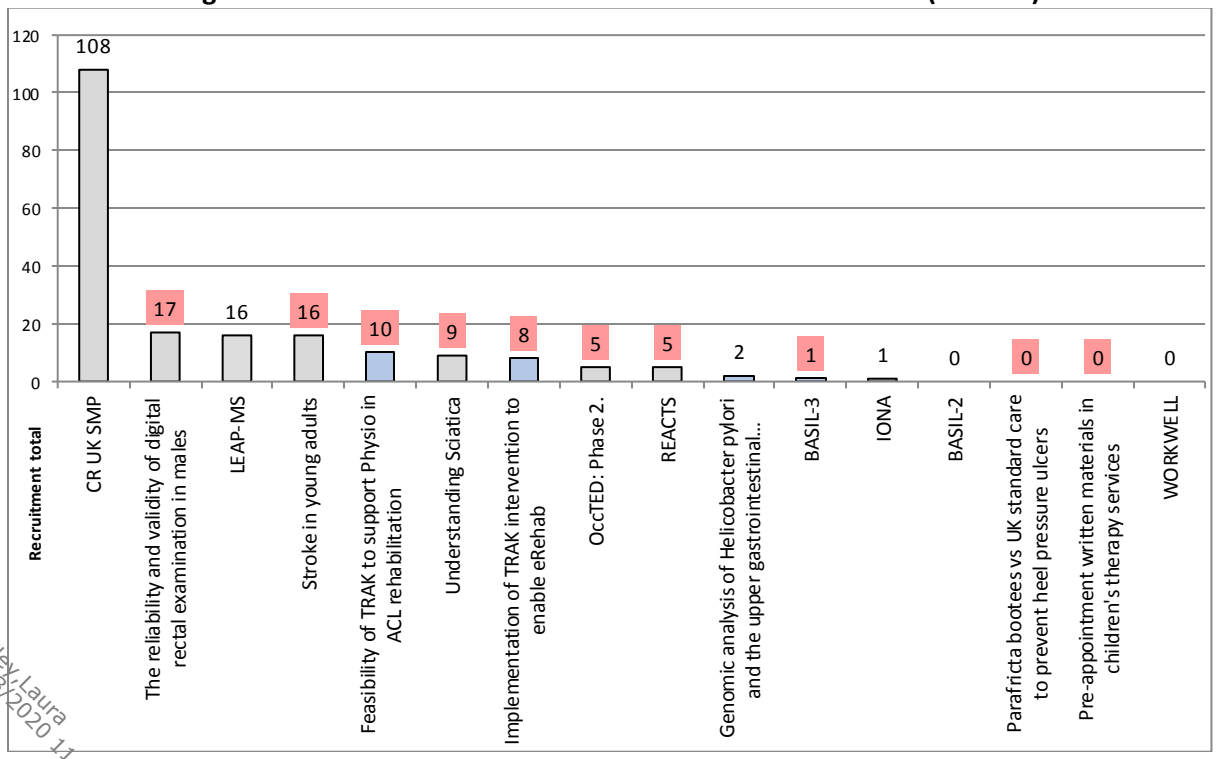


Figure 2 - CD&T Clinical Board Non-Commercial Recruitment (2018-19)



*CD&T also work on **PAVE** (IRAS: 176799) – Please see recruitment - Specialist Services: Nephrology & Transplant Chart (p.56)*

Figure 3 - CD&T Clinical Board Non-Commercial Recruitment (2019-20)

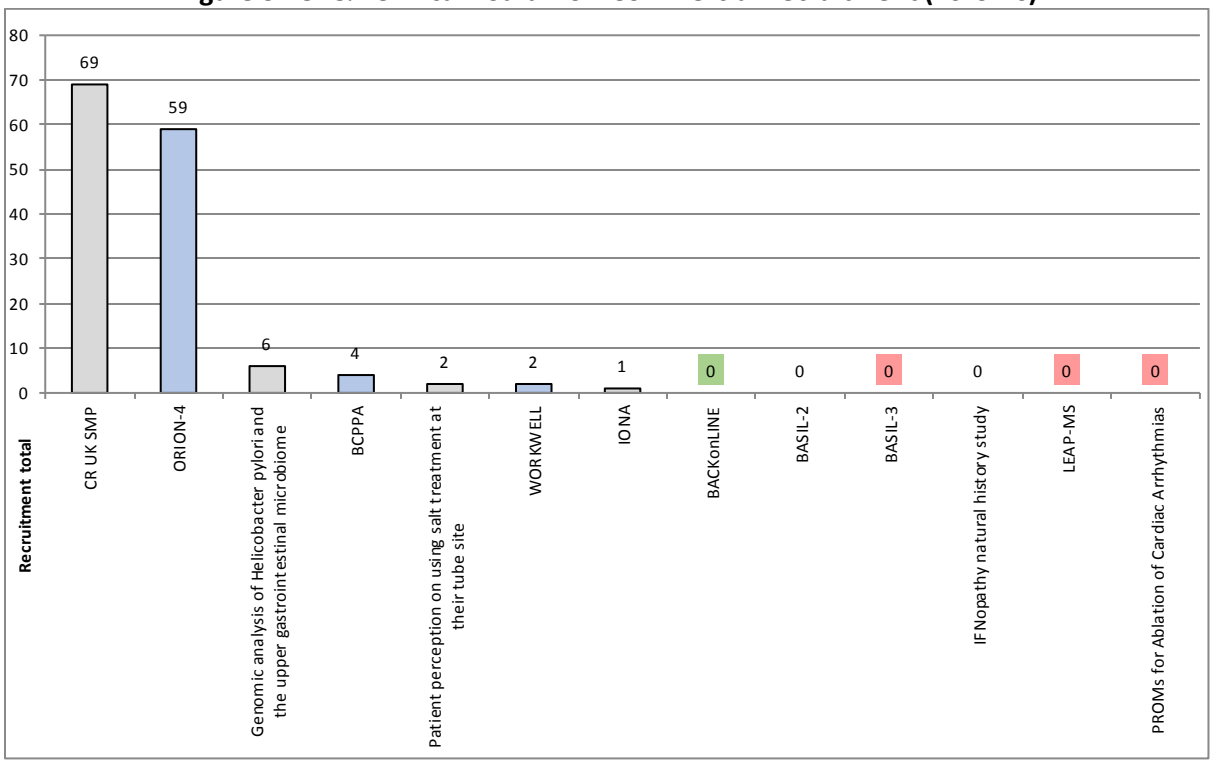


Figure 4 – CD&T Clinical Board Commercial Recruitment (2018-19)

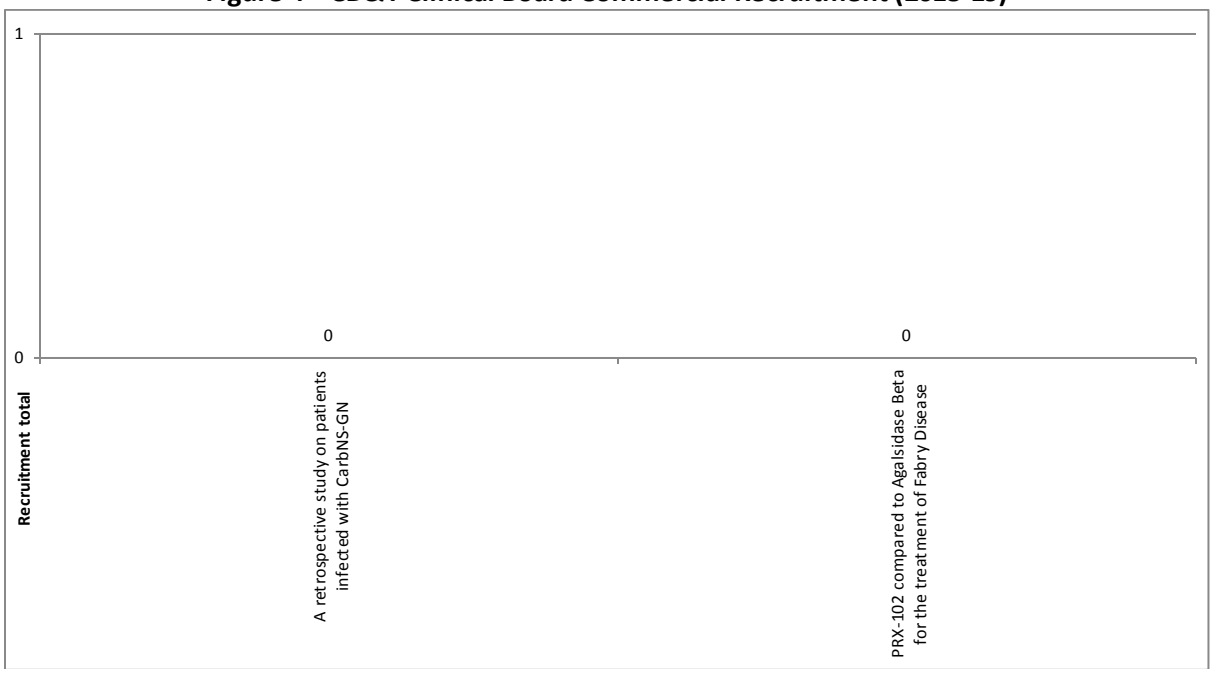
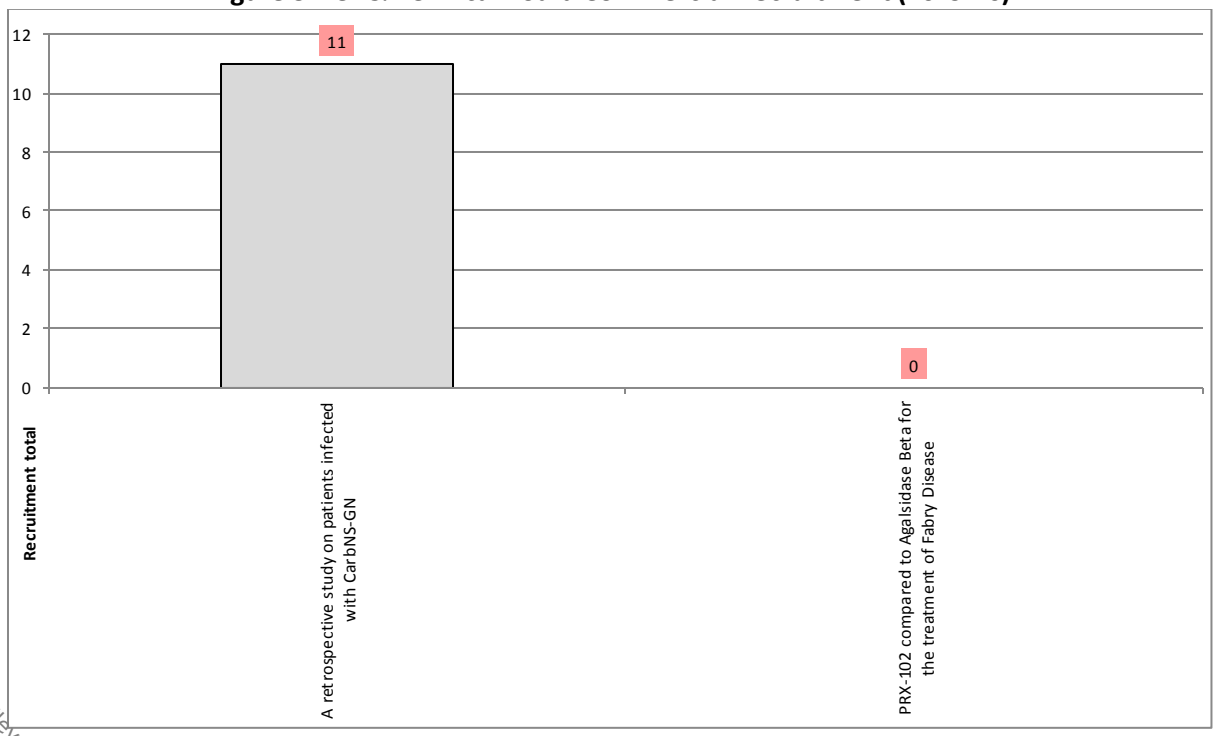


Figure 5 – CD&T Clinical Board Commercial Recruitment (2019-20)



: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Dental Services Clinical Board Non-Commercial Recruitment (2017-18)

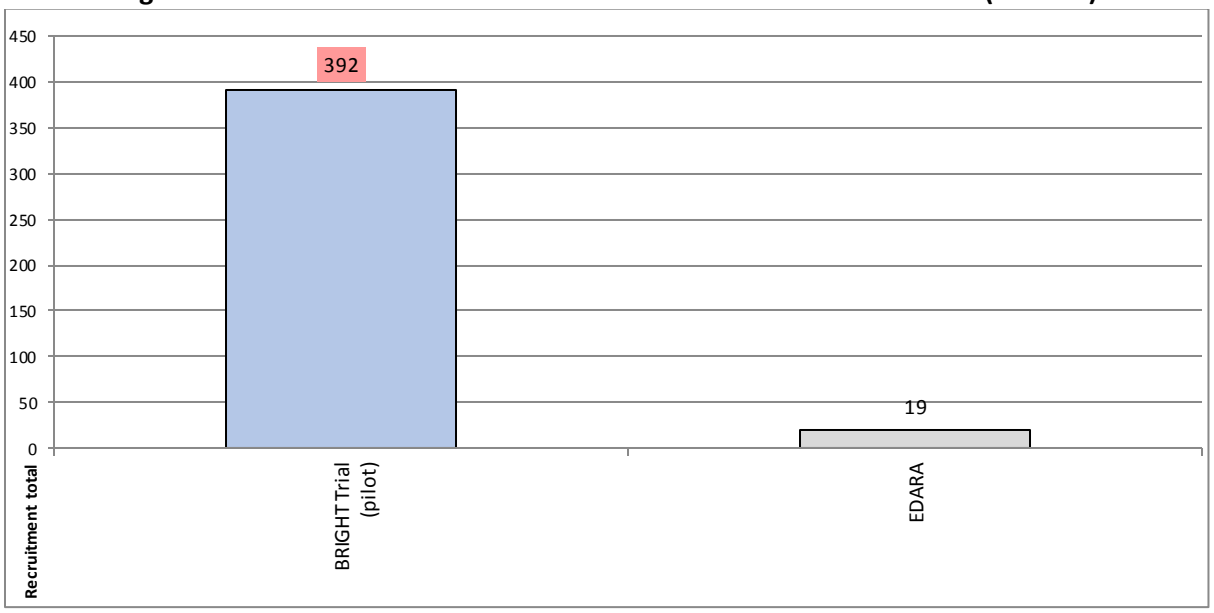
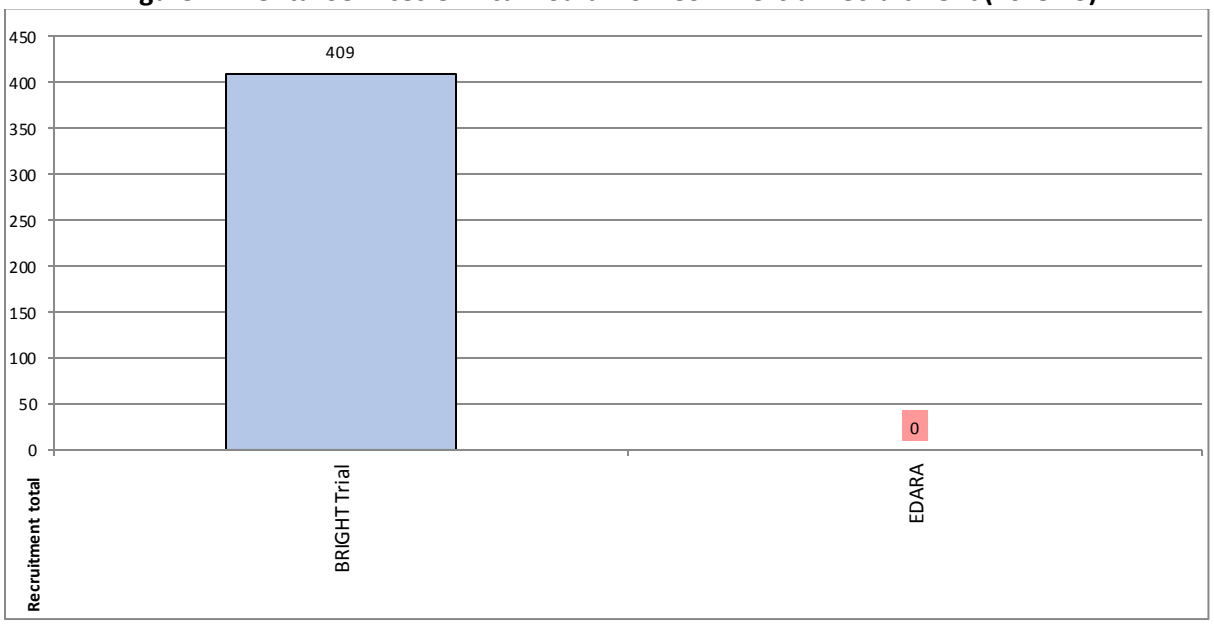


Figure 2 - Dental Services Clinical Board Non-Commercial Recruitment (2018-19)



No Dental Services 2018-19 Commercial Studies

Dental studies' data from 2019-20 now fall under Surgical Services Clinical Board

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Medicine Clinical Board Non-Commercial Recruitment (2017-18)

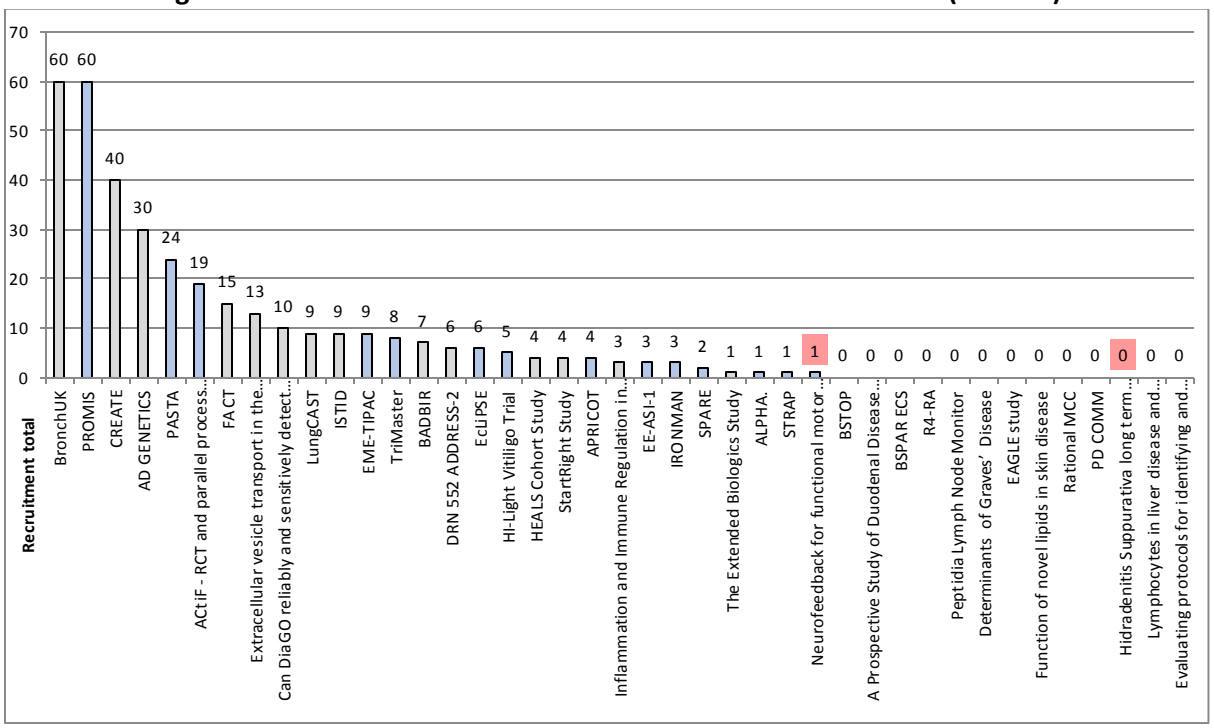


Figure 2 - Medicine Clinical Board Non-Commercial Recruitment (2018-19)

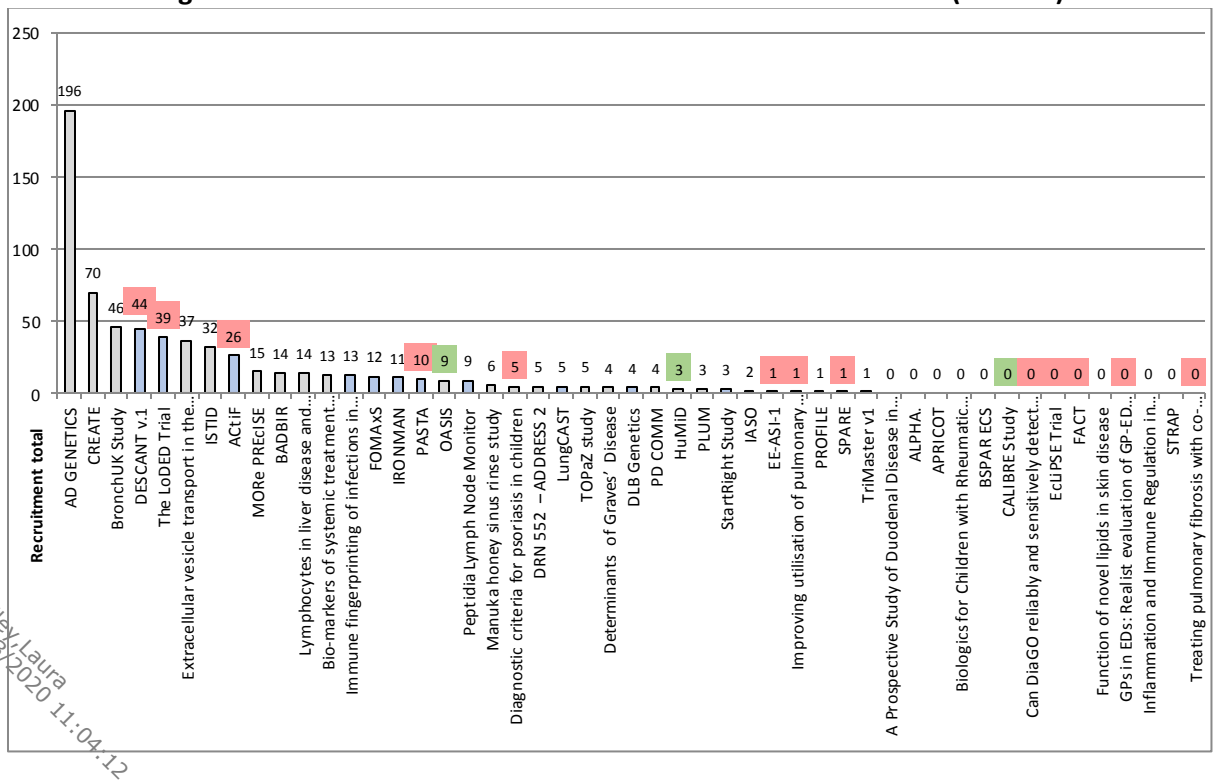


Figure 3 - Medicine Clinical Board Non-Commercial Recruitment (2019-20)

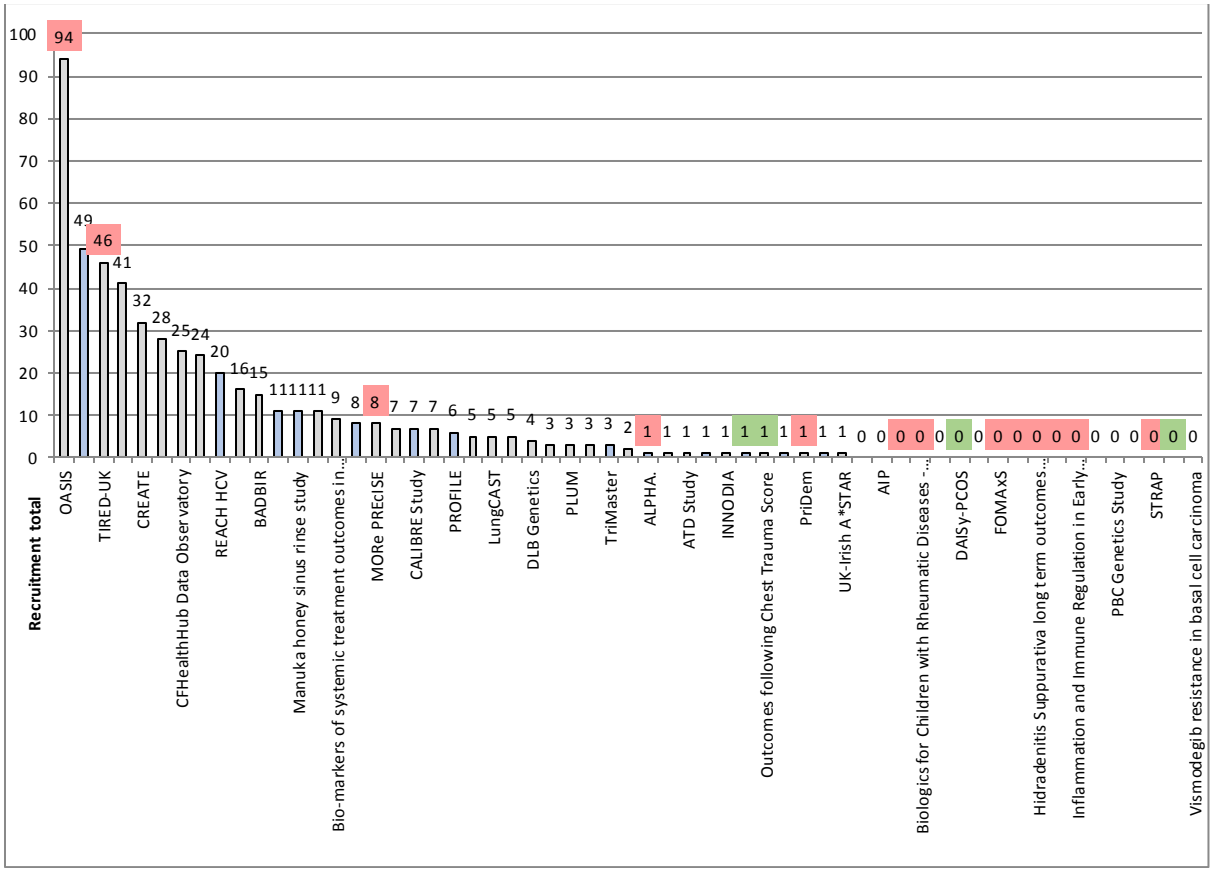


Figure 4 - Medicine Clinical Board Commercial Recruitment (2018-19)

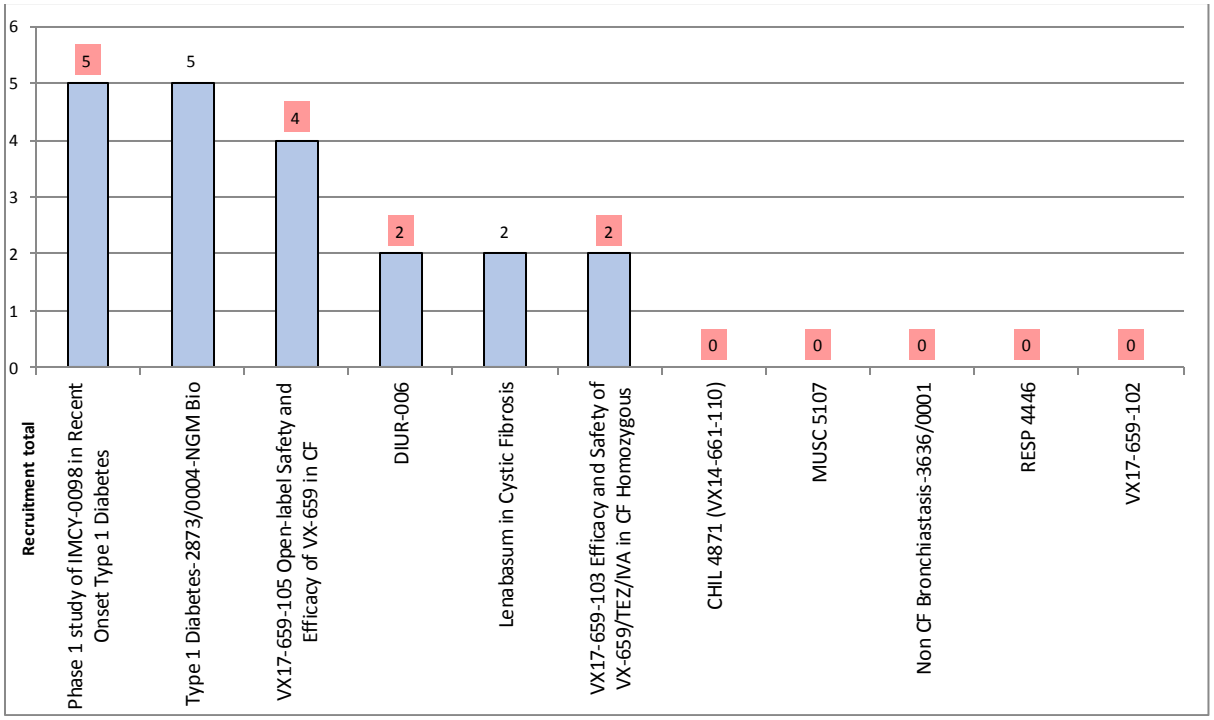
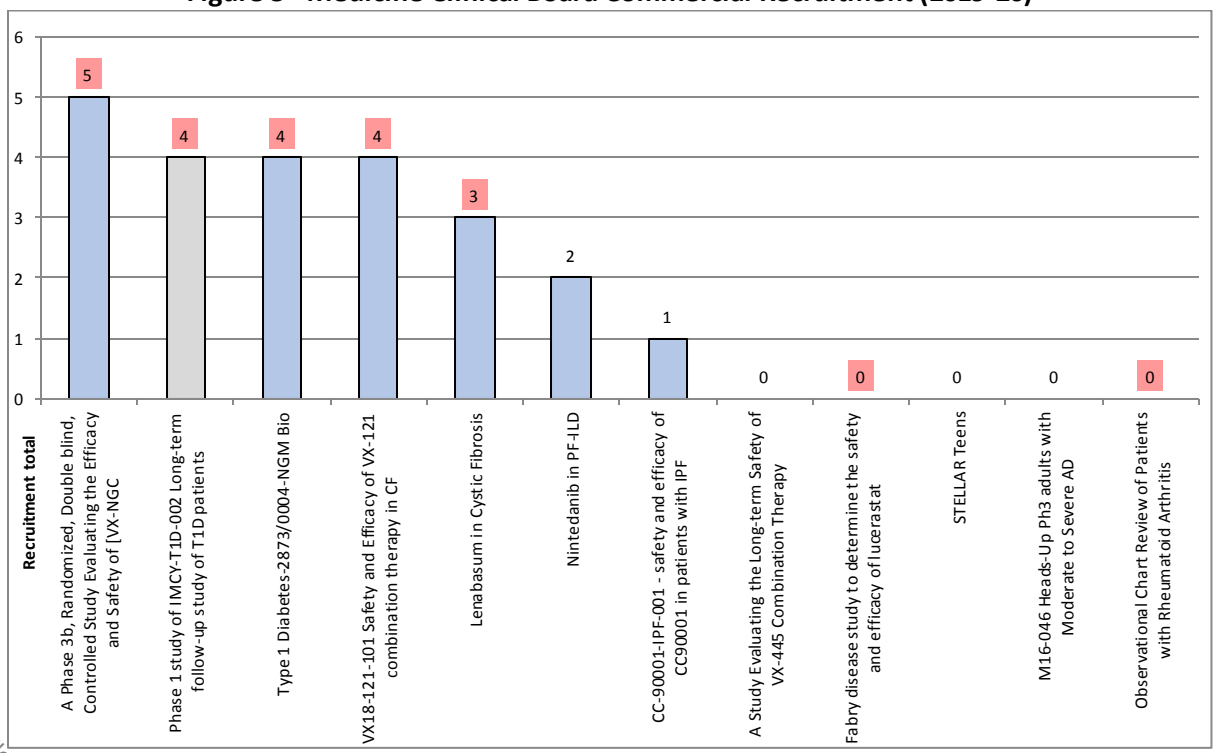


