Board Meeting - 26 November 2020

26 November 2020, 13:00 to 16:00
MS Teams

Agenda

1. Welcome & Introductions
Charles Janczewski

2. Apologies for Absence

3. Declarations of Interest

4. Minutes of the Board Meeting held on 24th September 2020
Charles Janczewski

04. Unconfirmed Board Minutes Sept 2020 SR Checked.pdf (15 pages)

5. Action Log – 24th September 2020
Charles Janczewski

05 - Action Log - 24.09.20 - V2.pdf (2 pages)

6. Standing Items

6.1. Chair's Report & Chair's Action taken since last meeting
Charles Janczewski

6.1 Chair's Report & Chair's Action taken since last meeting.pdf (7 pages)

6.2. Chief Executive Report
Len Richards

6.2 Chief Executive Report - Nov 2020.pdf (4 pages)

6.3. Corona Virus Update Report
Len Richards

6.3 Corona Virus Update Covering Report.pdf (2 pages)

6.3 Appendix 1 COVID 19 Update Report.pdf (5 pages)

6.4. Board Assurance Framework
Nicola Foreman

6.4 BAF Covering Report -Nov 2020.pdf (3 pages)

6.4 BOARD ASSURANCE FRAMEWORK (NOV 2020).pdf (23 pages)

6.5. Patient Safety, Quality and Experience Report
Ruth Walker - Stuart Walker

6.5 Patient Safety, Quality & Experience Report.pdf (18 pages)

6.6. Performance Report
Steve Curry - Chris Lewis

6.6 Performance report November 2020 (Final).pdf (11 pages)

6.7. Intensive Learning Academy

Jonathan Gray

- 6.7 Intensive Learning Academy.pdf (2 pages)
- 6.7 All Wales Academy for Innovation _CAV Board Briefingshort.pdf (5 pages)

7. Items for Review and Assurance

7.1. Nurse Staffing Act – Mental Health Nurse Staffing Levels

Ruth Walker

- 7.1 Nurse Staffing Act.pdf (5 pages)
- 7.1 Appendix 1 November Annual Presentation of the Nurse Staffing Levels to the Board FINAL.pdf (4 pages)
- 7.1 Appendix 2 Summary of Nurse Staffing Levels for 25B wards FINAL.pdf (11 pages)

7.2. Recognising and Responding to the Climate Emergency – Action Plan

Abigail Harris

- 7.2 Recognising & Responding to the Climate Emergency.pdf (4 pages)
- 7.2 SUSTAINABILITY_ACTION_PLAN_v5.pdf (18 pages)

7.3. Clinical Services Plan

Abigail Harris

- 7.3 Clinical Services Plan.pdf (4 pages)
- 7.3 Cardiff and Vale UHB - Shaping Our Clinical Services 21.10.2020.pdf (41 pages)

7.4. Genomics OBC and FBC process

Abigail Harris

- 7.4 Genomics OBC and FBC Process.pdf (8 pages)
- 7.4 Genomics OBC exec sum v4.pdf (15 pages)

7.5. COVID-19 Costed Vaccination Plan

Fiona Kinghorn

- 7.5 COVID-19 Vaccination Plan.pdf (6 pages)

8. Items for Approval / Ratification

8.1. Stakeholder Reference Group - Nomination of Chair and New Members

Abigail Harris

- 8.1 Stakeholder Reference Group Nomination of Chair and New Members.pdf (2 pages)

8.2. Corporate Meeting Schedule 2021-22

Nicola Foreman

- 8.2 Corporate Meeting Schedule.pdf (2 pages)
- 8.2 app 1 - YEAR PLANNER DRAFT 2021-22 v2 - FINAL1.pdf (14 pages)

8.3. Radiotherapy Satellite Centre Outline Business Case

Abigail Harris

- 8.3 Radiotherapy Satellite Centre Outline Business Case Report.pdf (6 pages)
- 8.3 Appendix 1 RSU Unit Submission of OBC to Commissioners (004).pdf (2 pages)
- 8.3 Appendix 2 RSC OBC Sept 2020 VUNHST ABUHB Logos v5.pdf (160 pages)

8.4. Outline Business Case Radiopharmacy

Abigail Harris

- 8.4 Radiopharmacy Outline Business Case.pdf (6 pages)
- 8.4 Radiopharmacy OBC Exec Summ (Final).pdf (16 pages)

8.5. Proposed Changes to Governance Arrangements

Charles Janczewski

- 8.5 Proposed Amendments to Governance Arrangements Covering Report.pdf (2 pages)
- 8.5 Appendix 1 - Proposed Amendments to Governance Arrangements 08 10 20.pdf (2 pages)
- 8.5 Appendix 2 - COVID 19 Report Template.pdf (3 pages)
- 8.5 Appendix 3 -COVID 19 Board Governance Group Terms of Reference.pdf (3 pages)
- 8.5 Appendix 4 - UHBGovernance Structure Covid 19V11NF.pdf (1 pages)

8.6. Committee Minutes

Nicola Foreman

8.6.1. Audit and Assurance – 8th September

John Union

- 8.6 i Audit & Assurance Minutes - 8th Sep.pdf (8 pages)

8.6.2. Finance Committee – 26th August & 23rd September

Rhian Thomas

- 8.6 ii Finance Committee Minutes - 26th Aug.pdf (8 pages)
- 8.6 ii Finance Committee Minutes - 23rd Sep.pdf (9 pages)

8.6.3. Strategy and Delivery Committee – 15th September 2020

Michael Imperato

- 8.6 iii Strategy & Delivery Committee Minutes - 15th Sep.pdf (15 pages)

8.6.4. Mental Health Committee – 21st July 2020

Sara Moseley

- 8.6 iv MHCLC Minutes - 21st Jul.pdf (6 pages)

8.6.5. Digital & Health Intelligence Committee – 9th July 2020

Eileen Brandreth

- 8.6 v DHIC Minutes - 9th Jul.pdf (5 pages)

8.6.6. Stakeholder Reference Group – 22nd July

Abigail Harris

- 8.6 vi SRG Minutes - 22 July.pdf (8 pages)

8.6.7. Local Partnership Forum – 3rd August 2020

Martin Driscoll

- 8.6 vii LPF Minutes 3rd Aug.pdf (5 pages)

8.6.8. WHSSC Joint Committee – 8th September and 13th October 2020

Nicola Foreman

- 8.6 viii WHSSC Joint Committee 8th Sep.pdf (3 pages)
- 8.6 viii WHSSC Joint Committee 13th Oct.pdf (2 pages)

9. Items for Noting and Information to Report

9.1. Chair's Reports

Nicola Foreman

9.1.1. Audit and Assurance Committee – 17th November 2020 Verbal

John Union

9.1.2. Finance Committee – 23rd September, 28th October and 25th November 2020 (Verbal)

Rhian Thomas

- 9.1 ii Finance Committee Chair's Report 23rd Sep.pdf (4 pages)
- 9.1 ii Finance Committee Chair's Report 28th Oct.pdf (4 pages)

9.1.3. Quality Safety & Experience – 13th October 2020

Susan Elsmore

- 9.1 iii QSE Chair's Report - 13th Oct.pdf (5 pages)

9.1.4. Strategy and Delivery Committee – 10th November 2020

Michael Imperato

- 9.1 iv S&D Chair's Report - 10th Nov.pdf (6 pages)

9.1.5. Health & Safety Committee – 24th November 2020(Verbal)

Akmal Hanuk

9.1.6. Mental Health Committee – 20th October 2020

Sara Moseley

- 9.1 vi MHCLC Chair's Report 20th Oct.pdf (3 pages)

9.1.7. Digital & Health Intelligence Committee – 8th October 2020

Eileen Brandreth

- 9.1 vii DHIC Chair's Report Oct 2020.pdf (3 pages)

9.1.8. Stakeholder Reference Group – 23rd September 2020

Abigail Harris

- 9.1 viii SRG Chair's Report - 23 Sep.pdf (3 pages)

9.1.9. Local Partnership Forum – 22nd October 2020

Martin Driscoll

- 9.1 ix LPF briefing 22nd Oct.pdf (3 pages)

9.2. Valuing the Health Board's Relationship with the Third Sector in Cardiff and the Vale of Glamorgan

Abigail Harris

- 9.2 Valuing the Health Board's Relationship with the Third Sector.pdf (3 pages)
- 9.2 CAV UHB and Third Sector Final MoU 2020.pdf (6 pages)
- 9.2 Third sector and CAV UHB 18mths in Review April 2019 - September 2020 finalv2.pdf (8 pages)

9.3. Quarter 3 & 4 Plan

Abigail Harris

- 9.3 Q3 & Q4 Plan Report.pdf (3 pages)
- 9.3 Q3 & Q4 Plan FINAL.pdf (64 pages)

9.4. Winter Plan

Abigail Harris

- 9.4 Winter Protection Plan - Nov 2020.pdf (2 pages)
- 9.4 CAV_RPB_Winter Protection Plan_final draft_22.10.20 (2).pdf (19 pages)

9.5. Board Effectiveness 2019-20 Self-assessment

Nicola Foreman

9.5 Board Effectiveness 2019-20 Self-assessement.pdf	(2 pages)
9.5 Appendix 1 Board Effectiveness Results.pdf	(7 pages)
9.5 Appendix 2 Board Effectivness Action Plan.pdf	(2 pages)

10. Agenda for Private Meeting:

1. Corporate Risk Register
2. Private Committee Minutes

iii. Covid-19 Board Governance Group Minutes

11. Review of the meeting

Charles Janczewski

12. Date and time of next meeting: Thursday, 28th January 2021 at 1.00pm Nant Fawr 1, 2 & 3 Woodland House

Charles Janczewski

Unconfirmed Minutes of the Board Meeting
Held on Thursday, 24 September 2020 at 12:00pm – 16:30pm
Via Zoom

Present:		
Charles Janczewski	CJ	UHB Chair
Len Richards	LR	Chief Executive Officer
Chris Lewis	CR	Deputy Executive Director of Finance
Martin Driscoll	MD	Deputy Chief Executive Officer / Executive Director of Workforce and Organisational Development
Susan Elsmore	SE	Independent Member – Local Authority
Akmal Hanuk	AH	Independent Member - Community
Abigail Harris	AH	Executive Director of Strategic Planning
Michael Imperato	MI	Interim Vice Chair & Independent Member - Legal
Professor Gary Baxter	GB	Independent Member - University
Eileen Brandreth	EB	Independent Member - ICT
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
John Union	JU	Independent Member - Finance
Stuart Walker	SW	Executive Medical Director
Ruth Walker	RW	Executive Nurse Director
Dawn Ward	DW	Independent Member – Trade Union
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Stephen Allen	SA	Chief Executive Officer - South Glamorgan Community Health Council
Lance Carver	LC	Director of Social Services, Vale of Glamorgan Council
Malcolm Latham	ML	Chair - South Glamorgan Community Health Council
Vanessa Davies	VD	Health Inspectorate Wales
Alun Jones	AJ	Interim CEO of HIW
Caroline Bird	CB	Deputy Chief Operating Officer
Allan Wardhaugh	AW	Chief Clinical Information Officer
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Observers:		
Apologies:		
Steve Curry	SC	Chief Operating Officer
Sara Moseley	SM	Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Capital and Estates

UHB 20/09/001	HIW Annual Report 2019-20 - Annual Summary for CAVUHB	ACTION

The Interim CEO of HIW (ICEO HIW) introduced the presentation which highlighted HIW findings for 2019-20, and would be included in the annual report to be published in October. The annual report provided an opportunity to reflect across a range of inspections and note any emerging themes. It was highlighted that this report largely represented a period where Covid restrictions were not in place and that the pandemic had impacted on HIW's physical inspections, approach, and placed a bigger emphasis on their intelligence and relationships.

A summary of the All Wales position was provided in terms of number of inspections undertaken and type of inspections. It was highlighted that C&V as an organisation had 50 concerns, 5 were ranked as high and the remainder low.

Within C&V, hospital, GP and dental practice inspections were carried out.

Last year saw a difficult inspection for the ED department in UHW, but positive feedback was provided regarding the UHB's immediate response to that. Overall, inspections were positive, staff were providing safe and effective care and Clinical Boards were responding in a constructive manner.

Five hospital inspections had been carried out with many positive outcomes however improvements were required in the checking of resuscitation equipment (main theme across Wales), availability of hand sanitizers, timely personal annual development reviews and mandatory training compliance.

The Executive Nurse Director (END) commented that the report reflected conversations had at Board and QSE Committee; the issues identified around hand sanitisers and resuscitation equipment had been resolved although due to Covid, appraisals and mandatory training had not yet been addressed.

ICEO HIW advised that the number of GP inspections were lower this year; again DBS checks was an issue and this had been raised to the Board last year. Other issues highlighted were policies and procedures and timely access to appointments (pre-Covid) which was in contrast to other Health Boards. The Deputy Chief Operating Officer responded that at the start of the pandemic, face to face appointments decreased and virtual appointments increased however since the end of the first wave, we were seeing a re-balance with face to face appointments increasing.

In terms of dental inspections, ICEO HIW highlighted reoccurring messages around use of peer reviews in clinical audit activity which had been raised nationally, the Board were encouraged to influence this if possible. There was also an issue in regards to clinical record

	documentation, specifically around recording of bitewings and robustness of documentation to enable appropriate handover of care. The Board were advised that the report for 2020-21 would include a focus on Covid. The END commented that staff were very open and transparent in sharing areas of concern with inspectors. She added that the organisation was large and complex and often themes ran across it. She concluded that areas of concern/need for improvement would always be found but that the UHB was grateful to HIW on how these were fed back to it. The Chair thanked HIW for sharing the report and added that the UHB appreciated and understood the importance of this work evidenced by the positive responses of Executives and staff to the recommendations.	
UHB 20/09/002	**Patient Story** The END referred back to a patient story presented at the previous Board meeting, the Board had asked that an update to the story be provided and the patient had consented to this. The Board were advised that unfortunately the patient was readmitted to hospital on 3rd September, required sedating and was on critical care for over a week. The patient was discharged on 11th September. The readmission was due to an underlying condition, present since birth which had presented itself in a different way due to the patient having been so unwell with Covid. The patient was feeling better since his discharge and was progressing well. On discharge, he had carers for 6 weeks to support him and his family as well as a physiotherapist for his rehabilitation journey. At an appointment with the Thoracic Consultant, the patient was talked through what had happened to him during both admissions and detail of his scans discussed. The patient shared the significance of that conversation for him which helped him understand his medical condition better, the practical aspects of his rehabilitation, financial position, and emotional support available for him and his family. He appreciated the open and honest conversations which made him feel that he had been looked at as a whole person which he really appreciated. The END emphasised that this showed how Covid affected individuals not as a one off but as an ongoing, long term condition for many of our patients. The patient wanted the Board to know that: • He was provided with all the equipment he needed upon his discharge, he was now living on the ground floor and had a physiotherapist who visited frequently; • He continued to walk with a Zimmer frame and occasionally a stick but was unable to bend very well;	

	• He was now working on his upper body strength however remained quite weak, but still felt he was making good progress which had lifted his spirits; • He wanted to remind the Board of the huge impact on his family, especially his partner who had now become his carer; • He was prevented from driving for 18 months which was a shock as he thought he would have recovered in 3 months. The END shared with the Board that the patient had nothing but praise for the staff who had taken care of him whilst in hospital and post discharge and that he felt treated with great dignity and respect in every aspect of his care. He also expressed his thanks to the Board for having a continued interest in his ongoing rehabilitation.	
UHB 20/09/003	**Welcome & Introductions** The Chair proceeded with the remainder of the meeting as per the scheduled agenda and formally welcomed all to the meeting.	
UHB 20/09/004	**Apologies for Absence** Apologies for absence were noted.	
UHB 20/09/005	**Declarations of Interest** The Chair invited Board Members to declare any interests in relation to items on the meeting agenda. No declarations of interest were noted.	
UHB 20/09/006	**Minutes of the Board Meeting held on 30th July 2020** The Board reviewed the Minutes of the meeting held on 30th July 2020. **The Board resolved that:** (a) the minutes of the meeting held on 30th July 2020 be approved as a true and accurate record.	

UHB 20/09/007	**Board Action Log following the Meeting held on 30th July 2020** The Director of Corporate Governance (DCG) introduced the Action Log and updated Board Members on progress made. The Board reviewed the Action Log and the following updates were provided: **20/03/014** – This action had been completed **20/05/011** – This action had been completed **20/05/014** – Discussion to be tabled at Management Executives then report into November Board **20/01/016** – This work was part of the Recovery Plan and would be presented to the Board in November **20/07/001** – On agenda for September meeting so now complete **20/07/012 & 20/07/009** – On agenda for September meeting so now complete **20/07/010** – The Executive Medical Director confirmed a formal output of the workshop would be brought back to a future Board meeting **The Board Resolved that:** (a) the Action Log and updates be received and noted.	
UHB 20/09/008	**Chair's Report & Chair's Action taken since last meeting** The Chair introduced his report and its new format. He shared the recent development in the local PSBs and the RPB which covered the whole of Cardiff and the Vale and added that the IM – Local Authority was the RPB Chair. The Chair referenced the early audit activity already undertaken in respect to Covid related work, served as a reminder that public sector officers were always subject to scrutiny. The Chair confirmed Chair's Action taken had been detailed and included within the report as follows: 1) to approve Chair's action of signing of legal documents undertaken at the Board Governance Group. **The Board resolved that:** (a) the Chair's report be noted (b) the Chair's Actions and the signing of legal documents be approved. Khan Raj 11/17/2020 16:20:13	
UHB	**Chief Executive Report**	

20/09/009	The Chief Executive Officer (CEO) introduced the report and highlighted the following within it: The launch of Advanced Therapies Wales, a Wales wide service, looking into advanced therapeutic medicinal products and their impact. The Board was also reminded of the CART-T programme which had continued throughout the pandemic and seen as very positive. It was proposed that advanced therapies and genomics be brought back to a Board Development day to showcase the exceptional service changes as a result of these new technologies. The CEO referred to the increased use of video consultations, 3000 consultations had taken place and clinicians and patients surveyed about "attend anywhere" provided positive feedback. The joint research office was also raised, following a presentation at a Board Development session around research conducted during Covid. This was a good collaboration between UHB and University and we were aligning our protocols with the aim of having a joint research office in Lakeside on the UHW site. The IM – Trade Union commented that the video consultations seemed to have gone well but gathered this was largely focused in outpatients and queried whether there was going to be a drive to expand it more to community and GPs. The CEO responded that it was already embedded within Primary Care settings and that the physiotherapy departments had embraced the technology to deliver classes. He added that we had scratched the surface and not fully understood the scope in the longer term. The Chief Clinical Information Officer added that Community Pharmacy, Dentistry and Community Optometry had also embraced use of video consultations and commented that there was learning from this experience which patients and clinicians had been positive about. He referred to the NHS Confederation report which would be soon published and agreed to share with the Board. Finally, the CEO highlighted the Prevention and Response Plan as a great piece of work that had been recognised by Welsh Government as the model plan and congratulated the Public Health and PCIC teams for this. **The Board resolved that:** (a) the Chief Executive Officer Report be noted.	**NF** **AW**
UHB 20/09/010	**Board Assurance Framework** The DCG reminded the Board that there had not been a fully developed BAF at the last meeting as the Covid-19 BAF risks and those from the original BAF needed to be combined, this had now been done and was presented to Board today for review. It was highlighted that Brexit had not been included on the BAF due to this risk being scrutinised via a separate task and finish group and the	

	continuity plan around this risk but it was still referenced in the report to provide assurance that it was being managed. The DCG highlighted the update provided regarding the rolling out of risk management training across the UHB which had been delayed by Covid. The CEO advised caution as although he did not disagree with the risks identified, the number of risks had increased since the first BAF and he was conscious of the need to not revert to the previous unmanageable risk document. The DCG responded that the additional items were mainly due to Covid risks such as TTP but reminded the Board that these were strategic risks that would impact on our delivery. The IM – Communities queried the two extreme financial risks that had no gaps in control and how these risks would be mitigated. The Deputy Finance Director responded that the financial risk was mainly the cost of managing Covid and until the UHB could secure Welsh Government funding, this risk would remain high even with all the internal controls in place. It was further clarified that Welsh Government had secured £1.3 billion to support the service and manage the impact of Covid-19 and that the UHB was waiting on the allocation from that money, at which point the level of risk would be re-assessed. The Chair queried whether there was a lack of visibility of the Brexit continuity plan to Board and the sub Committees. The Executive Director of Strategic Planning advised that she would bring the plan back to the Strategy and Delivery Committee. **The Board resolved that:** a) the 9 risks to the delivery of Strategic Objectives detailed on the attached BAF be approved b) the progress which has been made in relation to the roll out and delivery of effective risk management systems and processes at Cardiff and Vale UHB be noted.	**AH**
UHB 20/09/011	**Patient Safety, Quality & Experience Report** The END highlighted that a great deal of work had been done to manage complaints during the Covid period and that response times had been improved to 90%. In relation to Serious Incident reporting, the pre Covid Welsh Government standards had been reinstated. An increase in deaths of patients known to the substance misuse service had been seen and the END added that the spike needed to be recognised in the context of the spike shown in relation to physical health. Incidents around Covid in relation to PPE had decreased, time had been spent listening to staff, addressing concerns and making sure availability was right. Hoods had been introduced in critical care areas and a report on this was presented to the H&S Committee.	

	The Chair commented on recurring reference to teenagers being admitted to Hafn y Coed and whether there was a response or resolution to this. The END stated that this was a growing concern and that discussions had taken place with the Chief Operating Officer, Executive Director Strategic Planning and Local Authority colleagues. The frequency with which young people were presenting at A&E or Hafn Y Coed was concerning and the END had therefore asked for a meeting with Local Authority colleagues to consider the level of escalation put in place to prevent these children from presenting in crisis and to try and avoid them staying in A&E for long periods or having to be placed in an adult environment. **The Board resolved that:** (a) the content of the report was considered (b) the areas of current concern were noted and the current actions being taken were agreed sufficient.	
UHB 20/09/012	**Performance Report** The Deputy Chief Operating Officer (DCOO) highlighted that the context remained the same as the previous report, particularly in terms of the relaxation of targets and monitoring by Welsh Government. With that in mind, the same report format had been used and this would be kept under review. Previous comments regarding CAMHS and easier interpretation had been taken on board, and the UHB continued to report more widely, including demand at this stage, which was an important indicator. The DCOO advised that the approach had not changed, with the first principle being to remain Covid ready and patients continued to be prioritised based on risk not time to minimise hospital attendances and use technology wherever possible to meet patient need. The DCOO confirmed that CAV 247 had gone live, essential services continued to be maintained and routine services were reintroduced where safe to do so. Over the last few months, activity had increased but remained at lower levels than previously. Future demand in the context of a combined Covid/winter period remained uncertain, complex and presented potential risks. The DCOO reassured the Board that the risks would be balanced across the system, with guidance from clinicians and consideration of national advice. The CEO credited the operations team on the approach taken. The Chair queried the 4 hour wait times in A&E and why performance during Covid had decreased despite less pressure on the department. The DCOO responded that although performance should be measured against the level of attendances, there had been significant changes in the EU departments which had probably impacted on how performance had been captured. A number of these changes were now reverting back to normal so issues like the 4 hour wait time should be resolved. The Deputy Finance Director led the finance section of the report. He	

	reiterated that the UHB's revenue against its resource limit, progress on underlying deficits and managing pressure on the capital programme were all dependent on Welsh Government funding. **The Board resolved that:** (a) the contents of the report be noted.	
UHB 20/09/013	**Outbreak at UHL – Learning Outcomes** The END advised that this had been previously discussed in private Board and QSE committee. The only area of the report that had been updated was the graph which showed the presentation of Covid within the hospital setting and runs up to 10th September. She highlighted that it had been 87 days since the last hospital acquired Covid in UHW, 82 days in Llandough, 9 days since a community acquired patient was admitted into Llandough, and 1 day since a community acquired patient was admitted into UHW. The report provided detail on location of Covid patients and their Covid status. All Covid related outbreaks were shown for complete transparency. Positive feedback had been received from HIW regarding the 11 case outbreak in Rookwood and the learning around this. East 2 had a significant outbreak over a 28 day period with 31 patients and 13 staff affected, the report provided actions taken. The QSE Committee had asked that the issue around social distancing be raised at Board as it was a theme throughout every outbreak and the Committee was keen for the Board to reinforce that message. **The Board resolved that:** (a) the incidents and outbreaks of COVID-19 infection within the hospital settings in Cardiff & Vale UHB during the pandemic be noted (b) the actions taken to control these incidents and outbreaks, with particular emphasis to East 2, University Hospital of Llandough be noted (c) there have been no further incidents since this outbreak be noted (d) the request from QSE Committee to raise the impact of failing to socially distance be actioned.	**CJ**
UHB 20/09/014	**Socio-economic Duty** The EDSP confirmed that the report updated the Board on the important duty that would come into force on 31st March. The EDSP commented that there was initial concern that it would duplicate other legislation such as WBFGA and existing equalities legislation but it was now viewed as very worthwhile for organisations to have due regard of the socio economic impact when making strategic decisions.	

	The EDSP added that this was very pertinent for the UHB as a significant portion of its population were living in high levels of deprivation and poverty, this duty would place a requirement on the UHB to take that into consideration and consider its decisions would impact positively on that socio economic disadvantage. The EDSP highlighted that it was important to undertake equality and health impact assessments purposefully and to use them to inform UHB decision making. IM-TU requested that Trade Union engagement around the equality and health impact assessments be strengthened and take place earlier. The Chair added that the UHB often does not label items effectively and therefore it was important to properly reference the socio economic duty when developing plans and strategies going forward. **The Board resolved that:** a) the requirements of the Socio-economic Duty that comes into force in April 2020 be noted b) the approach recommended as set out within the report be supported.	
UHB 20/09/015	**Winter Protection Plan – Verbal Update** The EDSP updated the Board that since its last meeting, Welsh Government had published a national winter plan. The plan was fairly wide ranging and did not contain any surprises in terms of the high level actions needed to prepare. The RPB would be leading the production of a local protection plan for submission by 31st October. Q3/Q4 plans, aligned with the winter protection plans, were also required. The EDSP gave assurance that all partners were working together to ensure the plans were delivered on time. It was highlighted that it was unclear whether there would be any specific funding for winter preparedness so existing resources may have to be reprioritised. The ESDP assured the Board that all the processes were in place to produce the winter plan. It was confirmed that an update would be provided at the October Board Development session. The Chair stated that he would like the opportunity to review the plans before they were submitted but was mindful of the tight deadlines. The DEDF commented that additional allocation was expected but it was not known how much at present. In addition the DCOO provided assurance that the UHB was prepared for the coming months and was not waiting for the final plan. **The Board resolved that:**	**AH**

	(a) the Verbal Update and progress made be noted.	
UHB 20/09/016	**COVID-19 Vaccination Plan Update – Verbal Update** The Executive Director of Public Health (EDPH) informed the Board that a high level plan for Covid mass vaccination was not available within the timescales for Board papers but was happy to circulate this to the IMs. The EDPH advised that there were currently 176 vaccine candidates against this virus, 33 of which had entered clinical trials and 2 were currently in the most advanced phase 3 trials - Oxford Astrazeneca Vaccine and Biontech Pfizer Vaccine. The UK Government had announced the purchase of 4 different vaccine technologies totalling £314 million indicating that we would be delivering a mass vaccination programme on a scale not provided before. The intention was to deliver the vaccination programme over a 12 month period and final guidance was awaited from SAGE around how the sequencing of the virus might be provided, which could be a phased approach. Preliminary plans were submitted by 3rd September to the Chief Medical Officer and feedback had been mainly positive, detailed plans would now follow. The themes, around which detailed planning was required, were: • Logistics • Workforce and training • Vaccine requirements • End to end journey (experience of person receiving) • Communications The EDPH assured the Board that progress was being made and the costed plan would be brought to Management Executive and Board. A sense of the scale in terms of staffing estimates was provided: neighbourhood areas were looking at 100 immunisers, clinic operations 300 staff, booking and reporting 30 staff together with a small pharmacy workforce. This would be challenging as there would also be staff needed for multiple other arenas. The timeline to commence was expected to be late winter but was subject to change. The Chair queried how the increased workloads of the Flu and Covid vaccines possibly running in parallel would be managed. The EDPH responded that a blended approach to provision was expected, with different staff groupings delivering to different public/staff groups. The Board was reminded that the Flu plan had been in place for some time and flu vaccinations had already started, nevertheless the challenge was acknowledged and consideration was being given to the type of workforce needed. In the arena of mass vaccinations, the regulations would change to enable Healthcare Support Workers to provide the vaccine which would be an enormous asset.	**FK**

	The Board Resolved that: (a) the verbal update was noted.	
UHB 20/09/017	**Public Services Ombudsman for Wales Annual Letter** The END confirmed that a more detailed paper would be taken to the QSE Committee to look at the detail of the reports. The Ombudsman's letter referred to a relationship manager, the UHB had not had one of these for the last 2 years so this had been queried with the Ombudsman's office, the Ombudsman remained of the view that a relationship manager was not required and a refreshed letter may be issued stating that. The END confirmed that the deadline of 30th November for a response to the letter would be met. **The Board Resolved that:** (a) the findings of the Ombudsman's Annual Letter 2019/2020 be noted (b) the need to respond by the 30th November be noted.	
UHB 20/09/018	**Nurse Staffing Act** The END advised that this was an annual report and the Board would be aware from previous meetings that she had provided updates on the Act due to the level of changes being made at times on a daily basis to environments. In line with the Act, an annual assurance report was due in May 2020 but it was agreed with the CNO to delay to September. This report related to the period of April 2019-2020 but still demonstrated the ongoing work in relation to the Act. A further detailed report would be presented in spring 2021. The Chair emphasized the importance of this piece of work and understanding the work pressures of our nursing complement especially during Covid and with the potential of a second wave. **The Board Resolved that:** a) the nurse staffing levels in line with the Nurse Staffing (Wales) Act (2016) for the time period April 6th 2019 – April 5th 2020 be approved.	
UHB 20/09/019	**Board Champion Roles and Responsibilities** The DCG informed the Board that this was last updated in May 2019, with the delay predominantly being due to Covid.	

	There were a number of roles that Welsh Government were removing and this would be confirmed in the awaited Welsh Health Circular. Appendix 1 provided the suggested roles, which had been reduced to only 5 IM roles. It was likely however that Welsh Government would in time put in other roles to replace the ones removed, and this would be revisited as necessary. The board was further advised that this would be revisited when the Vice Chair was recruited and ICT role filled. A role description had now been developed to provide clarity as to the role and to ensure the IM roles and responsibilities do not cross over into the operational duties of staff. **The Board Resolved that:** a) the proposed Board Leads and Champions set out in Appendix 1 be approved b) the Board Champion Role Description set out at Appendix 2 be approved.	
UHB 20/09/020	**Director of Public Health Annual Report** The EDPH advised that the initial plan was to publish the report in March but that this had been delayed. The EDPH touched on the aging population and the challenges faced in this regard. It was highlighted that this year the report was presented in different ways via infographics, films, web and paper. The report provides evidence to support the three themes: Purpose in life, Connections for life, and Places for life. The recommendations and actions for our PSBs and RPBs to support this agenda were highlighted as well as actions for the UHB to lead on. **The Board Resolved that:** a) the Annual Report, including the impacts on health and well-being of the three key themes of having purpose, social connections and a physical environment that supports health and wellbeing into later life be noted b) current and future initiatives and interventions to deliver against the recommendations across the UHB and with wider partners be supported.	
UHB 20/09/021	**Committee Minutes** i. Audit and Assurance Minutes – 7 July 2020 ii. Finance Committee – 29 July 2020 iii. Quality Safety & Experience – 16 June 2020	

	iv. Strategy and Delivery Committee – 14 July 2020 v. Local Partnership Forum – 18 June 2020 vi. Emergency Ambulance Services Committee – 14 July 2020 **The Board resolved that:** (a) the minutes outlined above be ratified.	
UHB 20/09/022	**Reports from Committee Chairs:** i. Audit and Assurance Committee – 8 September 2020 ii. Finance Committee – 29 July & 26 August 2020 iii. Strategy and Delivery Committee – 15 September 2020 Verbal Update iv. Quality Safety & Experience – 8 September 2020 v. Digital Health Intelligence Committee – 9 July 2020 vi. Stakeholder Reference Group – 22 July 2020 vii. Local Partnership Forum – 3 August 2020 viii. Emergency Ambulance Services Committee – 8 September 2020 The Interim Vice Chair & Independent Member – Legal updated the Board following his first meeting as Chair of the Strategy and Delivery Committee. The Committee had received a good report from the COO and DCOO on strategy to rebalance CAMHS care, which outlined the hard work to tackle waiting list volumes and a bespoke model that was strategic, clinician led, and exactly what the Committee should be considering. The Executive Director of Workforce and Organisational Development raised some points regarding the Local Partnership Forum. He advised that the shielding arrangements had now halted and that safe return to work was being arranged for this group. Furthermore, work was being progressed around agile working (home working); questionnaires had been sent out to staff who had been remote working. ¾ expressed satisfaction and felt it should be embedded into normal working processes to provide a hybrid work style of people working partly in the office and partly at home. It was confirmed that this work was tied into an All Wales piece of work which was ongoing. **The Board resolved that:** a) the Committee Chair reports outlined above be noted.	
UHB 20/09/023	**TTP Prevention and Response Plan** The EDPH referred to the EDWOD's comments about home working and mentioned that the Minister highlighted that home working should be encouraged as much as possible. The context of this was that we had a rising rate of per 100,000 over a 7 day period, which was already above 40 per 100,000 for Cardiff and almost 30 for the Vale. Welsh Government had provided guidance on thresholds of actions for incident management teams, with a rating of case incidents and a RAG rating. Incident management team meetings had taken place together	

	with leadership group and also political leadership group meetings which followed. The EDPH and her team had made recommendations to Welsh Government, most of which were local.	
UHB 20/09/024	**Agenda for Private Meeting** i. Private Committee Minutes ii. COVID-19 Board Governance Group Minutes iii. Corporate Risk Register	
UHB 20/09/025	**Review of the Meeting** All present confirmed the meeting had run well via Zoom.	
UHB 20/09/026	**Date, Time & Venue of Next Board Meeting:** Thursday, 26th November 2020 at 1.00pm	

ACTION LOG
Following Board Meeting
24 September 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
20/07/001	Patient Story	It was requested the COVID related patient story be brought back to a future meeting	24.09.2020	R Walker	Complete
20/07/012	Nurse Staffing Act	An update report would be provided to the Board on a number of occasions due to constant changes	24.09.2020	R Walker	Complete
20/07/009	Board Assurance Framework	The BAF would be developed and presented to the Board Meeting in September.	24.09.2020	N Foreman	Complete
UHB 20/09/009	NHS Confederations VC Report	Report for the NHS confederations which will be published soon to reflect not only on Video Consultation itself but also on its implementation in Wales	TBC	Allan Wardhaugh	Allan to share the report on VC after it has been published & also to be taken to Board Development in February
Actions In Progress					
20/05/014	The Nurse Staffing Levels for Adult Acute Medical and Surgical Wards	A further discussion to be had at an executive level to consider Mental Health Nurse staffing levels for feedback to the Board.	**26.11.2020**	R Walker	Discussion to be tabled at Management Executives then report into November Board
20/01/016	Recognising and Responding to the Climate Emergency	To bring back an action plan to a future meeting	**26.11.2020**	A Harris	This work was part of the Recovery Plan and will be presented to the Board in November
UHB 20/09/016	COVID-19 Vaccination Plan Update	Development of a costed plan which will be brought to Management Exec and Board	**26.11.2020**	Fiona Kinghorn	On Agenda for November

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions referred to Committees of the Board/Board Development					
UHB 20/09/010	Brexit Continuity Plan	CC queried that we may have a lack of visibility on the Brexit continuity plan to the Board and the sub committees	10.11.2020	Abigail Harris	Brexit Continuity Plan to be brought to Strategy and Delivery Committee
UHB 20/09/015	Winter Protection Plan	CC was keen on the opportunity to review the plans before they are submitted on 31/10/2020	10.11.2020	Abigail Harris	On Agenda for next S&D Committee Meeting
20/07/010	Patient Safety, Quality & Experience Report	A 'Learning Committee' would be discussed and considered with operational colleagues.	17.12.2020	R Walker / S Walker	Workshop scheduled for 17/09/2020 Learning Committee will be considered formal output of the workshops would be brought back to the Board Development & to Board in January

Report Title:	**Chair's Report to the Board**								
Meeting:	Board Meeting						**Meeting Date:**	26th November 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Chair of the Board								
Report Author	Executive Assistant to Director of Corporate Governance								

Background and current situation

This report provides an update of key activities that have taken place since the last Board Meeting on the 24th September 2020 together with a brief overview of the contribution from Primary Care services during the pandemic. An update on the Health Board's Joint Escalation and Intervention status is also included.

Update on Primary Care

Primary care is the first point of contact for most people to health care. There has been a significant contribution from primary care during the pandemic, with some of the key highlights including:

- A shift in how services are delivered, with use of telephone triage, e-consult and video consultations to ensure people have access to services.
- All clusters established robust plans by which to maintain GMS services. There was collaborative working to establish centralised hubs within the cluster by which to manage patients displaying respiratory/Covid symptoms.
- The establishment of five urgent dental centres and the provision of urgent and emergency dental appointments for people not registered with a practice.
- The establishment of dedicated primary care optometric centres. Whilst it has been a challenging time, there have been a number of initiatives introduced during this period to shift suitable eye care activity traditionally taking place in hospital settings to primary care based optometry services. These include:
  - Independent Prescribing supporting Eye Casualty in the community - averaging 180 appointments per month (in 6 optometry practices rather than UHW Eye Casualty for complex acute eye conditions).
  - Glaucoma ODTCs assessing new and follow up glaucoma appointments.
  - Continued focus on ensuring primary care support to care homes and those on palliative care pathways through a Directly Enhanced Service (DES) to increase specific support to care homes.
  - There are regular multiagency care home position meetings held with representatives of the care home and domiciliary care sector. This includes advice, guidance and support in relation to testing, outbreaks, business continuity and PPE, as well as supporting safe discharge from hospital including the commissioning of intermediate care isolation beds.

An urgent primary care hub has been established in Central Vale to provide additional capacity

for a range of patients with urgent primary care needs to be seen at the hub, or directed to other services as appropriate. Proposals have been developed to extend this hub as part of the pathfinder work for urgent primary care centres which will be supported by Welsh Government funding.

A new phone first triage model has also been introduced. CAV 24/7 went live on the 5th August 2020. This was Wales' first phone first approach to Unscheduled and Urgent Care. Patients are able to phone CAV 24/7 prior to attending the Emergency Unit and receive a clinical triage via the telephone. If, after the telephone triage, it is felt that the patient needs to attend the Emergency Unit, they will be given a timeslot to arrive. This not only provides a much more amenable experience for the patient but also allows the department to conform to social distancing. If a patient rings CAV 24/7 and it is felt they do not need the Emergency Unit, they are referred in to specialities, or signposted to Primary Care services. Around 150-250 calls a day are being received by CAV24/7 (in addition to the usual Urgent Primary Care/Out of Hours calls). Around 64% are being booked into EU/MIU and others dealt with or signposted to other primary care services. Feedback from clinicians and operational managers has been extremely positive. Whilst the number of attendances to EU has not reduced as originally expected, they have remained fairly flat, whereas prior to introduction of CAV24/7 attendances were increasing. With the booking facility it also means it has been easier to manage as these are now planned attendances. Feedback from patients has been extremely positive. A survey has been completed by more than 650 people with the key messages:

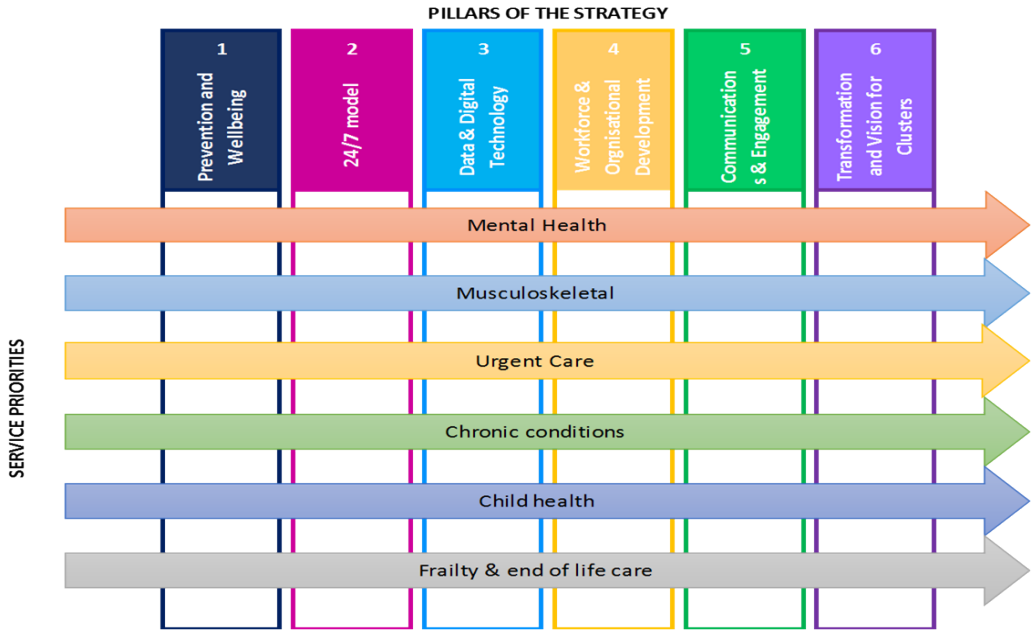
- ✓ 87% would be happy to use the service again.
- ✓ 86% happy with the time taken to answer the call.
- ✓ 86% satisfied with the service from the call handler.
- ✓ 78% had the call back on time, or earlier from a clinician.
- ✓ 87% satisfaction with the service from the clinician.
- ✓ 81% seen within 1 hour of appointment given.

Strategic context and next steps

There are a number of priorities for primary care that have been agreed at a national level, these are:

- Delivery of essential services
- COVID-19 local outbreaks or second wave
- Care Homes
- Rehabilitation
- Step-up and step down bedded community services
- Urgent primary care

The strategic approach for primary care within the Health Board, can be shown in the following diagram. The pillars align to the work streams within the National Strategic Programme for Primary Care and the service priorities reflect the work we have delivered through the establishment of MH/MSK services across Cardiff and Vale, as well as the initiatives in relation to urgent primary care. The other service priority areas are still to be developed and discussions are ongoing with external stakeholders.



Investment in Primary Care MH Services

In anticipation of the 'wave' of mental health referrals which have subsequently been realised, the MHCB increased its 3rd sector funding and capacity by 25% for the foreseeable future – this is to meet the demand for foundation level mental health and well-being support to those affected by covid-19 as well as its knock on effects on financial worries, housing, employment, with particular vulnerabilities for ethnic minorities, people from lower socio-economic groups and those with pre-existing health problems. The 3rd sector provision has been specifically commissioned to meet those needs and are available at a pre-GP level. The support of the PCIC Clinical Board has been vital in making decisions.

Developed a single point of assessment access for the Primary Mental Health Support Service and the Primary Care Counselling services. This change has been designed into the service to improve access to those in need of high intensity psychological interventions and simplify referral pathways for GPs. The waiting list for PCCS has almost halved for those in the greatest need and ensured professionals spend more time working optimally to their skills level. Risks include overwhelming PMHSS who are returning to previous referral numbers, which is being monitored.

Digital Platforms

The MHCB introduced access choice into its service user therapeutic contacts and are now the highest user of Attend Anywhere by over 100% in the UHB. This has offered service users additional choice with modes of contact and enabled the clinical services to return to previous activity and contact levels even with the covid restrictions.

MHSOP Transformation

As part of Covid-19 preparation, older peoples mental health services has given a ward over to use for covid streaming and reinvested the resource in hospital admission prevention, particularly considering its benchmarked position with bed numbers. This has proved very successful with enhancements to crisis, community and care home support. In addition, the requirement to care

and treat covid positive patients within MHSOP in patient areas has positively enhanced the skills of mental health staff with the support of the Medicine Clinical Board.