Figure 5 - Medicine Clinical Board Commercial Recruitment (2019-20)



: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Mental Health Clinical Board Non-Commercial Recruitment (2017-18)

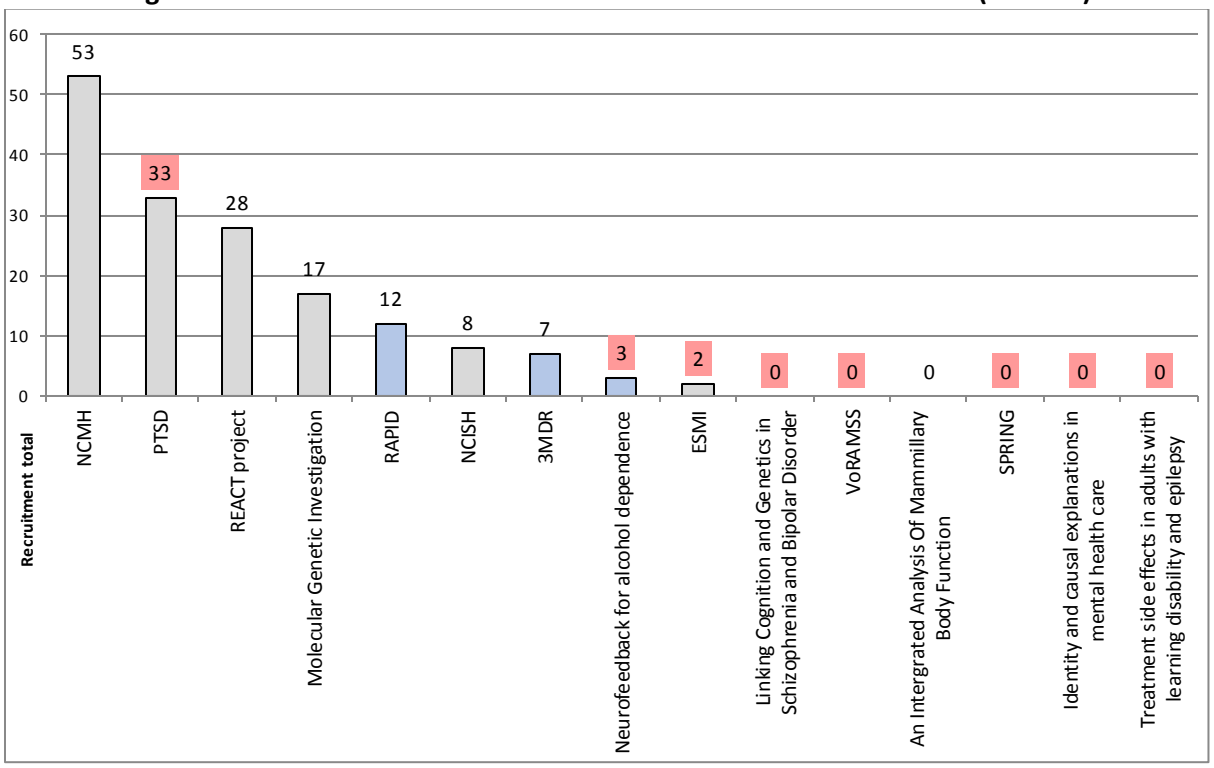


Figure 2 - Mental Health Clinical Board Non-Commercial Recruitment (2018-19)

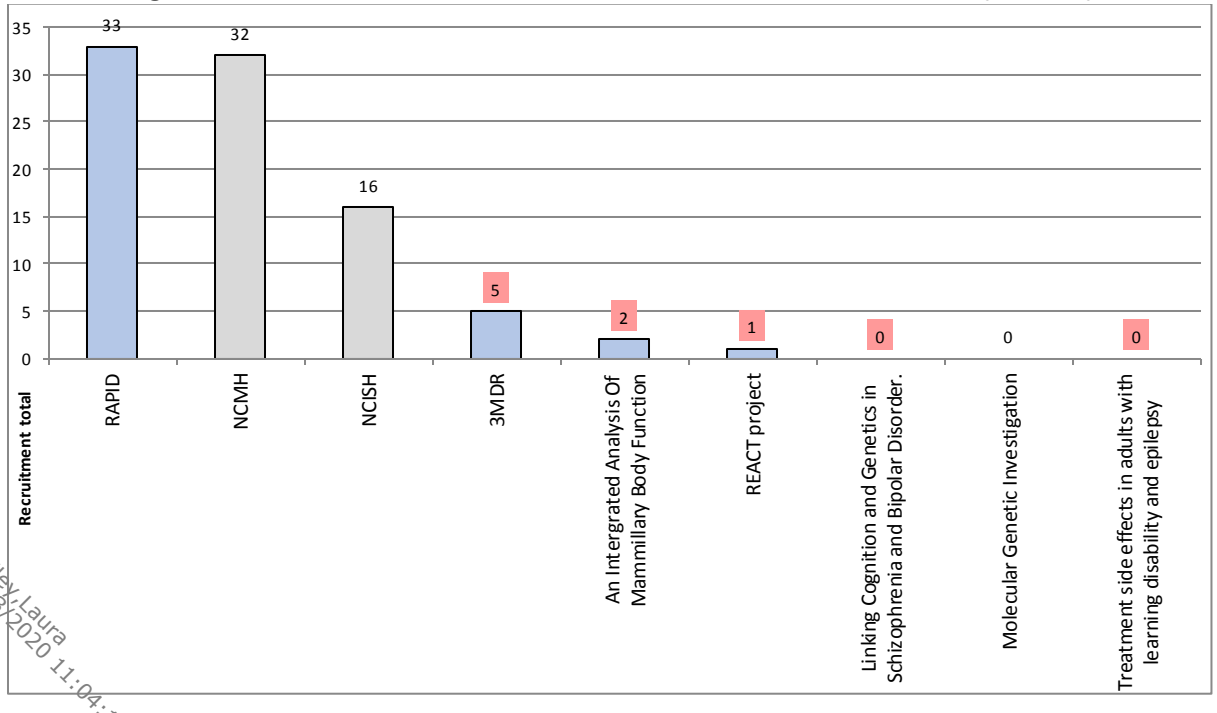
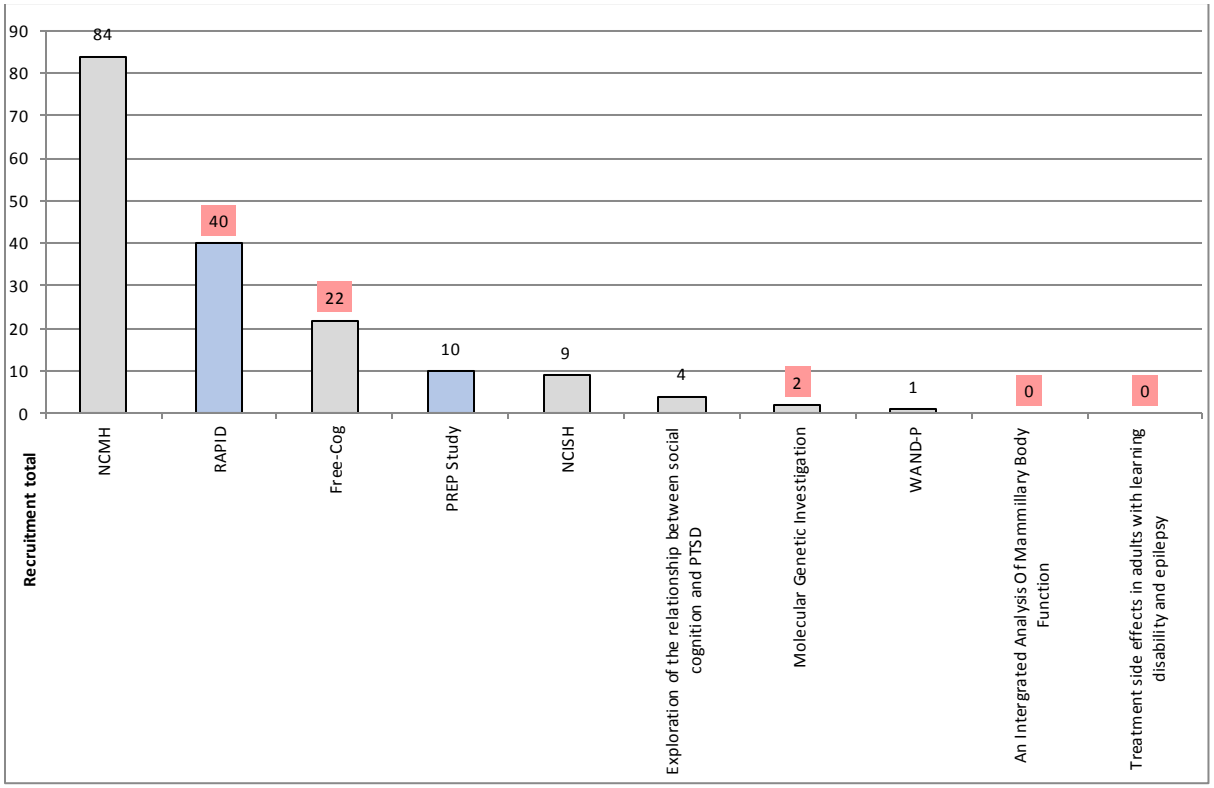


Figure 3 - Mental Health Clinical Board Non-Commercial Recruitment (2019-20)



No Mental Health Commercial Studies for 2018-19/ 2019-20

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - PCIC Clinical Board Non-Commercial Recruitment (2017-18)

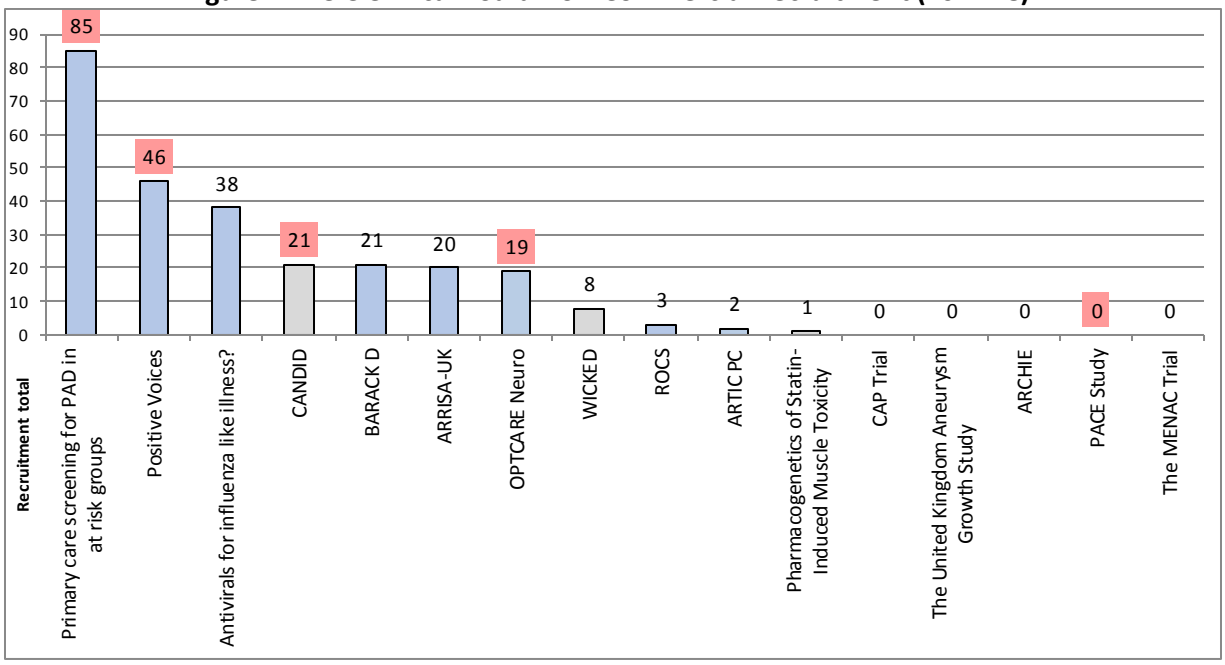


Figure 2 - PCIC Clinical Board Non-Commercial Recruitment (2018-19)

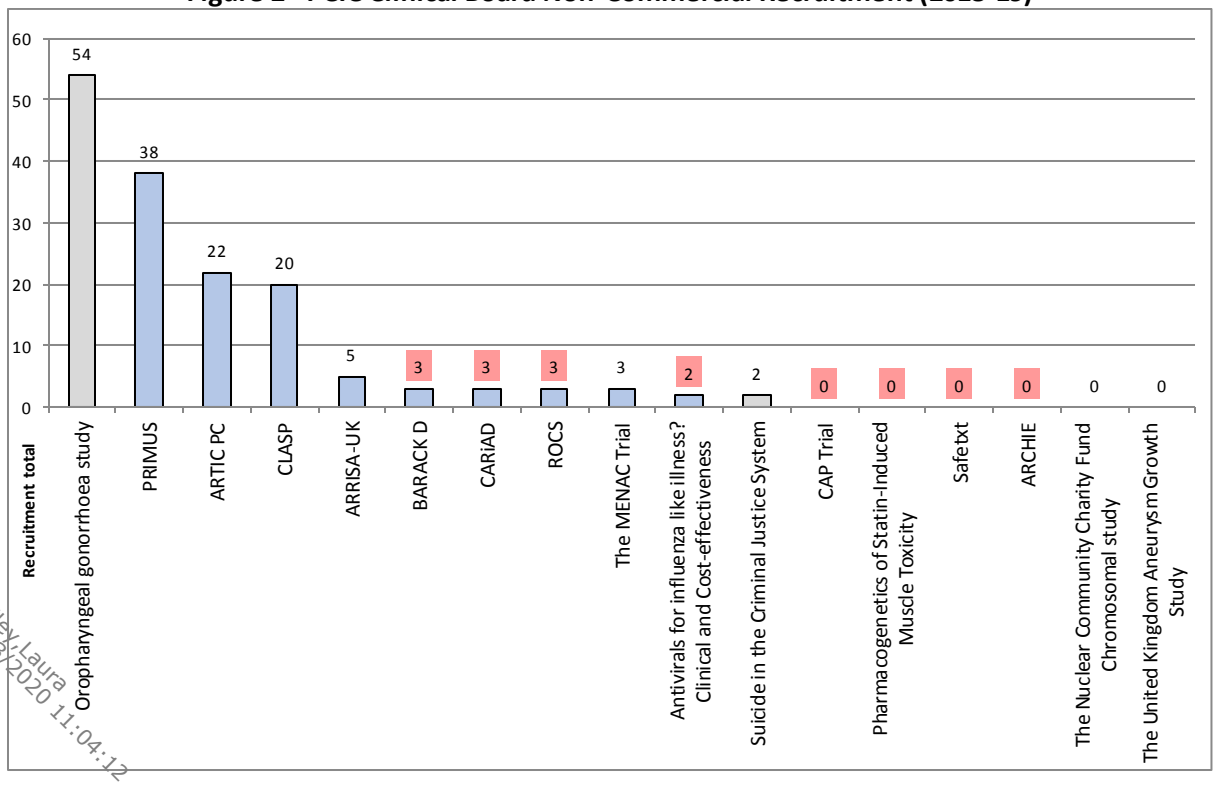


Figure 3 - PCIC Clinical Board Non-Commercial Recruitment (2019-20)

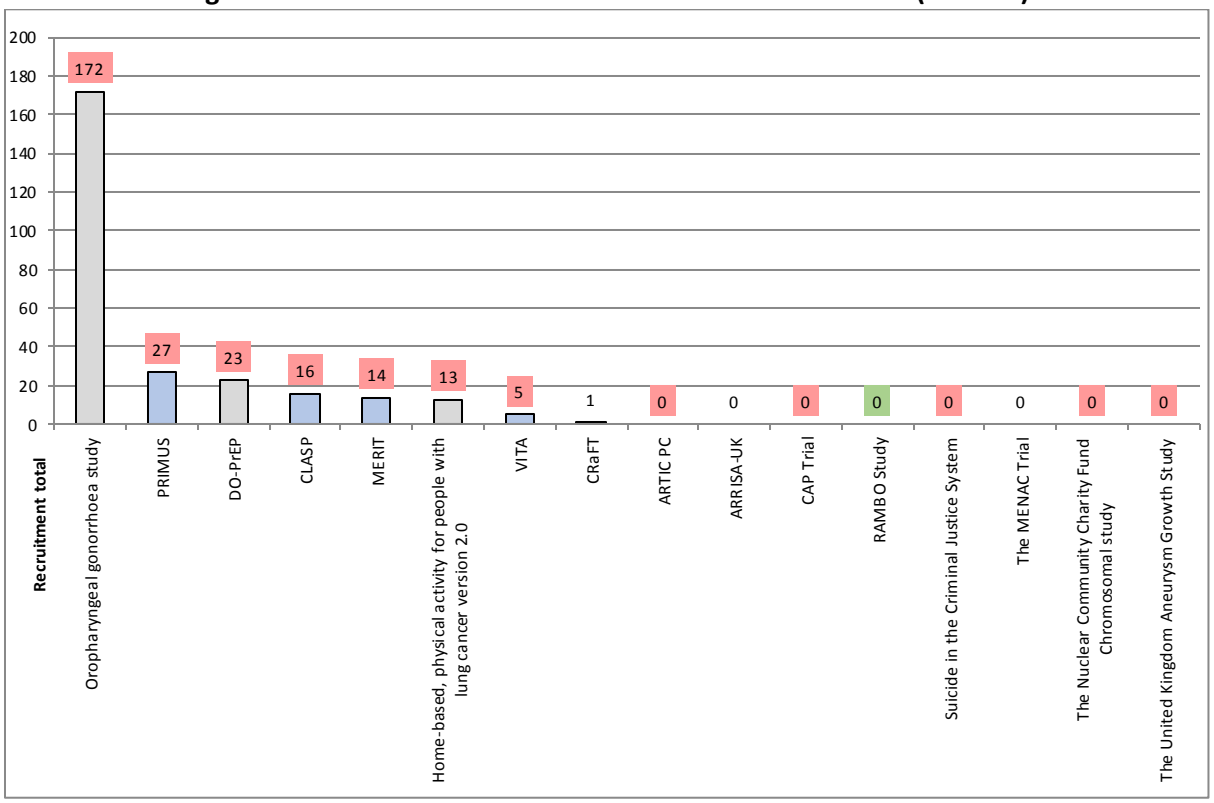


Figure 4 - PCIC Clinical Board Commercial Recruitment (2018-19)

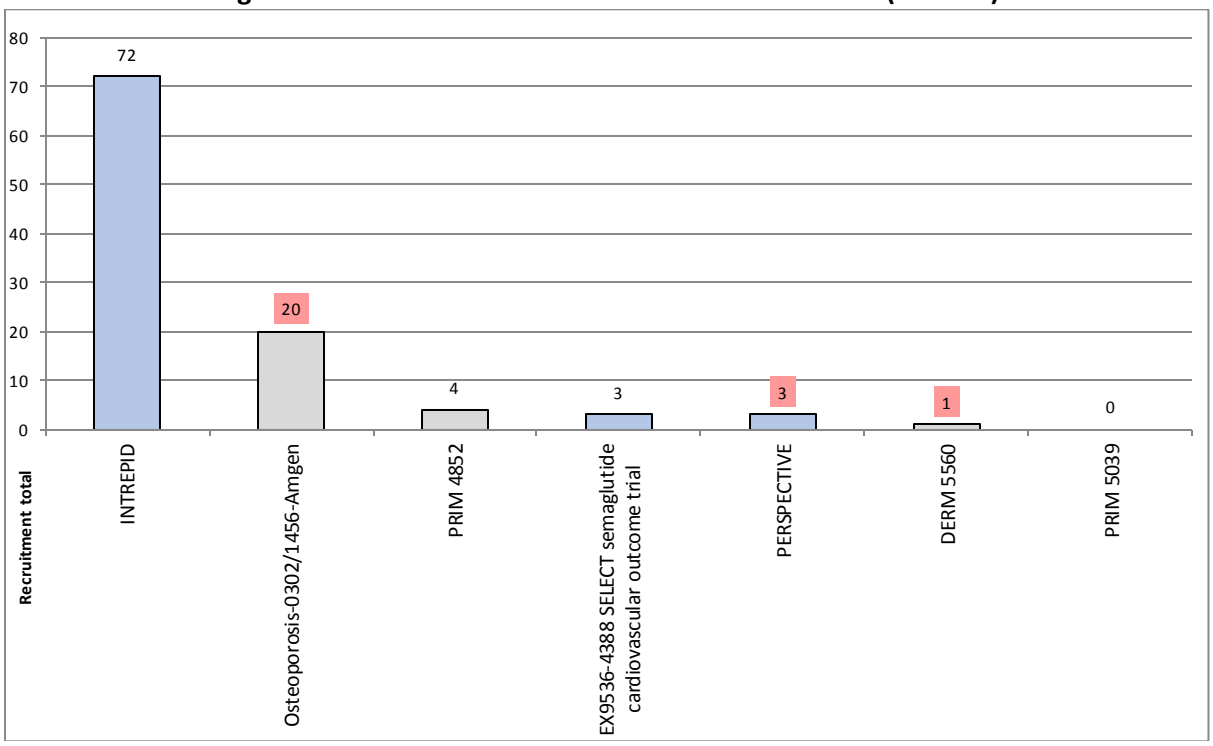


Figure 5 - PCIC Clinical Board Commercial Recruitment (2019-20)

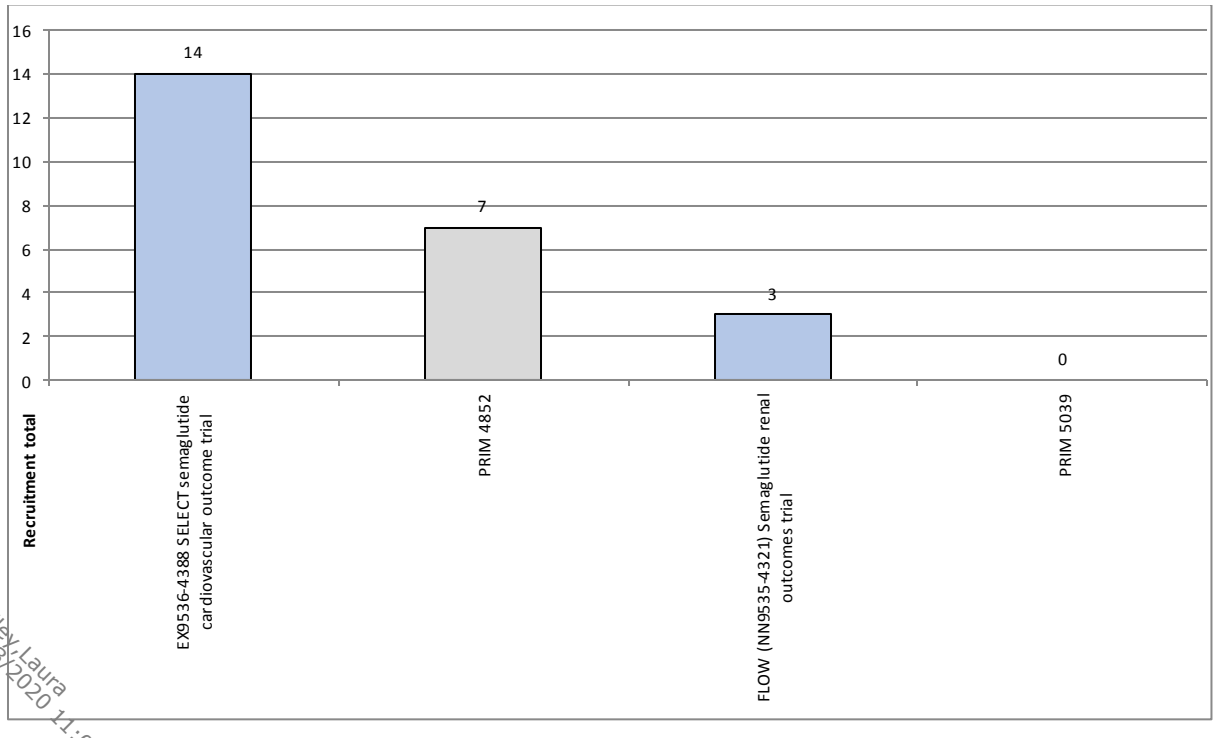


Figure 1 - Specialist Services Clinical Board Non-Commercial Recruitment (2017-18)

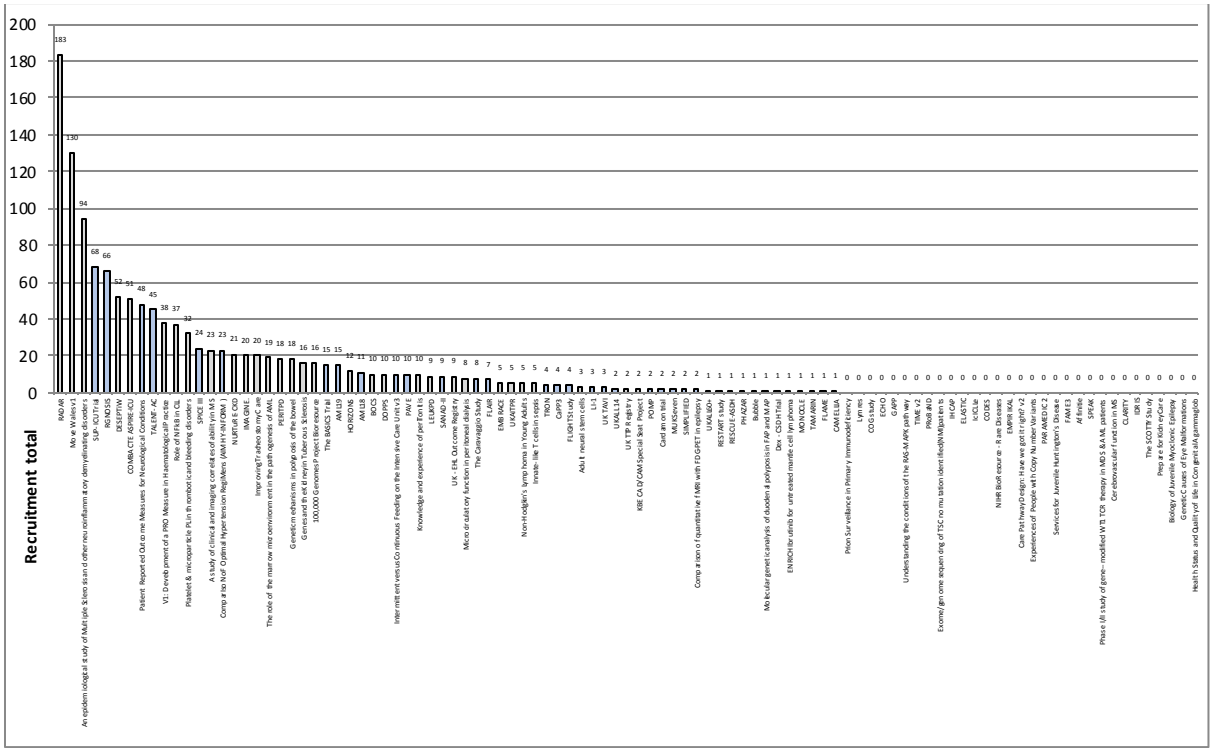


Figure 2 - Specialist Services Clinical Board Non-Commercial Recruitment (2018-19)

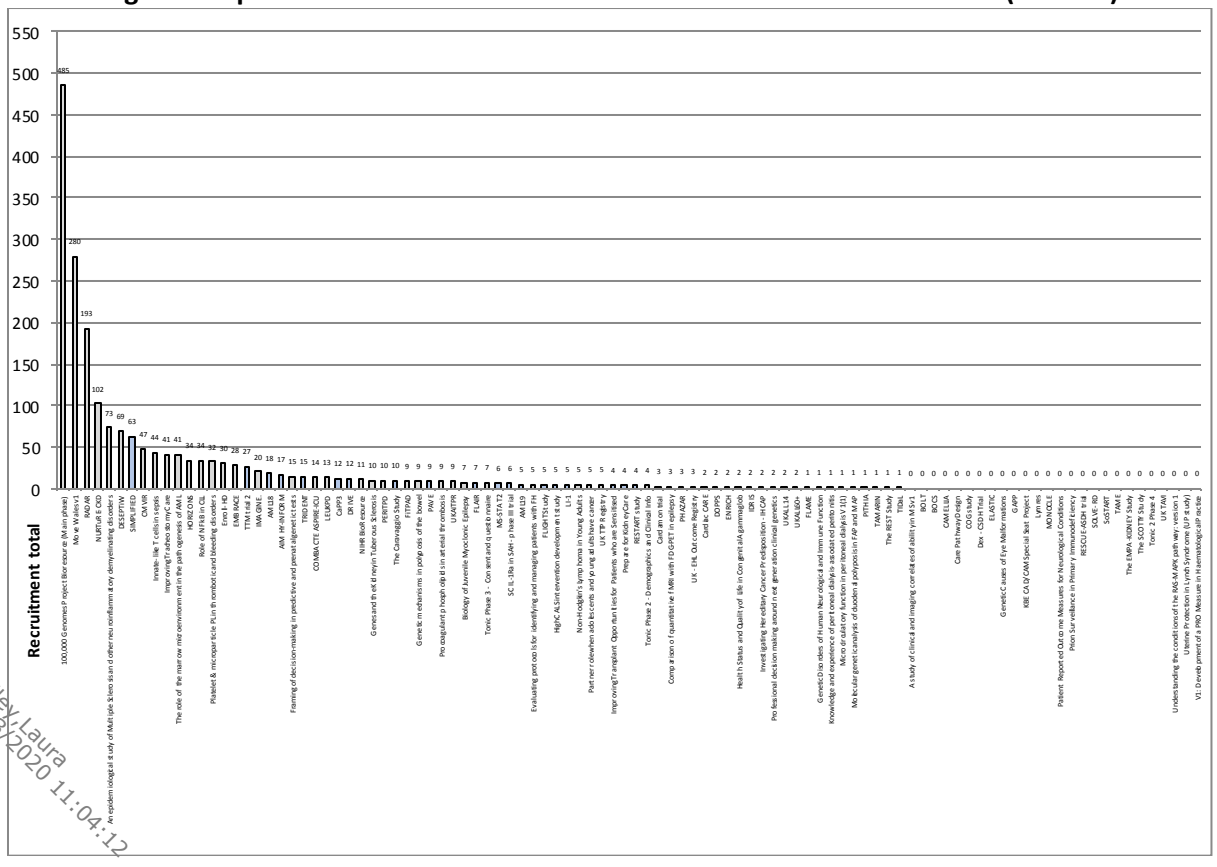


Figure 3 - Specialist Services Clinical Board Non-Commercial Recruitment (2019-20)

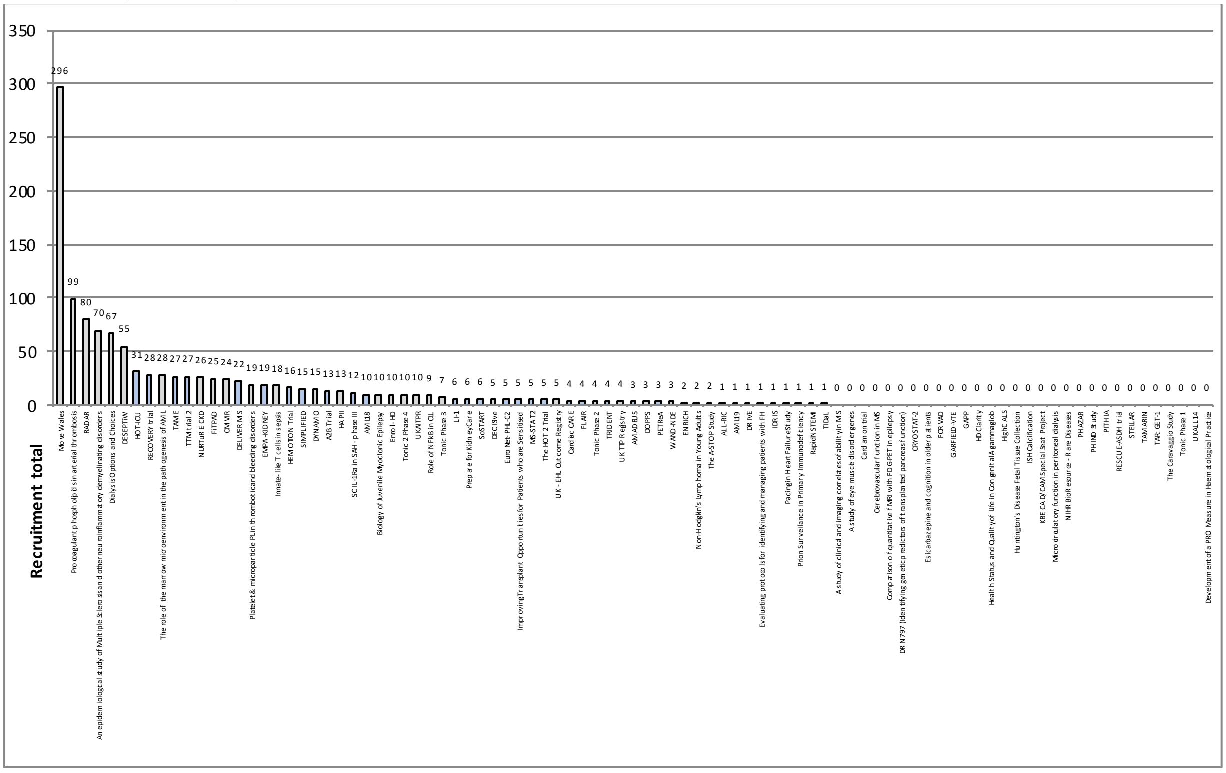


Figure 4 - Specialist Services Clinical Board Commercial Recruitment (2018-19)