Recovery College

The Clinical Board intends to press ahead with transformational and cultural change within the context of its flattened and widened leadership structure, with the opening of the Recovery College, delivering a program of 'care aims' training to practitioners as well as launching 'open dialogue' approaches within the service, which will see a view into the future for the social and educational movement of mental health services.

Strategic Direction

That mental health transformational story has seen over a decade's worth of shift in resources and activity from hospital to community services with a landmark reached in 2018 of that resource balance tipping to over 50% in community based services. This has been accompanied by tectonic shifts in activity and the extending 'reach' of services to 1000s of community contacts to 10s of 1000s of primary care contacts a year. This upstream model has been added to with development of liaison interdependencies across record numbers of areas such as EU, Primary Care, care homes, general hospital beds, the criminal justice system, community dementia services to name a few.

Joint Escalation and Intervention Arrangements

We received some very positive news relating to the UHB's escalation status with Welsh Government. As you are aware, under the Joint Escalation and Intervention Arrangements, the Welsh Government meets with Audit Wales and Healthcare Inspectorate Wales twice a year to discuss the overall assessment of each health board and trust in relation to the arrangements. A tripartite meeting has recently taken place and I am delighted to let you know that Andrew Goodall, on the basis of the tripartite group discussion, has advised us that Welsh Government officials will be recommending to the Minister that the escalation status of Cardiff and Vale University Health Board remains unchanged at 'routine arrangements'. The group acknowledged that progress has continued over recent months and were complimentary about the continued openness and transparency of the health board.

This is excellent news which recognises the considerable positive work that our executives and staff have undertaken across our organisation. It is perhaps particularly noteworthy bearing in mind our need to respond to the exceptional and extraordinary demands of the Covid-19 pandemic.

a. Fixing the Common Seal / Chair's Action and other signed documents

This section details the action that the Chair has taken (through the Board Governance Group) on behalf of the Board since the last meeting. The Board is requested to ratify these decisions in accordance with Standing Orders.

The common seal of the Health Board has been applied to 2 documents since the last meeting of the Board.

Seal No.	Description of documents sealed	Background Information
940	Lease relating to Unit 4 Parc Ty Glas, Llanishen, Cardiff. Sunflower Industrial Property	DWF Law LLP – Cardiff & Vale UHB.
941	NEC 4 ECC Option E for Dragons Heart Surge Hospital, Cardiff	Cardiff & Vale UHB – ES Global Limited

The following legal documents have been signed since the last meeting of the Board:

Date Signed	Description of Document	Background Information
30/09/2020	Eye-Care Digitisation Programme NHS Wales Contract	Cardiff and Vale UHB on behalf of NHS Wales Health Boards & Toukan Labs UK

Khan,Raj 11/17/2020 16:20:16

Chair's Action was taken (and approved by the COVID-19 Board Governance Group) in relation

to:

Date	Chair's Action	Background & Recommendation approved	Independent Member approval		Queries raised by IMs
			Independent Member 1	Independent Member 2	
01.10.2020	WRU Occupancy of Dragon's Heart Hospital	Retrospective and Prospective contract costs for the Health Board's occupancy at the Principality Stadium was approved.	John Union	Rhian Thomas	No queries raised
01.10.2020	Cardiff Blues Support for Dragon's Heart Hospital	Retrospective and Prospective contract costs for support provided by Cardiff Blues was approved.	John Union	Rhian Thomas	No queries raised
06.10.2020	Mott McDonald Professional Consultancy and Design Services for Dragon's Heart Hospital	Additional Expenditure for Professional and Design Services from Mott Macdonald at the DHH approved	John Union	Rhian Thomas	No queries raised
15.10.2020	Third Sector Covid Funding Allocation	Approval given for the allocation of £33,000.00 to Glamorgan Voluntary Services for the provision of Third Sector Covid-19 funding.	John Union	Rhian Thomas	No queries raised
20.10.2020	Funding Proposal for the UHB Patient at Risk Team (PART)	Approval given for the funding of the Patient at Risk Team model and its associated revenue funding.	John Union	Rhian Thomas	No queries raised

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

The COVID-19 Board Governance Group was set up to ensure robust, effective decision making could take place at pace. This has ensured that due process has continued to be followed.

Recommendation:

The Board is recommended to:

- **NOTE** the report
- **APPROVE** the Chair's Actions and signing of legal documents undertaken at the Board Governance Group.

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	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		Long term	x	Integration	x	Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**CHIEF EXECUTIVE'S REPORT**							
Meeting:	CARDIFF AND VALE UHB BOARD MEETING					**Meeting Date:**	26.11.2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓
Lead Executive:	**CHIEF EXECUTIVE**							
Report Author (Title):	**EXECUTIVE ASSISTANT TO THE CHIEF EXECUTIVE**							

Background and current situation:

This is the sixteenth written report being presented and, where appropriate, has been informed by updates provided by members of the Executive Team.

At each public Board meeting, the Chief Executive presents a report on key issues which have arisen since its last meeting. The purpose of this Chief Executive report is to keep the Board up to date with important matters which may affect the organisation.

A number of issues raised within this report may also feature in more detail in Executive Directors' reports as part of the Board's business.

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

Executive Director of Finance

I am delighted to extend a warm welcome to our new Director of Finance, Catherine Phillips. Catherine joins us from North Bristol NHS Trust, where she has been the Director of Finance for nearly eight years. During this time, Catherine has given outstanding financial leadership to the Trust at a significant point in its history. She calmly navigated them through a complex PFI contract, with considerable settling in of services and commissioning issues as the new hospital came into effect. With Catherine's stewardship they exited Financial special measures in less than one year and have for the last four years met the financial control total set by NHS England. This new role enables Catherine to further develop her system leadership in a different political and social context, and I am looking forward to her beginning her role with us here in Cardiff and Vale UHB.

Cardiff and Vale Recovery College

On 29 September, we marked the launch of our very own Recovery & Wellbeing College with a virtual event. Staff, key stakeholders and service users were all invited to join us in celebrating the occasion.

The Cardiff and Vale Recovery & Wellbeing College provides free courses on a range of mental health and wellbeing topics - available to people who are currently using or have used mental health services, their carers, and mental health workers in the Health Board, Local Authority and Charitable Sector.

This is a fantastic extension to the mental health services available across Cardiff and Vale UHB

– allowing people to understand more about mental health issues to better aid recovery and wellbeing. All of the courses are co-produced by professionals and individuals with lived experience of mental health issues.

UHW Lakeside Wing

You may have seen some pictures on social media of the first modules being placed on our UHW site. These modules form part of the 'Northern wing' of the UHW Lakeside Wing which will house 166 beds; these will be available from 25 November.

I am pleased to say the UHW Lakeside Wing is being delivered on time and within budget; I cannot thank enough all of the colleagues who are working on this project, particularly in the Capital, Estates and Facilities team. Darwin Group (the main contractor working on the Lakeside Wing) has kindly produced a 'walkthrough' of what the UHW Lakeside Wing will look like illustrating the exterior and inside the building, please visit our website to watch the video.

There is also a dedicated webpage.

Queen's Birthday Honours List

I am delighted to say that five members of staff from Cardiff and Vale UHB were recognised in the Queen's Birthday Honours this year. The members of staff who have been awarded are:

- Dr Graham Shortland, Consultant Paediatrician – For services to Paediatrics, Patient Safety and the NHS in Wales - Officer of the Order of the British Empire (OBE)
- Claire Salisbury, Head of Procurement – For services to the NHS in Wales during Covid-19 - Member of the Order of the British Empire (MBE)
- Jade Cole, Critical Care Research Lead – For services to the NHS and Critical Care Research during Covid-19 – Medallist of the Order of the British Empire (BEM)
- Paula Gallent, Ward Sister – For services to the NHS during Covid-19 - Medallist of the Order of the British Empire (BEM)
- Alice Bretland (Richards) - Home Ventilation Service Lead and Specialist Respiratory Physiotherapist - For services to the NHS particularly during Covid-19 - Medallist of the Order of the British Empire (BEM)

A COVID-19 first for Wales at UHL

You may have read earlier this month that Melanie James, from the Pontprennau area of Cardiff, recently became the first patient in Wales to receive a transfusion of monoclonal antibodies to treat COVID-19 at University Hospital Llandough.

It is the latest treatment to be added to the global RECOVERY trial, which we were the first health board in the UK to open back in March. This new arm of the trial aims to determine the effectiveness of monoclonal antibodies in preventing COVID-19 from entering the cells of patients infected with the virus, and preventing patients from becoming more severely unwell. Melanie was breathless and receiving oxygen when she received the transfusion of the

monoclonal antibodies, but I am glad to confirm that she is now feeling better and continuing her recovery at home. Of course, it is important to remember that this arm of the trial is still in its very early stages, and the wider effectiveness of this treatment is not yet known.

I know that the team is rightly very proud of their contribution to research throughout the COVID-19 pandemic, and I would like to thank them for their outstanding efforts. Our thanks are also due to Melanie and the many patients like her who have agreed to take part in these vital trials, helping to seek effective treatments for COVID-19.

Diabetes Network recognised at National Diabetes Awards

I am delighted to report that our Children and Young People's Wales Diabetes Network have been recognised at the prestigious National Diabetes Awards for their *Hypo Dino* initiative. The Hypo Dino was created by children in order to inspire others.

It was a finalist in the Type 1 Diabetes Specialist Service category at the 2020 Quality in Care (QiC) Diabetes Awards which were held virtually on Thursday 15 October. This category recognises initiatives that deliver specialist support for children, young people and emerging adults, and adults with Type 1 Diabetes, and have demonstrated a positive impact on the diagnosis and management of type 1 diabetes and associated secondary complications.

Barry Hospital Celebrates 25th Anniversary

On 25 October, Barry Hospital celebrated its 25th Anniversary. Despite the COVID-19 pandemic meaning that our planned celebrations could not go ahead, the Health Charity still managed to celebrate with a look back on the work which they have undertaken there recently. You can read more here: https://healthcharity.wales/celebrating-the-25th-anniversary-of-barry-hospital/

Joint Escalation and Intervention Arrangements

Following a tripartite meeting between Welsh Government, HIW and Audit Wales in early October, we were notified that we will be maintaining our rating of 'routine arrangements.' Andrew Goodall also recognised the professional and considered way in which the NHS and the UHB responded to the extraordinary circumstances of the pandemic response.

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

The Executive Team contributed to the development of information contained in this report.

Recommendation:

The Board is asked to **NOTE** 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

Report Title:	**Corona Virus Update Report**								
Meeting:	Board						**Meeting Date:**	26.11.20	
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**		**x**
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Corporate Governance**								

Background and current situation:

As detailed in the Proposed Changes to Governance Arrangements report, a new COVID-19 Update Report has been developed for approval following recent review of Governance arrangements. As with the other measures being implemented, the intention is to ensure robust and improved governance arrangements are in place during the second wave of the pandemic.

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

The attached COVID-19 Report (Appendix 1) provides the first update of this type to the Board regarding the pandemic, and covers key activities in the areas of Quality and Safety, Workforce, Governance, Operations and Public Health.

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

Provision of this report as standing agenda item for Board will further strengthen what was previously in place and ensure increased transparency of reporting around COVID-19.

The COVID-19 Report is not intended to duplicate information and where reference can be made to other more detailed Board reports, authors are encouraged to do so.

Should any amendments be required to the template following consideration at this meeting, these will be implemented for the next Board.

Recommendation:

The Board is asked to:

- Note the attached COVID-19 Update 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	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		Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

COVID 19 – Update Report covering key activities in relation to • **Quality and Safety** • **Workforce** • **Governance** • **Operations** • **Public Health**	**Month: November 2020**
Quality and Safety	Executive Nurse Director/Executive Medical Director

There are currently a number of wards across the UHB where there are outbreaks of COVID-19. There is robust monitoring of the situation with daily operational meetings chaired by the Executive Nurse Director and outbreak procedures in place for all affected areas.

Work is underway to review the deaths of all patients who died with a diagnosis of COVID-19 on the death certificate. Reviews are being undertaken in line with the All Wales investigation toolkit.

The UHB has been working with Cardiff University to undertake a thematic review of COVID-19 related incidents. The results are to be presented to the Medical Leadership Group and will be used to identify learning opportunities. The work will continue with prospective analysis of all reported incidents during the 3 next months (GP trainee will be working with the Patient Safety Team) to ensure rapid learning as necessary.

The PPE cell continues to meet to ensure appropriate procurement, distribution and management of PPE related issue across the UHB (see Board report for further information in relation to PPE reported incidents).

Workforce	Deputy CEO and Executive Director of Workforce and OD

- Workforce Hubs are established for Nursing, Medical, AHP, Facilities and Primary Care brought together through a Workforce Steering Group chaired by Director of Workforce & OD
- Lakeside Wing Workforce model developed to support phases - 25 beds then increasing by 50 beds to a total of 400 beds
  - Risk rating the first 100 Covid beds is either a Green (low risk) or Yellow/Amber (low/medium risk)
  - Risk rating is as a result of many other options being considered to provide safe staffing numbers e.g. internal deployment, dietetics nurses being utilised, Physician Associates being hired
  - Trade Union Representatives have been consulted and are supportive
- Increasing temporary recruitment - 50 Temporary Facilities Staff hired. Further 35 in progress. Created a Facilities Bank. Engaged with Agency to provide further Plan B back-up
- Mass Immunisation & Vaccination Programme - Recruitment Plan & support in place

- Staff-wellbeing being prioritised with a comprehensive full range of initiatives and support in place
- Temporary enhanced pay incentive Scheme for Substantive Registered Nursing staff in development to increase bank supply.

Governance	Director of Corporate Governance

See Board report relating to Proposed Changes to Governance Arrangements following learning from the first wave of COVID-19.

Operations including Operational Framework	Chief Operating Officer

The revised Covid-19 operating framework previously presented to Board and set out in the Health Board's IMTP remains in place. The key components of the revised operating framework continue to guide operations in the second wave of the pandemic. The first principle of remaining 'covid ready' remains, along with a number of key operating principles which include using a 4-6 week planning horizon, a service 'gearing' approach in response to covid demand, Protected Elective Surgery Units (PESU) or 'green zones' and an increased emphasis on site-based management and leadership through Local Co-ordinating Centres (LCC's).

Having scaled back the Executive-led operations meeting which ran in the first peak, the Chief Operating Officer has reintroduced these in the current wave. These are now delivered virtually and remain open to all Health Board staff who wish to join, understand the position, participate in decision making, raise concerns etc. The intention is to further embed front line empowerment and clinically-led design which was a feature or the wave response.

In support of the Operations Group, a number of Executive-led support cells have been re-instated to enhance the operational response. Executive Directors are leading workforce, IP&C and testing cells.

The Health Board has experienced increased operational pressure across its system. General Practice and Primary Care remains challenged, with one GP practice having to temporarily close due to staff quarantining (with a planned contingency cross-cover arrangement quickly enacted) and an expected 'lag' in impact on Mental Health has materialised with significant rises in PMHSS referrals.

As community prevalence increased the Health Board has seen a gradual increase in covid admissions to hospital - rising steadily to just over 100 active covid-positive patients as at mid-November. The overall covid related bed occupancy (including suspected and recovered patients) had risen to nearly 190 patients at the same time. Demand for critical care beds has also been gradual – remaining at 6 critical care covid patients for a prolonged period before rising to 10 patients as at mid-November.

From mid-October to mid-November the in-patient covid occupancy volumes have been driven to a greater extent by nosocomial spread. As at mid-November, this a greater cause of concern in relation to hospital bed occupancy than community acquired admissions. The operational impact of this is material, with over a 160 beds 'blocked' and 74 empty beds closed at UHW alone due to IP&C restrictions.

In terms of hospital bed capacity the Health Board's operational plans have been able to meet overall demand (covid and non-covid) admissions to date. However, the complexities associated with 'streaming' several new cohorts of infected or potentially infected patients have brought exceptional operational challenge. In bed availability terms, the Health Board has plans in place to expand capacity to meet the current demand trends. The rate limiting factor in this plan will be securing sufficient clinical staff. Please see workforce return.

Overall capacity planning may be seen as three phases. Phase 1 refers to an expansion in capacity within the pre-existing Health Board footprint. Phase 2 relates to a number of newly commissioned areas within the Health Board estate and Phase 3 relates to the replacement of the Dragon's Heart Hospital with a new 'field hospital wing' on site at UHW. The new wing will begin to be available from the 25th November, with all 400 field hospital beds being available by February 2021.

The current position is that the Health Board has moved through Phase 1 deployment and is likely to be moving into Phase 2 in November. Modelling suggests an element of phase 3 may be needed to aid winter pressures in December/January, with the remainder being reserved for a worst case scenario. The Health Board's bed plan has been guided by Welsh Government modelling assumptions.

As with the first peak of covid, the Health Board has continued to provide essential services throughout the second wave. Since the first wave much work has been done to recover cancer referrals and treatments to pre covid levels. Beyond essential services, a range of other services have been reinstated – particularly where the resource needed does not denude essential services provision. The Health Board is currently delivering at just over 60% of its pre covid treatments and has plans through Q3 and 4 to increase this to above 75%. These plans are contingent on the pattern and service impact of the pandemic.

Finally the Health Board, whilst under significant pressure at points, has generally declared lower levels of overall escalation. This is testament to our clinical and operational team's pro-active approach and commitment. Due to much higher levels of escalation in a number of neighbouring health boards Cardiff & Vale UHB has been regularly offering support through a regional 'mutual aid' arrangement. C&V UHB is frequently assisting with urgent and emergency care diverts from a number of other Health Boards and, more recently, have systematically agreed a change in emergency patient flows from CTM UHB - during its significant challenges as a result of nosocomial spread.

Public Health	Executive Director of Public Health

October saw a significant increase in new cases of COVID-19 in the Cardiff and Vale region. The biggest rise was seen in Cardiff, attributable in large part to rapid spread among young people aged 17-25, and particularly (but not exclusively) first year and returning students. The current new case rate in Cardiff reached 351.6 per 100,000 over 7 days on 26 October, representing 184 new cases per day; this trend appeared to be stabilising in early November. However in the Vale of Glamorgan, after initially appearing to stabilise, a more recent upward trend has been evident which has taken the case rate above 100 per 100,000 over 7 days, with test positivity also rising. Of potential concern is the fact that case rates

among over 60s have begun to increase in both Cardiff and Vale, although the rate remains below the level among people aged under 60.

A multiagency regional team (Public Health Protection Group) meets daily during the week; and a weekly Test, Trace, Protect Operational Board reports into a monthly Test, Trace, Protect Senior Executive Group. In addition, a Regional Incident Management Team meets twice weekly to make recommendations to Welsh Government. The significant rise in new case numbers has necessitated rapid expansion of contact tracing capacity and a prioritised approach to contact tracing high risk settings such as: care homes, healthcare, schools and certain workplaces. Strong partnership arrangements with local Higher Education Institutions have been established to manage the sharp rise in cases in university students, including offering onsite testing (conducting in excess of 2,000 tests) within halls of residences, and practical support to those individuals in both halls and rented accommodation that needed to isolate.

There are signs that the number of cases among our young people may be starting to level off. However we continue to see a number of workplace clusters, mostly linked to larger employers. We have recently seen the re-emergence of a number of outbreaks within our hospitals, which is of concern, they are being actively managed. Care home incidents continue to be managed by multidisciplinary teams in each local authority area. Our ongoing 'whole home' testing programme, including symptomatic and asymptomatic staff and residents of care and residential homes (closed settings) with new and ongoing outbreaks of possible or confirmed COVID-19 remains a priority; alongside continued active engagement with homes that have experienced cases.

At the wider population level we remain concerned about the role of individual behaviours in spread of infection, particularly in the colder months when people will be indoors more. Backward contact tracing is identifying, for example, that people comply well with social distancing during work hours then go out for a social event after work where compliance with measures drops. Whilst the 17 day firebreak will have a short term effect on such social interactions, as we exit this phase we need to renew our focus on the basic messages of maintaining 2m distance, hand and respiratory hygiene and wearing a face covering where appropriate.

The Community Testing Units (CTU) at Whitchurch and Splott continue to provide the basis of testing for symptomatic staff or a symptomatic family member from the Health Board, Welsh Ambulance Service and Velindre NHS Trust (Cardiff & Vale of Glamorgan residents). Testing for staff and patients in their own home remains an option if they unable to get to a CTU following safe guidelines. Work to enhance the testing provision by adding a further testing lane at Whitchurch in nearing completion, and the team now has capacity to capacity to undertake circa 600 test daily (up from 350-400) between Splott and Whitchurch.

Throughout September and into the early part of October, in line with the rest of the UK, the UHB experienced significant delays with the turnaround times for results in Lighthouse Labs which was widely covered in the media. Tests from: Cardiff City Football Stadium Population Testing Centre; local testing centres; mobile testing

units and care home portals all go through this route. This is monitored alongside the turnaround times for Welsh labs on a weekly basis by the NHS Wales Test, Trace, Protect Team, who are working closely with the Department of Health and Social Care to understand delays and help improve performance.

With cases now rising in parts of the Vale of Glamorgan, we are collectively working to deploy mobile testing opportunities to better understand the spread of Covid across different communities, including in the Barry area.

We have been working with partners to identify and deploy local testing sites across Cardiff and the Vale of Glamorgan. These sites are a UK Government provision (similar to that provided at Cardiff City Stadium), specifically designed for localised testing on a smaller site in a high density urban area. The first site has been operating on Museum Ave in Cardiff city centre since 14 October, 7 days per week from 0800-2000hrs, to support the whole community as a 'walk-in testing' facility; with 432 daily appointments bookable via the gov.uk online portal.