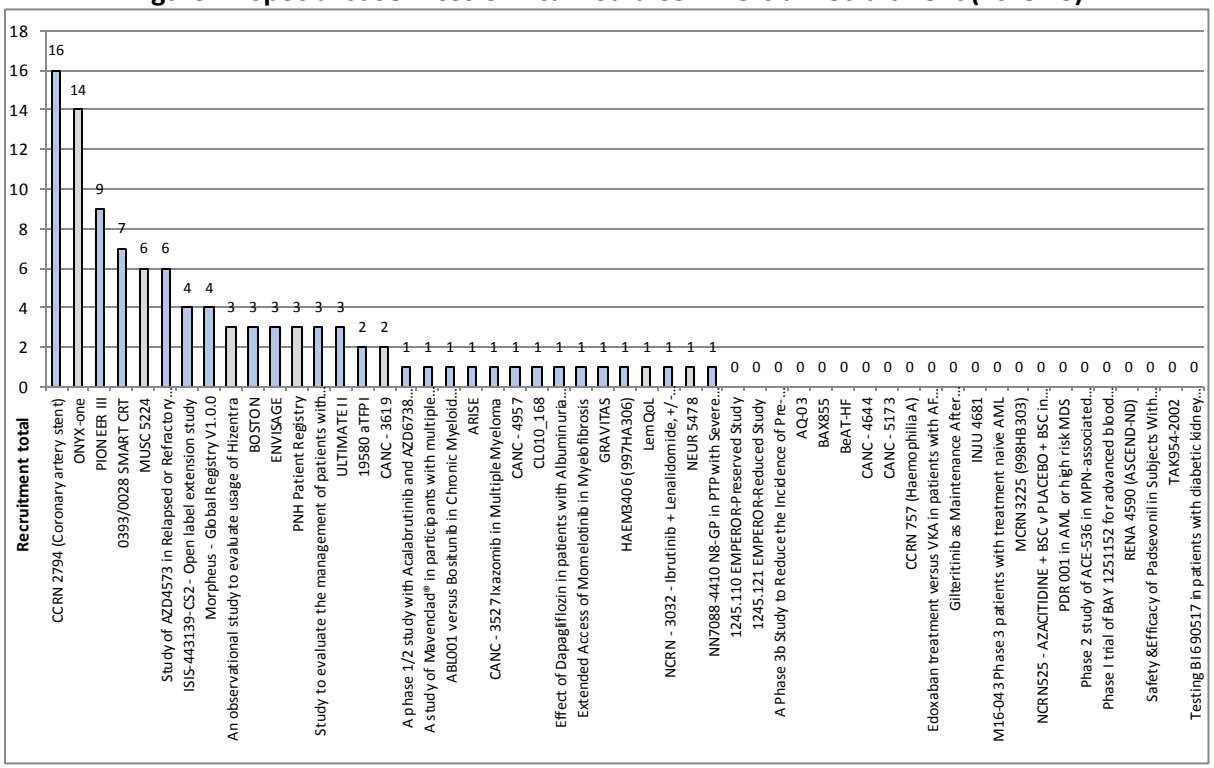
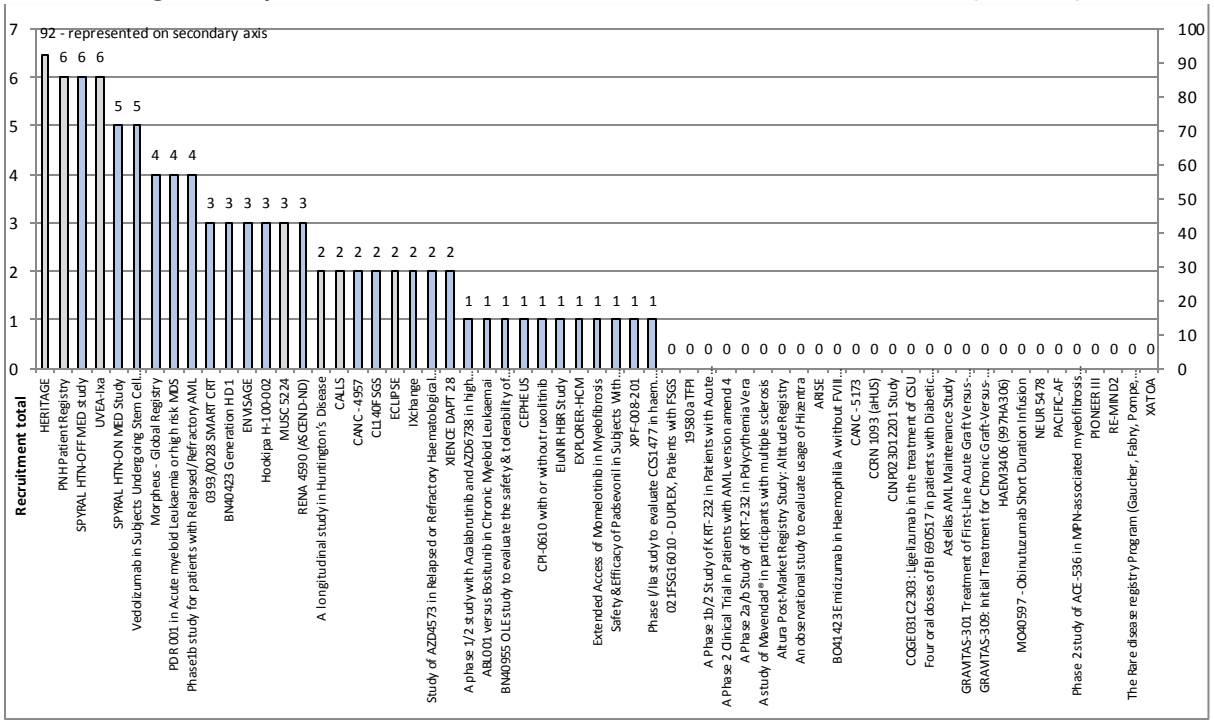


Figure 5 - Specialist Services Clinical Board Commercial Recruitment (2019-20)



Specialist Services Directorate Recruitment:

ALAS (inc. Rehabilitation Engineering)

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Specialist Services - ALAS (incl. Rehabilitation Engineering) Non-Commercial Recruitment (2017-18)

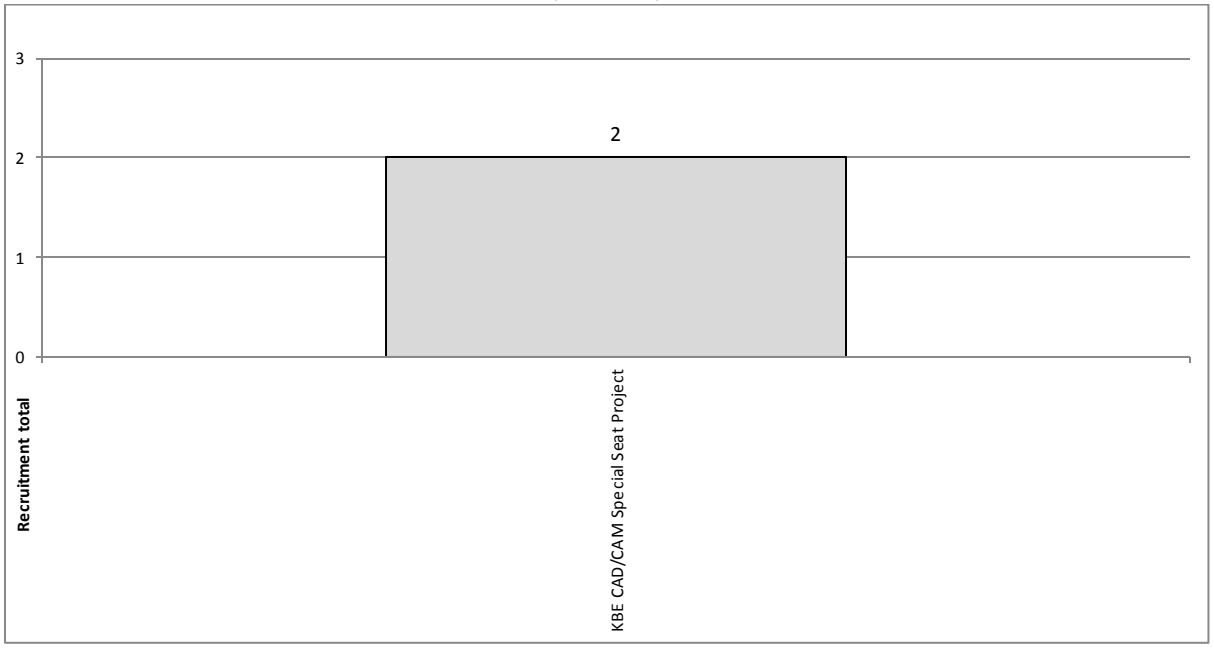
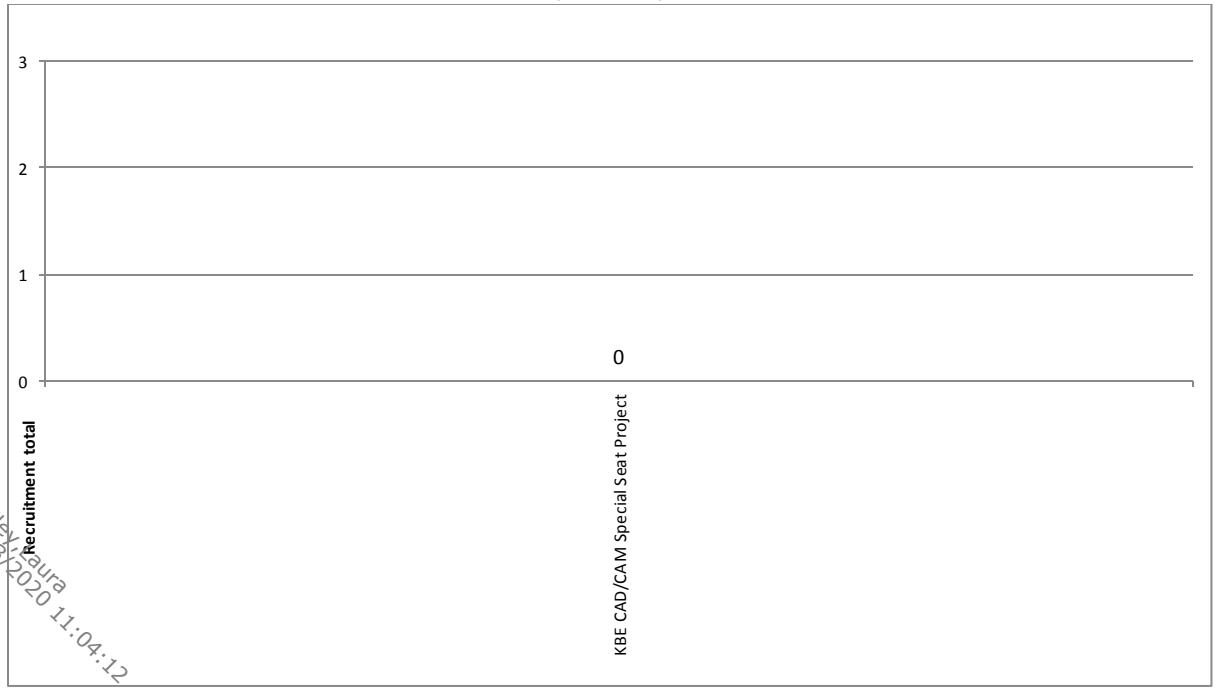


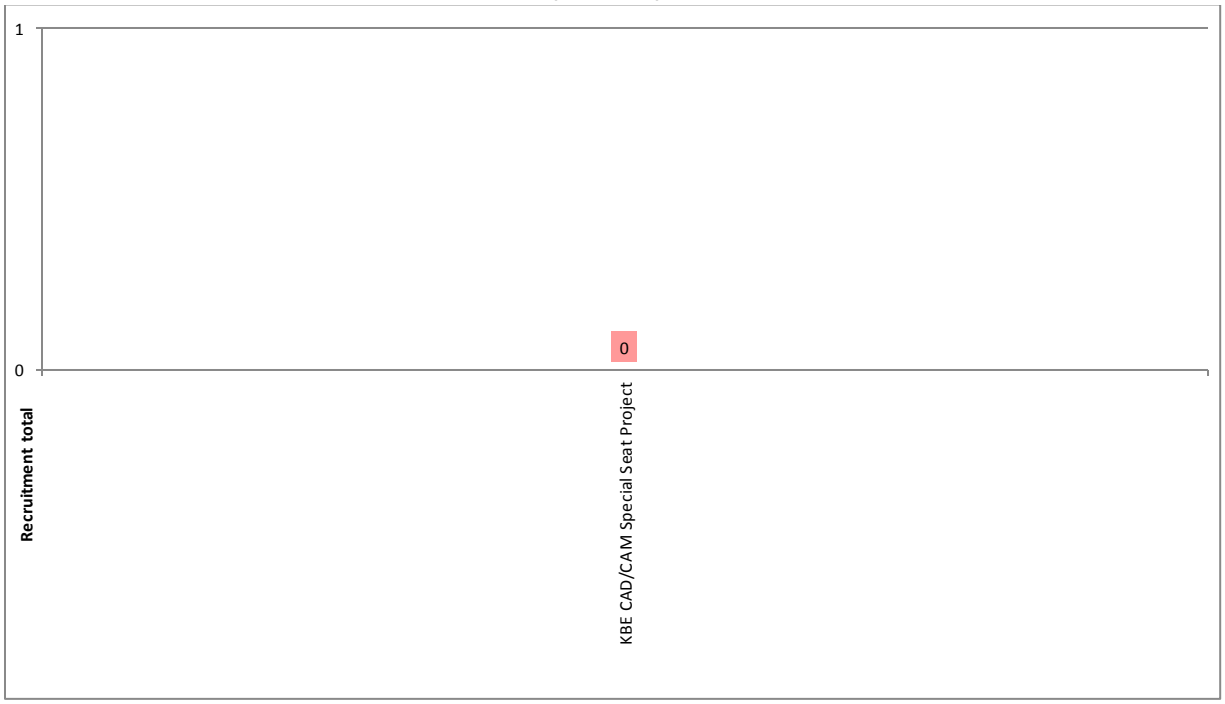
Figure 2 - Specialist Services - ALAS (incl. Rehabilitation Engineering) Non-Commercial Recruitment (2018-19)



Specialist Services Directorate Recruitment:

ALAS (inc. Rehabilitation Engineering)

Figure 3 - Specialist Services - ALAS (incl. Rehabilitation Engineering) Non-Commercial Recruitment (2019-20)



No ALAS Commercial Studies for 2018-19/ 2019-20

Specialist Services Directorate Recruitment: CARDIAC SERVICES

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Specialist Services - Cardiac Services Non-Commercial Recruitment (2017-18)

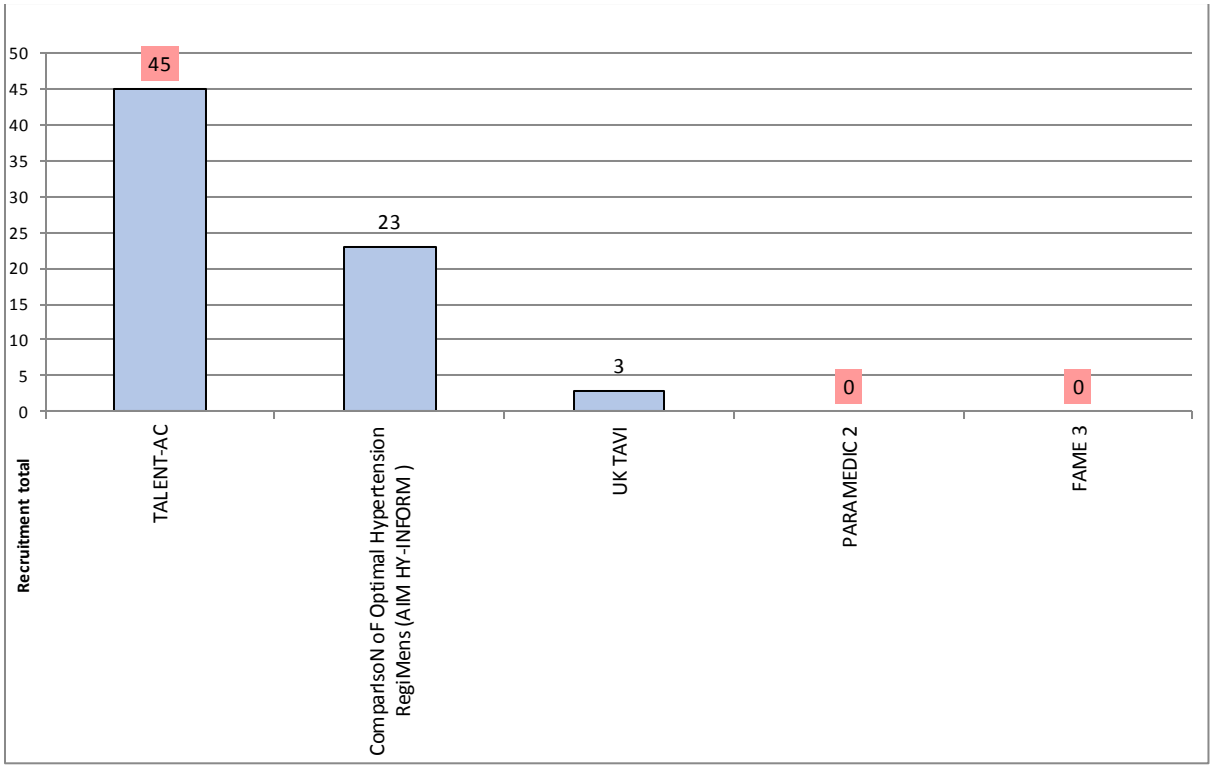
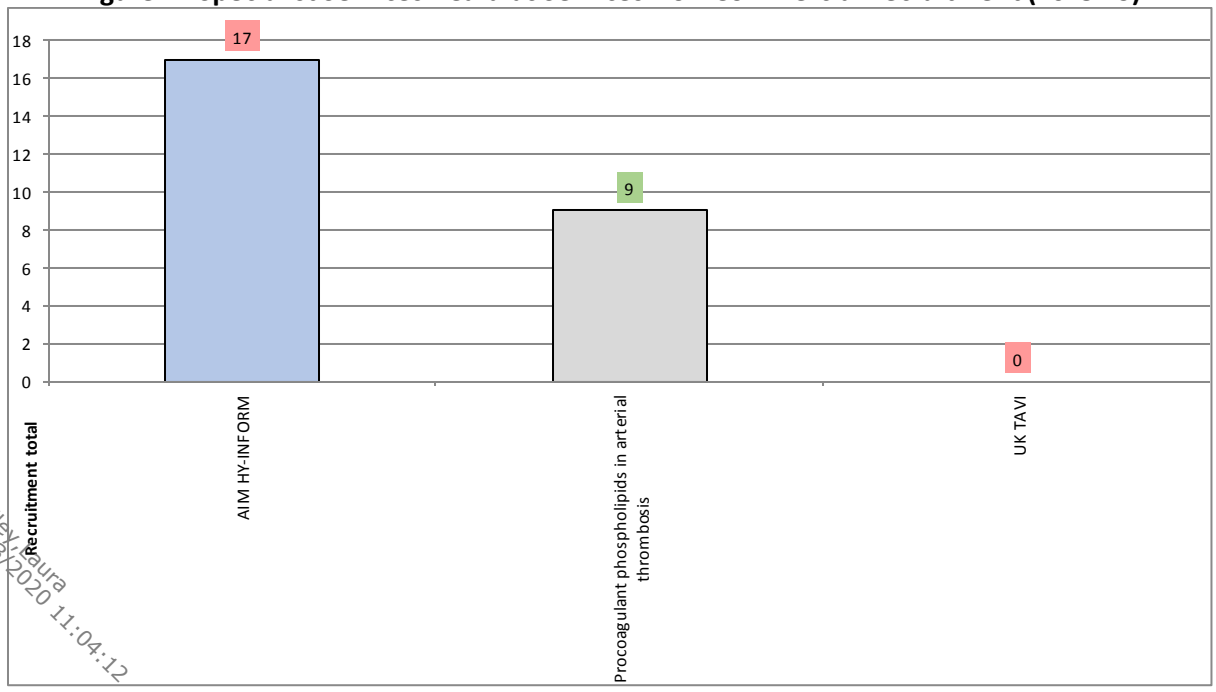
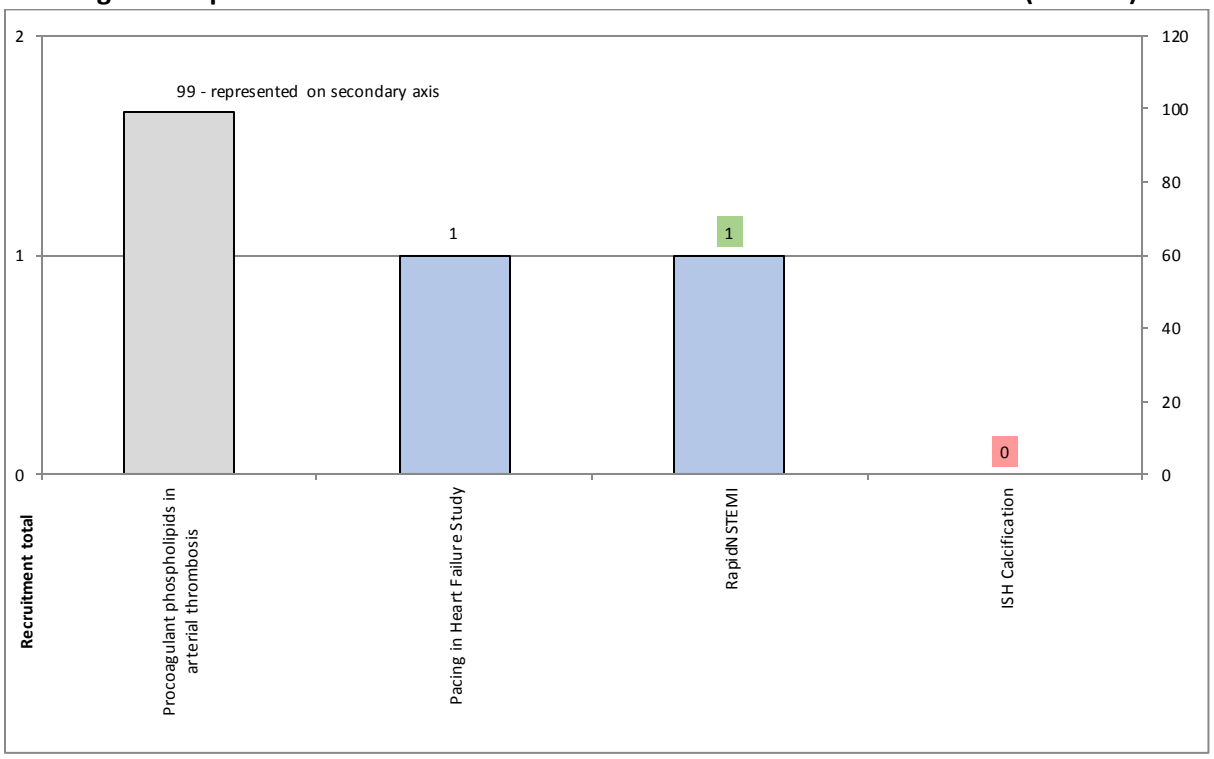


Figure 2 - Specialist Services - Cardiac Services Non-Commercial Recruitment (2018-19)



Specialist Services Directorate Recruitment: CARDIAC SERVICES

Figure 3 - Specialist Services - Cardiac Services Non-Commercial Recruitment (2019-20)



Specialist Services Directorate Recruitment: CARDIAC SERVICES

Figure 4 - Specialist Services - Cardiac Services Commercial Recruitment (2018-19)

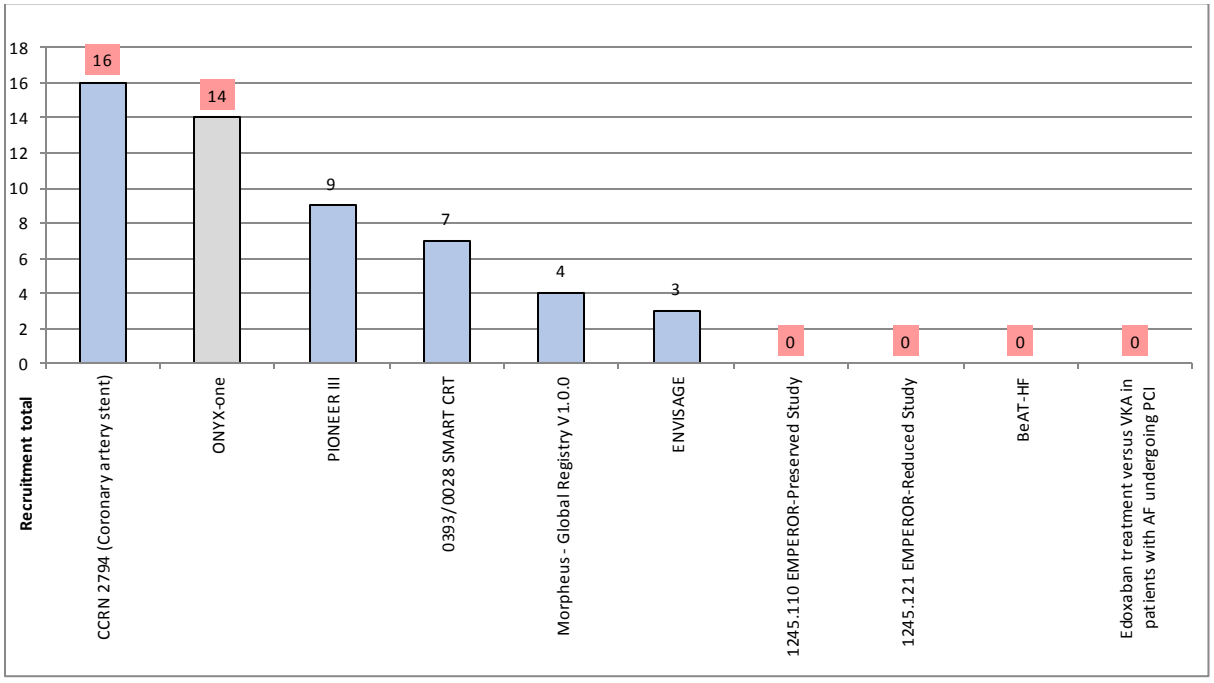
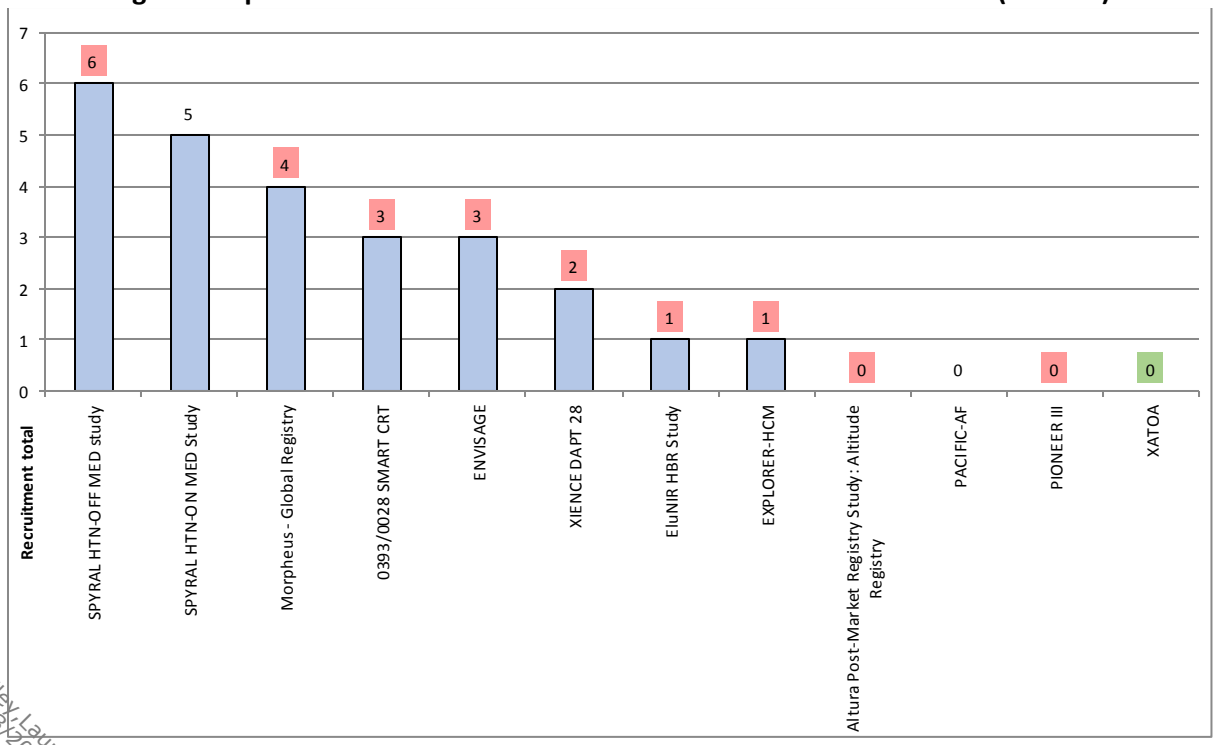


Figure 5 - Specialist Services - Cardiac Services Commercial Recruitment (2019-20)



Specialist Services Directorate Recruitment: CLINICAL GENETICS

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Specialist Services - Clinical Genetics Non-Commercial Recruitment (2017-18)