Every Health Board in Wales was tasked with submitting preliminary plans for the delivery of the COVID-19 vaccination programme locally by 3 September 2020 to the Chief Medical Officer for Wales. Cardiff and Vale UHB submitted a strategic level plan, approved by the CVUHB Chief Executive Officer setting out our proposed strategy, aims and objectives. Priority groups for vaccination identified by the Joint Committee for Vaccination and Immunisation (JCVI) currently include healthcare and social care staff, staff and residents of care homes and people aged 50 years and over. Further guidance on priority groups is expected imminently. The majority of people who are eligible for vaccination will attend a Mass Vaccination Centre. Three sites for Mass Vaccination have been approved across the localities of Cardiff and the Vale of Glamorgan – in Barry, Pentwyn and Splott. Healthcare staff employed by the UHB will be vaccinated by existing Flu Champion Peer Vaccinators. Care home staff will be vaccinated by mobile vaccination teams going on-site from mid-December, and possibly earlier (pending availability of vaccine). People unable to attend a Mass Vaccination Centre will be visited by mobile/outreach vaccination teams. It is estimated that approximately 220,000 people across Cardiff and the Vale of Glamorgan will be eligible for COVID-19 vaccination, according to current national guidance.

Report Title:	**Board Assurance Framework (BAF)**						
Meeting:	Board				**Meeting Date:**	26th November 2020	
Status:	**For Discussion**		**For Assurance**	x	**For Approval**	x	**For Information**
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Director of Corporate Governance**						

Background and current situation:

The Board Assurance Framework provides the Board with information on the key Strategic Risks that could impact on the delivery of the Health Board's Strategy 'Shaping our Future Wellbeing'. It provides information on the controls and assurances in place to manage and/mitigate the risks identified and any further actions which are required.

At the last Board Meeting it was agreed that a new BAF would be developed which would comprise the following risks:

1. Workforce
2. Financial Sustainability
3. Sustainable Primary and Community Care
4. Patient Safety
5. Sustainable Culture
6. Capital Assets
7. Test, Trace and Protect
8. Risk of Delivery of IMTP
9. The risk of inadequate capacity to manage future COVID-19 peaks and introduce planned work safely.
10. Brexit

The risk in relation to Brexit has not been added to the BAF due to the fact that there is a separate document already in place which details all the risks in relation to Brexit. It would also be very difficult to wrap 'Brexit' up into just one risk on the BAF. The Brexit Risk document is in the form of a Business Continuity Plan and is regularly reviewed by the Brexit Task and Finish Group. The plan details the risks, likely impact and mitigating actions. The last review of the Brexit Business Continuity Plan was undertaken on 9th September. The Chair of the Group is the Executive Director for Strategic Planning. The Business Continuity Plan has also been reviewed by the Strategy and Delivery Committee on 10th November in order to provide assurance to the Board and appropriate scrutiny.

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

The above risks have all been fully reviewed with each Executive Director lead to ensure that the BAF presented is up to date. The BAF includes the controls, assurances and actions the Executive Team are taking to reduce the risks going forward. It also includes which Committees of the Board should be reviewing the individual risks on the BAF in order to provide further assurance to the Board.

Since the last meeting of the Board the risk in relation to Sustainable Cultural Change has been reviewed by the Strategy & Delivery Committee on 10th November 2020. Going forward other Committees of the Board will also be reviewing their risks on the BAF to provide further check and challenge and assurance to the Board when the BAF is presented in full.

The Corporate Risk Register references have also been added to the BAF to enable the Corporate Risks to be linked to the Strategic Risks of the Health Board.

The Strategic Objective have now also been mapped to the risks on the BAF so there if clarity which risks impact on the objectives.

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

Risk Management continues to develop at Cardiff and Vale Health Board. Significant progress had been made but actions have been stalled for a number of months due to COVID-19. Work on now moving these actions forward has now restarted and includes the following:

Action	Update
Report the new BAF to the Audit Committee and the Board to ensure key risks to the achievement of objectives are identified.	**Complete –** Presented to Board on 24th September and will be reviewed by Audit Committee when it meets in November.
Report individual risks on the BAF to the relevant Committees of the Board to allow the Committees to undertake a more detailed review and then provide assurance to the Board	**Complete and ongoing** – reported to S&D on 15th September. BAF risk reviews will also be added to the Committees of the Board going forward routinely.
Assess the organisation's 'Risk Appetite'	**Complete and ongoing** – A session was held at the Board Development on 29th October, further work is now required to roll out the 'Risk Appetite' across the organization and ensure it is properly embedded in decision making.
Review Risk Management and Board Assurance Framework Strategy.	This was approved by the Board initially in July 2019. There is a requirement within Standing Orders to review the Strategy on an annual basis. This will be presented to the Board, alongside the 'Risk Appetite' roll out plan in January **(28th January 2021).**
Development of Risk Management Procedure	**Complete –** A new procedure has been developed to support the Strategy approved by the Board on 25th July.
Ensure that the work on the Corporate and Clinical Board Risk Registers is completed within a timely manner and in line with the Risk Management Strategy and Procedure.	**Continuing** - There will be a phased approach to the development of risk registers within Corporate Directorates and Clinical Boards. This approach will be in line with the Risk Management and Board Assurance Framework Strategy presented to Board. The new Risk and Regulation Officer commenced on 12th October and will be developing and taking forward a programme of risk management training throughout the Health Board.
Corporate Risk Register to be presented to the Private Board July 2020	**Complete** – The last Corporate Risk Register was presented to the Board in private in March 2020. Again, due to COVID-19 work in this area was delayed however, a register is on the agenda for the July 2020 Private Board.
Ensure actions from Internal Audit Review are undertaken in line with timescales agreed	**On track** - The actions identified by Internal Audit were mainly around consistency of risk registers within the Clinical Board which included risk identification and scoring. Work in this area is on track to commence in September with the roll out of a Training

	Programme led by the Head of Risk and Regulation. The internal audit is planned to take place in the final quarter of 20/21.
Move to web based risk reporting	**On track**: Action due by April 2021.

Assurance is provided by:

- Discussion with Executive Directors on progress being made against the management and mitigation of risks which they lead upon on the BAF.
- Internal audit providing 'reasonable' assurance.

Recommendation:

The Board is asked to:

- **Approve** the 9 risks to the delivery of Strategic Objectives detailed on the attached BAF.
- **Note** the progress which has been made in relation to the roll out and delivery of effective risk management systems and processes at Cardiff and Vale UHB.

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	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		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

BOARD ASSURANCE FRAMEWORK 2020/21 – NOVEMBER 2020

It is essential that Cardiff and Vale University Health Board is aware of the major risks which could impact upon the delivery of Strategic Objectives as set out in Shaping Our Future Wellbeing.

Strategic Objectives	Key Risks Mapped to Delivery of Strategic Objective
1. **Reduce health inequalities**	• Financial Sustainability • Sustainable Primary and Community Care • Sustainable Cultural Change • Planned Care Capacity • Delivery of IMTP
2. **Deliver outcomes that matter**	• Sustainable Primary and Community Care • Patient Safety • Sustainable Cultural Change • Financial Sustainability • Delivery of IMTP
3. **Ensure that all take responsibility for improving our health and wellbeing**	• Sustainable Primary and Community Care • Sustainable Cultural Change • Delivery of IMTP
4. **Offer services that deliver the population health our citizens are entitled to expect**	• Sustainable Primary and Community Care • Delivery of IMTP • Planned Care Capacity • Workforce • Financial Sustainability
5. **Have an unplanned care system that provides the right care, in the right place, first time.**	• Financial Sustainability • Sustainable Primary and Community Care • Patient Safety • Delivery of IMTP
6. **Have a planned care system where demand and capacity are in balance**	• Planned Care Capacity • Financial Sustainability • Workforce • Sustainable Primary and Community Care • Delivery of IMTP
7. **Reduce harm, waste and variation sustainably so that we live within the resource available**	• Patient Safety • Financial Sustainability
8. **Be a great place to work and learn**	• Workforce • Financial Sustainability • Sustainable Cultural Change
9. **Work better together with partners to deliver care and support across care sectors, making best use of people and technology**	• Workforce • Financial Sustainability • Sustainable Primary and Community Care • Delivery of IMTP
10. **Excel at teaching, research, innovation and improvement.**	• Workforce • Financial Sustainability • Sustainable Cultural Change

Key Risks

Risk	Corp Risk Register Ref.	Gross Risk	Net Risk	Target Risk	Context	Executive Lead	Committee
1. Workforce	5,10,17, 42	**25**	**10**	**5**	Across Wales there have been 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. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Deputy CEO & Executive Director of Workforce and OD	Strategy and Delivery Committee
2. Financial Sustainability	6,9,27,28, 31,32,33, 34,35,36, 37,38,39, 41	**25**	**20**	**15**	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future. Covid 19 has had a significant impact on the finances of Healthcare in Wales and the UHB has significant financial pressures to now deal with.	Executive Director of Finance	Finance Committee
3. Sustainable Primary and Community Care	12,13,15	**20**	**15**	**10**	The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in	Chief Operating Officer	Strategy and Delivery Committee

					their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.		
4. Patient Safety	1,2,7,8,16 ,18,19,20, 21,22,24, 25,26,29, 40,44,45, 46,47	**25**	**15**	**10**	Patient safety should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.	Executive Nurse Director/ Executive Medical Director /Executive Director for Therapies and Health Science	Quality, Safety and Experience
5. Sustainable Culture Change		**16**	**8**	**4**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	Executive Director of Workforce and OD	Strategy and Delivery Committee
6.Capital Assets	3,4,11,23, 30,43,19, 20,22,40	**25**	**20**	**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Deputy Chief Executive, Executive Director of Therapies and Health Science	Finance Committee
7.Test, Trace and Protect	147,16,2 6,47,48	**20**	**15**	**10**	The Welsh Test, Trace, Protect strategy is to enhance health surveillance in the community, undertake effective and extensive	Executive Director of Public Health	Strategy and Delivery Committee

					contact tracing, and support people to self-isolate where required to do so. Test, Trace, Protect will mean asking people to report symptoms, testing anyone in the community who is showing symptoms of COVID-19, and tracing those they have come into close contact with. Contacts will be advised to self-isolate in order to stop further spread among family, friends and the community. Contact tracing is a long established public health approach to containing the spread of many infections and has proven effective in controlling coronavirus in other countries.		
8.	Planned Care Capacity		**20**	**16**	**12**	The impact of COVID 19 has had many consequences to Healthcare and in particular the continuation of the Health Board being able to undertake Planned Care both during the peak of the pandemic and any future peaks. This is due to the need to ensure that there is available capacity should there be a further peak in COVID 19 patients requiring hospital treatment.	Chief Operating Officer	Strategy and Delivery
9.	Delivery of IMTP		**20**	**15**	**10**	The Integrated Medium Term Plan is the key planning document for the Health Board setting out the milestones and actions we are taking in the next 1 to 3 years in order to progress Shaping Our Future Wellbeing, our ten-year strategy. It is based on the health needs of our population, delivering quality services and ensuring equitable and timely access to services and sets out how we will deliver our mission Caring for People; Keeping People Well, and vision that a person's chance of leading a healthy life is the same wherever they live and whoever they are.	Executive Director of Strategic Planning	Strategy and Delivery Committee

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 and CAV 24/7 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 Winter Wards temporary bed expansion and COVID-19 – temporary 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 Career Development Scheme launched in September for band 5 nurses Nurse Adaptation Programme commenced October 2018 (in house OSCE programme) – over 63 UK based nurses have qualified to date (98% pass rate) 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 – 63 international nurses have joined us to date. The Framework remains open to us going forward. Medical international recruitment strategies Programme of talent management and succession planning Medical Training Initiative (MTI) 2 year placement scheme Collaboration with Medics 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 home working, track and tracing etc.		

	Central workforce hub continues to meet demand of recruiting temporary workforce. This has now been expanded to co-ordinate all Hubs, chaired by the Executive Director of Workforce & OD. On-going review of medical rotas to flex and increase medical cover capacity Advertising for Physician Associates to supplement MDT in a number of Clinical Boards 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 vacancy monitoring at meetings with CB's Trajectory showing next vacancies in nursing Majority of MTC posts filled successfully and high engagement As at 30.9.2020 94% substantive posts filled at Bands 5 & 6 (combined).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) Medicine 2% gap (98% fully established) - on permanent nursing lowest it's been for 3 years		
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 and further temporary requirement for COVID-19 remains unpredictable Clarity on any further extension of Government CMO shielding letters		
Gap in Assurances			

Actions	Lead	By when	Update since September 20
1. Internal Nurse Career Development Scheme	RW	Relaunched in April 2020 and continuing	This scheme started in September 2019 but will be re-launched in April 2020 Has been re-launched 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	**Complete** - Plan in place with 2nd part of International Nurse Recruitment approved. Financial Savings still being monitored and actions include Switch Off Sunday to help manage costs. Some international nurses delayed due to worldwide travel restrictions. Resumed
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	**Complete** - Majority of posts filled

5.	Local Social Media and Virtual Interview Campaigns to resume to support permanent nurse recruitment	MD	From 31/10/2020 31.01.2021	Campaign took place July and October. New social media plan in place. Virtual recruitment on-going to support social distancing. Hoping to run face to face interviews in January if it is possible but will be restricted and tightly managed.
6.	Virtual Recruitment Panels established up to recruit to Consultant posts	SW/MD	From 30.9.2020	On-going permanent recruitment plan in place to ensure posts are not held up during COVID-19
Impact Score: 5	Likelihood Score: 1	Target Risk Score:	**5 (Medium)**	

2. Financial Sustainability

Across Wales, Health Boards and Trusts set out plans to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent Healthcare. The planning process in NHS Wales has been paused this year to allow organisations to focus their attention on managing the COVID 19 pandemic. The costs of which are significant and above previously planned levels. At this point there is uncertainty over the funding available to support this. Therefore the UHB continues to manage the impact of COVID 19 without knowing the total amount of additional resources available to cover it.

Risk **Date added:** 7.09.2020	There is a risk that the organisation will not be able to manage the impact of COVID 19 and other operational issues within the financial resources available.		
Cause	The UHB has incurred significant additional costs arising from managing the COVID 19 pandemic, this includes the non-delivery of savings plans. It also has to manage its operational budget. All additional costs need to be managed within the additional resources made available by Welsh Government to manage the pandemic.		
Impact	Unable to deliver a year end balanced financial position. Reputational loss. Increase in the underlying financial position which is dependent upon recurrent funding provided		
Impact Score: 5	Likelihood Score: 5	Gross Risk Score:	**25 (Extreme)**
Current Controls	Additional expenditure in Managing COVID 19 is being authorised within the governance structure that has specifically been put in place which is reported to Management Executives on a weekly basis. This aligns with the UHB Scheme of Delegation. The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board. Financial performance is a standing agenda item monthly on Management Executives Meeting.		
Current Assurances	The UHB is now assuming an additional £153m funding to help manage the COVID 19 pandemic. Based upon this assumed additional funding, the financial forecast is now an in year break even position at year end. The in year reported position at month 6 is an under spend of £0.3m. COVID 19 expenditure is monitored, reviewed and approved by Management Executives on a weekly basis. Financial performance is monitored by the Management Executive. Finance report presented to every Finance Committee Meeting highlighting progress against mitigating financial risks.		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	To confirm COVID 19 funding assumptions with Welsh Government in a few specific areas. Certainty of COVID 19 expenditure and the management of non COVID 19 operational pressures		

Actions	Lead	By when	Update since September 20
1. Continue to work with Welsh Government to confirm additional funding to manage our	CL	30/11/20	Updated action

response to Covid 19.				
2. To monitor and control additional expenditure and financial performance to ensure that the year-end forecast is within the resources available		CL	31/03/2021	New action
Impact Score: 5	Likelihood Score: 3	Target Risk Score:	**10 (high)**	

3. Sustainable Primary and Community Care

The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of Primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.

Risk **Date added:** 12.11.2018	The risk of losing resilience in the existing service and not building the capacity or the capability of service provision in the Primary or Community care setting to provide the necessary preventative and responsive services.		
Cause	Not enough GP capacity to respond to and provide support to complex patients with multiple co-morbidities and typically in the over 75 year age bracket. GP's being drawn into seeing patients that could otherwise be seen by other members of the Multi-disciplinary Team. Co-ordination of Health and Social Care across the communities so that a joined up response is provided and that the patient gets the right care. Poor consistency in referral pathways, and in care in the community leading to significant variation in practice. Practice closures and satellite practice closures reducing access for patients. Lack of development of a multidisciplinary response to Primary Care need. Significant increase in housing provision		
Impact	Long waiting times for patients to access a GP Referrals to hospital because there are no other options Patients turning up in ED because they cannot get the care they need in Primary or Community care. Poor morale of Primary and Community staff leading to poor uptake of innovative solutions Stand offs between Clinical Board and Primary care about what can be safely done in the community Impact reinforces cause by effecting ability to recruit		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (red)**
Current Controls	Me, My Home , My Community Signals from Noise to create a joined up system across Primary, Community, Secondary and Social Care. Development of Primary Care Support Team Contractual negotiations allowing GP Practices to close to new patients Care Pathways Roll out of MSK and MH First Point of Contact Services by Cluster Implement new urgent care Phone First helpline at Primary Care Level (CAV24/7) Implement nationally supported digital supported enablers (Consultant Connect and Attend Anywhere)		
Current Assurances	Improved access and response to GP out of hours service Sustainability and assurance summary developed to RAG rate practices and inform action Three workshops held to develop way forward with engagement of wider GP body in developing future models. Leading to the development of Mental Health and Risk Care Models at scale being implemented. Second peer review of PCOOH Services undertaken with commendations and exemplars referred to in WG reports		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (red)**
Gap in Controls	Actively scale up multidisciplinary teams to ensure capacity Achieving scale in developing joint Primary/Secondary Care patient pathways Recruitment strategies to sustain and improve GP availability and develop multidisciplinary solutions		
Gap in Assurances	No gaps currently identified.		

Actions	Lead	By when	Update since September 20
1. Health Pathways – to create a protocol driven of what should and can be done in Primary care/Community care.	~~SC~~ SW/JG	31/03/2021	Health pathways launched on 14/02/2019. As at 07/05/2019 32 pathways were live. Pathways will continue to be developed until the end of the financial year. 65 pathways are now active. Chief Operating Officer has met with partners in New Zealand who are rolling it out. This continues to be rolled out.
2. Roll out of Mental Health and MSK MDT's to reduce the primary care burden on GP's	SC	From 28 August 2020	GMS Sustainability Implementation Board continues to see roll out of First Contact MDTs within all 9 clusters being covered for MSK and 7 out of 9 clusters being covered for MH services. However, all 9 clusters have access to an MH service as cross cover arrangements are in place CAV24/7 services implemented as at 5 August 2020 Attend Anywhere digital enabler in 56 of 61 practices as at July 2020 Consultant Connect available to all practices as at July 2020
3. Roll out digital solutions for smart working	DT	31/03/2021	Platform procured- phased roll out plan to be implemented with completion due by end of the financial year
4. Other digital platforms being considered e.g. Primary Care CAHMS Assessment platform being deployed	SC	31/03/2021	Digital Platform now been agreed for CAHMS. Contract has now been agreed and is currently being rolled out. Digital platform deployed and CAHMS assessment against Part 1 to be reached in Feb/Mar 2020 NB Digital platform successful in contributing to CAMHS access targets. Currently under review in terms of the FM New platforms being considered – Attend Anywhere and Consultant Connect
5. Development of recruitment strategies for GP	MD	Ongoing	GP Support Unit helps with

	and non GP service solutions			recruitment and finding GP alternatives action also lined to No 2 above. As an indicator of in hour's resilience GP fill rates for PC out of hour's service have improved leading to a lower escalation status. The focus on a multi-disciplinary solution continues.
6.	Develop Health and Social Care Strategies to allow seamless solutions for patients with health and or social needs	AH	Ongoing	These are being developed through the Public Service Board and Transformation work and progressing well
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

4. Patient Safety (Lead Directors Stuart Walker, Ruth Walker and Fiona Jenkins)

Risk	Patient safety may be compromised because of: Future national shortage of COVID treatment capacity (Beds, critical care, drugs, workforce, oxygen, other equipment – ventilators/renal replacement/CPAP) in the event of a second COVID surge Or because some elective services are not currently available for non-COVID patients Or because of sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care to a larger number of patients in relation to a further COVID surge, alongside increasing demand for non-COVID unscheduled care and urgent scheduled care and winter pressures and activity. Or because patients are choosing not to ask for medical help, despite genuine illness, related to PH messaging and awareness of the COVID crisis Or because patients are contracting COVID 19 whilst in a hospital setting.		
Date added:	March 23.03.2020		
Cause	Patients not able to access the appropriate care because demand is outstripping supply, or patients fail to seek appropriate care in a timely way. Presentation of COVID 19 virus in inpatient settings due to patients presenting who are asymptomatic but are positive Possible lack of PPE, poor IPC or inappropriate management		
Impact	Worsening of patient outcomes and experience, higher death rate.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25**
Current Controls	• Plans developed to continue with expanded critical care and COVID bed capacity within footprint of hospitals, taken alongside patient cohorting in 'non-COVID' areas. • Plans developed and deployed to optimise internal acute and critical care capacity with external options having been utilised for significant internal and external surge/field hospital capacity. • Internal estates and facilities team deployed to provide infrastructure enhancements to enable internal capacity plan • Principality stadium no longer available with further surge capacity available in Lakeside facility from late November • National/local procurement processes for under-supplied resources • Maintaining Training/Education of all staff groups in relation to delivery of care to COVID patients • Use of Spire Hospital as a dedicated facility for urgent cancer work - ongoing • Ongoing training and simulations for staff working in unfamiliar areas. • Recruitment of additional staff • Cancer patients treatment being reviewed and prioritised where appropriate • Restrictive visiting arrangements • Outbreak management plans and delivery		
Current Assurances	• Internal capacity expansion plans commissioned and reviewed regularly at		

	Operational and Strategic Group to ensure right phasing • Operational Group meeting daily to ensure clinical staff remain engaged in managing phased expansion/area utilisation. • Establishment of workforce hubs to ensure that staff are deployed on a competency basis • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives • Audit of IPC and Audit outcomes • Reporting of IPC Outbreak meetings into ME • IPC Daily Cell Meeting &Weekly PPE Cell Meeting • Expert and independent advice in outbreak meetings

Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15**
Gap in Controls	.		
Gap in Assurances			

Actions	**Lead**	**By when**	**Update since September 20**
1. Reconfiguration of COVID/Non-COVID capacity delivery in light of new pandemic modelling projections – ongoing process.	Steve Curry	31.03.21	Ongoing discussion currently and gearing plans developed. Plan in place which is continually been reviewed in relation to demand and capacity – see separate risk on BAF: **the risk of inadequate capacity to manage future COVID 19 peaks and planned work safety**
2. Reconfiguration of COVID/Non-COVID workforce skill mix and staffing numbers in light of new pandemic modelling projections	Workforce groups	31.03.21	Discussions continuing staffing mix being reviewed in line with action 1 above.
3. Internal COVID 19 outbreaks being reported to Quality, Safety and Experience Committee with lessons learnt been fed back into the organisation.	Ruth Walker	24.09.20	**Complete & ongoing**
4. Learning from COVID 19 outbreaks at CTM and AB Health Boards and being utilised in management of outbreaks	Ruth Walker	From mid October	**New action**
5. Genotype testing which shows whether outbreaks are linked and core case	Ruth Walker	From mid October	**New action**
Impact Score: 5 **Likelihood Score: 2**	**Target Risk Score:**		**10**

5. Leading Sustainable Culture Change

In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which is building upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.