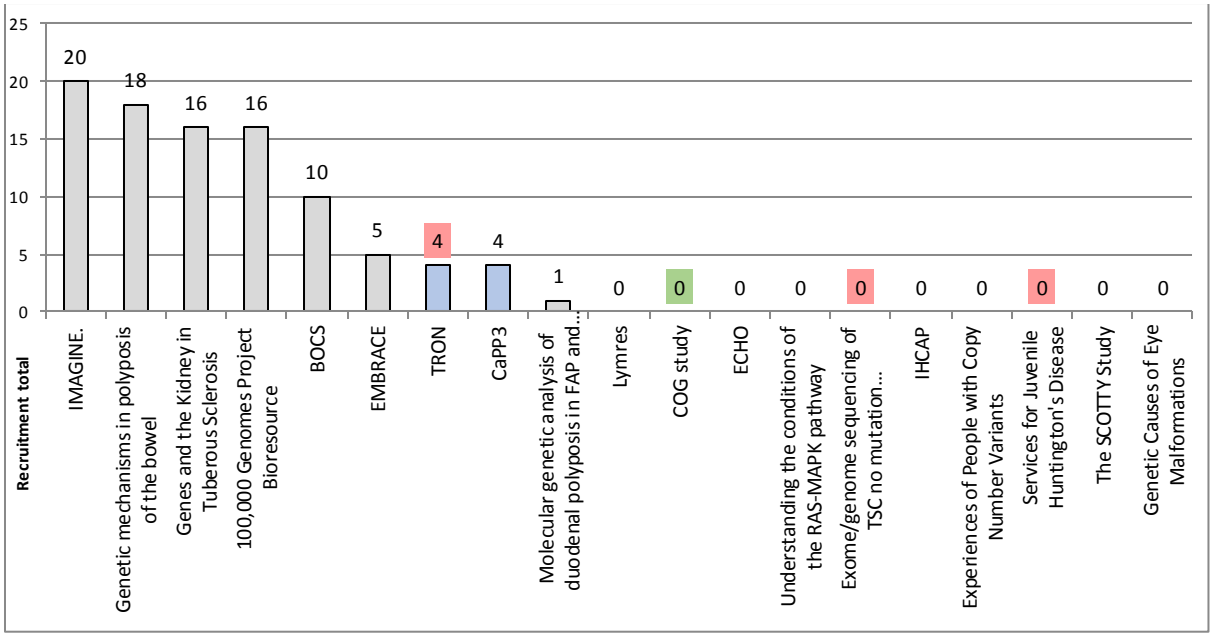
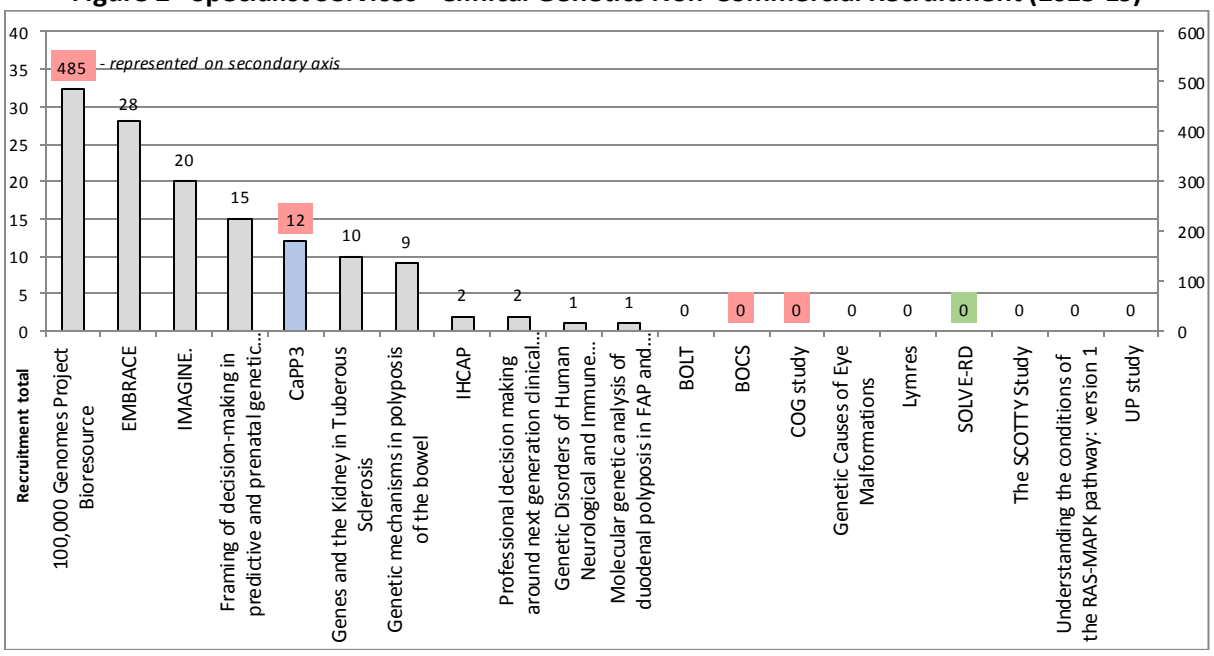


Figure 2 - Specialist Services - Clinical Genetics Non-Commercial Recruitment (2018-19)



No Clinical Genetics 2018-19 Commercial Studies

Clinical Genetics studies now included under All Wales Medical Genetics Clinical Board from 2019-20

Specialist Services Directorate Recruitment: CRITICAL CARE

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Specialist Services - Critical Care Non-Commercial Recruitment (2017-18)

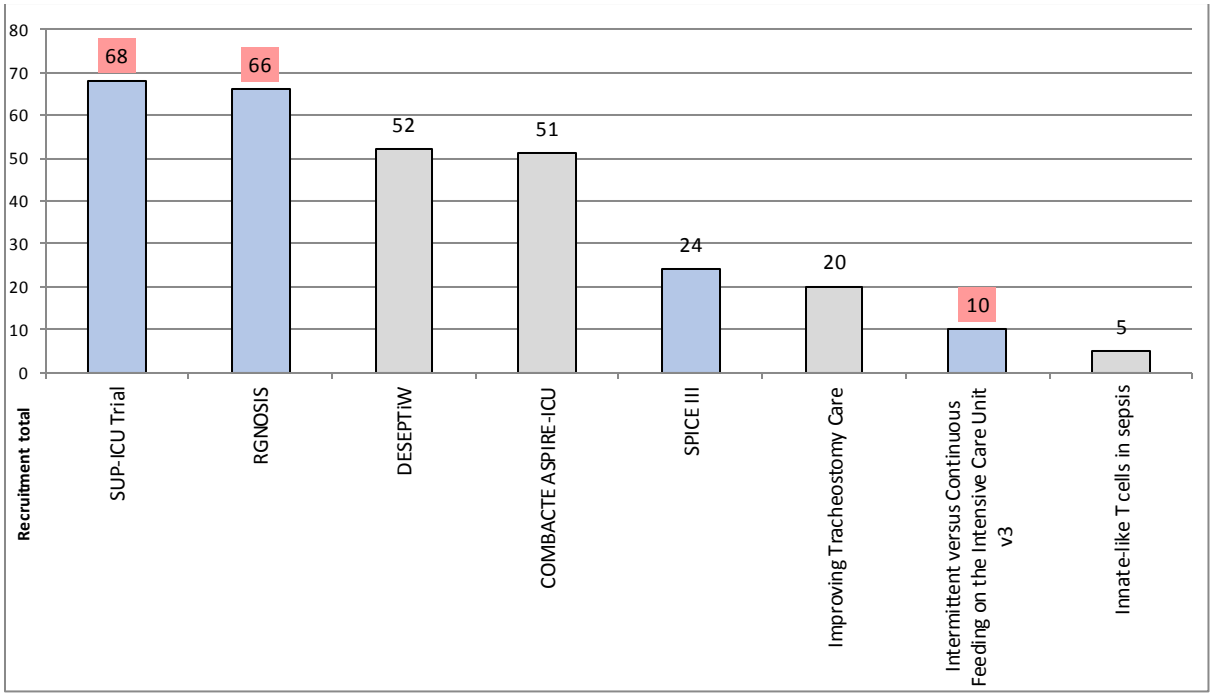
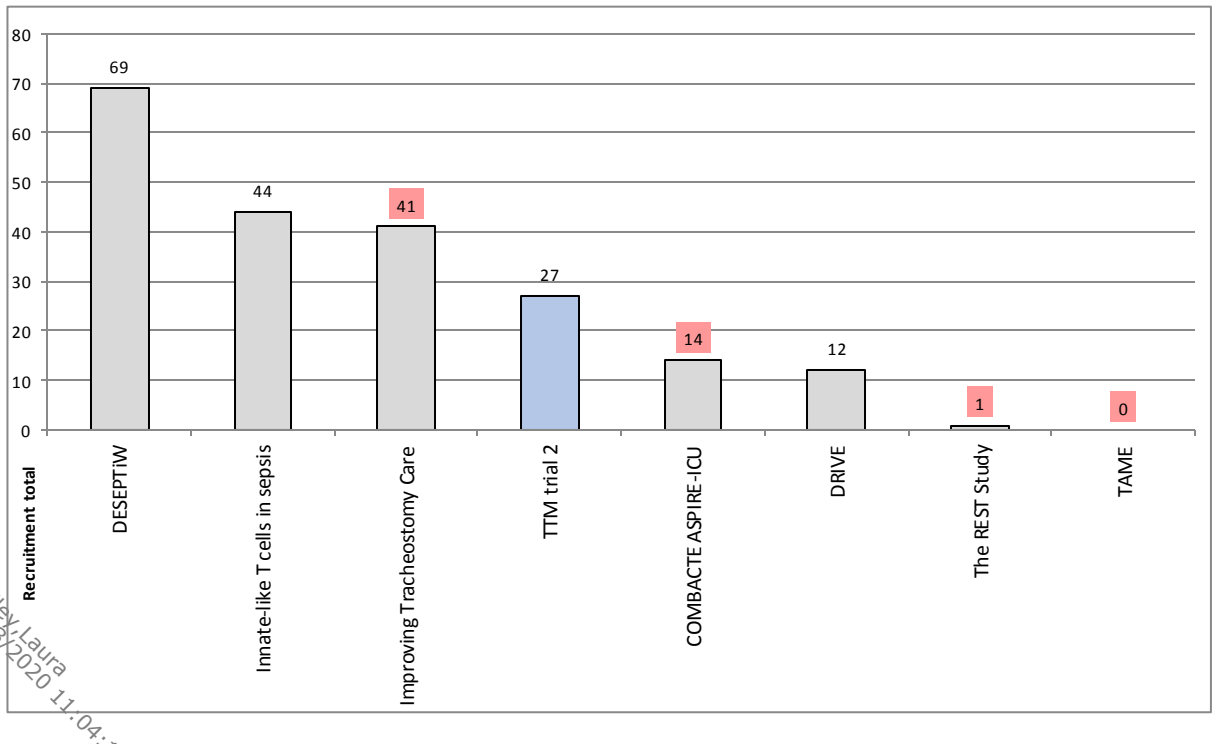
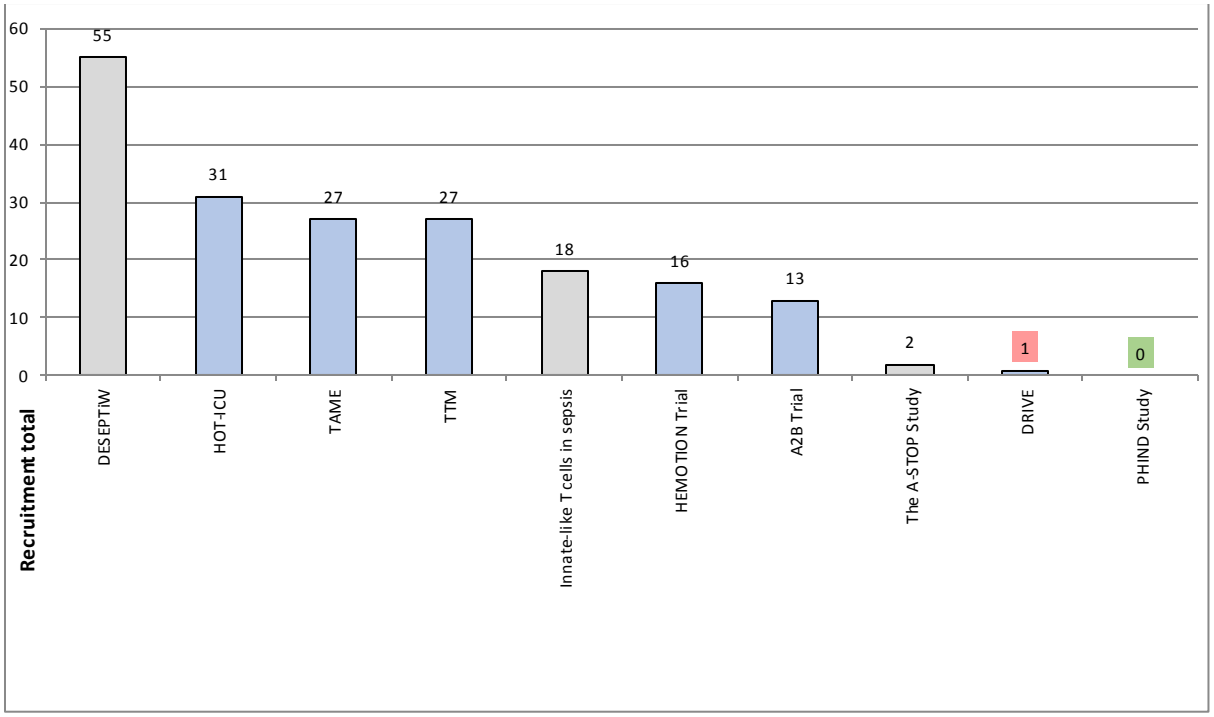


Figure 2 - Specialist Services - Critical Care Non-Commercial Recruitment (2018-19)



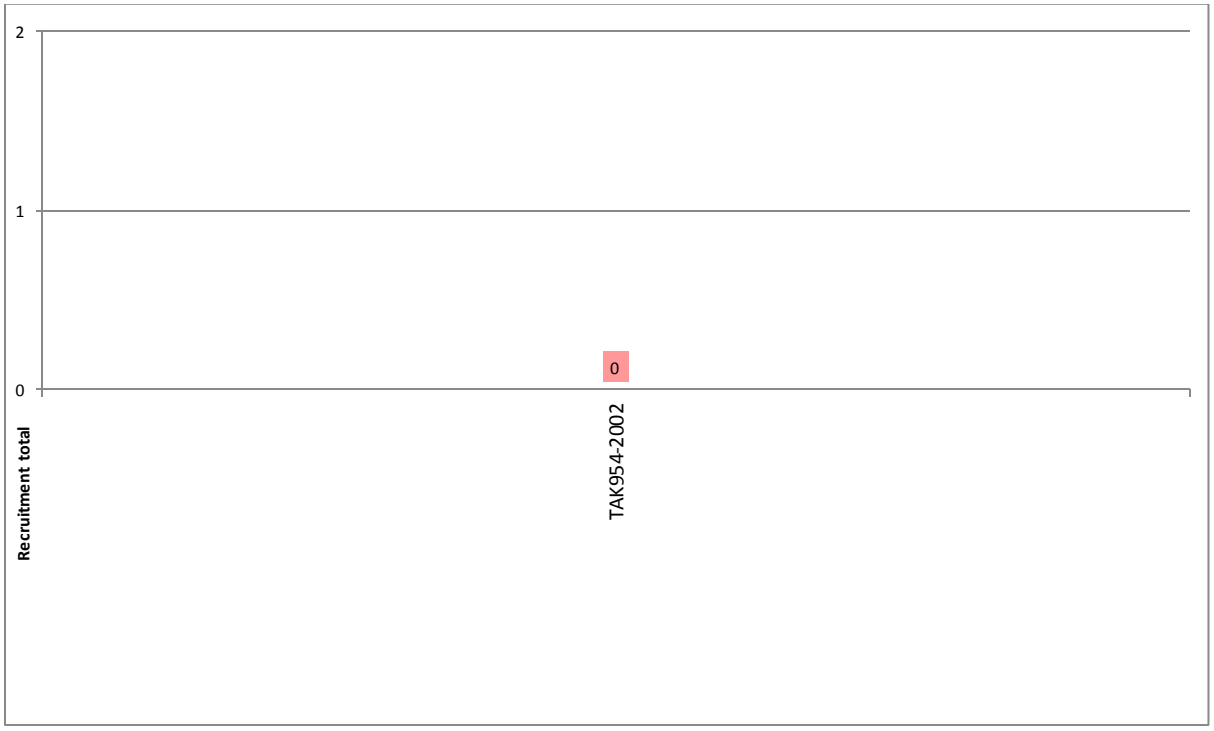
Specialist Services Directorate Recruitment: CRITICAL CARE

Figure 3 - Specialist Services - Critical Care Non-Commercial Recruitment (2019-20)



Specialist Services Directorate Recruitment: CRITICAL CARE

Figure 4 - Specialist Services - Critical Care Commercial Recruitment (2018-19)



No Critical Care 2019-20 Commercial Studies

Specialist Services Directorate Recruitment: HAEMATOLOGY & CLINICAL IMMUNOLOGY

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Specialist Services - Haematology & Clinical Immunology Non-Commercial Recruitment (2017-18)

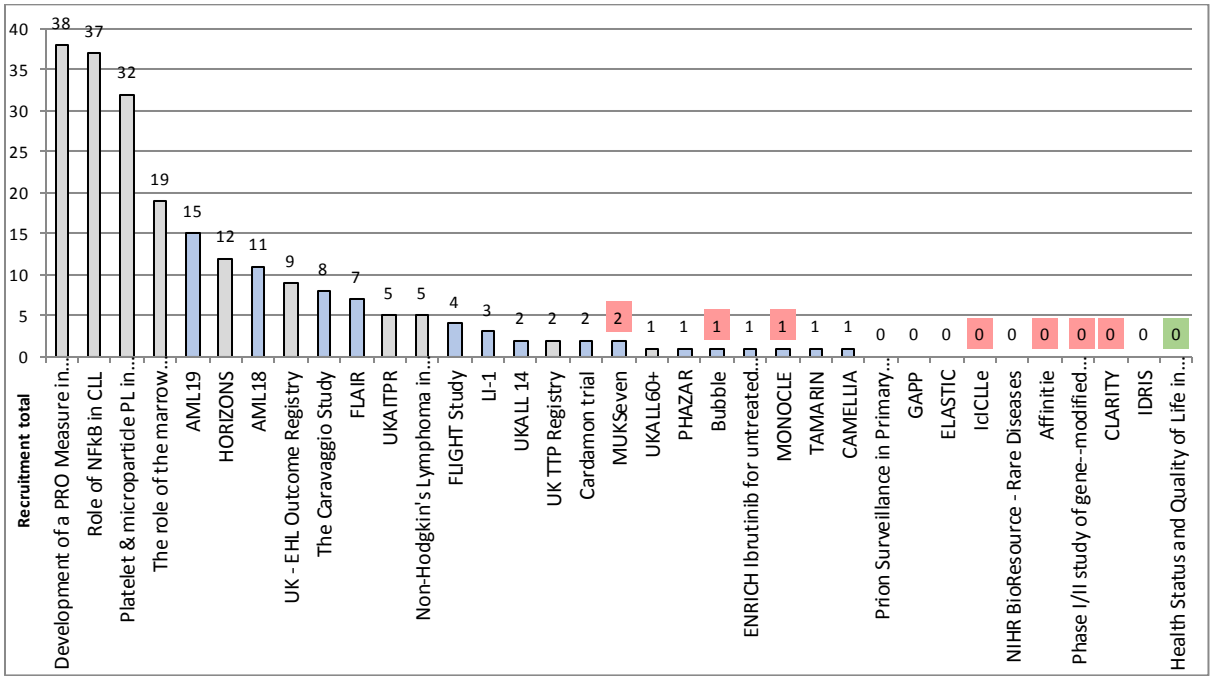


Figure 2 - Specialist Services - Haematology & Clinical Immunology Non-Commercial Recruitment (2018-19)

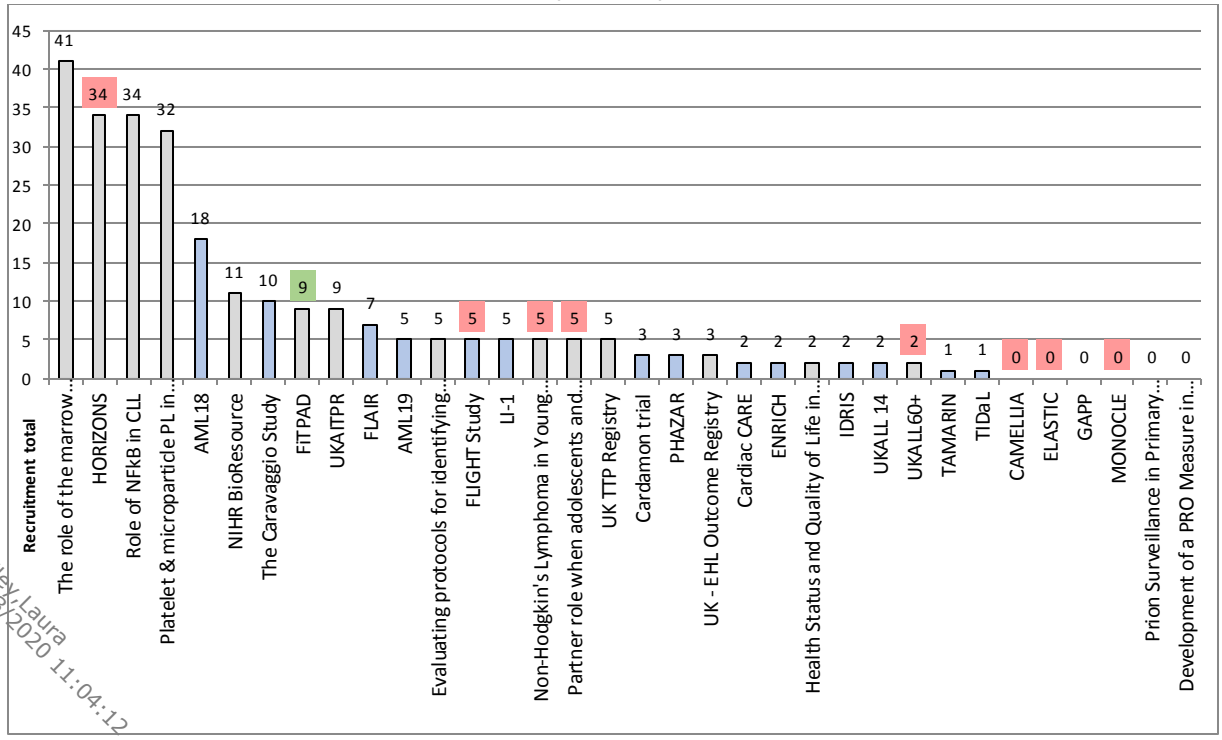


Figure 3 - Specialist Services - Haematology & Clinical Immunology Non-Commercial Recruitment (2019-20)

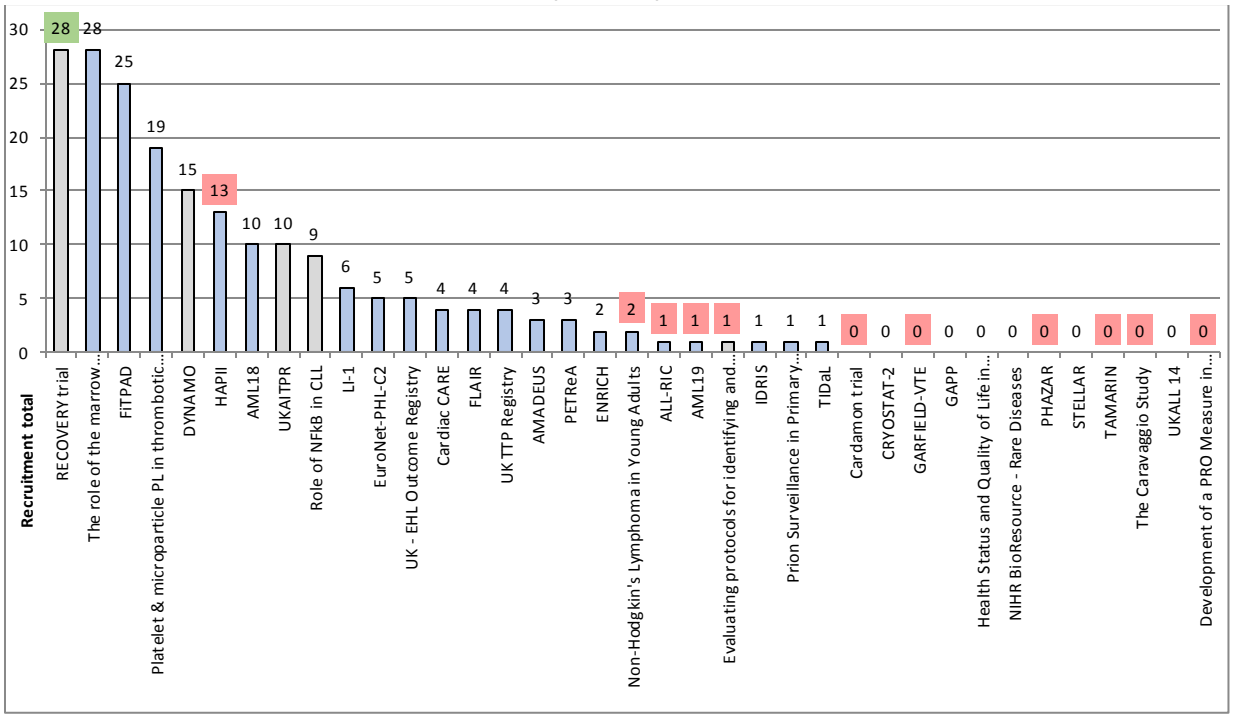


Figure 4 - Specialist Services - Haematology & Clinical Immunology Commercial Recruitment (2018-19)

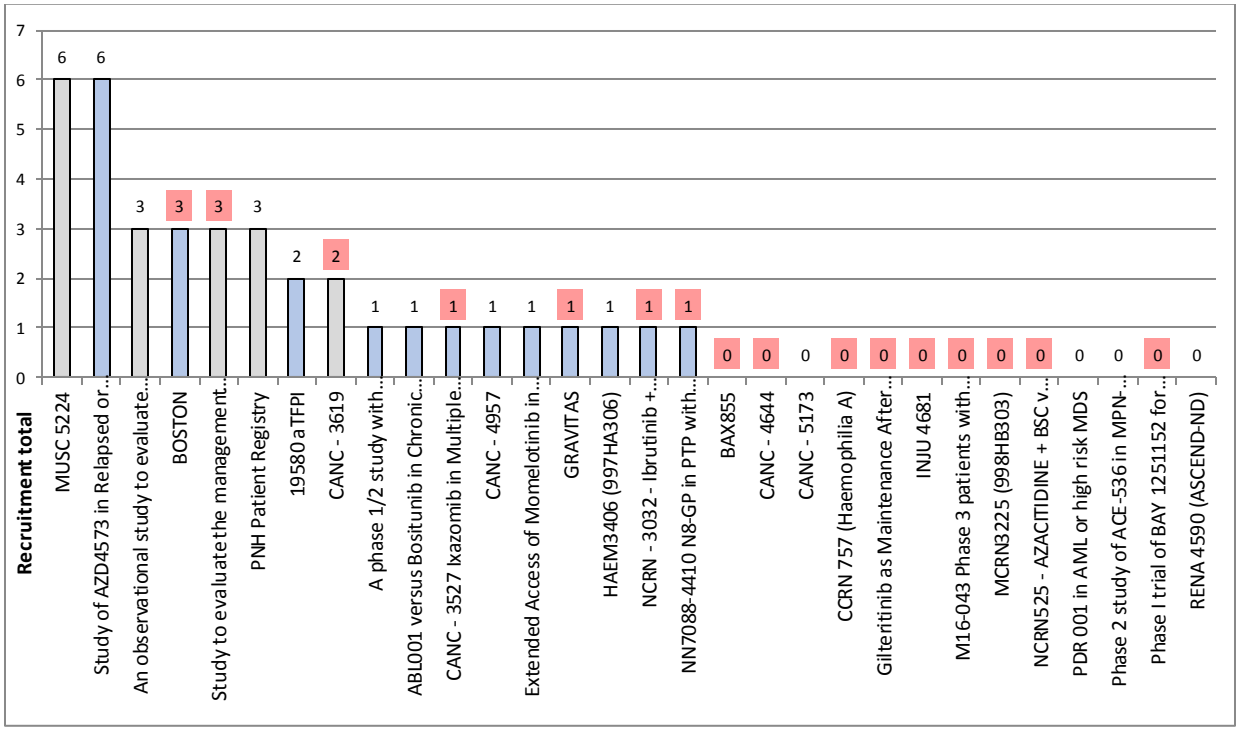
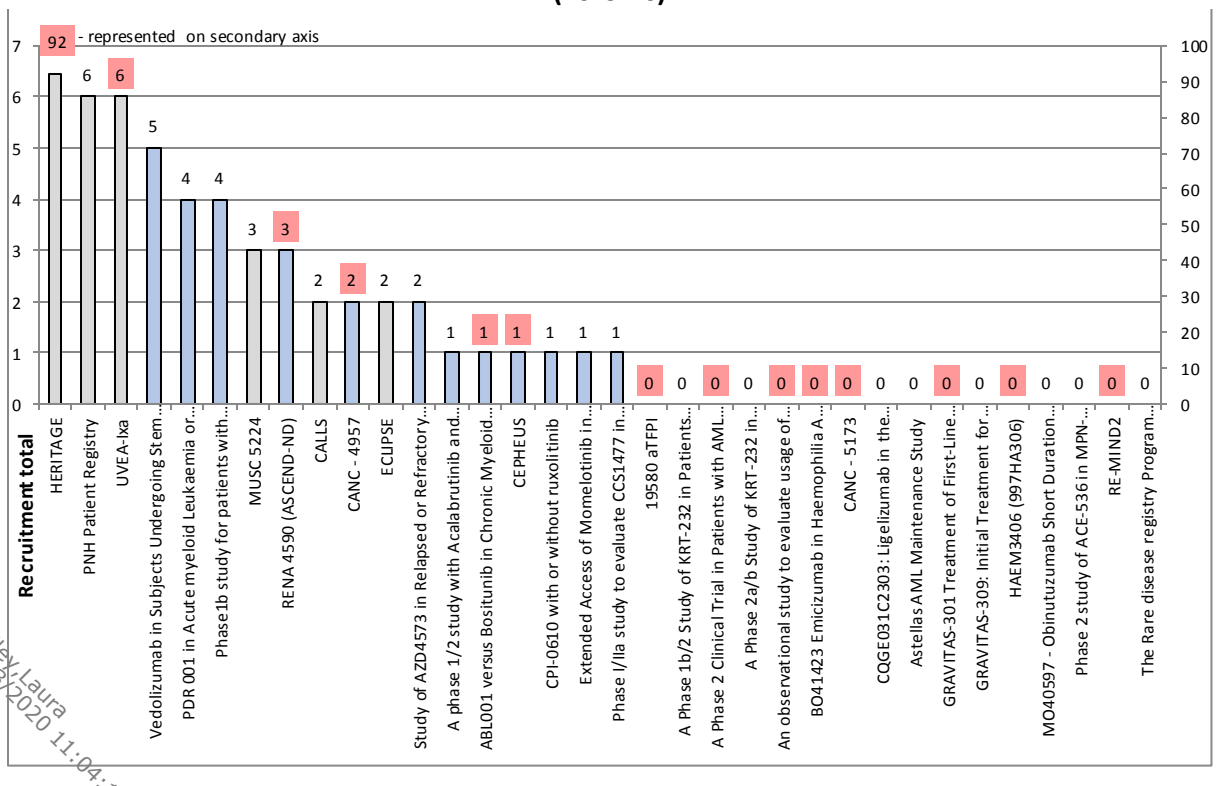


Figure 5 - Specialist Services - Haematology & Clinical Immunology Commercial Recruitment (2019-20)



Specialist Services Directorate Recruitment: NEPHROLOGY & TRANSPLANT

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Specialist Services - Nephrology & Transplant Non-Commercial Recruitment (2017-18)