Risk	There is a risk that the cultural change required will not be implemented in a sustainable way		
Cause	There is a belief within the organisation that the current climate within the organisation is high in bureaucracy and low in trust. Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition. Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB.		
Impact	Staff morale may decrease Increase in absenteeism Difficulty in retaining and recruiting staff Potential decrease in staff engagement Transformation of services may not happen due to staff reluctance to drive the change through improvement work. Patient experience ultimately affected. UHB credibility as an employee of choice may decrease		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**
Current Controls	Values and behaviours Framework in place Task and Finish Group weekly meeting Cardiff and Vale Transformation story and narrative Leadership Development Programme Management Programmes Talent management and succession planning cascaded through the UHB Values based recruitment Staff survey results and actions taken – led by an Executive (WOD) Patient experience score cards CEO and Executive Director of WOD sponsors for culture and leadership Raising concerns relaunched in October 2018 "Neyber" launched to support staffs financial wellbeing with an emphasis on education Conducted interviews with senior leaders regarding learnings and feedback from Covid 19 Lessons learnt document to be completed by September 30th 2020 looking at the whole system		
Current Assurances	Engagement of staff side through the Local partnership Forum (LPF) Matrix of measurement now in place which will be presented in the form of a highlight report		
Impact Score: 4	**Likelihood Score: 2**	**Net Risk Score:**	**8 (High)**
Gap in Controls			
Gap in Assurances			

Actions	Lead	By when	Update since September 20
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Three Programmes have been developed: (i) Acceler8 (ii) Integr8 (iii) Collabor8 (iv) Oper8 (for Directorate Managers or equivalent)	MD	01.04.2021	Currently all the leadership programmes are on hold due to the recovery phase of covid. Awaiting Intensive learning academy bid if successful large leadership development. Programmes to restart 2021
2. Showcase	MD	31.03.21	Proposal for a virtual showcase now being considered and linking with the Clinical Service Redesign and exploring catering for bigger numbers
3. Welsh Language Standard being implemented.	MD	From 14.12.20	Equality Strategy Welsh Language Group commencing and will take place on a monthly basis with senior leaders across the organisation. Two Welsh Language translators now recruited.
4. Proactive Wellbeing intervention	MD	Immediate	**New action** - Wellbeing Group commencing and will be Chaired by Executive Director for Workforce and OD
5. CAV Convention	MD	From 12.11.20	**New action** - The CAV Convention is clinically-led and is based on the values of the Health Board. It makes it easier for clinicians to do their jobs through rapid and agile change, flexible working, unlocking resources such as budgets and staff, and more productive relationships between staff members with the needs of the patient at the heart of everything. Proposal being presented to Management Executive 12.11.20
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4(Moderate)**

6. Capital Assets (Estates, IT Infrastructure, Medical Devices)

The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.

Risk **Date added:** 12.11.2018	There is a risk that the condition and suitability of the UHB estate, IT infrastructure and Medical Equipment impacts on the delivery of safe, effective and prudent health care for the patients of Cardiff and Vale UHB.		
Cause	Significant proportion of the estate is over-crowded, not suitable for the function it performs, or falls below condition B. Investment in replacing facilities and proactively maintaining the estate has not kept up the requirements, with compliance and urgent service pressures being prioritised. Lack of investment in IT also means that opportunities to provide services in new ways are not always possible and core infrastructure upgrading is behind schedule. Insufficient resource to provide a timely replacement programme, or meet needs for small equipment replacement		
Impact	The health board is not able to always provide services in an optimal way, leading to increased inefficiencies and costs. Service provision is regularly interrupted by estates issues and failures. Patient safety and experience is sometimes adversely impacted. IT infrastructure not upgraded as timely as required increasing operational continuity and increasing cyber security risk Medical equipment replaced in a risk priority where possible, insufficient resource for new equipment or timely replacement		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	Estates strategic plan in place which sets out how over the next ten years, plans will be implemented to secure estate which is fit for purpose, efficient and is 'future-proofed' as much as possible, recognising that advances in medical treatments and therapies are accelerating. Statutory compliance estates programme in place – including legionella proactive actions, and time safety management actions. The strategic plan sets out the key actions required in the short, medium and long term to ensure provision of appropriate estates infrastructure. IT SOP sets out priorities for next 5 years, to be reviewed in early 2019 Medical equipment WAO audit action plan to ensure clinical boards manage medical equipment risks The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP, with regular oversight of the programme of discretionary and major capital programmes. Medical Equipment prioritisation is managed through the Medical Equipment Group Additional discretionary capital £0.5m for IT and £1.0m for equipment which enabled purchasing of equipment urgently needing replacement.		

	Business Case performance monitored through Capital Management Group every month and Strategy and Delivery Committee every 2 months.
Current Assurances	The estates and capital team has a number of business cases in development to secure the necessary capital to address the major short/medium term service estates issues. Work is starting on the business case to secure funding to enable a UHW replacement to be build. The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised. The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks. Regular reporting on capital programme and risks to Capital Management, Management Executive and Strategy and Delivery Committee IT risk register regularly updated and shared with NWIS. Health Care Standard completed annually Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group, health care standard completed annually.

Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**

Gap in Controls	The current annual discretionary capital funding is not enough to cover all of the priorities identified through the risk assessment and IMTP process for the 3 services. In year requirements further impact and require the annual capital programme to be funded by capital to be re-prioritised regularly. Traceability of Medical Equipment The Welsh Government current capital position is very compromised due to COVID 19 expenditure which will impact significantly on the Capital Programme of the UHB.
Gap in Assurances	The regular statutory compliance surveys identify remedial works that are required urgently, for which there is no discretionary capital funding identified, requiring the annual plan to be re-prioritised, or the contingency fund to be used. Medical equipment is also subject to regulatory requirements, and therefore requires re-prioritisation during the year

Actions	**Lead**	**By when**	**Update since September 20**
1. Progress implementation on the estates strategic plan	AH/CL	31.03.21	Priorities for Capital Programme included within 2020-2023 IMTP which were prioritised by Management Executive
2. Had to give up discretionary capital £1m allocation reduced to £500k	FJ	31.03.21	Prioritisation of capital managed through capital management group but overall capital position worse than last year.

Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 high)**

7. Risk that Test Trace and Protect Service will fail to deliver effective contact tracing in Cardiff and the Vale of Glamorgan

Risk	The Cardiff and Vale Test, Trace and Protect (TTP) Service fails to deliver effective mass population contact tracing		
Date added:	18.5.20		
Cause	Setting up the TTP Service has been a complex and substantial partnership endeavour, delivered to a challenging timetable; Cardiff Council is hosting the TTP Service. Risks to effective delivery include: • Upgrades to the national CRM (Customer Relationship Management) system are not sufficiently timely to support local delivery • Failure to maintain sufficient staff (either via redeployment or new appointment) at all levels to meet demand • Insufficient telephony/IT equipment to support home working model • Non coordinated working between partner organisations • Lack of engagement with the local population and settings in promote compliance with contact tracing, as well as adherence to infection control and preventative advice (including physical distancing) • Increased demand created by influx of students to the City with reopening of universities • Increased demand due to co-circulation of flu during the winter months • Surveillance system unable to detect local disease activity • Insufficient funding to support longer term service delivery • Inability to maintain service for up to a year • Vaccine development and delivery: failure to develop an effective vaccine; delayed development of an effective vaccine; failure to vaccinate at sufficient scale and/or pace once a vaccine is available		
Impact	The TTP Service would not run effectively with the result that there would be sub-optimal control of disease activity in Cardiff and the Vale of Glamorgan. This could result in avoidable cases of COVID-19 and an increased R value, meaning that community transmission could escalate, with the consequent risk to population health and demand on health and social care services. It may also necessitate reinstatement of restrictions and controls.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score: 20**	**20 (Extreme)**
Current Controls	• Governance structures in place with partnership representation. Strategic and operational boards meet regularly. Work streams identified and leads named. Cardiff and Vale Prevention and Response Plan submitted to Welsh Government. • Cardiff and Vale representatives identified for all key national groups. Links established at a National level with Welsh Government, NWIS and PHW to optimise communication and influence service design and digital solution • Partnership communications plan in place, informed by both national and regional insight work, and taking in to account local population characteristics. • Regular, multidisciplinary and multi-agency regional team meetings to review cases and incidents. Regional SOP developed. Proactive engagement with settings e.g. schools, healthcare settings and universities • Links established at a National level with Welsh Government, NWIS and PHW to optimise communication and influence service design and digital solution • In response to local increase in cases a Regional Incident Management Team was established on 22nd September 2020, chaired by the Director of Public Health, which has met twice weekly and provided advice on the actions to be taken. These have been signed off by a Regional Leadership team and recommendations for national action escalated to Welsh Government • Regional and local surveillance systems in place and providing timely information		

	to inform the local response at all levels. • Partner organisations committed to offering staff for at least the first 6 months using a secondment arrangement. Service model based on home working, allowing shielded staff to contribute and increase the pool of available staff. Student workforce identified through links with HEIW and Environmental Health. Significant new recruitment by Cardiff Council in the last month, on behalf of the partnership, has ensured that tracing capacity is able to meet demand. • Welsh Government has agreed funding to support TTP delivery • Comprehensive flu immunisation plan and project team in place		
Current Assurances	• Strengthened and functioning governance and operational arrangements in place		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score: 15**	**15 (Extreme)**
Gap in Controls	• Fully agreed mass vaccination programme • Issues with compliance with Covid-19 prevention measures for a variety of reasons, including 'fatigue', confusion at complexity of messages, as well as some active resistance		
Gap in Assurances	• Longer term funding • Full functionality of national CRM (to include self-directed contact tracing)		

Actions	**Lead**	**By when**	**Update since September**
1. Develop a surveillance system with the ability to monitor local clusters	Fiona Kinghorn	30/9/20	Complete
2. Further strengthen regional structures and processes to manage demand as we move in to winter	Fiona Kinghorn	30/10/20	Complete
3. Development and delivery of mass vaccination plan	Fiona Kinghorn	31/12/20	In progress – dependent on arrival of vaccine
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score: 10**	**10 (High)**

8. Inadequate Planned Care Capacity

The impact of COVID 19 has had many consequences to Healthcare and in particular the continuation of the Health Board being able to undertake Planned Care both during the peak of the pandemic and any future peaks. This is due to the need to ensure that there is available capacity should there be a further peak in COVID 19 patients requiring hospital treatment.

Risk	There is a risk that there will be inadequate capacity due to constraints of being 'covid ready' resulting in reduced access to planned care and potential associated risks		
Date added:			
Cause	Covid pandemic resulting in a cessation of elective activity Our operating models assumes we will remain 'covid ready' resulting in reduced capacity and efficiency		
Impact	A growing waiting list for planned care An ageing waiting list Potential clinical risk associated with delayed access		
Impact Score: 4	**Likelihood Score: 5**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	Clinical risk assessments by specialty to prioritise access Following risk stratifications where available i.e. Royal College of Surgeons L1 to L4 classifications Development of 'green zones' to provide confidence for low risk operating environments Increase the use of virtual consultation to avoid person to person contact Securing additional capacity within the private sector		
Current Assurances	Growth in 'green zone' activity Surgical audit to provide assurance on outcomes Growth in virtual outpatients activity Growth in diagnostics activity		
Impact Score: 4	**Likelihood Score: 4**	**Net Risk Score:**	**16 (Extreme)**
Gap in Controls	Roll out Health Board-wide risk stratification Maximise use of green pathways whilst balancing risk and outcome Virtual platforms need to be rolled out across the Health Board and clinical teams persuaded to make use Contractual arrangements are still under review – need to negotiate a contract to prolong access		
Gap in Assurances	Able to meet the highest priority caseloads – essential services Surgical audit needs to be supported to continue to provide evidence of safe and effective surgery Digital platforms need to roll out further and clinical engagement needs to result in their use		

Actions	**Lead**	**By when**	**Update since September 20**
1. Roll out virtual consultation platforms	Information	July onwards	1/3 of outpatient activity now taking place virtually.
2. Establish private sector pathways for in-patients, outpatients and diagnostics	COO	April onwards	Private sector pathways in negotiation to continue beyond the end of the year. There has been a presentation to Management Executives and reflected in Board Reporting

Impact Score: 4	**Likelihood Score: 3**	**Target Risk Score:**	**12 (High)**

9. Risk of Delivery of IMTP (Lead Director – Abigail Harris)

Risk	There is a risk that the Health Board will not delivery the objectives set out in the IMTP due to the lack of a robust recovery plan for COVID 19		
Date added:	April 20		
Cause	The focus of executive and operational efforts is on directing the organisational response creating the operational capacity to meet the immediate acute demand generated by the COVID-19 pandemic.		
Impact	The UHB may not be appropriately prepared to manage the consequences of a protracted and disruptive emergency response particularly in terms of: workforce (e.g. many will be exhausted and many will have built up leave) Infrastructure – decommissioning where appropriate (significant in respect of Principality Stadium) Planned care Unplanned care Financial delivery The benefits of emergency changes may not be adequately captured. There may be learning opportunities missed.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20**
Current Controls	• Welsh Government has suspended the IMTP process and Health Boards are working to quarterly operational plans that reflect the current COVID29 situation and the need to re-establish as much of our non-COVID19 activity as possible, recognising the need to continue to provide services in different ways in light of the service transformation that took place in the emergency response phase and the ongoing requirement for social distancing and infection prevention and control measures. • Q2 plan developed and submitted to WG by the deadline required. • 'Recovery planning' with roadmap presented to Board for discussion on 29th June – planning underway with partners to reflect impact of COVID19 on communities and the need to accelerate delivery of Shaping Our Future Wellbeing and the Area Plan.		
Current Assurances	Recovery presentation to Board Development 30.04.20 Q2 plan received by the Board in July. WG review meeting on Q2 plan completed with regular meetings with key officials and planning and operations teams.		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15**
Gap in Controls	Timeliness of planning requirements for Q3/4 plan issued by WG. Risk of request for multiple overlapping plans – agreement with Local Authority Directors of Social Services – to pull this into one coherent plan with more detailed specific action plans where needed.		
Gap in Assurances	RPB required to sign off Winter Protection Plan – no clear guidance but work progressing in line with framework suggested by WG.		

Actions	**Lead**	**By when**	**Update since September 20**
1. Work is ongoing to review strategy road map in light of COVID19 and milestones needed to achieve SOFWB's goals by 2025. Milestones and metrics to be reflected in Q3/4 plan.	Abigail Harris	End of September	**Complete -** Presentation to Board development session in October.
2. Worked commenced on Q3/4 plan (including winter preparedness plan) despite WG planning guidance not yet available.	Abigail Harris	Deadline for Q3/4 plan not yet confirmed with WG.	Work on this is complete with final sign off by the Board on 26th November Q3 /4 Plan linked back to existing IMTP and Strategy
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10**

Key:

1 -3	**Low Risk**
4-6	**Moderate Risk**
8-12	**High Risk**
15 – 25	**Extreme Risk**

Report Title:	**PATIENT SAFETY QUALITY AND EXPERIENCE REPORT**						
Meeting:	Board Meeting				**Meeting Date:**	26.11.20	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Executive Nurse Director Executive Medical Director						
Report Author (Title):	Assistant Director, Patient Safety and Quality 029 2184 6117 Assistant Director, Patient Experience 029 2184 6108						

Background and current situation:

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from September to November 2020.

The development of an integrated Patient Safety Quality and Experience report, presents an opportunity for greater triangulation and analysis of information. It enables Clinical Boards and the Corporate Teams to identify areas of good practice but also to identify emerging trends and issues that require action in order to improve safety and quality of services.

The UHB has a wide range of data which provides a level of assurance on the safety and quality of services, as well as on the experience of patients and families. This report provides an analysis of information drawn from the reporting of patient safety incidents, Serious Incidents (SIs) and Never Events, as well as concerns raised by patients and families and feedback from national and local patient surveys. Themes emerging from internal and external inspections of clinical areas also provide a very valuable level of assurance in relation to the quality and safety of clinical services.

Where available, benchmarking data with peers is provided. Assurance in relation to the action that is being taken to address areas for improvement is also described.

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

The UHB continues to see a number of young people under the age of 18 being admitted to adult wards at Hafan Y Coed, in the absence of suitable tertiary mental health placements. The UHB continues to work with partners in Local Authority and with WHSSC to find effective solutions on a case by case basis as well as a long term solution to the issue.

The UHB has reported a number of Covid 19 outbreaks over the last two months. The situation is under robust scrutiny with daily operational infection, prevention and control meetings and outbreak procedures in place for each affected area.

The Medical Examiner Service is expected to be fully operational by 1st April 2021. This will be hosted in 4 hubs across Wales. Recruitment for South East Wales is under way. There will be some changes in practice associated with this given that the base will not be in DGHs as originally proposed and the UHB is currently putting in place systems to ensure that the transition is as effective as possible. The ME service is currently being piloted across some areas of Wales and it is anticipated that the UHB will begin working with the ME's office from December 2020.

The UHB has continued to collate Patient experience feedback scores and the current scores are 88% UHW, 89% UHL and 78% St David's. The team is involved in Patient Experience evaluation of some of the key programs of work across the UHB such as CAV 24/7 and several bespoke studies.

The Concerns 7 day service has continued and the current complaints 30 working day response time is 84%.

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

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT

September - October 2020

Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

During September and October 2020, the following Serious Incidents and No Surprises have been reported to Welsh Government:

Serious Incidents		
Clinical Board	**Number**	**Description**
Children & Women	• 1 • 1	• A baby was born in poor condition and later diagnosed with grade 2 hypoxic ischaemic encephalopathy. . • A teenage girl known to Child and Adolescent Mental Health Services (CAMHS) has died.
Clinical Diagnostics & Therapeutics	Nil	
Executive Nurse	Nil	
Medicine	• 1 • 5	• A joint investigation is underway with WAST following an incident in which a patient died when WAST was unable to respond to a call. There were some hospital delays. • Five patients suffered injurious falls.
Mental Health	• 11	• Patients who were known to Adult Mental Health services have died unexpectedly. The circumstances of the deaths are individually being investigated by the Coroner.

	• 2 • 5 • 1 • 1 • 1	• Patients who were known to Addictions services have died unexpectedly. The circumstances of the deaths are individually being investigated by the Coroner. • Five incidents of young people under the age of 18 years being admitted to Adult Mental Health Services in Hafan Y Coed were reported. • Patient under Section 3 Mental Health Act absconded from a low forensic secure ward at Hafan Y Coed. • A patient known to Mental Health Services was arrested by police following a serious assault on two family members. • Medication incident that is being managed as a Never Event – wrong route administration
Primary Care & Intermediate Care	• 1 • 1 • 1	• Concern has been expressed regarding the treatment and follow up arrangements of a patient further to an Optometry appointment. • Avoidable grade 3 pressure damage • A patient queried if the correct tooth had been extracted following a visit to the Emergency Dental Service. There was concern this was a Never Event but review of the incident revealed that the treatment was appropriate.
Specialist	• 1 • 1	• Treatment and transfer of a young child at The Major Trauma Centre • Closure of a cardiology ward at UHW due to a number of staff and patients testing positive or being symptomatic of COVID-19.
Surgery	• 2	• Concerns regarding follow up mechanisms subsequent to unexpected adverse results in two patients.