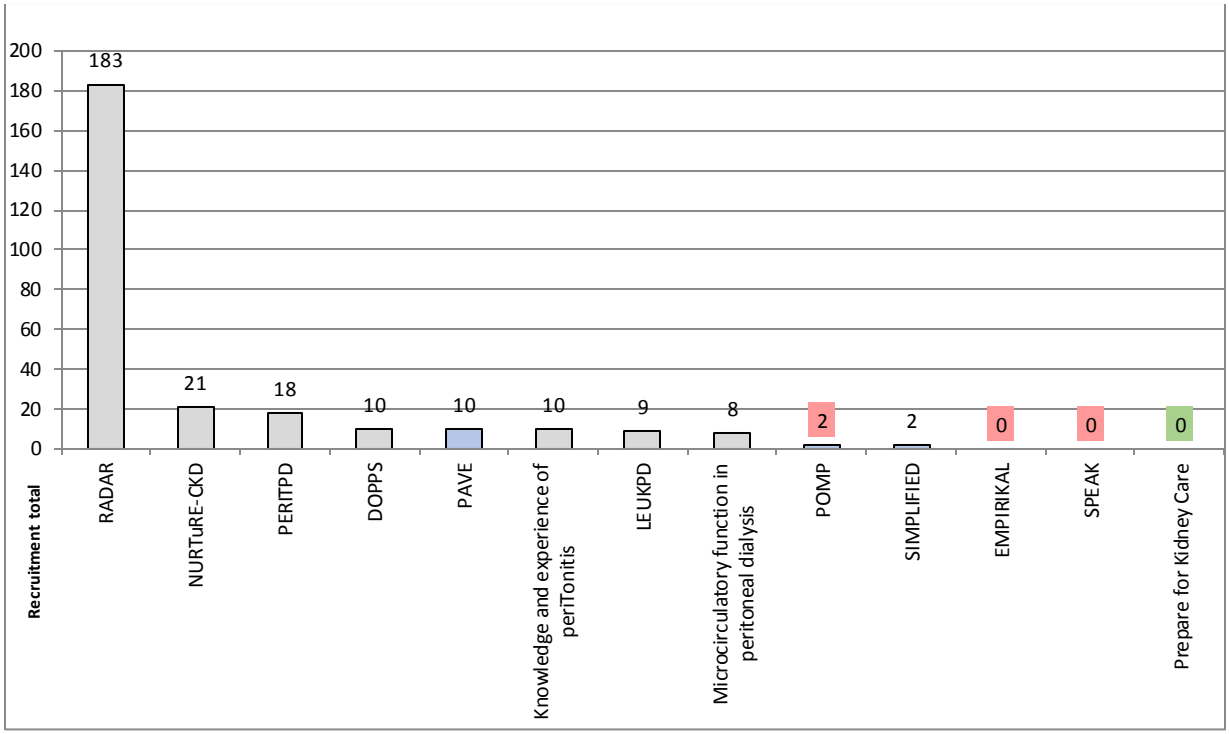
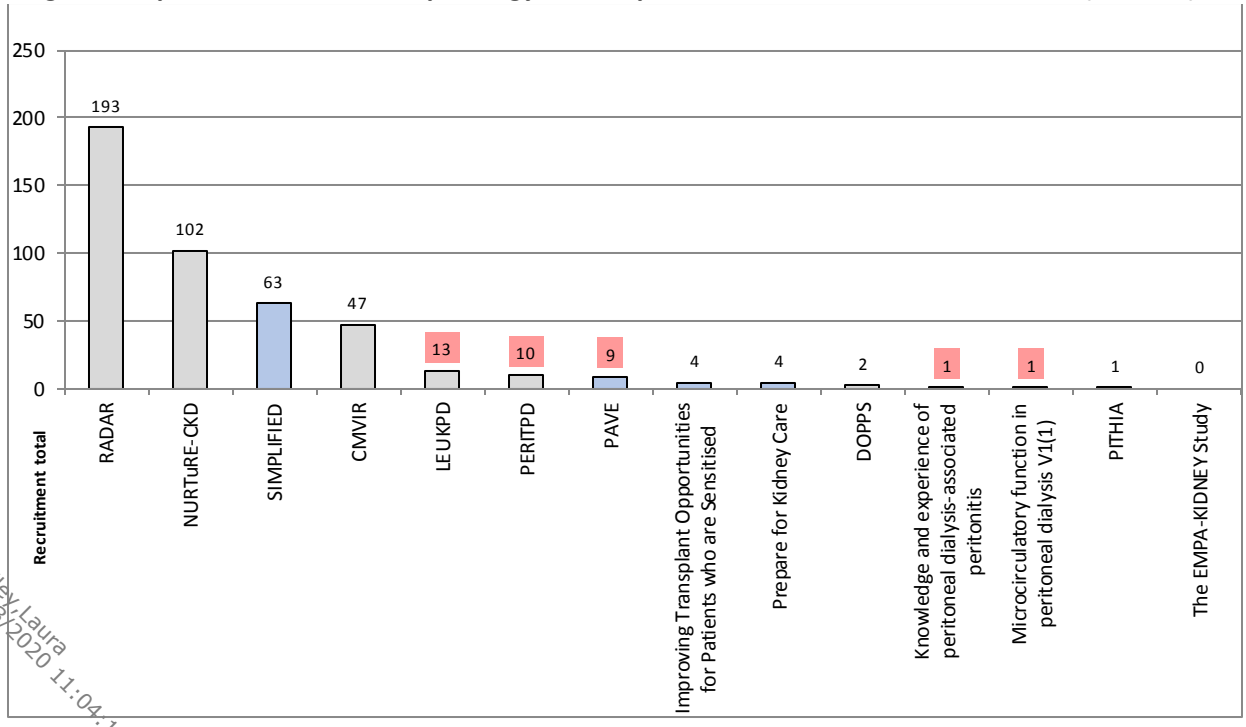
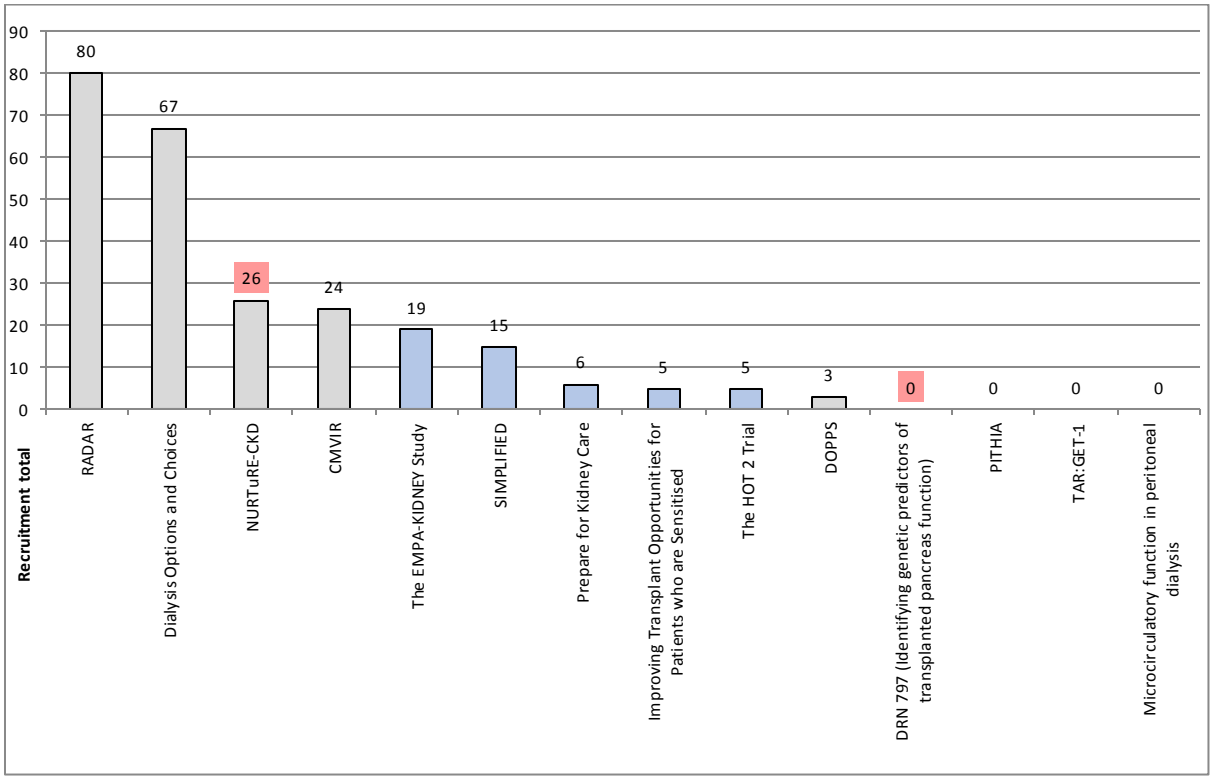


Figure 2 - Specialist Services - Nephrology & Transplant Non-Commercial Recruitment (2018-19)



Specialist Services Directorate Recruitment: NEPHROLOGY & TRANSPLANT

Figure 3 - Specialist Services - Nephrology & Transplant Non-Commercial Recruitment (2019-20)



Specialist Services Directorate Recruitment: NEPHROLOGY & TRANSPLANT

Figure 4 - Specialist Services - Nephrology & Transplant Commercial Recruitment (2018-19)

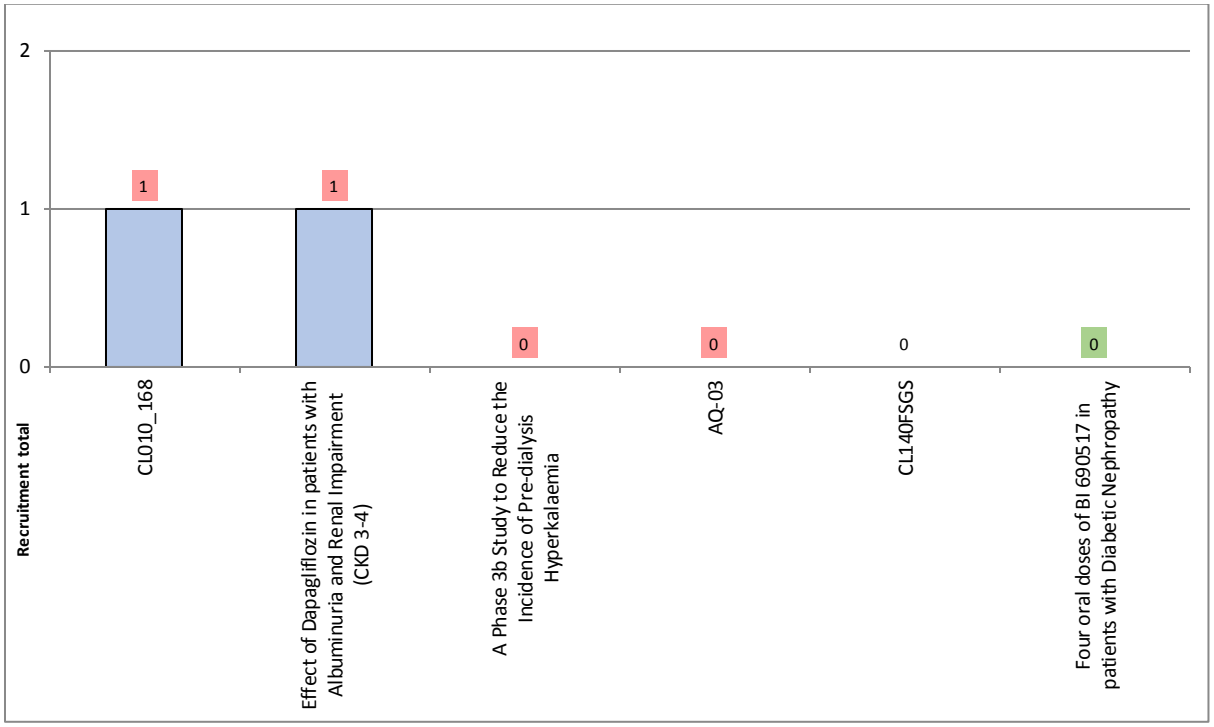
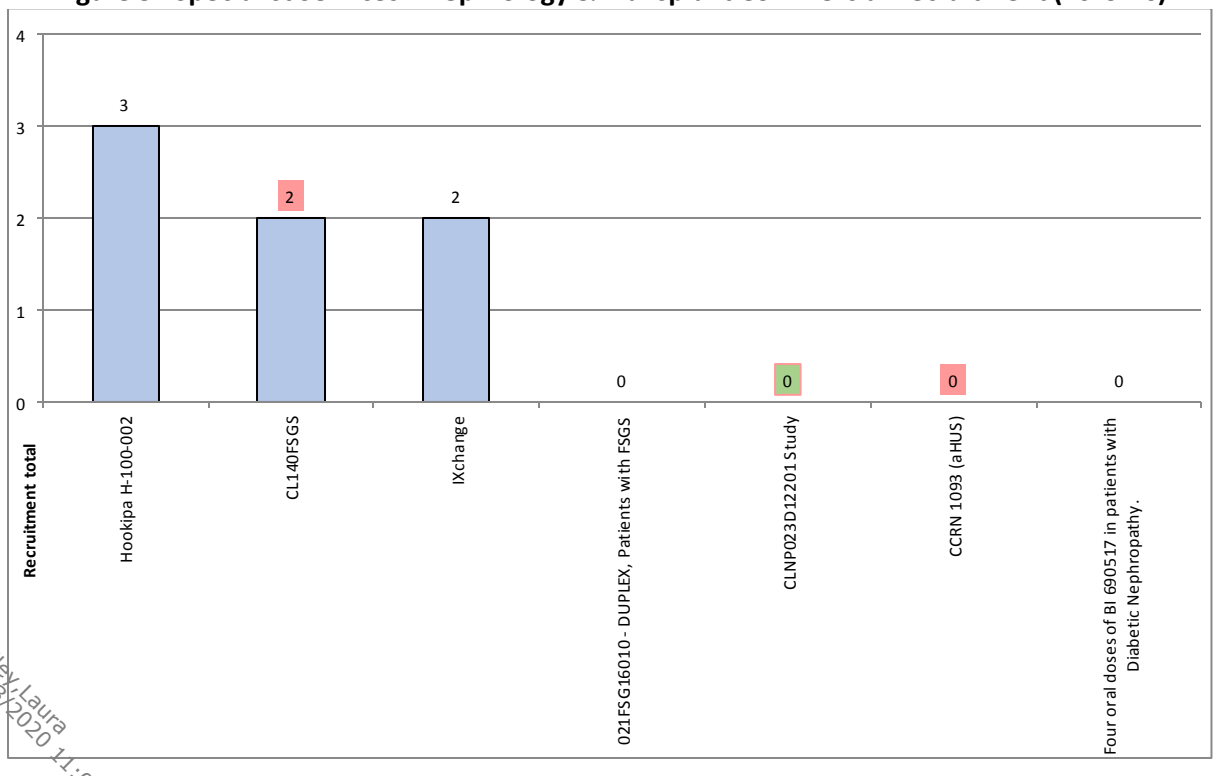


Figure 5 - Specialist Services - Nephrology & Transplant Commercial Recruitment (2019-20)



Tolley, Laura
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Specialist Services Directorate Recruitment: NEUROSCIENCES

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Specialist Services - Neurosciences Non-Commercial Recruitment (2017-18)

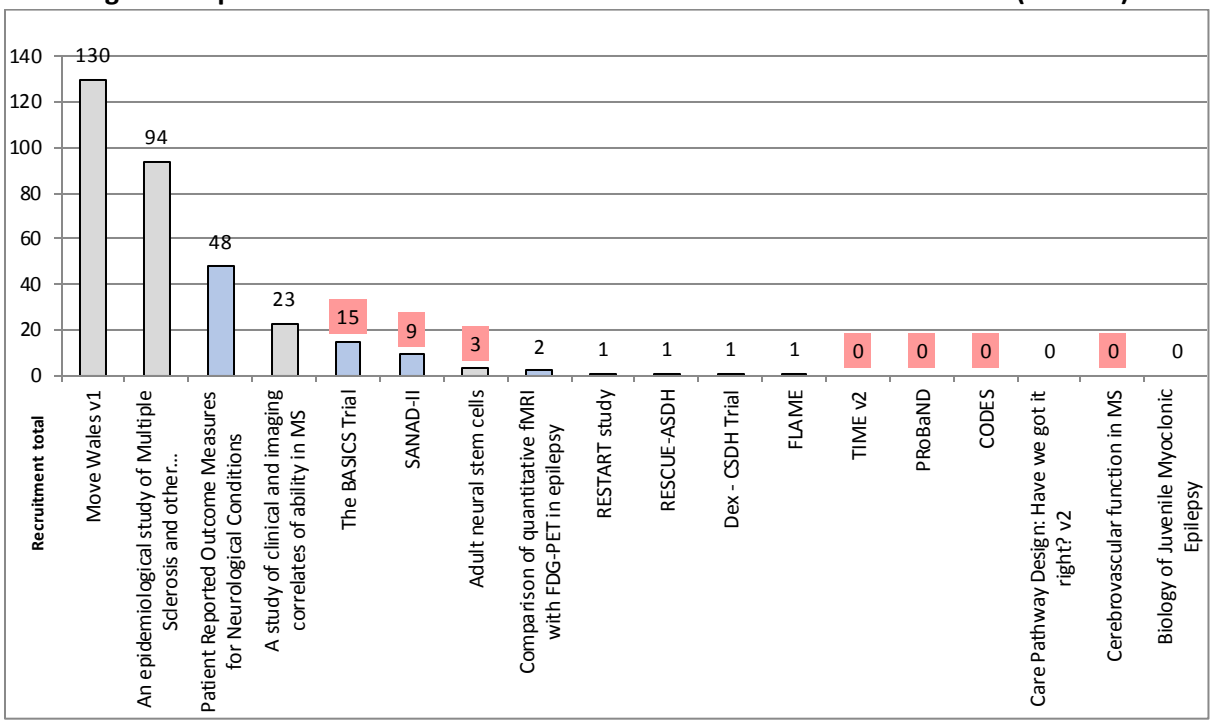
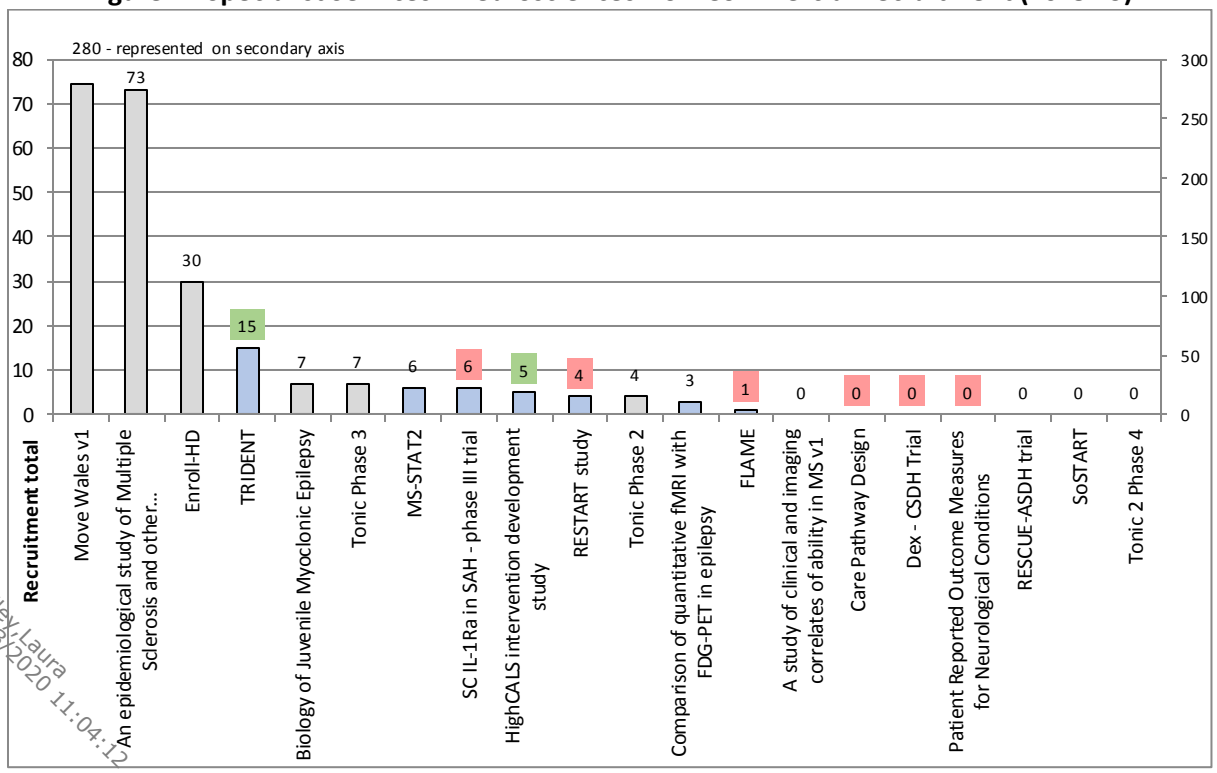
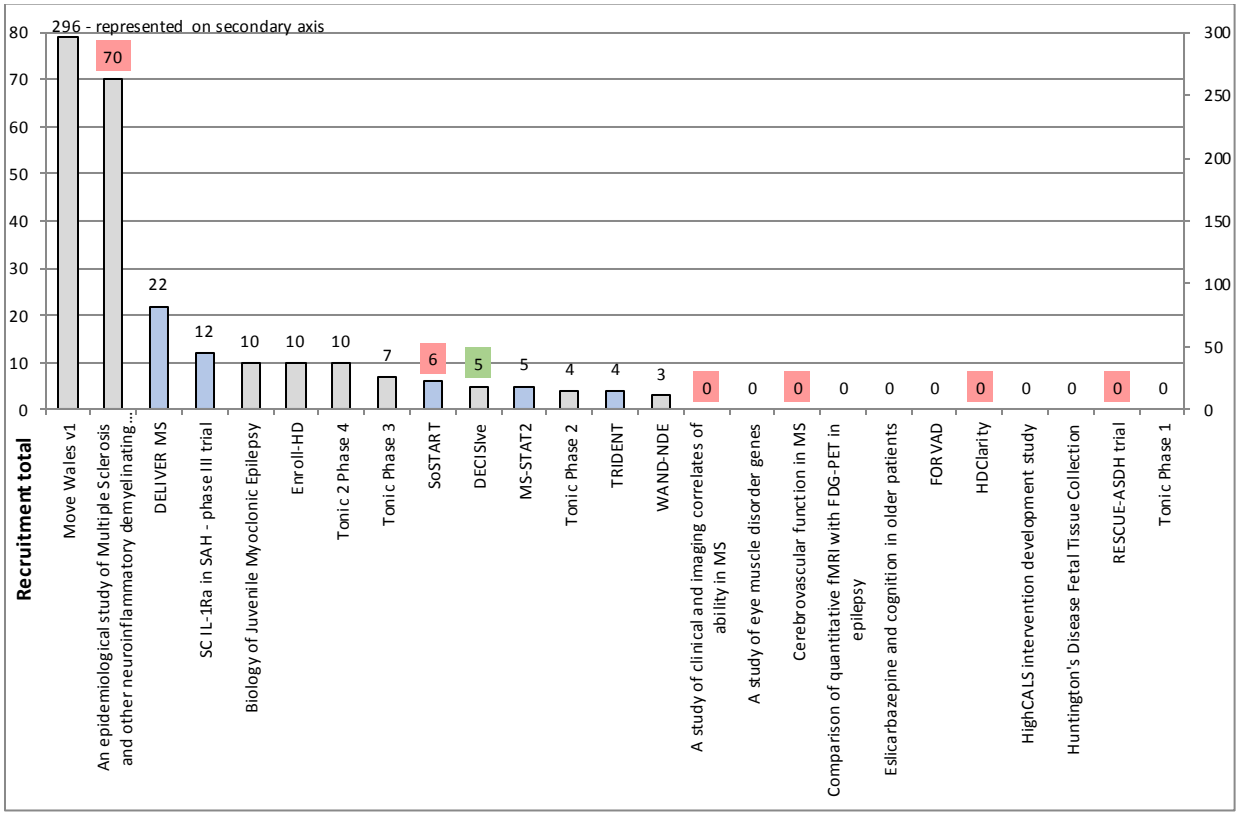


Figure 2 - Specialist Services - Neurosciences Non-Commercial Recruitment (2018-19)



Specialist Services Directorate Recruitment: NEUROSCIENCES

Figure 3 - Specialist Services - Neurosciences Non-Commercial Recruitment (2019-20)



Specialist Services Directorate Recruitment: NEUROSCIENCES

Figure 4 - Specialist Services - Neurosciences Commercial Recruitment (2018-19)

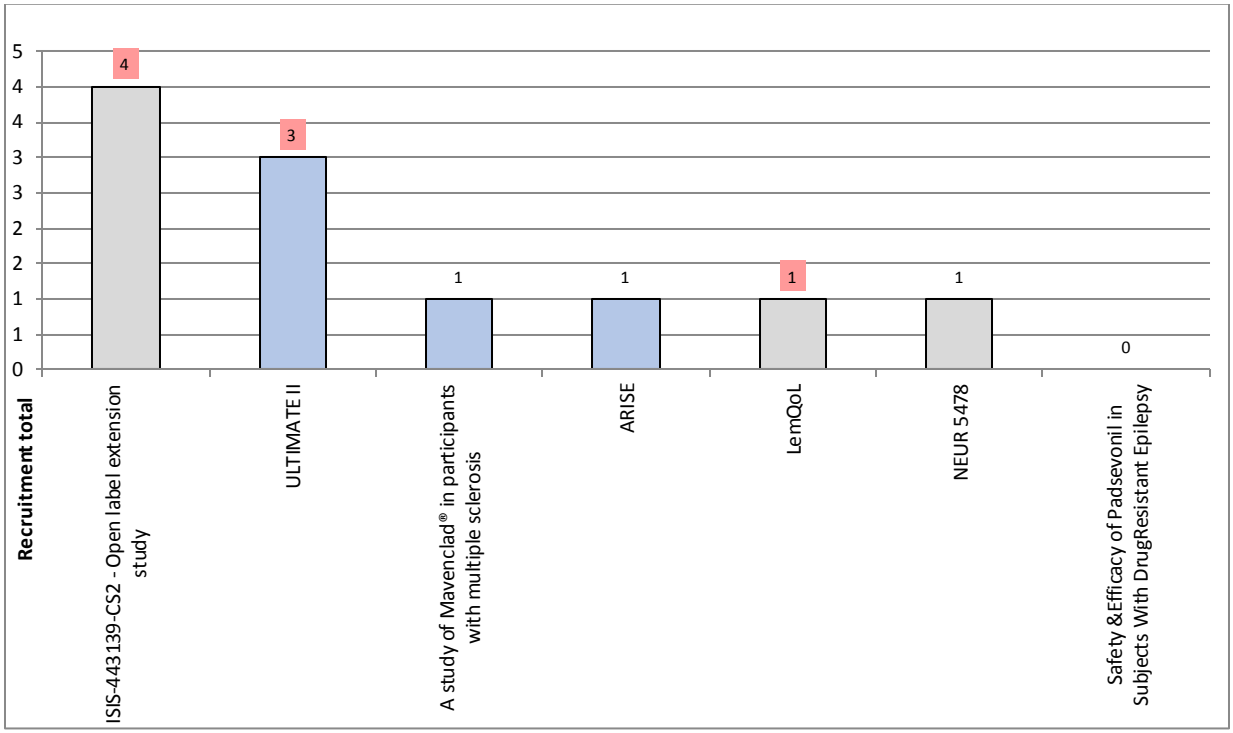


Figure 5 - Specialist Services - Neurosciences Commercial Recruitment (2019-20)

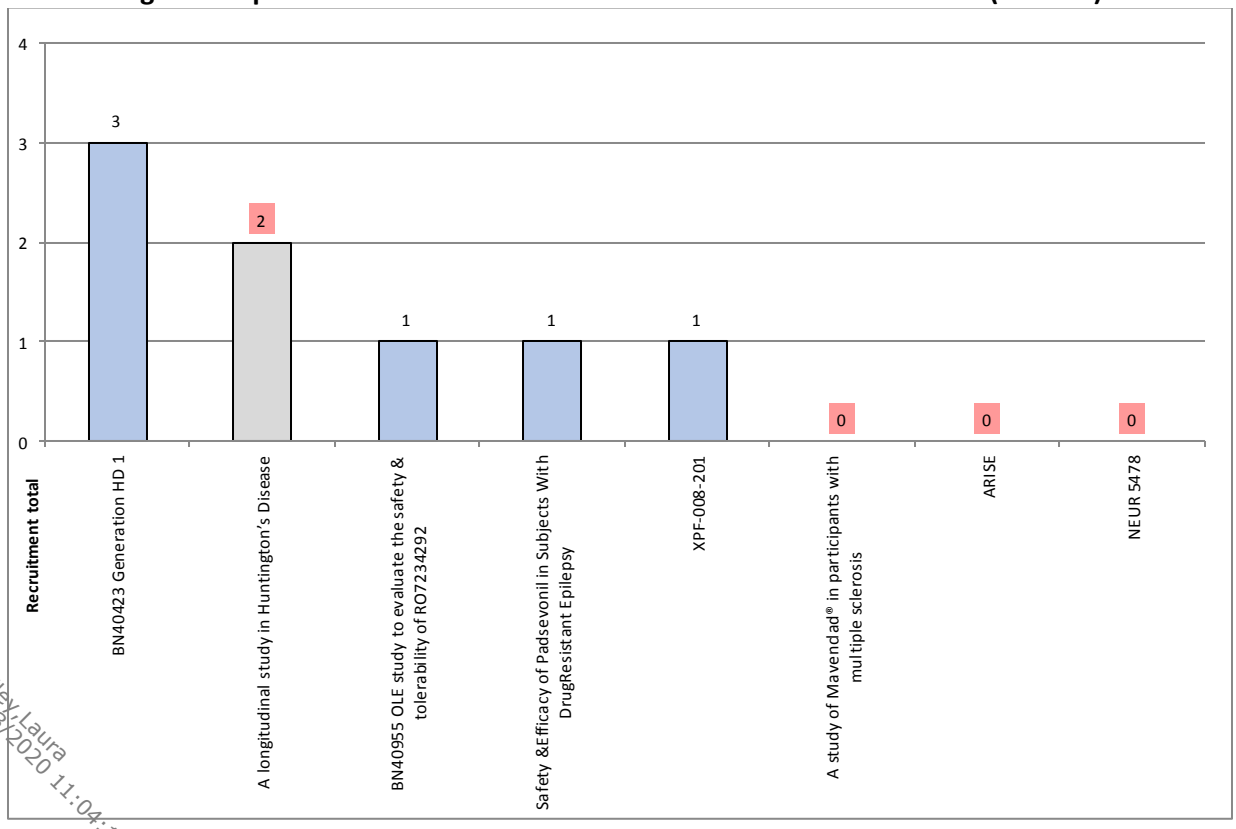


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Figure 1 - Surgical Services Clinical Board Non-Commercial Recruitment (2017-18)

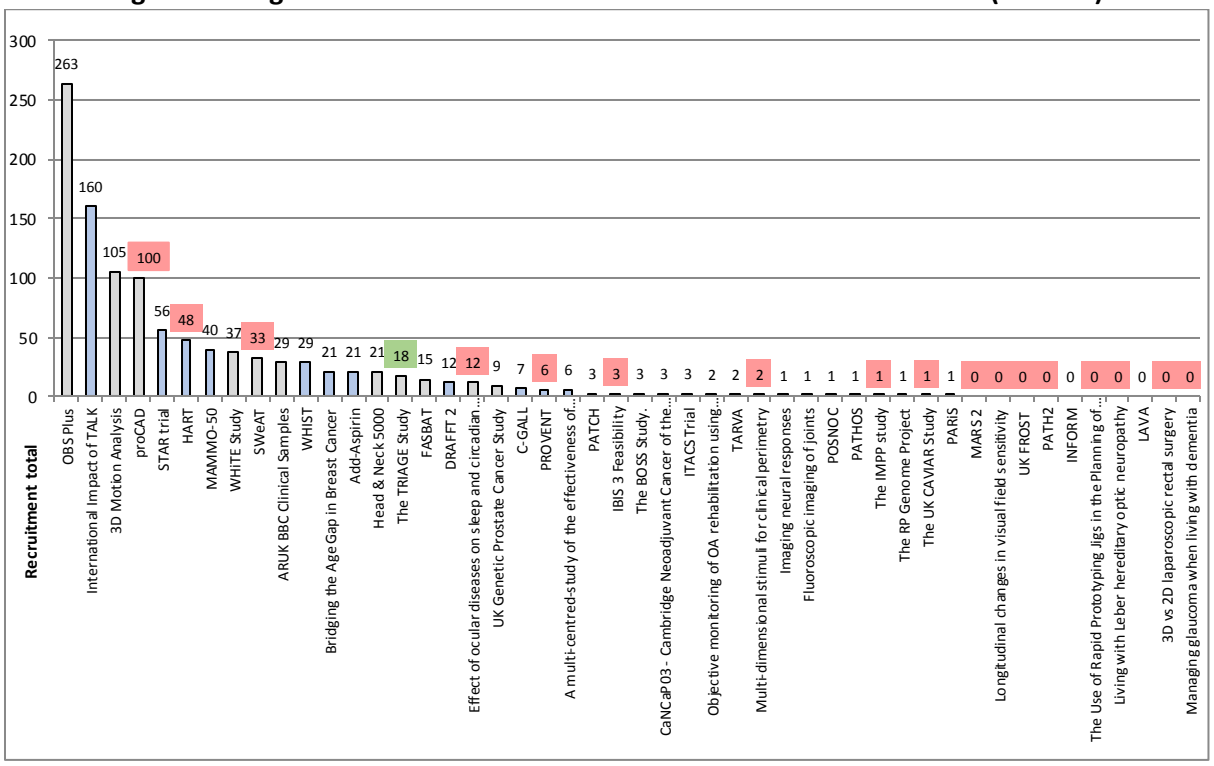


Figure 2 - Surgical Services Clinical Board Non-Commercial Recruitment (2018-19)