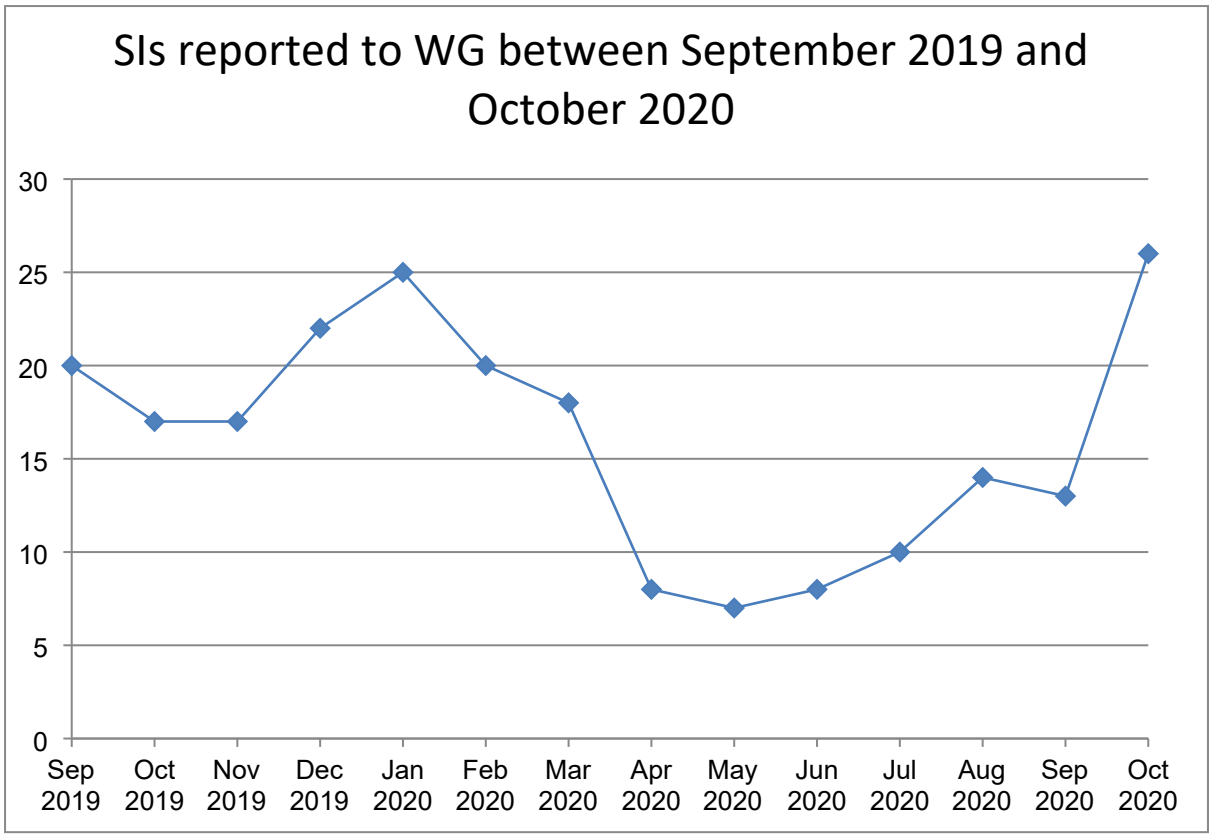
	• 1 • 1	• Injury to a child when a plaster cast needed to be split due to swelling of the limb. • Incorrect tooth extraction which is being managed as a Never Event.
Total	**38**	

No Surprises		
Clinical Board	**Number**	**Description**
Children & Women		
Medicine	• 1	• A medical ward at UHL was closed due to several staff testing positive to COVID-19.
Miscellaneous	• 1	• Welsh Government were alerted to a number of safeguarding cases that are proceeding to court hearings. Two cases related to Mental Health Clinical Board and one case to Surgery Clinical Board.
Surgery	• 1	• A surgical ward at UHW was closed on the south side due to several patients and staff positive or being symptomatic of COVID-19.
Total	**4**	

How do we compare to our peers?

The following graph depicts the number of SIs reported to WG by month between September 2019 and October 2020. Welsh Government (WG) wrote to organisations in NHS Wales on 18th March 2020 to set out SI reporting requirements during the pandemic and this led to a reduced volume of SI reportable incidents. WG wrote once more on 13th August 2020 to reinstate usual SI reporting requirements. It is evident that SI reporting rates have returned to pre-pandemic levels.

Information to compare organisations across NHS Wales is not currently available. It is anticipated that the forthcoming solution via the Once For Wales Concerns Management System will address this. This complex, ambitious project will see the implementation of a new RL Datix system across NHS Wales.



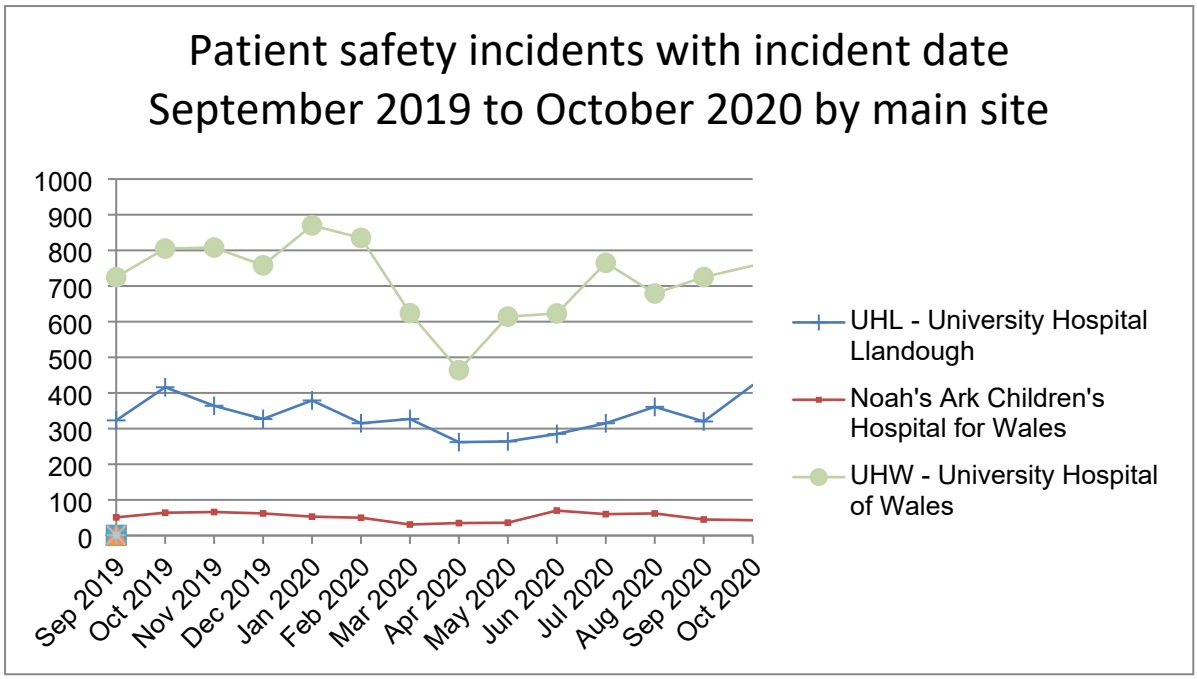
The top three reported categories of Serious Incidents reported overall during this timeframe include:

- Behaviour (including suicide, serious self-harm, absconsion)
- Patient accidents/falls
- Unexpected deaths or severe harm

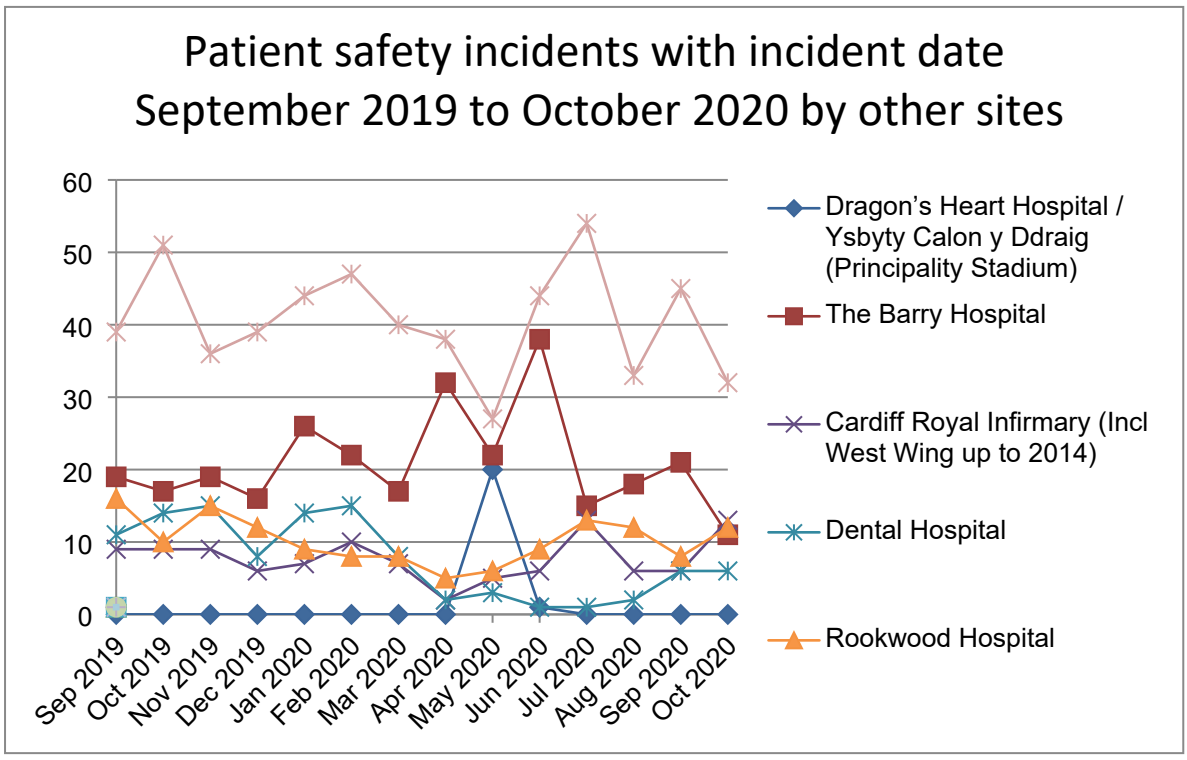
These incidents are all reported to Board meetings and are subject to internal investigation by the Clinical Boards and Her Majesty's Coroner where appropriate.

An analysis of the themes and trends in Quality, Safety and Patient Experience was presented to the Quality, Safety and Experience Committee in October 2020.

With regards to general incident reporting, it is evident that incident reporting rates fell initially during the pandemic, especially at UHW. The profile of incidents being reported and the reporting areas has been largely unchanged and it is believed that reduced clinical activity contributed to the situation. Review of current data suggests a return to usual reporting rates.

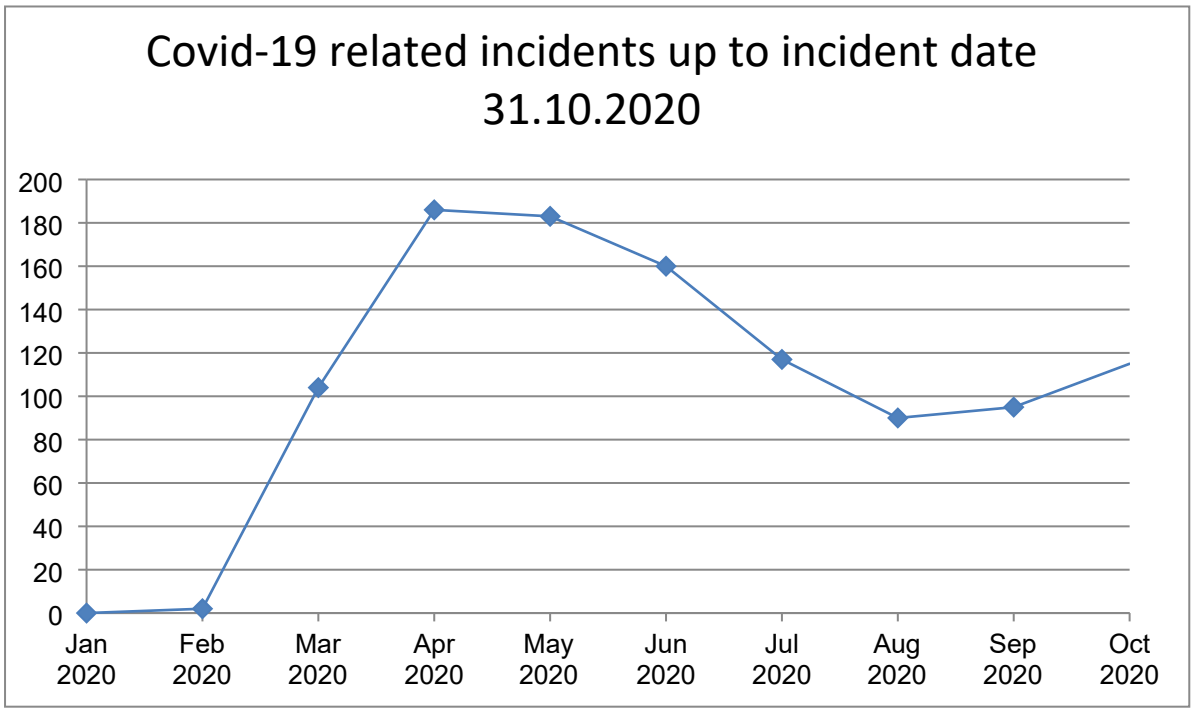


Review of patient safety incident reporting at other sites demonstrates fluctuating reporting rates at The Barry Hospital and St David's Hospital. There are low levels of reporting at the other sites for patient safety incidents. The incidents that are reported are overwhelmingly patient accidents/falls. Greater than 90% of these incidents resulted in low harm to patients.

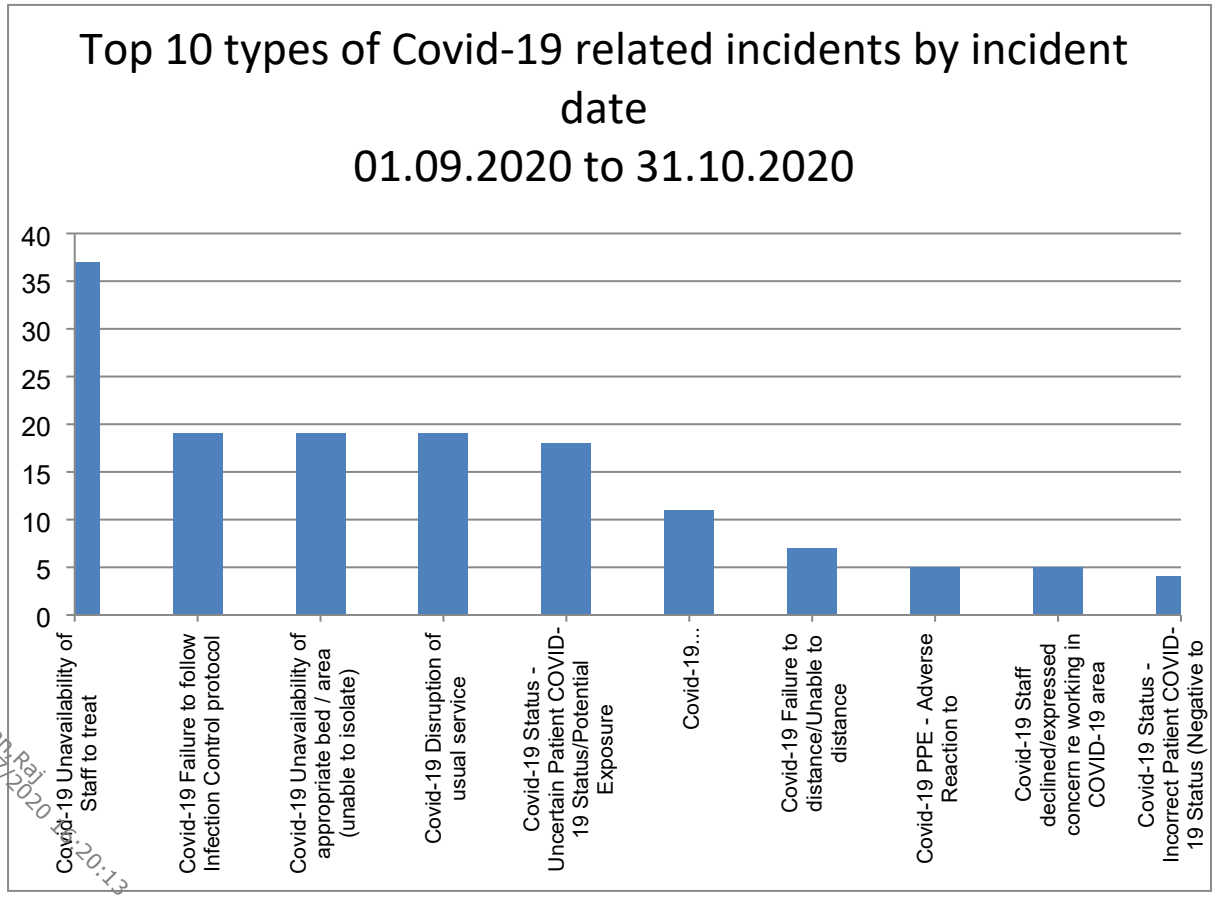


The UHB has been capturing incident forms where staff are raising issues in relation to Covid-19. It is evident that the volume of incidents has been steadily decreasing

following a steep initial incline in the early phase of the pandemic, however, the number of reported incidents is beginning to rise during the second lockdown.



The following graph demonstrates the top 10 categories of Covid related incidents between September and October 2020.



The highest volume of incidents is in the 'Unavailability of staff to treat' category. The majority of the incidents are reported by staff in the Paediatric Emergency Department. They predominantly raise shortages in nursing staff. An establishment review is underway.

A number of the incidents regarding 'Failure to follow infection control protocol' describe issues with maintaining zones where patients, visitors or staff sometimes walk through areas inappropriately. Work is underway to ensure appropriate signage is in place with volunteers helping to direct people appropriately.

'Unavailability of appropriate beds' tends to include incidents where there are difficulties placing patients due to constraints with availability of cubicles or whilst managing reduced bed capacity when a ward has had to close. The operational challenges associated with this are discussed at length in various forums, for example, Infectious Outbreak meetings with senior managers and representatives of the Infection Prevention and Control Department.

'Disruption of usual service incidents contain a wide range of issues highlighted by staff following change being implemented in response to the pandemic. Individual incidents are reviewed at the time by line managers and the Patient Safety Team will further explore what lessons can be learnt from what is reported.

'Uncertain patient Covid-19 status / Potential exposure' incidents tend to include issues such as patients being transferred to X-ray where it hasn't been clear that the patient is awaiting a swab result or where surgery is being planned but the outcome of the patient's swab is not known at the time the theatre list is being prepared. There have also been issues with patients / family members attending hospital and reporting to staff on arrival that they should in fact be isolating. These are key messages to continue to convey.

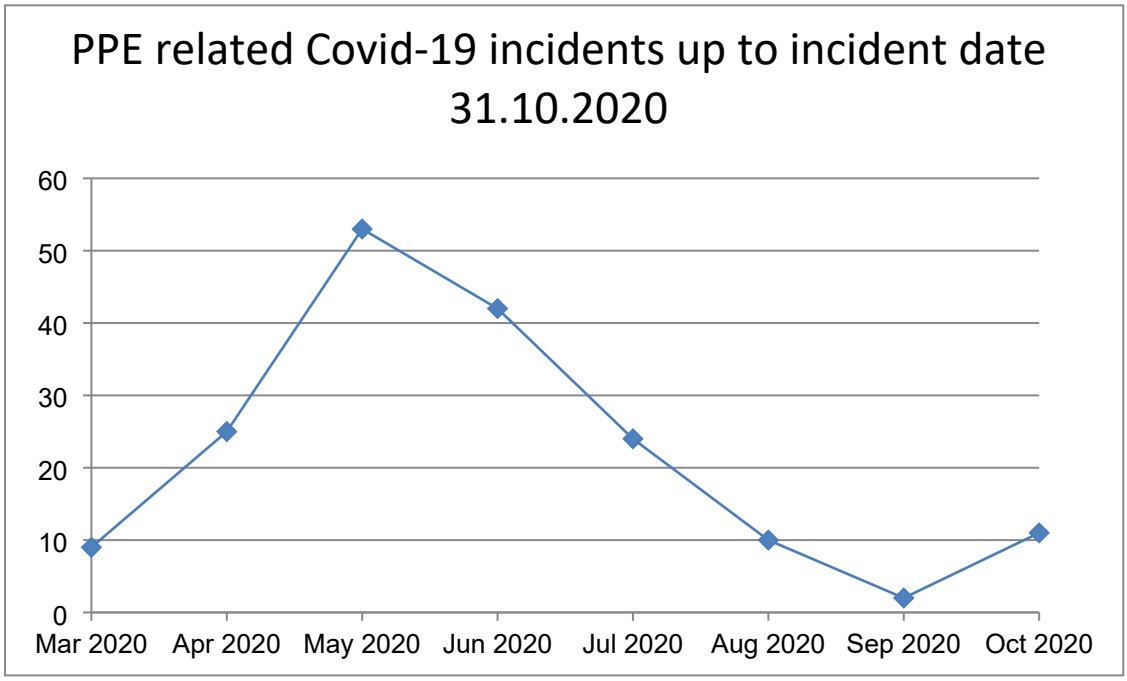
Incidents involving aggressive/inappropriate behaviour between staff and from patients towards staff were a concerning trend in the earlier stage of the pandemic. The reported incidents in this period were all patients and visitors displaying aggressive behaviour to staff for various reasons. These are monitored by the Health and Safety Department.

'Failure to distance / unable to distance' incidents are reported by a number of hospital and community services due to challenges within their environment, when attending patient's homes or in waiting rooms. Continued reinforcement of the physical distancing message is required with managers supporting staff to ensure implementation in their areas.

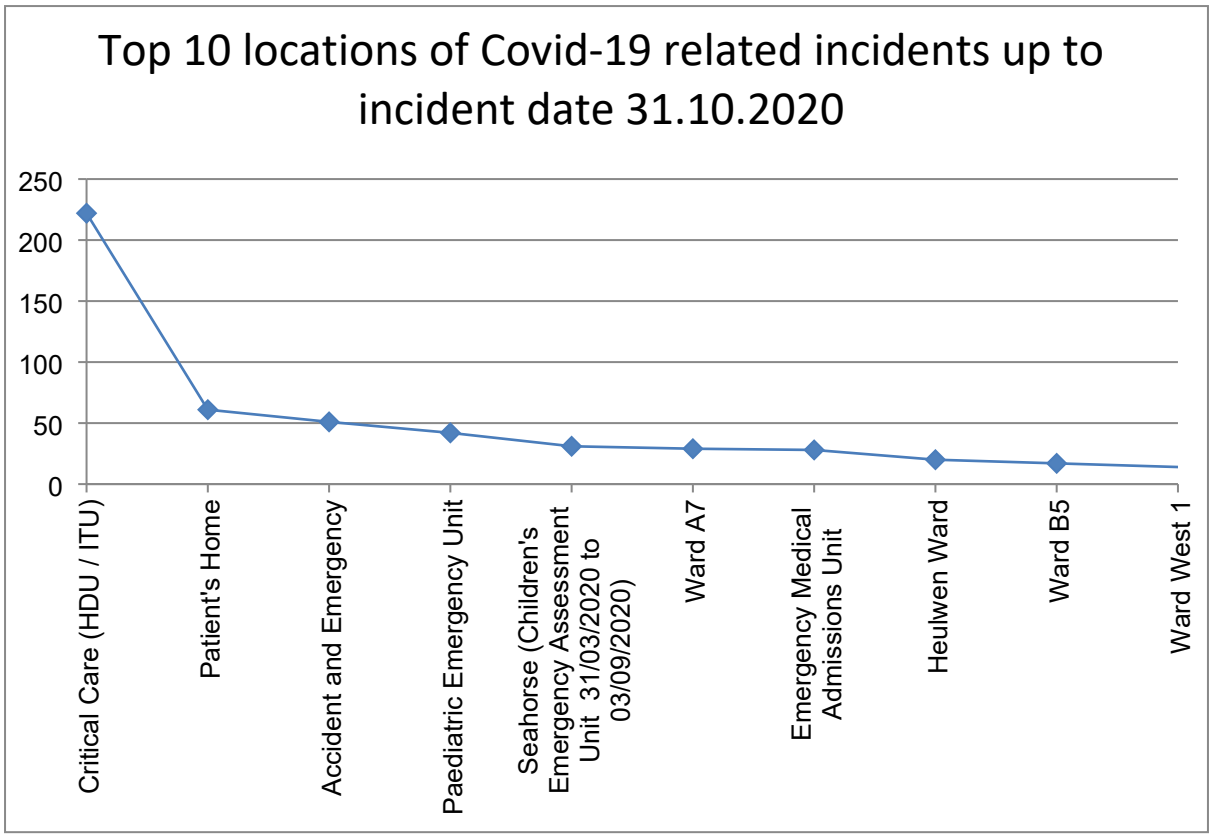
'Staff declined / expressed concern re: working in Covid-19 area' incidents are reported on the UHL site during this reporting period. Staff are concerned when Covid-19 positive patients are on their wards if they have their own risk factors to consider or if they have vulnerable family members at home. The incidents have been escalated to senior nursing staff.

‘Incorrect patient Covid-19 status (negative to positive)’ include incidents where wards/departments have been told prior to transfer that a patient was negative only for documentation to indicate this was incorrect. It is imperative that staff communicate this information accurately and effectively and this will be reinforced.

There has been a significant decrease in the number of PPE related incidents reported since a peak of reporting in May 2020. All incidents are routinely reported to and discussed at the PPE cell chaired by the Executive Nurse Director.



The overwhelming majority of Covid-related incidents up to 31.10.2020 were reported by the Critical Care Directorate. The majority of these incidents reported concerns in relation to PPE. The other areas most frequently reporting Covid-related incidents are set out in the graph below.



The Patient Safety Team is working in partnership with Cardiff University to prospectively analyze covid –related incidents as they are reported over the coming weeks and months. This will help to accelerate the early identification of themes and trends and to accelerate learning.

Regulation 28 Reports

The UHB has not received any Regulation 28 Prevention of Future Deaths reports from Her Majesty's Coroner in this reporting timeframe.

Inquests continue to be significantly disrupted and postponed due to the pandemic. Cases are being rescheduled by the Coroner in order to bring them to a conclusion.

Patient Experience

Since March 2020, the PE (Patient Experience Team) has worked very differently having modified working practices to a 7-day working system and utilised a variety of methods to gain patient feedback.

Prehab survey

A follow up to the Prehab work has been carried out with the evaluation of the 'nudge' information sent out to patients awaiting their surgical procedure. To date the team

has sent out information nudges on ‘Healthy Eating’ and ‘Mindfulness’ and the feedback received from those responding to an evaluation survey on each, has been very positive. For example, **90%** (Healthy Eating) and **84%** (Mindfulness) of respondents found the information helpful. In relation to the ‘Mindfulness’ information evaluation, the breakdown of responses was as follows:

Positive comments received included:

- *This was excellent however I would find it more reassuring if it came more often perhaps in smaller sections.*
- *I think the texts are really helpful.*

However, we received a number of comments asking when their surgery was taking place:

- *When is my cancelled operation going to take place?*
- *Time scale on my operation?*

The information provided to all people on the waiting lists included contact details for the Concerns Team so than any queries could be addressed. The queries from many who called us was assurance that they remained on the waiting list and information regarding when their procedure was likely to take place.

CAV 24/7 ‘at the front door’ survey.

The CAV 24/7 ‘at the front door’ survey was a short survey designed to gain feedback from patients arriving at the EU on whether they had contacted the CAV 24/7 service first. We placed two volunteers at the entrance to EU and they spoke with 55 patients, **67%** (37 respondents) had not contacted the CAV 24/7 service first. Of these, **22%** (8 respondents) were not aware of CAV 24/7.

Apart from not knowing about the service, other reasons for not contacting the service first included:

- Admitted by GP
- Rung for ambulance
- Child hit head so booked through GP

24% (9 respondents) felt the matter was too urgent and some of those that gave the response of ‘Other’ echoed this concern. It was evident in the small sample that parents attended if concerned about their child and some people with Mental Health concerns were familiar with attending EU in person.

Following this survey which will be repeated in November there is a plan to text those who arrive at the door of EU and at Barry Hospital with the contact number 24/7 to be stored in their phone. As a routine a printed slip with contact details for CAV 24/7 is handed to all people who arrive without phoning at EU.

In-patient surveys

During October, we also carried out the routine surveying of areas using paper surveys, but again this was limited. In total, **83** surveys were completed. (37 UHW, 28 UHL and 18 St David's). Of those, **86%** (88% UHW, 89% UHL and 78% St David's) stated that they were satisfied with their overall experience.

The majority of compliments received related mostly to staff and the care received.

Carers and our communities

There have been several recent reports highlighting the impact of the pandemic upon unpaid carers. The **Carers Week 2020** report estimated that there are 13.6 million unpaid carers in the UK today. Most of these unpaid carers, 9.1 million, were already caring before the coronavirus outbreak. A staggering 4.5 million people have started providing unpaid care since the outbreak. This represents nearly a 50% increase in the number of unpaid carers since the crisis began. An estimated 26% of the UK adult population is providing unpaid care to an older, disabled or ill relative or friend – that is equivalent to one in four adults. This report suggests there are currently as many as 683,000 unpaid carers in Wales.

The Carers Wales Activity Report contacted 580 carers in wales

- Four in five unpaid carers in Wales are providing more care for relatives
- 76% reported that the needs of the person they care for have increased during the pandemic
- 76% reported they are exhausted and worn out as a result of the pandemic
- 68% are worried about further lockdowns

We have continued to support Carers in some limited ways throughout the pandemic. Our Young Carers in Schools is run through Carers Trust South East Wales and designed in collaboration with our local Authority partners. Some work undertaken since March was via a virtual platform but the scheme has continued throughout the pandemic. We continue to identify young carers in secondary schools and we work with the schools to develop a support system.

'Get There Together' Project

People living with dementia, their family and members of other vulnerable groups and carers have expressed how fearful they feel about going back out into the community through the impact of Covid-19. People have expressed feelings of worry and fear about accessing healthcare services as well as community shops and support groups.

The project's aim is to encourage people to connect, build awareness and empower inclusion and reduce isolation, encouraging people to return to places that they previously used on a regular basis by giving them an idea of what to expect and opportunity to rehearse beforehand, practice skills and lessening anxiety.

As part of the Cardiff and Vale Sub-Group we will participate and support in the development of a national resource 'Get There Together'. This resource will capture digital stories of locally identified priority areas, settings, venues and places of interest. The resource will demonstrate through the making of a focused digital stories on these particular safety measures are being supported in the community. Our Volunteers will be supporting with this project which supports Dementia actions plan for Wales, Ageing well in Wales and Strategy for older people in Wales.

Patient Experience - Drop off and Collection Service for Patients

The UHB has introduced a new service supporting families, carers or friends, to bring essential items such as clothing and toiletries to their loved ones following the restricted visiting regulations due to Covid-19. The Patient Experience team implemented a service which ran Monday, Wednesday and Friday from UHW and Tuesday and Thursday UHL between the hours of 10.00am -2.00pm supported by eight volunteers. During the dates from the 7-23rd of October the team were able to support by delivering 534 bags of essential items to individual patients at UHW and UHL. Unfortunately due to the Fire Break lockdown the service was suspended but we hope to resume again on the 9th November.

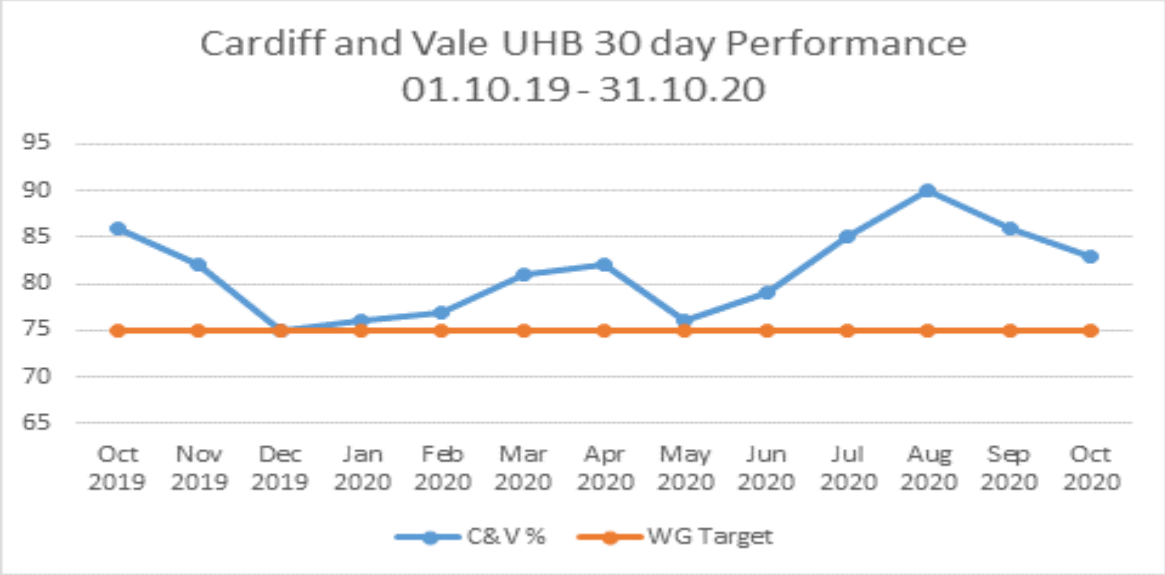
Benchmarking

It is very difficult to compare Patient Experience activity across Wales but we are anticipating that the once for wales service user experience system which will be introduced in April 2021 will enable comparison. On a national level the team were pleased to be finalists in the PENA–patient experience national award for team of the year and runner up in a category with our Young Carers in Schools project.

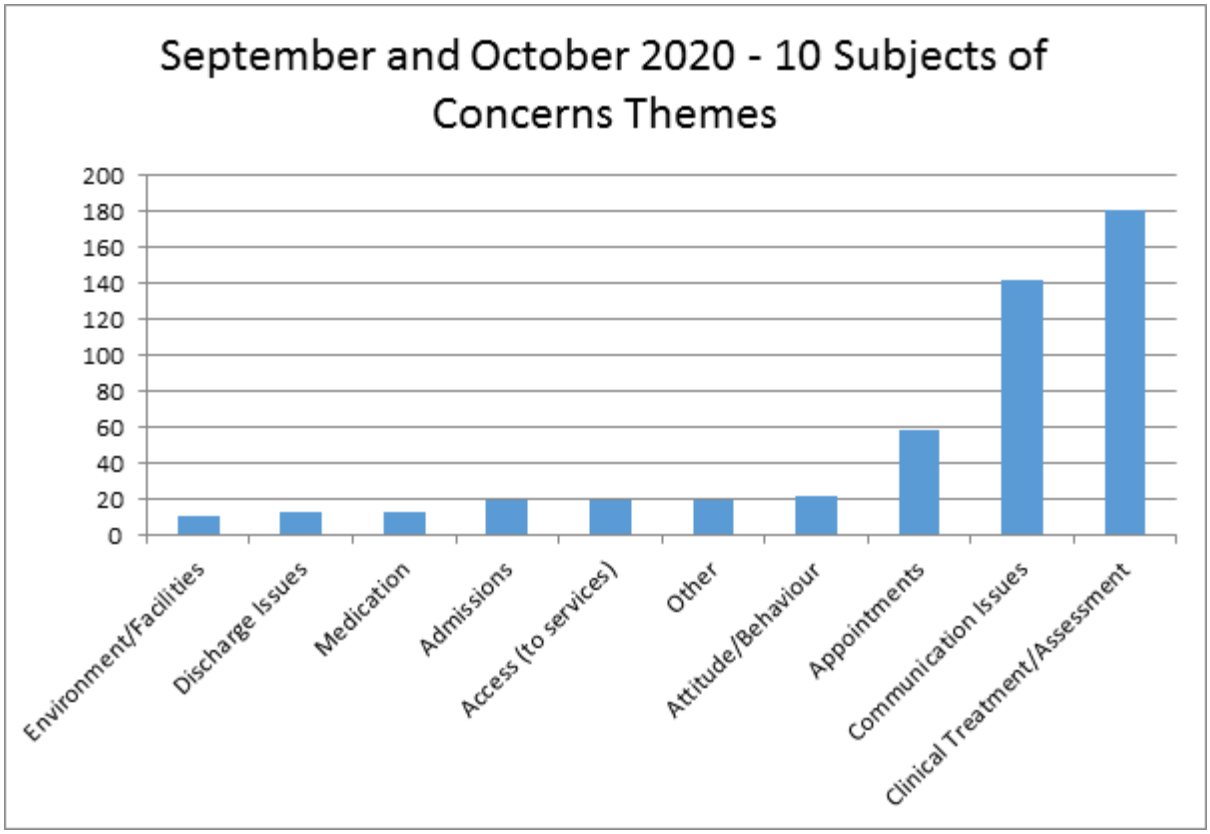
Complaints Management/Redress

In September and October 502 concerns were received, which is a significant increase when compared with the 338 received in July and August. The numbers are slightly less than September and October of 2019 when 596 concerns were received.

It is pleasing to note that the 30-working day performance for this period was 84%. Performance with this measure over the last 12 months is demonstrated below:



The Health Board continues to receive a high number of concerns regarding communication and clinical treatment and assessment and this is demonstrated in the diagram below:



Patients, are raising concern relating to delays in follow up appointments and planned procedures, particular under Surgery Clinical Board. In an attempt to manage patient expectations, the Trauma and Orthopedic Directorate has contacted patients on the waiting list to apologise for the delays and provide an update. Some Surgical Procedures have been undertaken at Spire. Through the Prehab to Rehab work we have also

contacted patients on other elective waiting lists and they were provided with the Patient Experience contact phone number to speak with a member of the team if they had any enquiries. The feedback has been very positive and patients appreciated knowing that they had not been forgotten about and that they were on a waiting list. The program provides information about improving and maintaining a healthy lifestyle whist awaiting surgery.

We have noted an increase in concerns relating to car parking at both UHL and UHW; patients are worried that they will receive a parking charge for parking in a restricted areas. They have commented upon some of the unsafe parking that is occurring on these sites. Patients and visitors are being reassured that they will not receive a Parking Charge Notice and signage has been amended to direct patients and visitors. The CEO has also reminded staff to ensure they park safely.

Visitors and staff continue to express concern about staff not adhering to social distancing. To address this, the UHB has continued to highlight the importance of social distancing in the CEO Connects and on posters displayed across all sites. The Executives and Communication Team are actively reminding people of the importance of social distancing through many social media and other routes. The Communications Team actively send out reminders about social distancing through all available media channels.

Surgery Clinical Board and Medicine Clinical Board received 45% of concerns across the Health Board. However, it should be noted that the level of activity in these clinical boards is significant.

Training:

The Concerns Team continue to provide training and recently we attended an away day for various members of Emergency Unit staff to discuss the themes of concerns and what actions could be taken. A further bespoke training session was provided for Band 6 nurses in Paediatric Intensive cate Unit (PICU). The feedback for both sessions was very positive.

One of the continuing themes of Redress cases and Claims is informed consent particularly in view of the Montgomery ruling.

A live virtual interactive session with Clinical Negligence Barrister, Will Wraigh has been arranged. The topic is Montgomery and Informed Consent and this takes place on 6th November 2020. This session is open to all staff and there will be an opportunity at the end of the session to ask any questions. There will also be a recording available for those who are unable to attend on the Patient Experience pages.

This is timely as the General Medical Council have published updated guidance - Decision-making-and-consent-guidance GMC which came into effect on 9 November 2020 and is intended to support doctors in undertaking shared decision making and help their patients to make healthcare decisions that are right for them.

Benchmarking

Whilst there is not any published benchmarking date for concerns performance across Wales we are maintaining consistently a 30 working day performance which exceeds the Welsh Government target. One of the aims of the Once for Wales system for concerns management is that benchmarking data will be available.

Quality, Safety and Experience Workshop

On World Patient Safety Day 2020 (17th September), a virtual Quality, Safety and Experience (QSE) Workshop was held to engage with senior clinicians and managers across the organisation in order to start the discussion to identify our QSE priorities for the next 5 years. A total of 66 people attended the workshop for part or all of the day.

Prior to the workshop, a short safety culture survey was sent out to all delegates. Themes from the survey and the pre-reading material were identified and facilitated virtual groups were set up to discuss each theme and feedback to the main virtual room. The key themes identified were:

- Organisational Safety Culture
- Leadership and the prioritisation of quality, safety and experience
- Patient experience and involvement in quality, safety and experience
- Patient safety learning and communication
- Staff engagement and involvement in safety, quality and experience
- Patient safety, quality and experience data and insight
- Professionalism of patient safety, quality and experience

There was excellent engagement from all delegates and the workshop and approach that we took has been well evaluated. Key messages we heard and now need to build on:

- be brave but be simple
- engage everybody – patients, staff and stakeholders and be able to hear their voice. We need all of the data and all of the systems to support that.
- establish a range of regular learning events and share understanding and learning about team dynamics more
- establish better training and accreditation for QSE – safety curriculums and MDT engagement
- improve leadership in QSE at all levels ensuring that ALL of our staff have a platform that ensures their voice is heard.
- Agree a common language about QSE with our staff; one that embraces the positive as well as the negative
- think about the ways in which we value and appreciate staff recognising the positive contribution that they make and how we support and encourage them to grow.

A feedback session for all staff who attended has been arranged for Friday, November 13th. A UHB wide safety culture survey is planned over the coming weeks and follow up discussions with the wider organisation and external stakeholders during the early part of 2021. This will inform the development of a five year QSE Framework which we anticipate launching in April 2021.

Clinical Effectiveness Committee (CEC)

A UHB wide CEC has been established. This will be chaired by the Assistant Medical Director Patient Safety and Governance and the purpose will be to:

Provide strategic direction for the UHB's national and local clinical audit programme.
Monitor the implementation of national and local evidence, guidelines and standards to ensure best practice across the Health Board.
Reduce inappropriate variations amongst year on year performance data and strive to achieve the highest standards by using evidence based practices.
Receive reports from the sub groups and following analysis either escalate issues or provide assurance to the QSE committee and Board.

The first meeting is scheduled for December 2nd 2020. The Patient Safety Team are currently viewing electronic clinical audit systems to support the Clinical effectiveness agenda within the UHB. Purchase of a suitable system will greatly enhance the level of control over UHB audit activity and will provide real-time insight and reporting for clinicians, wards and the audit departments.

Learning from Deaths

There are three essential Wales-wide pieces of work related to learning from deaths that the UHB is participating in. These are the implementation of the Medical Examiner (ME) and supporting structures; the implementation of e-Datix for recording and monitoring mortality reviews and the revised all-Wales Mortality Review Steering Group to develop robust systems and processes and share learning.

The Medical Examiner Service is expected to be fully operational by 1st April 2021. This will be hosted in 4 hubs across Wales. Recruitment for South East Wales is under way. There will be some changes in practice associated with this given that the base will not be in DGHs as originally proposed and the UHB is currently putting in place systems to ensure that the transition is as effective as possible. The ME service is currently being piloted across some areas of Wales and it is anticipated that the UHB will begin working with the ME's office from December 2020.

A UHB Mortality Review Group is now established with membership consisting of senior representation from all the clinical boards and relevant corporate teams.

This group will oversee the local implementation of the MEs and the whole learning from deaths process including the governance arrangements. It will also collate the learning from deaths information and agree priorites for improvement.

At present the UHB does not have full oversight of stage 2 mortality reviews. We cannot provide robust assurance that these are being done and lessons are being learnt. The Patient Safety Team has insufficient resource to support this adequately at present. The two things impacting on stage 2 reviews are that there is yet to be agreement on the final stage 2 review form and there is no repository for stage 2 findings. The E-Datix mortality module will be rolled out across Wales which will be the repository for stage 1 and 2 reviews. This forms an important part of the Once For Wales Concerns Management project.

Recommendation:

The Board is asked to:

- **CONSIDER** the content of this report.
- **NOTE** the areas of current concern and **AGREE** that the current actions being taken are sufficient.

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

Report Title:	**PERFORMANCE REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	26/11/20	
Status:	**For Discussion**		**For Assurance**		**x**	**For Approval**		**For Information**	
Lead Executive:	Chief Operating Officer and Executive Finance Director								
Report Authors (Title):	Information Manager (029 20 745602) & AD Operations (Performance) (029 21 847549)								

Background and current situation:

The context for this performance report remains largely as that previously reported, with one exception regarding national publication of official statistics.

In mid-March, targets and monitoring arrangements were relaxed and publication of performance was suspended nationally. Welsh Government has, however, recently announced that it will recommence publishing official statistics on NHS performance measures on 19 November. The data published in November will include October's data for unscheduled care and September's data for planned care. During the COVID-19 pandemic, the assurance and accountability requirements for local health boards have changed to reflect the immediate needs of safety. Welsh Government have confirmed that the data planned for publication in November and going forward will continue to be used for management information and to provide assurance against the delivery of health board quarterly plans.

The impact of COVID-19 continues to be seen across a range of key performance indicators. At the start of the pandemic, the focus of the Health Board switched to managing COVID-19 and maintaining essential services, in line with national guidance. Subsequently, comprehensive quarterly plans have been developed and received by the Board, with the focus of the service delivery element on managing COVID demand, minimising the risk of in-hospital COVID transmission, maintaining essential services and increasing activity through the re-introduction of other more routine services when it is safe to do so.