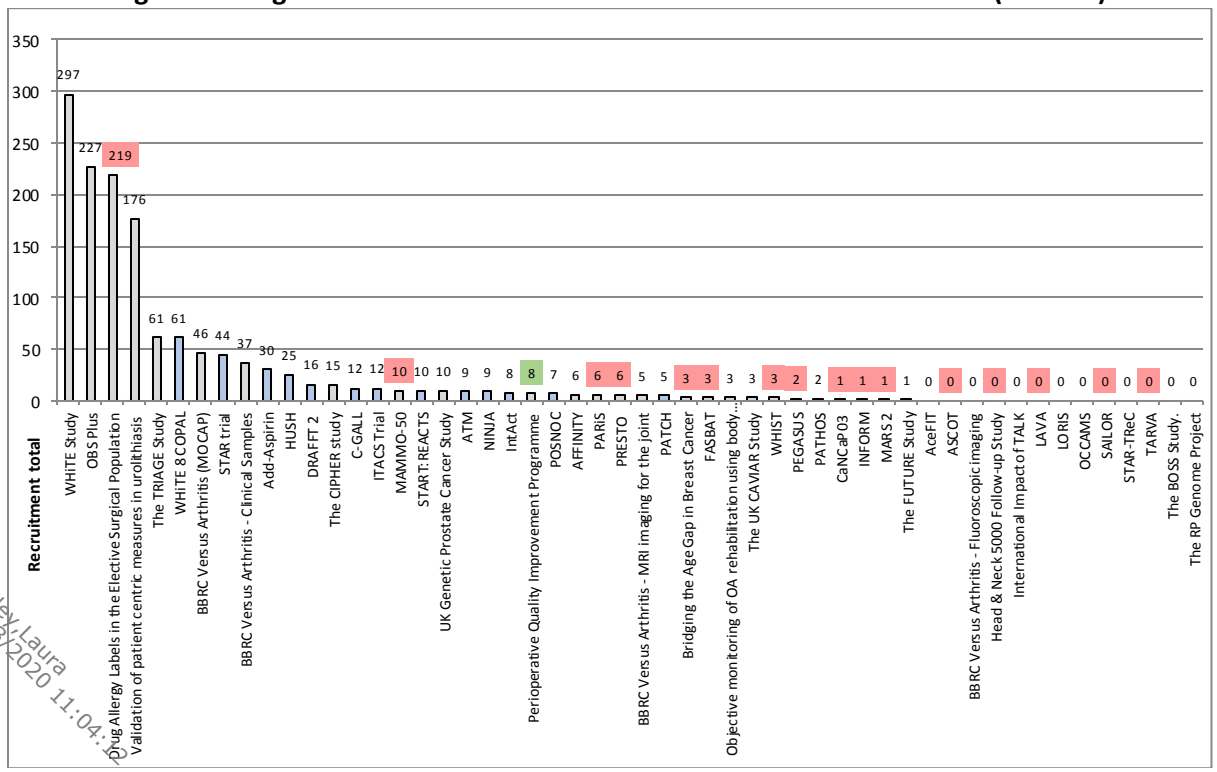
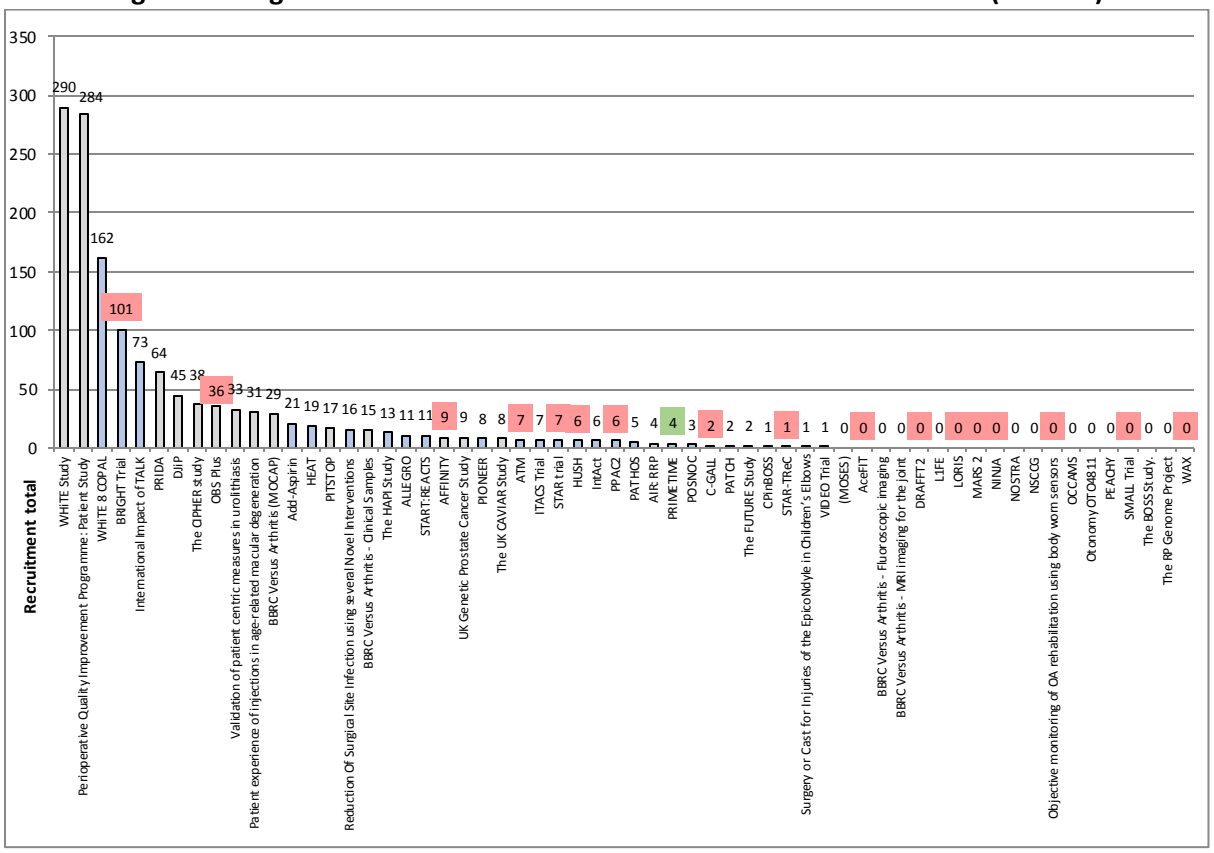


Figure 3 - Surgical Services Clinical Board Non-Commercial Recruitment (2019-20)



2019-20 data now includes Dental Services studies and recruitment.

Figure 4 - Surgical Services Clinical Board Commercial Recruitment (2018-19)

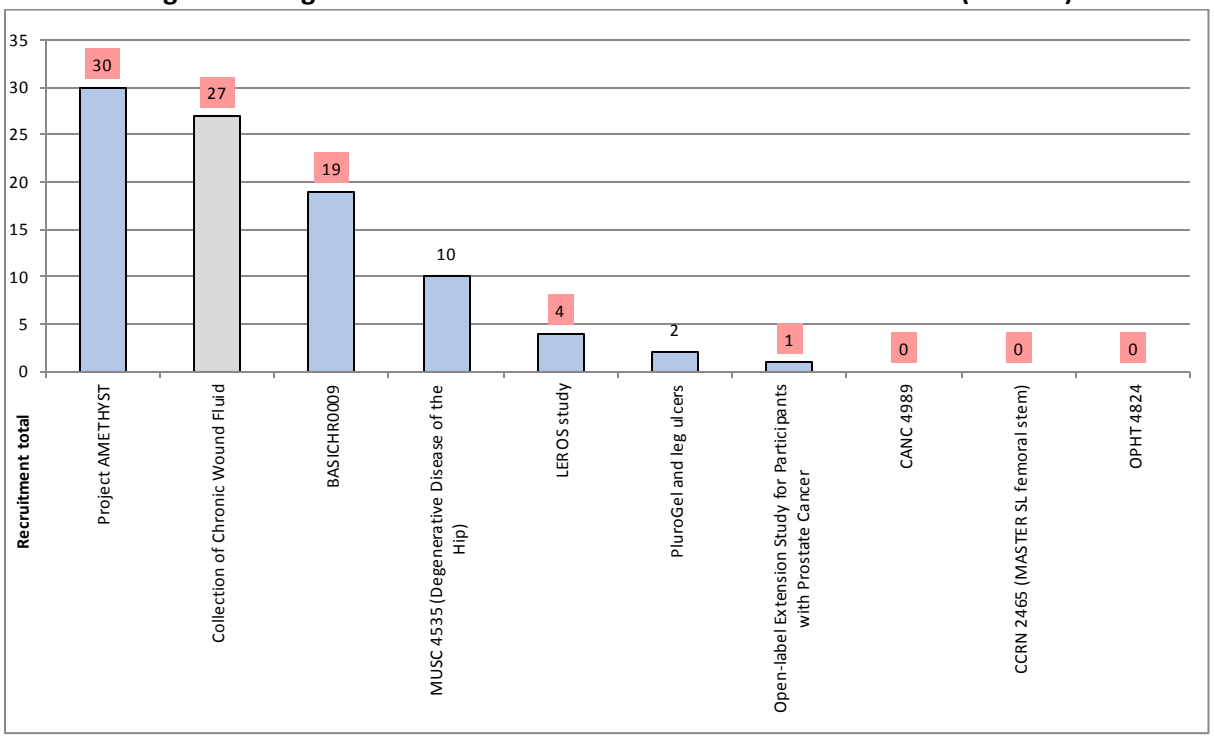
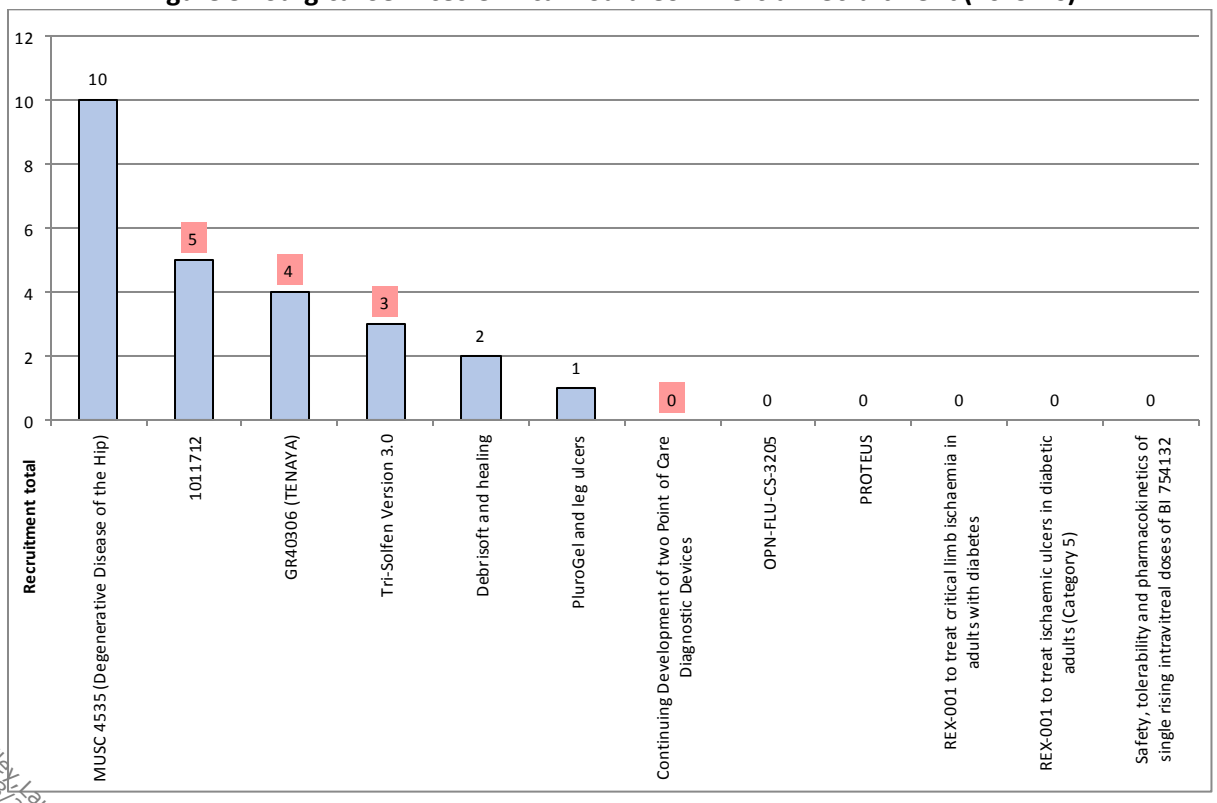


Figure 5 - Surgical Services Clinical Board Commercial Recruitment (2019-20)



2019-20 data now includes Dental Services studies and recruitment.

Other (Split) Clinical Board

: Interventional. : Observational. : Indicates study opened in Feb/March - towards the end of the financial year. : Indicates study closed to recruitment, suspended, on hold or withdrawn during the relevant financial year. *Charts exclude studies in set-up.*

Figure 1 - Split Clinical Board/Directorate Non-Commercial Recruitment (2017-18)

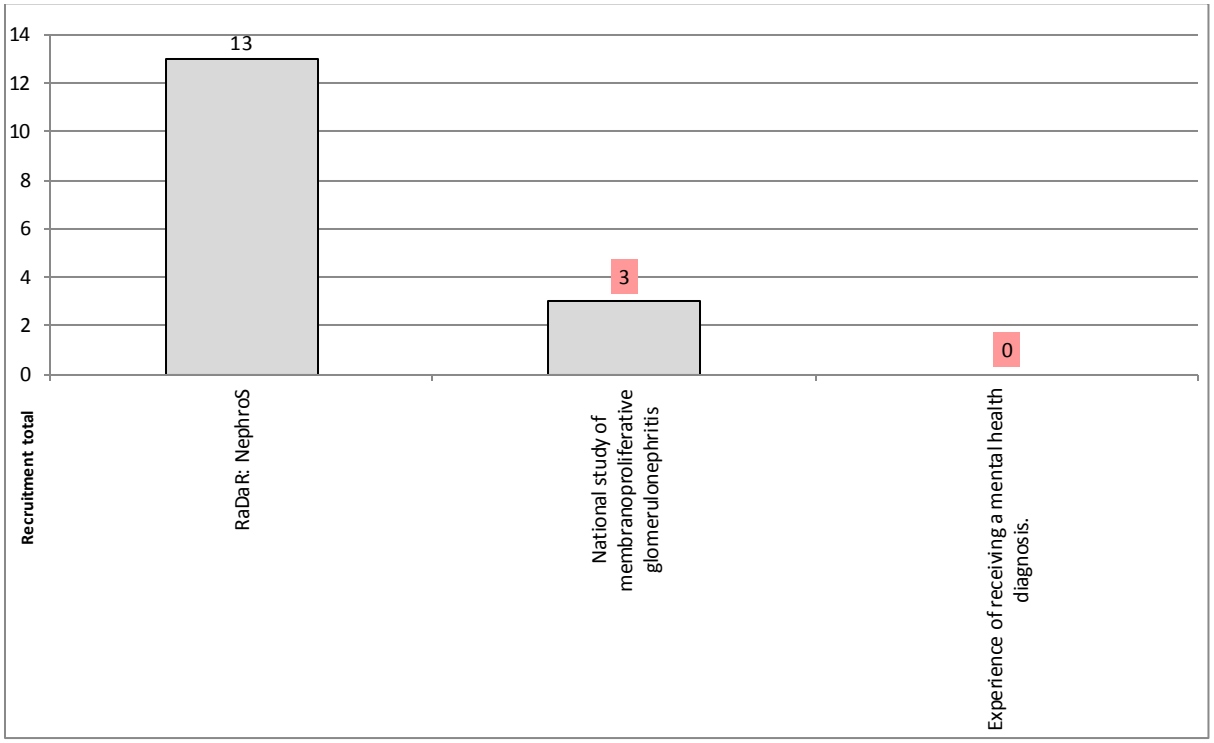
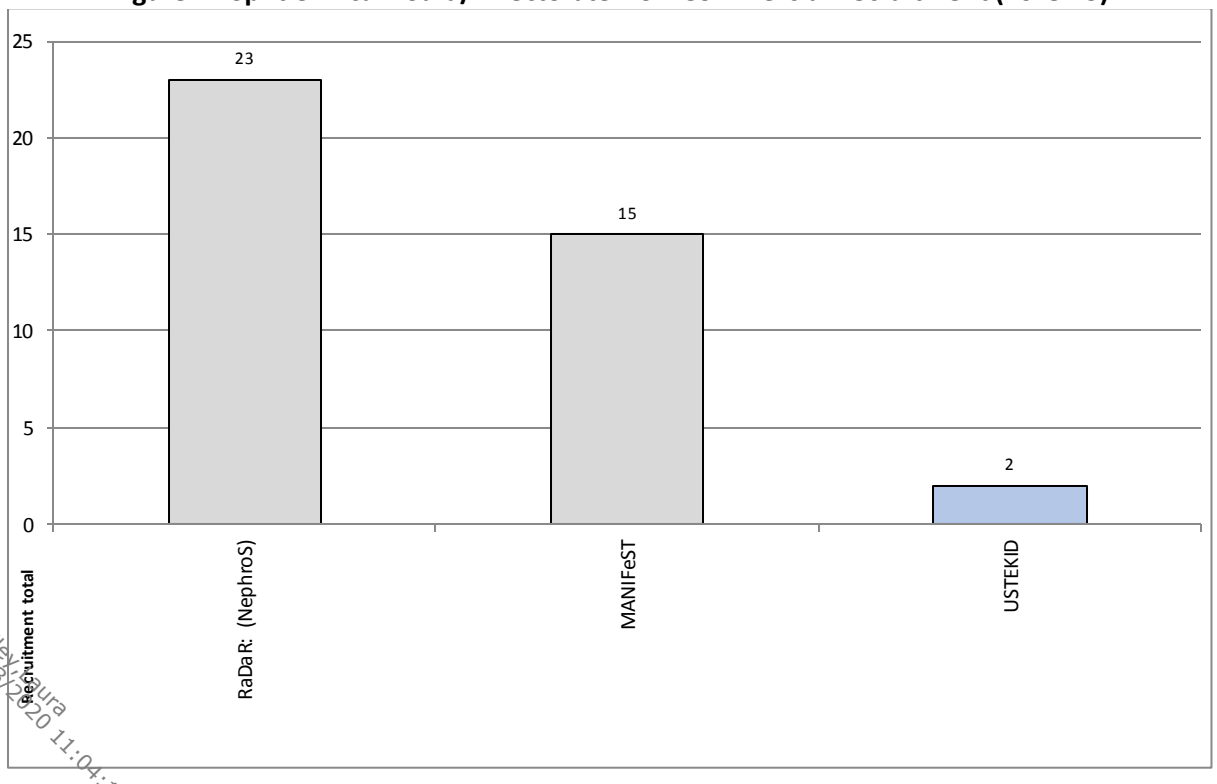


Figure 2 - Split Clinical Board/Directorate Non-Commercial Recruitment (2018-19)



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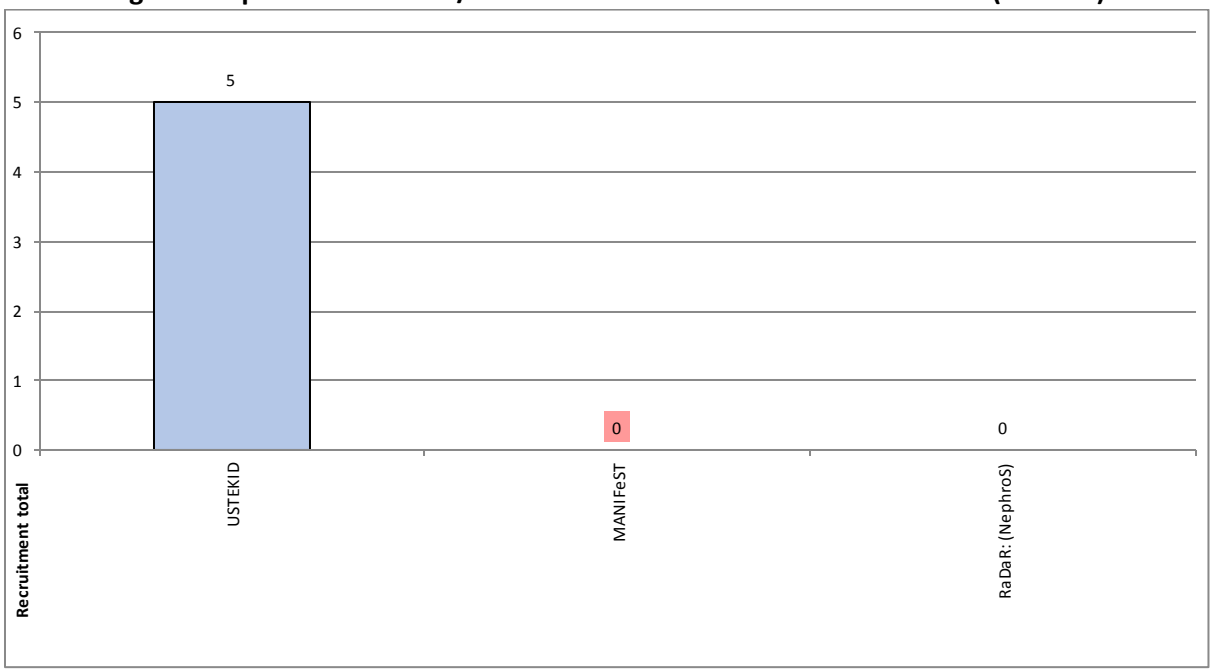

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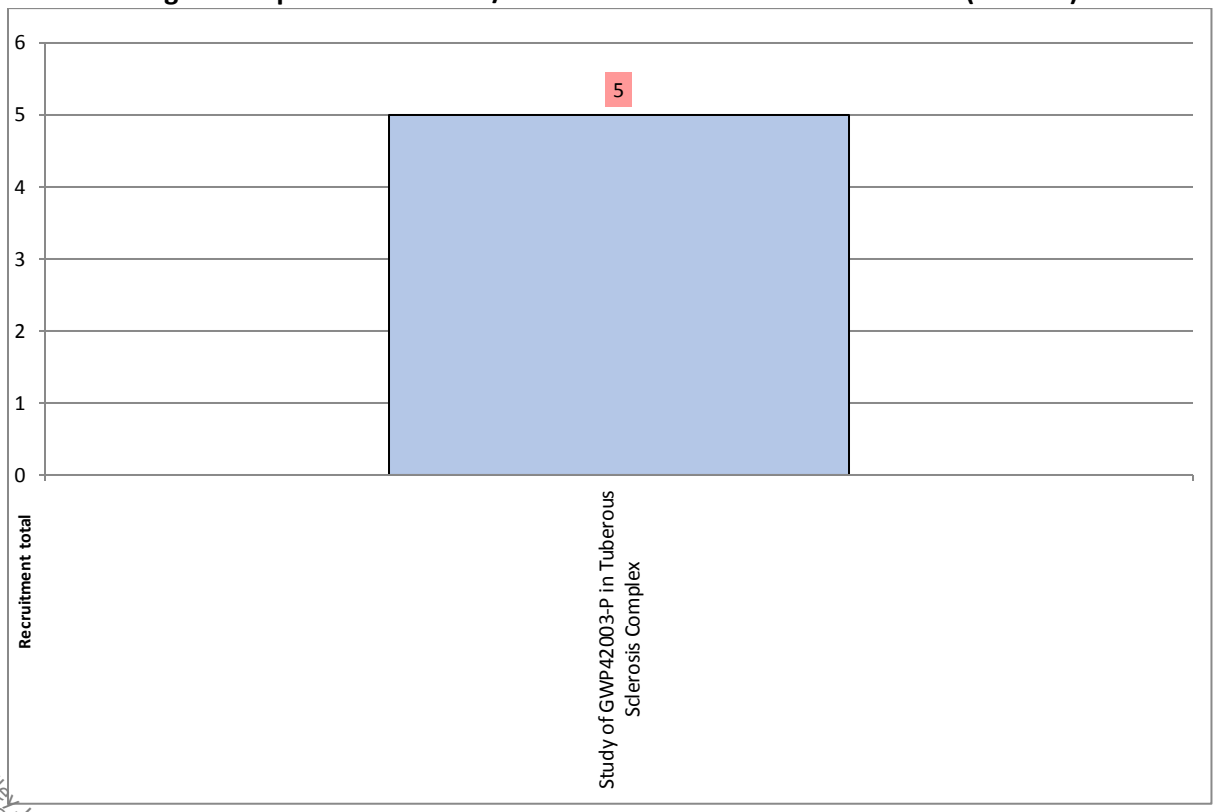
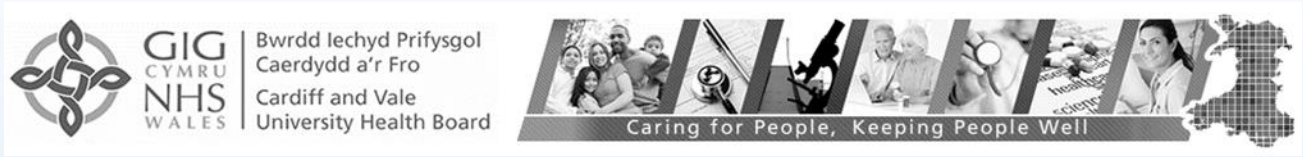


No 2019-20 Commercial Split Clinical Board/Directorate studies

Conclusion

During the pandemic we have seen CVUHB at its very best as it had no choice other than to face up to the enormous challenges coming its way and we move forward a much stronger organisation than we were before. The achievements across the whole spectrum of managing COVID were hard won and only realised by working together - for some key front line workers very selflessly - for the common good of our patients and staff. R&D played a key role in bringing new opportunities to patients and empowering staff to try and find new ways to solve problems which many felt at times were insurmountable. Everyone signed up to R&D playing a key role in the care pathway of COVID patients for whom we had no treatments at the start of the pandemic. This was done out of necessity; however, there are endless needs across the spectrum of our patients' illnesses where R&D has the potential to improve outcome.

The challenge going forward for R&D is how to increase that momentum, engage with clinicians to re-emphasise the value of R&D to their patients and continue our presence in all clinical areas. We will be moving into a new "normal" and given the recent achievements in using the R&D budget in the most impactful way, via the expertise and camaraderie of the Research Delivery Management Board, we are much better placed than previously in achieving these goals. Yes, there will be issues to resolve, but we have shown ourselves exactly what we are capable of.



Developing a Tertiary Services Strategic Plan for Cardiff & Vale UHB

"Delivering World Class Tertiary Healthcare in partnership across Wales"

Strategy & Delivery Committee Meeting

14th July 2020

Dr Navroz Masani, Project Director/

Ian Langfield, Associate Programme Director /

Aim

- To gain a detailed understanding of the tertiary services we provide; and

- To develop a strategic approach and action plan to provide high quality tertiary services for all of our (supra)regional patients.

Development

COVID-19

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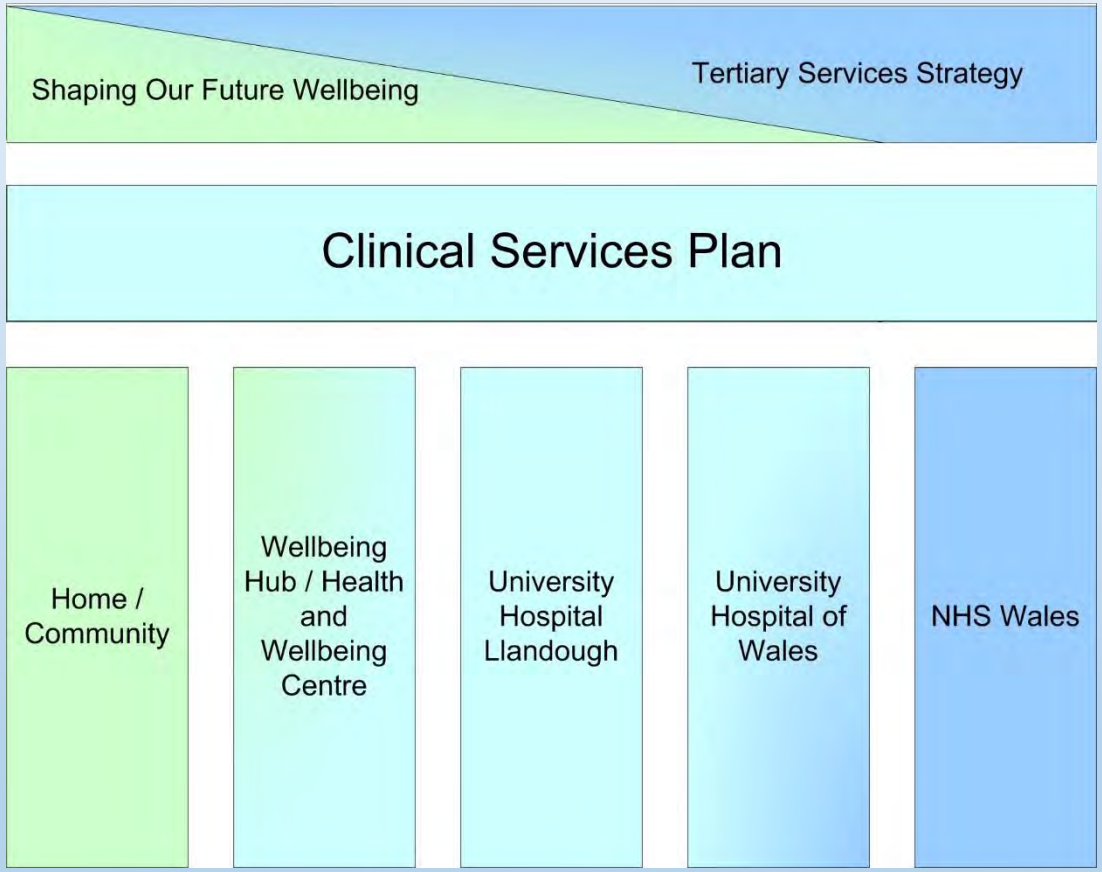
Tertiary Services Strategy

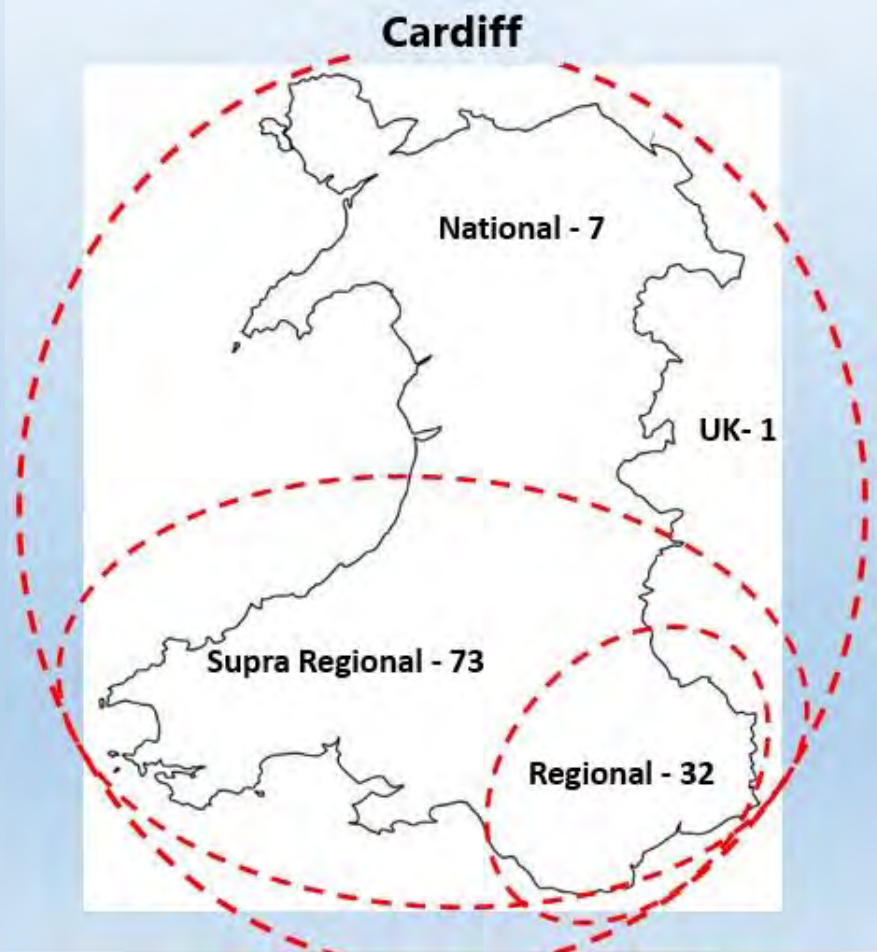
- A core component of the Clinical Services Plan
- Builds upon our Strategy for commissioning and providing services for our local population
- Will help to inform the:
  - Future configuration of services across UHW and UHL
  - Development of the UHW replacement
  - Commissioning of tertiary services



Baseline Assessment - Current Provision

114 services (55 WHSSC, 54 Health Boards, 4 Mixed):

- 104 tertiary services
- 2 enhanced secondary care services
  - Complex sinus disease
  - Haematological Malignancy
- 8 regional secondary care services
  - Audiovestibular Medicine
  - Secondary Care Allergy Service
  - Paediatric Tongue tie
  - Neonatal high dependency care
  - Orthotics
  - Neurology
  - Gynaecology services for Transgender patients
  - Restorative Dentistry



Baseline Assessment – Risk Assessment

- Three domains
  - Quality & Patient Safety
  - Service Sustainability
  - Delivery & Performance
- COVID-19 assessments:
  - Impact on patients
  - Impact on service
  - Implications for future delivery

QPS Impact	QPS Likelihood	QPS Score	QPS - Rationale for risks equal to / greater than 20	SS Impact	SS Likelihood	SS Score	SS - Rationale for risks equal to / greater than 20	D&P Impact	D&P Likelihood	D&P Score	D&P - Rationale for risks equal to / greater than 20	Aggregated Score Total
3	5	15		5	4	20	No sustainable solution due to limit of skill staff. This service is being held together by one physician and there are no people currently being trained. The service will need to change shape and the team have been asked to explore a different multi-discisplinary approach	5	4	20	We perform poorly and patients wait considerably longer then	55
3	5	15		5	4	20	No sustainable solution due to limit of skill staff. This service is being held together by one physician and there are no people currently being trained. The service will need to change shape and the team have been asked to explore a different multi-discisplinary approach	5	4	20	We perform poorly and patients wait considerably longer then	55

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Engagement

- Internal engagement
  - Clinical Boards/Directorates
  - Workshops
    - SWOT analysis
    - Vision statement
  - Feedback survey

- External Engagement
  - External SWOT analysis
  - Feedback survey
  - Workshops – cancelled

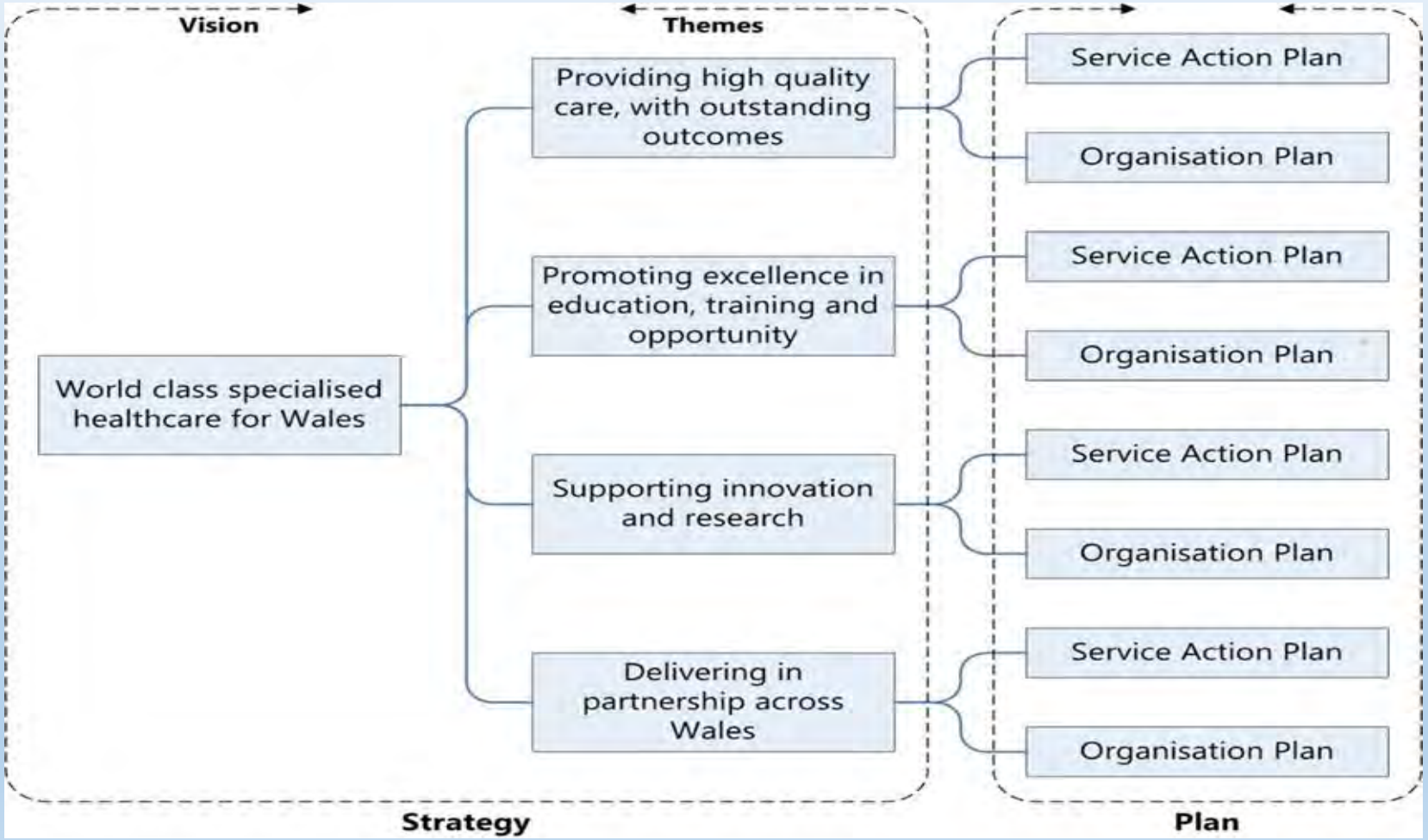
- NHS Wales Directors
  - Meetings – WHSSC, WG, MD's, (DoF's, DoP's)

SWOT Analysis

Two main themes:

1. The need to create a clear and cohesive identity for the Health Board as a provider of tertiary services for patients residing within each of it's service catchment areas; and
2. The need to identify and address the tensions that currently exist between secondary and tertiary services at both a clinical, operational, and strategic level.

Achieving our Vision



Service Action Plan

Aim – to support delivery of strategy

- High level service specification (Plan on a page)
- Service Optimisation
  - Addressing risks (incl. COVID)
- Future Service Developments

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Tertiary Service Action Plan

Part 1: Service Outline

Clinical Board:	**Directorate:**
Sub-Specialty/Clinical Service Title: *[broad service e.g. haem-oncology or sub-speciality e.g. myeloma]*	
Service Description: *[brief outline summarising the nature and scope of the service]*	

Service Specification on a page
Care Pathway (1) Referral Pathways: *[defined indications/guidelines, exclusion criteria]* *[referral process & access criteria]*
Care Pathway (2) Service Model: *[locations, clinical facilities (in- and out-patient)]* *[MDT and/or regional arrangements, IT infrastructure]*
Care Pathway (3) Discharge & Follow up: *[defined criteria, agreed repatriation pathway and mechanism, regional and local follow up arrangements, re-referral criteria]*
Care Pathway (4) Interdependencies: *[with other services/providers]*
Care Pathway (5) IT: *[infrastructure, significant issues]*
Care Pathway (6) Clinical Outcomes: *[quality/performance indicators, patient safety issues]*

Workforce: *[description, significant issues, positive/negative factors]*
Education & Training: *[significant issues, incl. HEIW and University co-dependencies]*
R&D: *[significant issues, incl. University, clinical trials]*

Commissioning Arrangements: *[WHSSC/UHB SLA's, commissioner policies, service specifications]*

Service Action Plan

Aim – to support delivery of strategy

- High level service specification (Plan on a page)
- Service Optimisation
  - Addressing risks (incl. COVID)
- Future Service Developments

Part 2 - Service Optimisation

Baseline Risk Assessment Scores (February 2020)

Quality and Patient Safety			Service Sustainability			Delivery and Performance		
Impact	Likelihood	Total	Impact	Likelihood	Total	Impact	Likelihood	Total
Summary: *[brief description]*			**Summary:** *[brief description]*			**Summary:** *[brief description]*		

Revised Risk Assessment: Impact of COVID-19

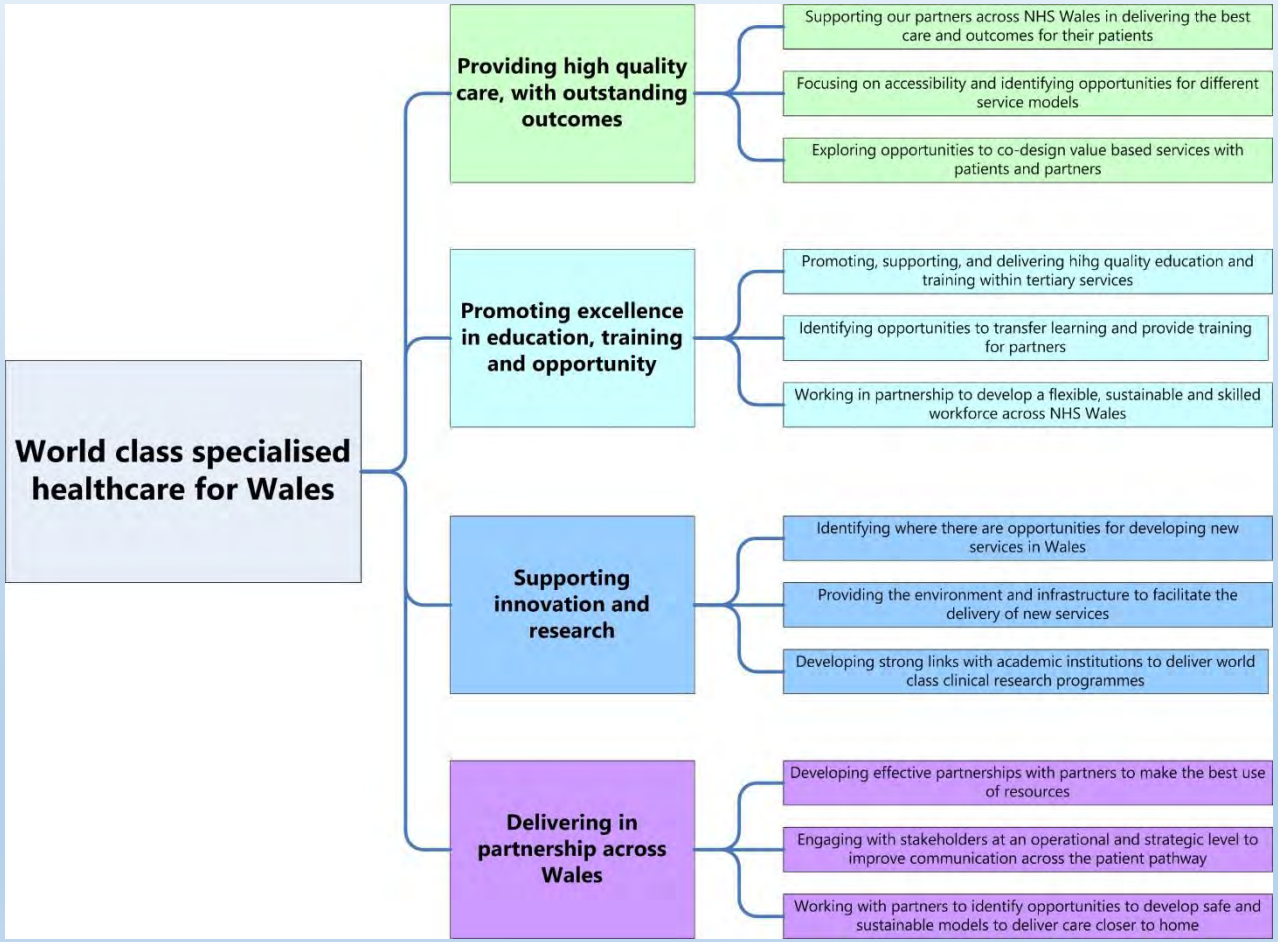
Impact on patients; clinical effects	*[susceptibility, likelihood - high/low][clinical impact - high/low]*
Impact on care pathway; operational effects on current service	*[pathway requirements – green/amber/red][impact on capacity/activity][workforce implications]*
Impact on future pathway; new ways of working	

Part 3 - Future Service Development

Achieving the Tertiary Services Vision – "World class tertiary healthcare for Wales"

Strategic Themes	Restart and Recover – immediate, interim & short term plans (1-3 years)	Rebuild and Renew – medium & longer term plans (3-10 years)
Providing high quality care, with outstanding outcomes		
Promoting excellence in education, training and opportunity		
Supporting innovation and research		
Delivering in partnership across Wales		

Service Action Plan



Organisation Plan

- Actions to support the delivery of the strategy, prioritised for
  - Immediate implementation
    - Restart and recovery
    - Rebuild and renew
  - Early implementation
    - Identity
    - Communication
  - Medium term implementation
    - Formalising commissioning arrangements for supraregional / regional services
    - Agreeing a framework to support non WHSSC commissioned services for
      - Mainstreaming – devolving service delivery to a secondary care provider
      - Service developments – reviewing, prioritising, and approving service developments
      - Patient focused service models – coproducing service models that meet the needs of the patient, identifying opportunities to deliver care closer to the patients home

Evaluation

- Evaluation framework in development to monitor strategy delivery
- To evaluate progress of organisation and service action plans
- To assess alignment with:
  - A Healthier Wales inc. Clinical Services Framework
  - Clinical Services Plan
  - Health Boards Strategies inc. SOFW
  - NHS Wales Operating Framework

Report Title:	**Update on Urgent Primary Care/Out of Hours Action Plan**								
Meeting:	**Strategy and Delivery Committee**						**Meeting Date:**	**14 July 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**	√	
Lead Executive:	**Chief Operating Officer**								
Report Author (Title):	**Director of Ops, PCIC**								

Background and current situation:

The OOH's national peer review panel, led by Dr CDV Jones, visited the Health Board in September 2018, with a follow-up review in November 2019. A range of clinicians and managers, as well as Executive Board members met with the panel. From both reviews an action plan was formulated focusing on the following terms of reference:

- Recognise good practice and identify what can be scaled up at a regional or national level
- Provide constructive peer comment and support
- Provide clarity of direction /focus for solutions
- Assist in the development of a solution focused, sustainable model for Wales within which workforce planning will be a central component.

A paper was provided in January 2020 on the proposed action plan recommended by the national OOH review panel. An update on progress is included at Annex 1

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

Whilst Covid-19 has inevitably meant some work has been put on hold, there has been a great deal of progress made since the national peer review. More detail is provided in Annex 1 but some key areas in relation to the themes in the action plan include:

<u>Sustainability of Service</u>

- A decision was taken to pilot a closure of the OOH base at UHW. It has been closed throughout the Covid-19 pandemic with no adverse outcomes. Work is being developed on CAV 24/7 which will provide a new phone first, triage model for patients who would usually have attended the Emergency Department to ensure they get to the right place, first time.
- The OOH's triage suite has a completion date of 22nd July and it is expected that all Barry Communication Hub staff will have moved to CRI by September 2020

<u>Multi-Disciplinary Working</u>

- Multi-disciplinary working within the OOH setting now includes Mental Health and Palliative Care Practitioners. The pilots have been positive and a formal report will be completed in July. Whilst the pilots have finished, these roles have continued within the service.
- Minor Illness sessiosn are gradually being introduced into the weekday rota, expanding on the success over weekends

Adastra Upgrade

- The Adastra IT upgrade was migrated on to the new server and went live in June.

Best Practice / Sharing

- Development of the 24/7 Business Case – a 24/7 ''phone first'' triage model – expanding on the Health Boards 'Alliance' work with Canterbury

Regional Working

- A Business case has been developed to take forward a Regional Dental Model hosted by Cardiff and Vale UHB. Negotiations have recommenced to develop a dental-nurse triage model 24/7 – firstly to mirror the OOH's model during daytime hours within Cardiff and Vale, then to move forward with Cwm Taf and Aneurin Bevan in a phased approach

Rollout of the 111 programme has been delayed at a national level due to the Covid-19 pandemic. The 111 Implementation Board has been stood down and will be re-established in 2021. The likely date for rollout in Cardiff is Q1 2022 but this will be subject to confirmation of the national rollout plan.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.)

The Urgent Primary Care/OOH's service is one of the key services within the Health Board and receives around 120,000 calls per year. There is increasing scrutiny on the unscheduled care system and performance is reported on a weekly basis to Welsh Government.

Throughout the Covid-19 pandemic OOH services have ceased at UHW – earlier than the trial closure planned for May, concentrating services from CRI and Barry Hospital. No adverse issues regarding patient pathways, clinical risk or impact on other LHB services, specifically ED have been noted.

Whilst not explicitly part of the OOH Peer Revew, the recent work on the CAV 24/7 model does have reputational risk due to it being a significant change in the way people will access services. Therefore, it is being carefully developed and implemented by clinicians and operational managers and a detailed communication and engagement plan has been developed.

Recommendation:

The Strategy and Delivery Committee is asked to:

- Note the progress of key issues within the OOH Action Plan, despite the Covid-19 pandemic.
- Note the likely new date for rollout of the 111 Programme in Cardiff and Vale - Q1 2022.
- Note the work that has commenced on CAV 24/7.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	√

3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	√	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	√	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	√	Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Cardiff and Vale University Health Board

Out of Hours Peer Review Action Plan: Update June 2020

Present:		
Panel	**Cardiff & Vale University Health Board**	
Dr Chris Jones (Chair of Peer Review Panel)	Sherard Lemaitre	Anna Kuczynska
Dr Harry Hunt – CTM HB	Helen Earland	Steve Curry
Richard Bowen – 111 Team	Danielle James	Nicola Evans
Jane Brown – 111 Team	Ailsa Pritchard	Lynne Aston
Charlette Middlemiss – (HEIW)	Matthew Williams	Alan Weatherup
Roger Perks – Welsh Government	Lisa Dunsford	
Leigh Davies – Welsh Government	Damian Crawley	
Helen Rees – 111 Team	Kay Jeynes	

	Key Issues to Address	Actions:	Lead	Timeframe	Progress
	Executive Support	Present the Executive Team with the OOHs peer review presentation so they are aware of the current pressures on the service and wider opportunities for urgent /unscheduled care in the future. Linked to the above, a business plan needs to be produced highlighting the future direction of the service, with clear milestones for delivery and the wider support functions required to support this	SC SC/LD SC/LD	January 2020 April 2020 July 2020	Complete. Paper presented in January 2020. Linked to IMPT planning for the next 3 years. Work commenced on 111 but implementation was paused at national level. Work underway in relation to CAV 24/7 model.
	Sustainability of Service	A decision on the future provision of an OOH base at UHW, needs to be taken as a matter of urgency.	Executive Team Executive Team	Dec - Jan 2019 20 June 2020	Proposal taken and agreed by Management Executive in principle with a pilot to commence in May 2020.

	Key Issues to Address	Actions:	Lead	Timeframe	Progress
					UHW base closed since March due to covid-19 pandemic – no adverse clinical, capacity issues and no impact on other services. Work underway on CAV 24/7 model.
		Exact timescales for moving the OOHs triage HUB from Barry to CRI needs to be confirmed. The current working environment for clinical triage at CRI is not appropriate and needs to be addressed as part of this upgrade.	LD/SC	Dec 2020	Some delay due to other work at CRI but completion date confirmed as 22/7/2020.
			LD/SC	July 2020	Comms Hub staff to be transferred by Sept 2020 at the latest
		Expansion of hub (CRI) to include other services needs to be considered.	Executive Team	Ongoing	Engagement with WAST on hold / Regional Dental Model on hold due to CoVid.
			Executive Team	Ongoing	CAV 24/7 model progressing
	Regional Working	Progress the SE Wales regional dental model as a potential blueprint for wider regional working and joint LHB approach for the future (linked to the new triage HUB at CRI).	Operational Manager/111 Project Lead	June 2020	Regional Dental Model was on hold due to CoVid. Regional Dental model discussions have recently recommenced – firstly to link the OOH dental service with the daytime service in C+V. Once completed discussions with CTM will progress. Permanent dental nurses to be employed.
			Clinical / Operational lead OOH /	September 2020	

	Key Issues to Address	Actions:	Lead	Timeframe	Progress
			111 Project Lead		Note extra space is likely to be required to deliver the regional dental model.
	Multi-Disciplinary Workforce	Building on the success of the minor illness role (at weekends) expand capacity further based on evaluation outcomes.	Clinical Nurse Lead	Ongoing	Minor Illness session are gradually being introduced into the weekday rota, expanding on their success over weekends.
		Take learning from Hywel Dda to expand the drivers remit /responsibility to become Healthcare Support workers to support GPs with home visits etc.	Clinical Nurse Lead/Operational Manager	Quarter 4 2019 /20	Initial work underway but has been paused due to CoVid 19.
		Develop (and evaluate) the Mental Health practitioner role for triage and F2F assessment.	Clinical Nurse Lead	January 2020	The 3mth pilot was successfully completed with positive outcomes. From May 2020 MH practitioners are a permanent fixture on the weekend rota – within current budget allocations. Formal evaluation of the project to be completed end July 2020
			Clinical / Operational Lead OOH	July 2020	
		Develop (and evaluate) the role of a Palliative Care practitioner within urgent primary care linked to the work being progressed by Marie Curie.	Clinical Director/Clinical Nurse Lead	January 2020	The 3mth pilot was successfully completed with positive outcomes. From May 2020 palliative care practitioners are a permanent fixture on the weekend rota – within current budget allocations. Formal
			Clinical / Operational Lead OOH	July 2020	

	Key Issues to Address	Actions:	Lead	Timeframe	Progress
					evaluation of the project to be completed end July 2020
	Workforce and Training	A workforce strategy linked to the Competency framework needs to be taken forward Training has been provided to all clinical and non-clinical staff on DATIX; however, overall reporting remain low.	Clinical Team Workforce leads Clinical Team Workforce leads Clinical and Operational Team	January 2020 September 2020 January 2020 Ongoing	Workforce strategy has been on hold due to CoVid but will be updated by end September 2020. Implement the good practice guide on DATIX that has been shared with Health Boards. Datix continue to be completed Training and sharing of best practice guidance continues.
	Wider Cultural change	Behavioural patterns of some GPs needs to change. The AMD /Clinical Director to consider establishing a Clinical Reference Group (similar to Aneurin Bevan) to openly share best practice and challenge.	Clinical and Operational OOHs Team	Quarter 4 2019 /20	Work has been on hold due to CoVid but will recommence after the Summer.
	Best Practice /sharing	It is reassuring that the wider learning from urgent primary care in Canterbury, New Zealand is being considered, however good practices in Wales /UK equally needs to be assessed and shared.	Clinical and Operational Team	Ongoing	Have taken forward some of the wider learning in relation to expanding the roles in the team. Also CAV 24/7 implementation ongoing (July 2020).
	Adastra upgrade Tolley, Laura 07/13/2020 11:04:12	Finalise the upgrading of server hardware and version upgrade of Adastra as per previous agreements. Do not move to hosted solution.	Operational IT Manager	Ongoing	Being progressed as part of 111 roll-out. Funding agreed and in place for all IT upgrades. Upgraded Adastra system migrated on to new server 24/6/20.

	Key Issues to Address	Actions:	Lead	Timeframe	Progress
		Concentrator connection between CAS as part of 111 roll-out.			Awaiting costings for concentrator, however 111 implementation is currently on hold.
	Physical Environment and Operational Issues	IT complications and (prescribing) printers continue to frustrate clinical staff. This needs to be addressed as a matter of urgency.	Clinical and Operational OOHs Team	ASAP	All IT equipment purchased and received – just waiting on installation in to new triage suite at the end of July
		Medication stock levels and basic equipment needs to be monitored and maintained. Suggest this could be a role of the driver/shift lead.	Clinical and Operational OOHs Team	December 2020	Ongoing. Two omnicells have been delivered to support management of stock. Additional estates likely to be required for regional dental model.
	Performer list issues	Work with Welsh Government Leads to explore the issue of specialist interest (ED) clinicians working in OOHs. Review the Welsh Performers list issues.	Clinical and Operational OOHs Team	January 2020	On hold re Covid-19
	Internal Peer Review of Service	Follow-up exercise internally in 6 months time wider the wider team to inform the next iteration of the next IMTP. Involve the Director of Planning and Workforce as part of process.	SC/LD	May 2020	On hold re Covid-19 (plan to do September 2020).

Report Title:	**KEY ORGANISATIONAL PERFORMANCE INDICATORS**						
Meeting:	Strategy & Delivery Committee				**Meeting Date:**	14/07/20	
Status:	**For Discussion**		**For Assurance**	√	**For Approval**		**For Information**
Lead Executive:	**Chief Operating Officer**						
Report Authors (Title):	**Deputy Chief Operating Officer** **Assistant Director of Operations (Performance)**						

Background and current situation:

Cardiff and Vale University Health Board has faced unprecedented challenges as a result of the Covid-19 pandemic, with this having a direct impact upon capacity to deliver activity across planned and unplanned care.

The performance context timeline (Appendix 1) shows key events and timescales impacting on the delivery of services and performance management arrangements. From mid-March the focus of the Health Board switched to managing COVID-19 and maintaining essential services, in line with national guidance. At the same time, targets and monitoring arrangements were relaxed and publication of performance was suspended nationally. This largely remains the case but some data submissions to Welsh Government have subsequently been re-instated and national guidance extended at the beginning of June to Health Board plans to increase activity but with the delivery of routine services remaining a local decision.

Key Issues to bring to the attention of the Board/ Committee:

- Covid-19 has had an unprecedented impact, with resources reprioritised March 2020 onwards to manage Covid-19 and maintain essential services.
- As a result of the pandemic, Welsh Government have relaxed targets and monitoring arrangements and suspended the publication of performance nationally.
- Whilst the Health Board continues to monitor the position for key operational performance indicators, prioritisation of need and service delivery is based on clinical stratification rather than time-based targets. The overriding operating principle is the need to minimise harm, balancing risks across the system and the different types of harm.
- There is a similar picture in levels of demand and activity across unplanned and planned care, with both decreasing in March and rising again in April onwards, albeit it to lower levels than previously.
- The Health Board is currently implementing plans to recommence some routine services in line with Welsh Government guidance, whilst ensuring the organisation remains able to respond to further increases in Coronavirus demand.

Assessment and Risk Implications

Whilst this paper will provide the current position for the Health Board against key organisational performance indicators, it is important to note the overriding operating principle is the need to minimise harm. The national approach focuses on the four types of harms arising from the pandemic - harms from COVID itself; harm from overwhelmed NHS and social care system; harm from reduction in non-COVID activity; and harm from wider societal actions / lockdown. The Health Board's local operating framework is aligned to the national approach and is outlined in Appendix 2. Prioritisation of need is based on clinical stratification rather than time-based targets.

The tables in Appendices 3 and 4 provide the year to date position against key organisational performance indicators but these should be viewed in the context of the current operating framework principles.

Planned Care overview (Appendix 3)

Generally, demand and activity for planned care fell significantly in March but have subsequently been recovering in April and May, albeit it to lower levels than previously.

Whilst the overall ***Referral to Treatment times*** waiting list volume has reduced, waiting times have deteriorated. The May position is 11,814 patients waiting greater than 36 weeks. 56% of these are at new outpatient stage. ***Diagnostic*** and **therapies** waiting times have also deteriorated, with greater than 8 week diagnostic waits rising to 10,688 and over 14 weeks therapies waits to 1,628 in May 2020.

Referrals for patients with suspected ***cancer*** reduced over the initial period but have started to increase since April following a targeted communication campaign led by our GP Cancer Lead. As one of the essential services, the Health Board expedited treatments in March and have maintained services in April – with treatments at 94% of previous levels. In April, 96.7% of patients on a non-urgent suspected cancer pathway were seen and treated within 31 days of the date of decision to admit and 75.3% of patients on an urgent suspected cancer pathway were seen and treated within 62 days of referral.

The overall volume of patients waiting for a ***follow-up outpatient*** *appointment* reduced in April and May, although overall waiting times have deteriorated.

98% of patients waiting for ***eye care*** continue to have an allocated health risk factor. 54% of patients categorised as highest risk (R1) are under or within 25% of their target date.

The percentage of ***Mental Health*** assessments undertaken within 28 days has improved – to 95% overall and 89% for CAMHs, the latter showing an improvement for the fourth month in a row. The end of May position for Part 1b is 79%.

Unscheduled Care overview (Appendix 4)

Following a significant decrease in unscheduled care activity during March, attendances at our Emergency Unit department have increased since the end of April but remain at a lower level. May attendances of 8,371 represent a reduction of 36% on the same period last year. Those patients who presented for emergency care experienced more timely access in April and May, with improvements seen in 4 and 12 hour waiting times and ambulance handover delays.

Recommendation:

The Strategy and Delivery Committee is asked to **NOTE**:

- The year to date position against key organisational performance indicators for 2020-21 but in the context of current operating framework principles.

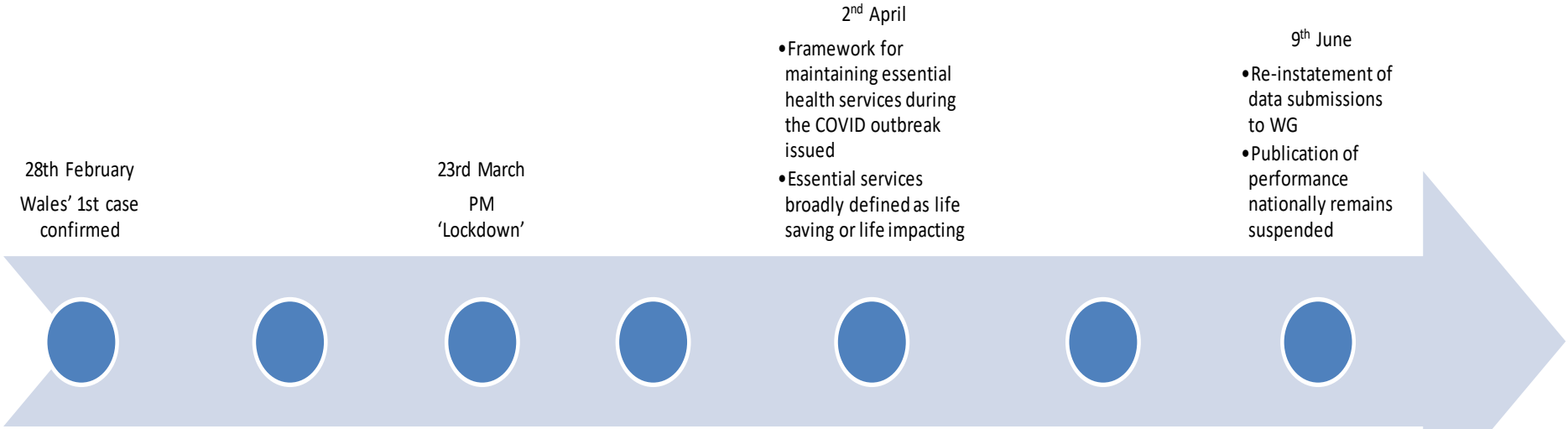
Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	√
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	√	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	√	Integration	√	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

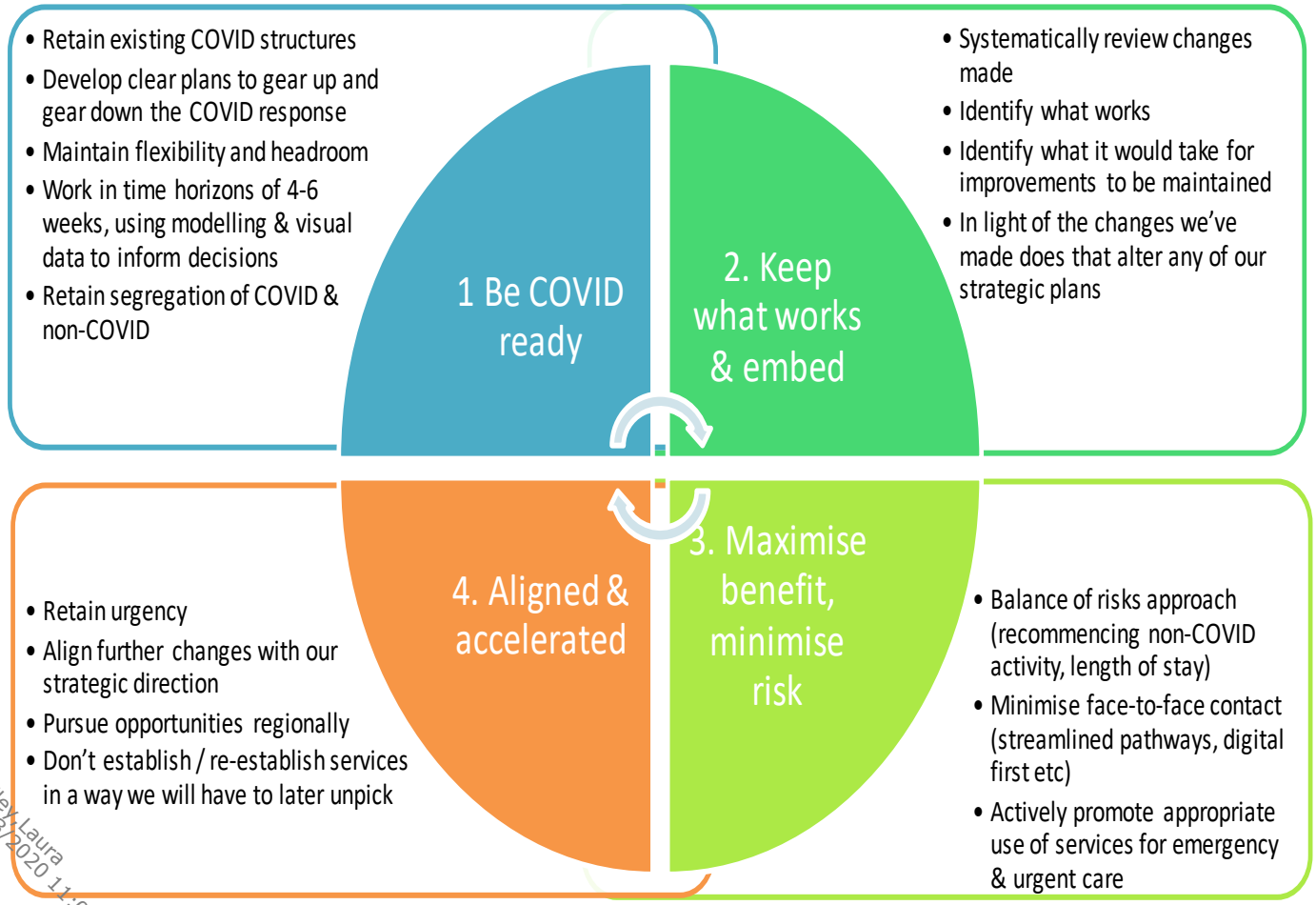
Appendix 1

Performance context - timeline

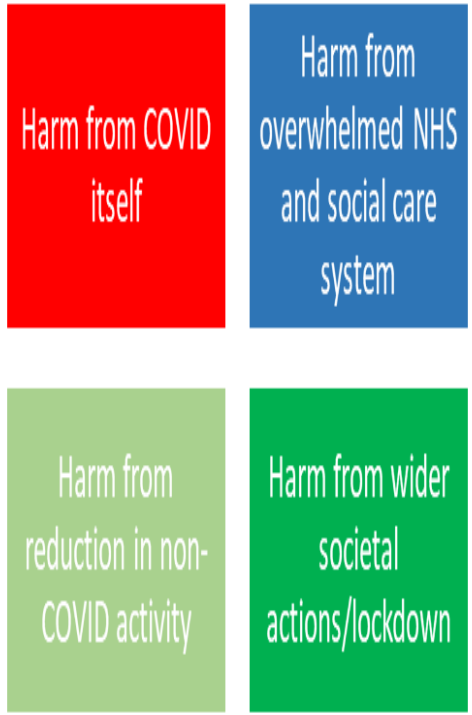


Performance context: Operating Framework principles

Local:



National:



Appendix 3

Performance against key operational performance indicators 2020/21: Planned Care

2020/21		Mar	Apr	May
Planned Care				
RTT - 36 weeks	20/21 Actual	3515	7330	11814
RTT - 26 weeks	20/21 Actual	81.7%	74.1%	66.3%
Total Waiting list	20/21 Actual	87579	85287	85611
Diagnostics > 8 weeks	20/21 Actual	782	6,105	10,476
Therapies > 14 weeks	20/21 Actual	106	379	1,628
Cancer				
31 day NUSC cancer	20/21 Actual	97.5%	96.7%	n/a
62 day USC cancer	20/21 Actual	81.1%	75.3%	n/a
SCP - with suspensions *(NB: Shadow Reporting Data)*	*20/21 Actual*	*79.0%*	*76.8%*	*n/a*
Outpatient Follow Up				
OPFU - > 100% delayed	20/21 Actual	44,519	47,422	49,636
OPFU - No Target date	20/21 Actual	98%	98%	98%
Total OPFU waiting list	20/21 Actual	185,964	178,822	175,161
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%
Mental Health				
Part 1a: % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	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%

Appendix 4

Performance against key operational performance indicators 2020/21: Unscheduled Care

2020/21		Mar	Apr	May
Unscheduled Care				
EU waits - 4 hours	20/21 Actual - Monthly	84.8%	91.3%	91.4%
EU waits - > 12 hours	20/21 Actual - Monthly	70	13	14
Ambulance handover > 1 hour (number)	20/21 Actual	255	97	45
Ambulance - 8 mins red call	20/21 Actual	67%	75%	81%
Stroke				
1a - % of patients who have a direct admission to an acute stroke unit within 4 hours	20/21 Actual	62.1%	45.2%	51.1%
3a - % of patients who have been assessed by a stroke consultant within 24 hours	20/21 Actual	90.0%	67.6%	75.0%

Report Title:	**Board Assurance Framework – Workforce**						
Meeting:	Strategy and Delivery Committee				**Meeting Date:**	14th July 2020	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**
Lead Executive:	Director of Corporate Goverance						
Report Author (Title):	**Director of Corporate Governance**						

Background and current situation:

The purpose of the report is to provide Members of the Strategy and Delivery Committee with the opportunity to review the risks on the Board Assurance Framework which link specifically to the Strategy and Delivery Committee.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

The Board Assurance Framework has now been presented to the Board since November 2018 after discussion with the relevant Executive Director and the Executive Directors Meeting. It provides the Board with information on the key risks impacting upon the delivery of the Strategic Objectives of Cardiff and Vale University Health Board.

During COVID 19 a separate BAF was developed and reported to the Board. This will now be combined into one BAF with the key risks impacting upon the delivery of strategic objectives identified. This will be reported to the Board at the end of July.

The attached Workforce risk is the combined workforce risk from both BAFs and details how COVID 19 is still impacting upon the recruitment of our workforce.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

There are currently nine key risks agreed by Executives which are impacting upon strategic objectives which will be developed into a Board Assurance Framework for review at the July Board and the risks which link to the Strategy and Delivery Committee are:

1. Workforce including potential capacity issues
2. Sustainable primary and community care
3. Sustainable culture
4. Capital assets
5. Risk of Delivery of IMTP
6. Ability to switch planned work back on safely

It has previously been agreed by the Committee that one risk would be reviewed at each meeting and the risk attached for review at the July Meeting is **Workforce.**

The role of the Committee in relation to the risk is to review it, check that the controls are in place and working and agree any further actions required in order to mitigate the risk further. The Committee can then provide further assurance to the Board that the risk is being managed or mitigated as much as possible at the current time. The Executive Director Lead for this risk is the Deputy CEO and Executive

Director of Workforce and OD.

To aid the process I have reviewed what has been presented to the Strategy and Delivery Committee in relation to workforce over the last 12 months and to provide triangulation and further assurance for the Board:

- **Workforce Key Performance Indicators**
- **Ensuring that Service, Quality, Finance & Workforce are aligned and integrated - Recruitment of Band 5 nurses**
- **Deep Dive report on Absence Rates & Hotspots**
- **Strategic Equality Objectives – Delivery Plan Framework**
- **Appraisal Rates**
- **Employment Policies**
- **Staff Survey Steering Group**

A summary of the detail discussed on each of the above reports is provided in the Annual Report to the Board for 2019/20.

Recommendation:

The Strategy and Delivery Committee is asked to:

Review the attached risk in relation to Workforce to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

1. Workforce

Across the UK there are increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff.

Risk **Date added: 2.7.2020**	There is a risk that the organisation will not be able to recruit and retain a clinical workforce to deliver high quality care for the population of Cardiff and the Vale. This may be further exacerbated by the demand to simultaneously stretch our workforce capacity to cover Covid-19 pandemic as well as business as usual.		
Cause	Increased vacancies in substantive clinical workforce – most recently to cover MTC specialist skill requirement Requirements of the Nurse Staffing Act and BAPM Standards Ageing workforce Insufficient supply of registered Nurses at UK national level High nurse turnover in Medicine and Surgery Clinical Boards Insufficient supply of Doctors in certain specialties at UK national level (e.g., Adult Psychiatry, Anaesthetics, General Medicine, Histopathology, Neurosurgery, GP) Changes to Junior Doctor Training Rotations (Deanery) Brexit COVID-19 – bed expansion, community testing, high staff absence, increased demands on step up and step down demand for GP and CRT		
Impact	Impact on quality of care provided to the population Inability to meet demands of both pandemic and business as usual Potentially inadequate levels of staffing Increase in agency and locum usage and increased workforce costs Rates above Welsh Government Cap (Medical staff) Low Staff moral and higher sickness absence Poor attendance at statutory and mandatory Training		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Nurse Recruitment and Retention Programme		

	• Recruitment campaign through social media with strong branding • Job of the week, Skype Interviews • Social Media Campaign Open Days (currently via virtual technology) • Nurse-led leadership embedded within recruitment drive • Values based recruitment • Comprehensive Retention Plan introduced from October 2018 – internal movement scheme for band 5 nurses in place • Nurse Adaptation Programme commenced October 2018 (in house OSCE programme) • Returners Programme in conjunction with Cardiff University • Student Nurse clinical placement and on-going nurturing of talent • International Nurse Recruitment in place – international supply plentiful, local support mechanism to support new recruits in place • Medical international recruitment strategies • Programme of talent management and succession planning • Medical Training Initiative (MTI) 2 year placement scheme • Collaboration with Medacs to fill hard to fill roles, search and selection methods, CV scanning by speciality • Link with Welsh Government Campaign *Train, Work, Live* to attract for Wales - GP, Doctors, Nursing and Therapies • Operationally, the development of Green Zones etc. which help stratify the workforce and maximise availability • Review of staff shielding to maximise homeworking, track and tracing etc. • Central workforce hub continues to meet demand of recruiting temporary workforce • On-going review of medical rotas to flex and increase medical cover capacity • Temporary recruitment of medical and nursing students • Retirement returners
Current Assurances	The pace of demand is not currently exceeding capacity available Workforce metrics reported to COVID-19 Operation Meetings, HSMB and Strategy and Delivery Committee High level temporary recruitment achieved at pace since March 2020 High conversion rates from media campaign and Open Day (some virtual ongoing) Again, this summer, student streamlining produced the biggest intake at C&V in Wales due to the way we engage, attract and support students Nurse monitoring at Nurse Productivity Group (NPG) Trajectory showing next vacancies in nursing Majority of MTC posts filled successfully and high engagement

	Predicted to be at 95% by October 2020 with some outliers in Surgery and Specialist CBs Deep dive monitoring at Clinical Board and operational level being undertaken monthly to ensure nursing capacity to meet BAU, Covid-19 and winter pressures Medical monitoring at Medical Workforce Advisory Group (MWAG) Paediatric Surgery now fully established A & E fully established since February 2019 Medical rotas being monitored by COVID-19 Operations team to ensure flexibility in place (RAG rated system)		
Impact Score: 5	Likelihood Score: 2	Net Risk Score:	**10 (High)**
Gap in Controls	Ability to retain flexible recruitment methods as level of permanent recruitment resumes Clarity on any further extension of Government CMO shielding letters		
Gap in Assurances			

Actions	**Lead**	**By when**	**Update since 30.01.20**
1. Internal Nurse Transfer Scheme	RW	Relaunched in April 2020 and continuing	This scheme started in September 2019 but will be relaunched in April 2020 Has been relaunched and first cases working well
2. Nurse recovery plan for Medicine and Surgery as part of financial recovery plan and business case for international recruitment	SC	31/03/21	Plan in place with 2nd part of International Nurse Recruitment approved. This will continue until March 2020. Financial Savings still being monitored and actions include Switch Off Sunday to help manage costs.

				Some international nurses delayed due to worldwide travel restrictions. Expect to resume in October.
3.	To consider how resources are used going forward in nursing	SC	31/03/2021	Resources being considered alongside bed occupancy plans – action ongoing
4.	Proactively recruiting to positions for the MTC and filling vacancies	MD	31/10/2020	Majority of posts filled
5.	Local Social Media and Virtual Interview Campaigns to resume to support permanent nurse recruitment	MD	31/10/20	New action - Campaign in place for 20-25 July
Impact Score: 5	Likelihood Score: 1	Target Risk Score:	**5 (Medium)**	

Tolley,Laura
07/13/2020 11:04:12

Report Title:	**Employment Policies Report**								
Meeting:	Strategy and Delivery Committee						**Meeting Date:**	14th July 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Executive Director of Workforce and OD**								
Report Author (Title):	Workforce Governance Manager								

Background and current situation:

This paper summarises for the Strategy and Delivery Committee details of the Reserve Forces - Training and Mobilisation Policy for NHS Wales which has been reviewed and should now be adopted by the UHB.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

All-Wales Policies are developed and agreed in partnership by the Welsh Partnership Forum and must be adopted, without amendment, by all Health Boards in Wales.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

The Reserve Forces - Training and Mobilisation Policy for NHS Wales has been reviewed in partnership and the revised version, with minimal changes, was agreed by the Welsh Partnership Forum on 5 March 2020 and now becomes the standard policy for the training and mobilisation of reservists within the NHS in Wales and can only be amended through agreement by the Welsh Partnership Forum

The revised Policy now needs to be adopted by the UHB and implemented at the earliest opportunity.

The Reserve Forces - Training and Mobilisation Policy is attached as **Appendix 1**. A Welsh language version is also available and will be published on the UHB internet site.

Recommendation:

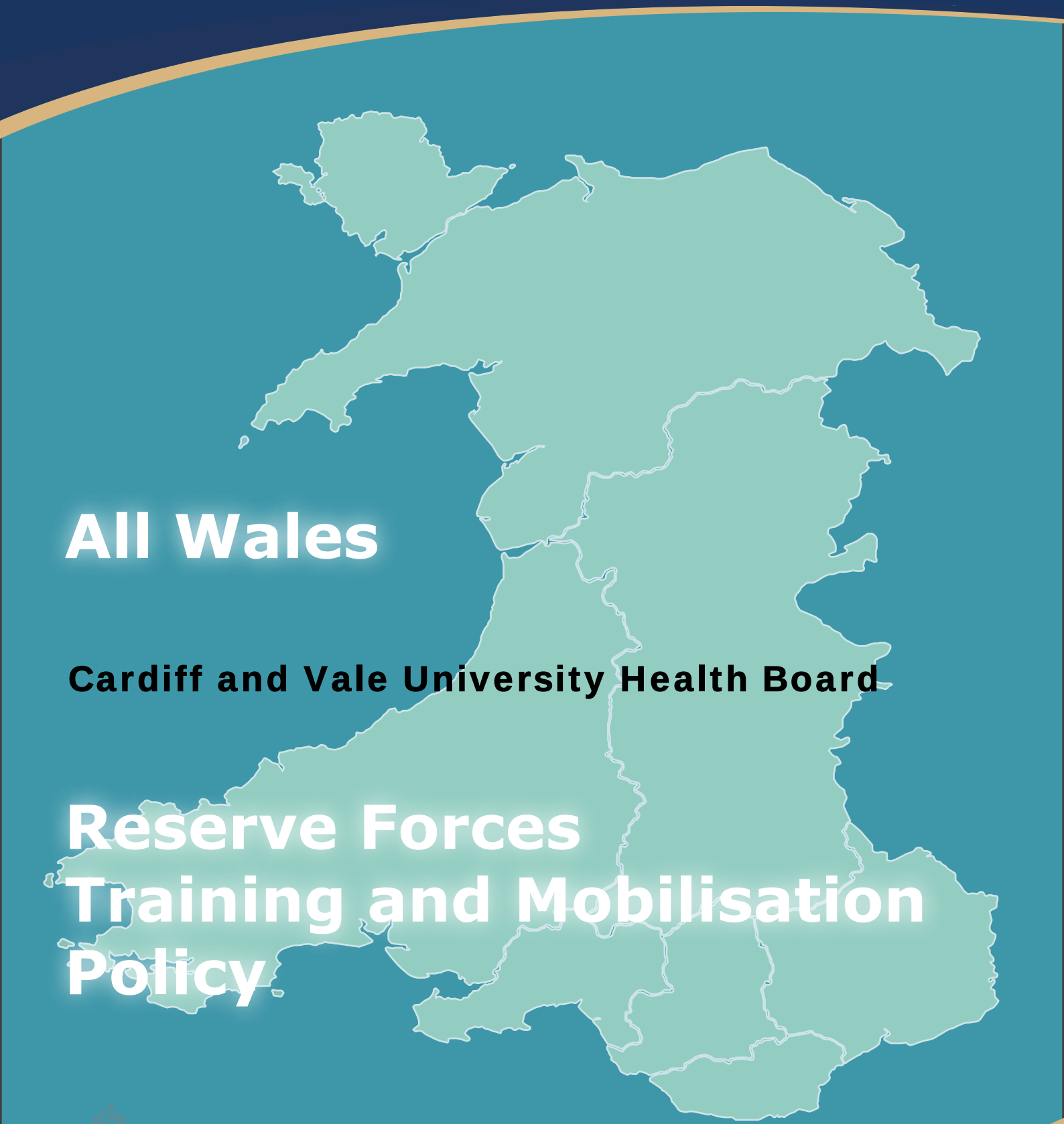
The Strategy and Delivery Committee is asked to:

- **ADOPT** the revised Reserve Forces - Training and Mobilisation Policy for NHS Wales NHS Wales

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/210092



All Wales

Cardiff and Vale University Health Board

Reserve Forces Training and Mobilisation Policy

GIG CYMRU NHS WALES

Sections

01

All Wales Reserve Forces Training and Mobilisation Policy

Approved by: Welsh Partnership Forum

Issue Date: March 2020

CONTENTS

01 All Wales Reserve Forces Training and Mobilisation Policy

1. General Introduction

1.1 NHS Wales supports employees who are members of or wish to join the Volunteer Reserve Forces. These consist of the Royal Naval Reserve (RNR), the Royal Marines Reserve (RMR), the Army Reserve, the Reserve Air Forces (RAFR and RAuxAF), and cadet forces. This policy will also apply to Regular Reservists, who are ex-regulars who may retain a liability to be mobilised. A member of staff should be provided with a copy of this policy as soon as the NHS organisation is aware that the individual is a reservist.

1.2 Employees who wish to take advantage of the provisions contained within this policy must inform their employer that they are a Reservist by contacting the individual identified at Appendix 1 for their NHS Organisation. The designated contact for each NHS Organisation will keep a register of all employees who are members of the volunteer forces and will ensure that the individual's line manager is aware of their membership of the Volunteer Reserve Forces.

1.3 This policy will also apply to High Readiness Reserves (HRR) and Civil Contingency Reaction Forces (CCRF), both of whom must inform their employer of their status given the relatively short notice of deployment. High Readiness Reserves will also require written consent from their employer if they work more than two days per week before they are able to hold this status.

1.4 The training undertaken by Reservists enables them to develop skills and abilities that can be of benefit to them as employees, and to the employer in terms of service delivery. Members of staff should be encouraged to share these with colleagues.

1.5 A greater understanding of the training and skills development carried out in the Reserve Forces will assist managers in conducting PADRs.

2. The Legal Framework

2.1 In most instances an employer's relationship with a Reservist member of staff should be like that of any other employee. However, there are areas where a Reservist's status may affect the operations of the organisation. Legislation exists to define the rights and liabilities that apply to both parties.

2.2 There are two main pieces of legislation relating to employers and the Volunteer Reserve Forces.

- Defence Reform Act 2014 (DRA 14)
- The Reserve Forces Act 1996 (RFA 96) which provides the powers under which Reservists can be mobilised for full-time service.
- The Reserve Forces (Safeguard of Employment) Act 1985 (SOE 85) which provides protection of employment for those liable to be mobilised and reinstatement for those returning from mobilised service.

3. Practical Support for Training

3.1 Cardiff and Vale University Health B will support an employee to become a reservist and provide access to annual or unpaid leave to support attendance at any training required in advance of an employee becoming a Reservist.

3.2 Paid leave of up to 10 days per year will be made available to Reservists to attend annual camp or equivalent continuous training. Any additional leave required should be taken as annual or unpaid leave.

3.3 Line managers will as far as possible facilitate work rosters to allow attendance for annual camp and other training commitments, e.g. weekly or weekend training sessions.

3.4 Reservist employees should give as much notice as possible to allow appropriate planning for absences. Permission will be granted where the notice exceeds one month and should normally be granted in other circumstances. Permission once given will not be rescinded except in exceptional and extreme circumstances.

3.5 Any disputes should be referred to the designated contact (see appendix 1) in the first instance. Employees who remain dissatisfied may thereafter use the grievance procedure.

4. Mobilisation

4.1 Mobilisation is the process of calling reservists into full-time service. (i) With the Regular Forces on the military operations (ii) To fulfil their part of the UK's defence strategy. The Reserve Forces Act 1996 and the Defence Reform Act 2014 provide the legal basis for mobilisation. Subject to the severity of the crisis there would normally be a minimum of 30 days' notice. Mobilisation will normally be for between 3 and 12 months.

4.2 An employee who wishes to volunteer for mobilisation must seek prior agreement of their employer through their line manager. Any such request will be considered within 5 working days.

4.3 Where there are multiple requests in a single department/unit these will be referred to the appropriate Senior Manager.

4.4 Where there is compulsory mobilisation of any employee the employer (following a similar process to 4.2 above) will decide whether to seek exemption or deferral. The grounds of exemption are strictly limited and would have to show serious harm to the employer's ability to provide services. The employer would only seek exemption in very exceptional circumstances.

4.5 Additional information regarding exemption and deferral from mobilisation is contained in Appendix 2.

5. Financial Assistance for Employers

5.1 Where an employee's mobilisation results in additional costs the employer may seek compensation from the MoD e.g.

- Overtime costs if another employee is used to cover the work of the Reservist.
- Any costs of hiring a temporary replacement that exceeds the Reservist's earnings.
- Advertising for replacement or agency costs.
- Training costs for any training the employee needs as a result of having been mobilised (the MoD will not pay for training that we would have carried out anyway) when they return to work to carry out their duties properly.

5.2 While the Reservist is mobilised,

the employer is not obliged to pay their salary or contractual benefits. However, staff will receive their full salary from the employer during the first month of their mobilisation or until they receive their first months pay from the MOD. The excess salary paid after the date of mobilisation will be recoverable when the individual returns to work. The designated contact for the NHS Organisation should ensure that the pay department is notified that the employee is being mobilised and the date when their pay should stop.

5.3 In order to claim financial assistance the employer will provide the Ministry of Defence with appropriate supporting documentary evidence e.g. invoices.

5.4 The latest date for submitting claims for financial assistance, other than for training, is within four weeks of the date the Reservist is demobilised.

6. NHS Pension whilst on Active Service

6.1 A Reservist who is called out is entitled to remain a member of the NHS Pension Scheme. The Ministry of Defence (MoD) will pay the employer's pension contributions whilst the individual is mobilised provided they continue to pay their individual contributions. Where mobilisation occurs, the employee will be given special unpaid leave of absence. The employee's pension contributions would be calculated and held over until the employee returns. These would then be recovered monthly from salary and over the same period as the employee was absent. The employer will continue, on request of the employee, to pay employer's contributions to the NHS Pension Scheme for the period of mobilisation and invoice the MoD to recover this amount.

See section 12 https://www.nhsbsa.nhs.uk/employer-hub/technical-guidance/pay-and-contributions

7. Annual Leave whilst Mobilised

7.1 Reservists have no entitlement to accrue annual leave whilst mobilised and on unpaid leave.

7.2 Reservists will have a period of 'post tour' leave which they accrue at the rate of one day for every nine calendar days deployed (JSP 753 Directive – Regulations for the Mobilisation of UK Reserve Forces) from the MoD. This leave must be taken before the individual is demobilised.

8. Carry Over of Annual Leave

8.1 Reservists should be encouraged to take any holiday accrued before mobilisation. However, any annual leave not taken will be carried forward.

9. Pay Progression

9.1 Where an employee is absent from work following mobilisation, the service will be considered continuous and an employee will not be penalised if it coincides with their pay step.

9.2 Line managers who carry out PADRs and / or appraisal meetings with a reservist should be made aware that the Volunteer Reserve Forces activities undertaken by an individual (either through training or mobilisation) bring essential skills into the workplace such as leadership, communication, team working and organisational ability, which ultimately lead to improved performance in the workplace. It is therefore good practice that we recognise these skills and abilities in an individual's PADR or appraisal meeting and acknowledge that

the activities can be regarded as evidence of achievement or in some circumstances contribute towards an individual being in a position to evidence application of knowledge and skills. These principles will also apply to reservists not employed on Agenda for Change Terms and Conditions, being mindful of professional requests, such as revalidation.

10. Support on Return to Work (Demobilisation)

10.1 Demobilisation may be a difficult time, with a Volunteer Reservist returning to work after a challenging period in deployment. Helping to ensure a smooth re-integration into the workplace/team will require consideration of:

- The need to update them on changes and developments in the organisation.
- The need to offer specific refresher training where it is sought/considered necessary.
- Where the job duties have changed since mobilisation a period of skills training may be required to assist them with new aspects of the job.
- Whether the Reservist can meet up with colleagues informally or socially (if appropriate) before or after return to work to prevent any feeling of dislocation, if this is sought.
- Reasonable time off to seek therapeutic treatment.

10.2 When an employer is advised by a Reservist that they want to return to work, the employer is obliged to employ them in their old job as stated in the Reserve Forces (Safeguard of Employment) Act 1985. Where this is not possible, they must be offered an equivalent position with the same terms and conditions of service in accordance with the Organisational Change Policy. The right to return to work lasts for six months after demobilisation

10.3 To enable the employer to plan for their return to work after their military service has ended, Reservists must advise the designated organisational contact and/or writing, copied to their line manager, the date they will be available to start work. This communication should be made no later than three weeks after the completion of military service.

10.4 The employer must be advised as soon as possible, if, due to illness or some other reasonable cause, the employee is unable to start work on the agreed date.

11. Review

11.1 This policy will be monitored and reviewed every two years or sooner in light of any legislative changes and in line with NHS changes.

12. Useful Sources of Help

Reserve Forces and Cadet Association for Wales

Tel: 02920 375746
www.wales-rcfa.org

Address: NHS Pensions Agency
PO Box 2269
Bolton
BL6 9JS

Tel: 0300 3301 346
www.nhsbsa.nhs.uk

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Appendix 1: Designated NHS Organisation Contacts

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Each NHS organisation has a responsibility to identify their designated contact, however, for the purposes of this policy the responsibility will be that of each NHS organisation's Director of Workforce and Organisational Development.

It will be the role of the designated NHS Organisation contact to ensure that: -

- they are fully aware of the provisions of this policy and are therefore able to advise employees of the support available to them;
- they maintain an up to date database of all Reservists working in their organisational area;
- they are available to work with both their employee and the employee's line manager to ensure the provisions of the policy are available;
- mechanisms in place to ensure that the pay department is notified that the employee is being mobilised and the date when their pay should stop;
- mechanisms in place to ensure that they maintain contact with the employee to ensure they are kept informed about their area. This may be through the provision of a staff newsletter, update e-mails, briefing notes etc;
- they act as first contact in any disputes.

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Appendix 2: Exemption and Deferral from Mobilisation

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1.1 The employer has the right to ask for exemption from, or deferral of, mobilisation if it is considered that the organisation will suffer serious harm because of their absence.

1.2 The definition of 'serious harm', varies from case to case, but the broad guidelines laid out in CORFA 05 specifically mention;

• Serious loss of sales, markets, reputation, goodwill or other financial harm.
• Serious impairment of the ability to produce goods or provide services.
• Demonstrable harm to research and development of new products, services or processes, provided that the harm could not be prevented by the employer receiving financial assistance under CORFA 05.

1.3 To be considered for exemption or deferral, the Reservist, or the employer, must make an application, within seven days of the Reservist being served with a mobilisation notice, to the Service Adjudication Officer (SAO) for the Service in which the Reservist will serve. Late applications can only be made with the permission of the SAO appointed by the MoD. A serving officer or MoD official normally holds this post.

Address: Army Adjudication Officer
Army Personnel Centre
PO Box 26703
GLASGOW G2 8YN
Tel: 0800 389 6585
Fax: 0141 224 2689
Email: apc-cmops-mob-so2@mod.uk

Address: Royal Navy and Royal Marines Adjudication Officer
West Battery (MPG-2)
Whale Island
PORTSMOUTH PO2 8BX
Tel: 02392 628858
Fax: 02392 628660
Email: NAVYLEGAL-RESERVESADJSO2@MOD.UK

Address: Royal Air Force Adjudication Officer
Royal Air Force Adjudication Service
c/o Imjin Barracks
GLOUCESTER GL3 1HW
Tel: 01452 712612 ext 6107
Fax: 01452 510939
Email: aira1-adjmlbx@mod.gov.uk

1.4 The following information must be provided when applying for exemption or deferral;

• Personal details including full name, address, payroll and national insurance number.
• Details of the job or role they perform within the Board.
• The effect that their absence would have on the Board and/or departmental business and/or service delivery.
• Justification for exemption in terms of the serious harm to the Board and department.

1.5 Once received, the application will be examined by the SAO who will decide if the case for exemption or deferral is acceptable. In making this decision, the SAO will seek to balance the needs of the Board and employing department against the operational needs of the Armed Forces for which the Reservist has been mobilised.

1.6 An appeal can be made to the Reserve Forces Appeal Tribunal if the Board is unhappy with the decision of the SAO. The SAO will provide information on making an appeal.

1.7 Reserve Forces Appeal Tribunals are independent of the MoD, with appointments made by the Secretary of State for Constitutional Affairs and Lord Chancellor. Each tribunal consists of a legally qualified chairperson and two lay-members drawn from a list held by the Employment Tribunals Service.

1.8 Appeals must be lodged with the office of the Secretary to the Tribunal no more than five working days after the SAO's decision is received. Appeals can be faxed or posted first class.

Address: Reserve Forces Appeal Tribunal
Tribunals Service
Alexandra House
14 – 22 The Parsonage
Manchester
M3 2JA

Email: rfat@tribunals.gsi.gov.uk

1.9 The employer will be advised of the date, time and place of the hearing of the appeal. Where considered necessary, employers may be asked to provide the Tribunal with additional information in support of their case. Appeals are normally heard within 28 days of receipt of the appeal, during which time the Reservist will not be deployed outside the United Kingdom.