The format developed for the last report to the Board is used again for this current reporting period, with the focus on indicators deemed as essential services and / or those that continue to be routinely reported. Normal actions associated with the measures in this report will continue to be covered in the latest quarterly plan.

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

- Publication of NHS performance measures is being reinstated from 19 November.
- The Health Board continues to operate within its local operating framework, with the first principle being to be COVID ready. This is congruent with the national framework.
- Whilst the Health Board continues to monitor the position for key performance indicators, prioritisation of need and service delivery continues to be based on clinical stratification rather than time-based targets.
- The continued uncertainty regarding future demand remains and is such that it will be some time before services are fully re-instated. Additionally, clinical re-design of services will continue and for some services this will result in a move away from traditional ways of delivery.

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

Appendix 1 provides sets out the current performance position for the following areas of performance:

- Unscheduled Care
- Primary Care
- Mental Health Measures
- Cancer
- Elective access – RTT, diagnostics and outpatient follow-ups

Since the first wave of COVID-19, there has been a constant balance of risk made in relation to the extent to which services could continue to operate versus the potential harm from COVID-19. The continued uncertainty regarding future demand and increased level of complexity, particularly in light of a potential second wave and the impending winter period, is such that there remains risk in the system. The balance of risk applied, therefore, since the first wave will continue, with actions guided by clinical advice, local Executive-led support groups and national guidance.

Appendix 2 provides the Finance report for the Board.

Note: Commentary and assessment on the latest quality and safety indicators is provided in a separate report from the Executive Nurse Director.

Recommendation:

The Board is asked to **NOTE**:

- The current position against specific performance indicators for 2020-21

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	X
2. Deliver outcomes that matter to people	X	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	X	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	X	Integration	X	Collaboration	X	Involvement	X

Equality and Health Impact Assessment Completed:	Not Applicable

Unscheduled Care

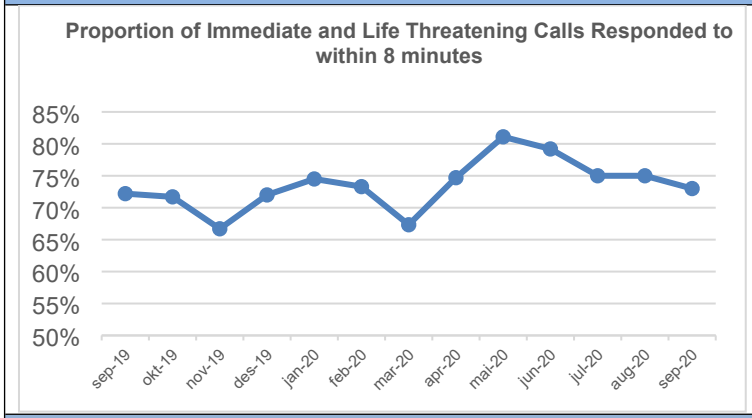
Overview

Emergency Unit attendances have continued to recover and were at 86% and 74% of pre covid levels in August and September.

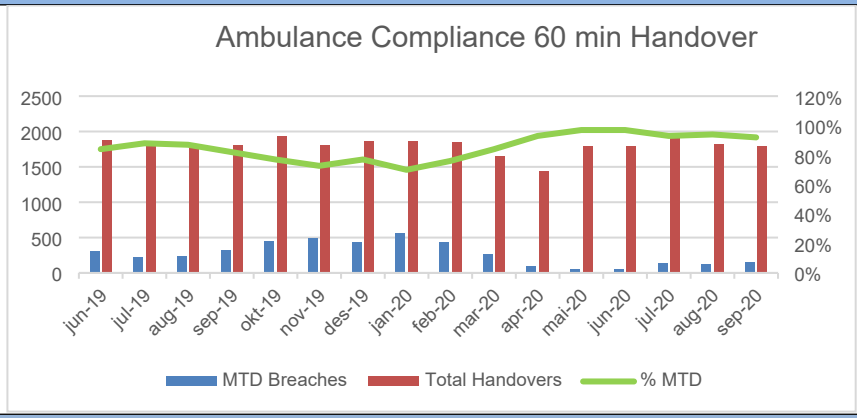
- 4 hour performance in EU recovered in September 2020 to 81.5% (Sept 2019 – 82%) which was an improvement from July 2020 (79.9%) and August 2020 (80.6%).
- There were 31 patients waiting greater than 12 hours in both August 2020 and September 2020 but volumes remain significantly lower than previous years. (Aug 2019 – 61, Sept 2019 – 137)
- In July 2020 and August 2020 75% of red calls were responded to within 8 minutes. This reduced to 73% at the end of September. This compares with 72.2% in September 2019.
- Ambulance Handover within 1 hour has remained over 90% since April and was 92% at end of September 2020.

Performance

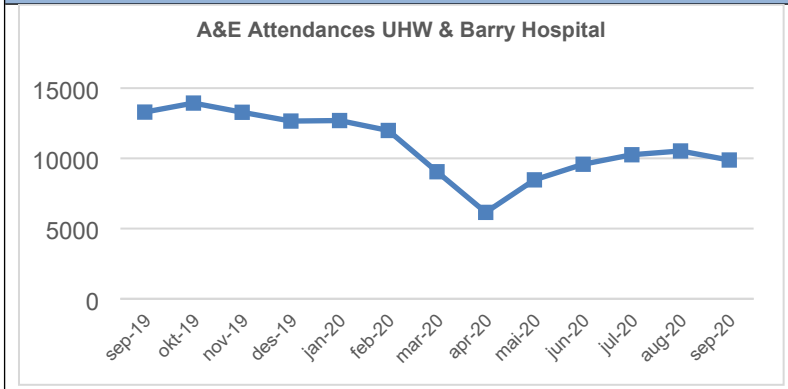
Graph 1: % Red calls responded to within 8 minutes



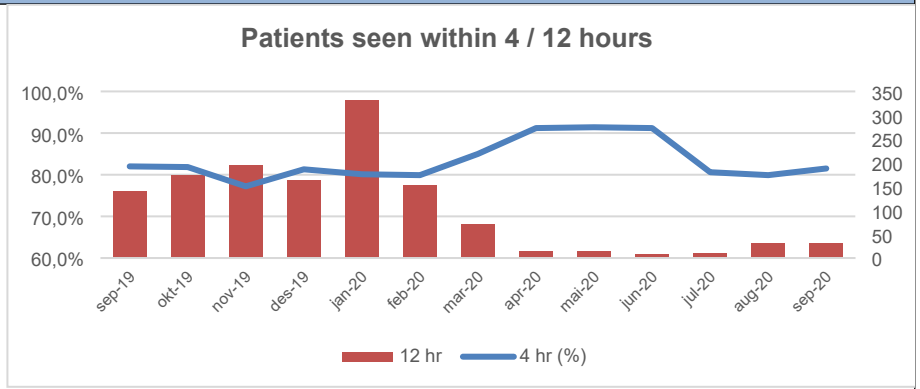
Graph 2: Ambulance handover > 1 hour



Graph 3: A&E Attendances



Graph 4: A&E waits – 4 & 12 hours



Primary Care

Overview

In relation to General Medical Services (GMS):

- *Sustainability applications*: The UHB currently has zero formal applications or closed practice lists.
- *Contract terminations*: There have been no contract terminations
- *Directly managed GP services*: The UHB presently has no directly managed primary medical care services

In relation to GP Out of Hours (GPOOHs):

- 71% and 43% of patients prioritised as 'emergency' requiring a home visit were seen within one hour in August and September 2020
- 90% and 80% of patients prioritised as 'emergency' requiring a primary care centre appointment were seen within one hour in August and September 2020

Performance

Chart 1: % of GP OOH appointments requiring a home visit provided within 1 hour

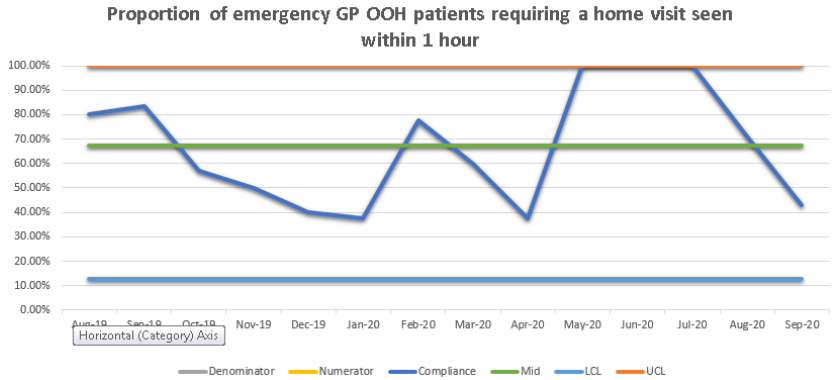
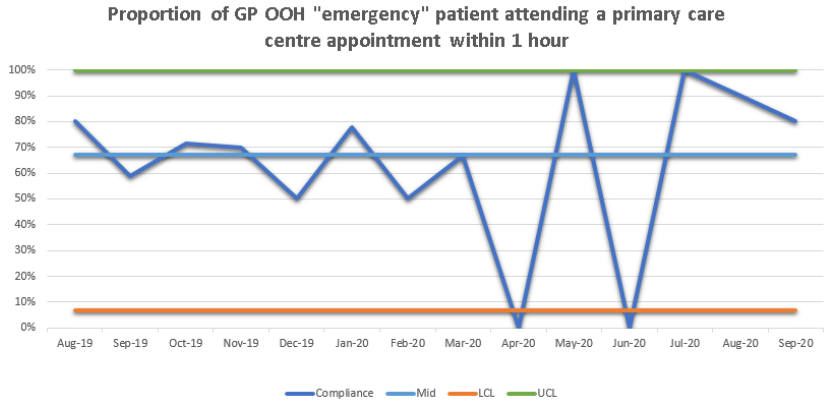


Chart 2: % of GP OOH "emergency" patients attending a primary care center appointment within 1 hour



Mental Health Measures

Overview

- Referrals for the Local Primary Mental Health Support Service (LPMHSS) have continued to rise and were exceptionally high in September, showing a 23% increase on last September.
- Part 1a: The percentage of Mental Health assessments undertaken within 28 days is 43% overall and 84% for CAMHs in September 2020. A significant increase in referrals following the first covid peak, along with referral pathway changes initiated to adapt to it, have resulted in a temporary reduction in Part 1A compliance.
- Part 1b: 98% of therapeutic started within 28 days following assessment at the end of September.
- Part 2: 88% of health board residents in receipt of secondary mental health services have a valid care and treatment plan (CTP) as at September 2020
- Part 3: 83% of health board residents were sent their outcome assessment report within 10 days of their assessment in September 2020

Performance

Chart 1: Mental Health Referrals

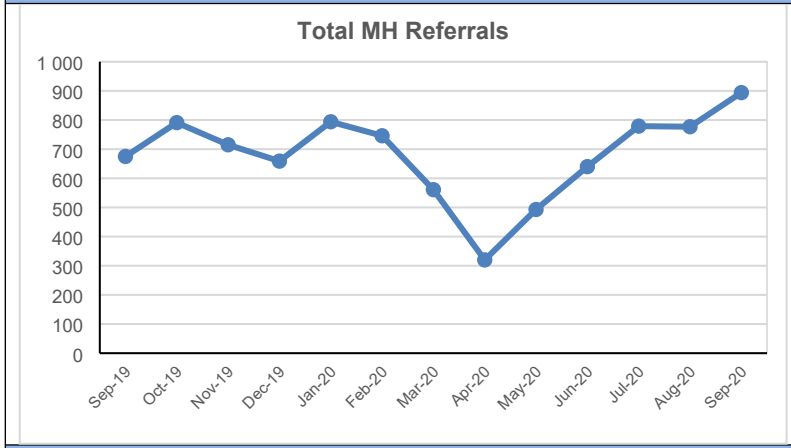


Chart 2: Performance against Mental Health Measures – Part 1a, 1b, 2 and 3

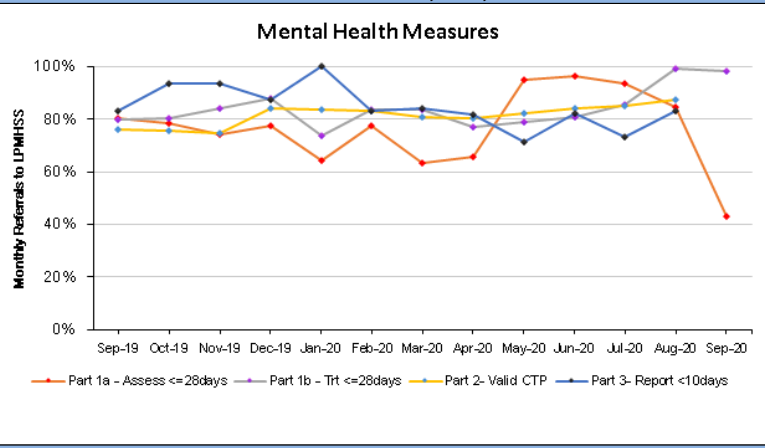
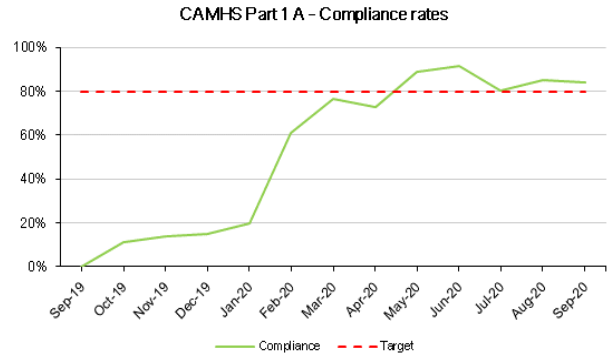


Chart 3: CAMHs Part 1a compliance



Cancer

Overview

- Referrals for patients with suspected Cancer have broadly returned to expected levels, with the cumulative position between July to September being 97% of pre-covid levels.
- 148 patients started first definitive treatment in August, the same number as last August. The number of first definitive treatments commenced in September was 204, the highest in recent months.
- Whilst no formal notification has been received, Welsh Government have indicated that there will be a switch to reporting the Single Cancer Pathway only, with minimal suspensions, in the next three months.
- 68% of patients on the Single Cancer Pathway were seen and treated within 62 days of the point of suspicion in September.
- An aggressive approach to reinstating cancer activity (fully reinstated by August) following the first covid peak has resulted in headline 62 day performance reducing. It is expected that this will correct over the next two months as the backlog is cleared.

Performance

Chart 1: Cancer referrals

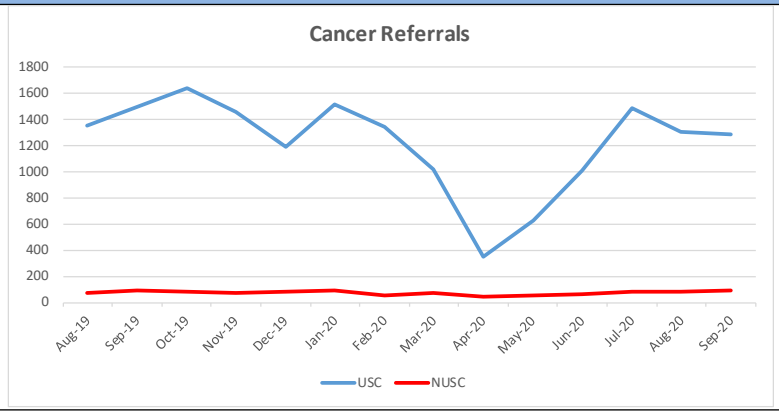
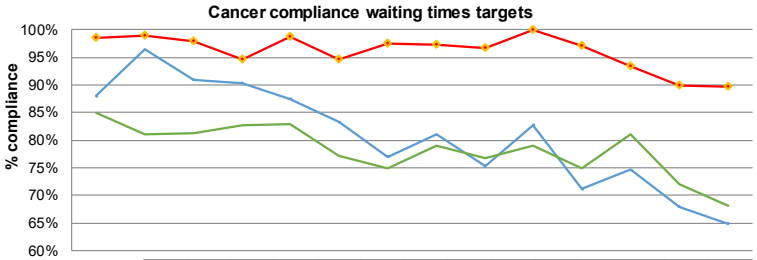


Chart 2: Performance against USC 62 day, NUSC 31 day and SCP performance



	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
62 Day Actual	88%	96%	91%	90%	88%	83%	77%	81%	75%	83%	71%	75%	68%	65%
31 Day Actual	99%	99%	98%	95%	99%	95%	97%	97%	97%	100%	97%	93%	90%	90%
SCP %	85.0%	81.0%	81.4%	82.7%	83.0%	77.2%	75.0%	79.0%	76.8%	79%	75%	81%	72%	68%

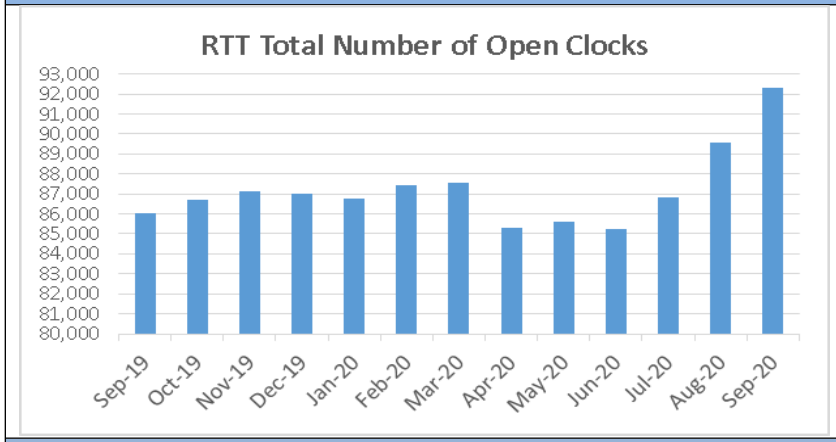
Elective access

Overview

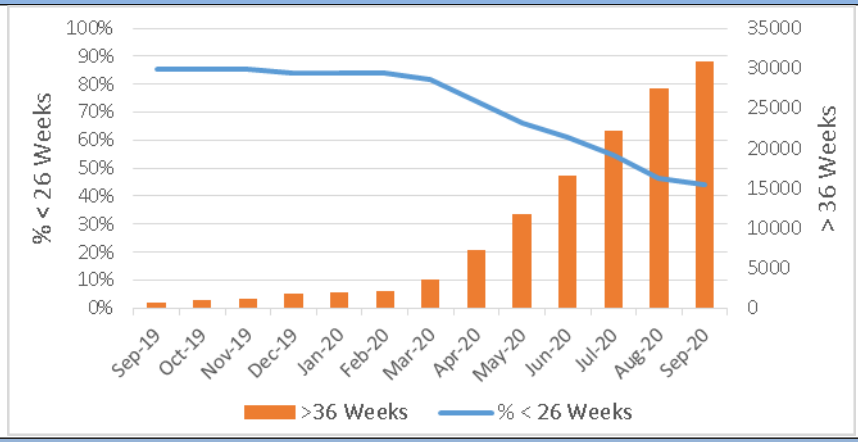
- The overall Referral to Treatment (RTT) waiting list increased in September to 92,295. Waiting times have continued to deteriorate with 30,919 patients waiting over 36 weeks. However the in-month increase in over 36 week breaches of 3,411 was the lowest monthly increase since March 2020.
- Patients waiting greater than 8 weeks for a diagnostic test reduced to 9,250 in September and are now at the lowest level since April 2020.
- The overall waiting list volume for a follow-up appointment continues to reduce – to 170,686 at the end of September. The number of Follow Up patients waiting over 100% beyond their target date declined for the first time in 6 months to 51,015 patients at the end of September

Performance

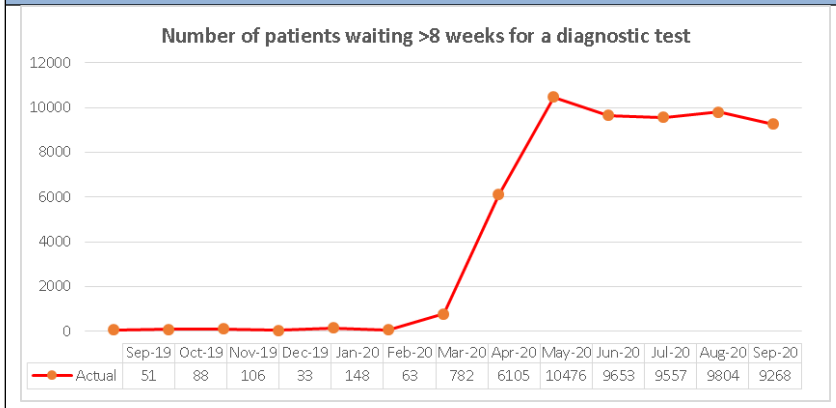
Graph 1: RTT total size of the waiting list



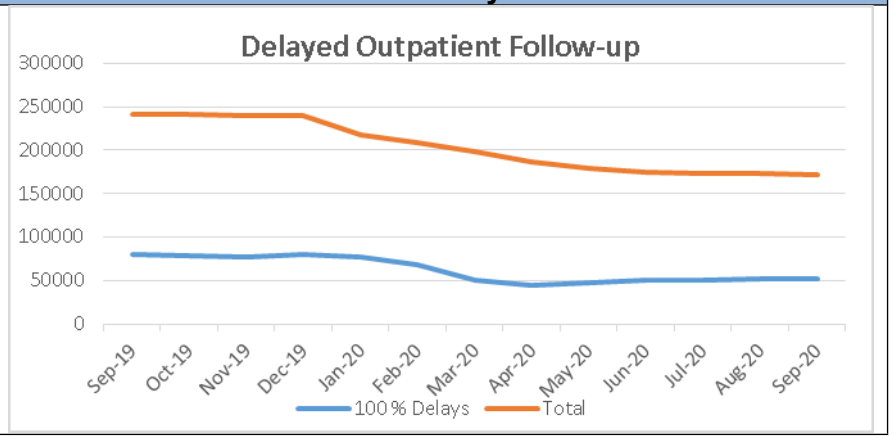
Graph 2: RTT % of patients 26 weeks and number of patients > 36 weeks



Graph 3: Diagnostics > 8 weeks



Graph 4: Outpatient follows ups – Total waiting list and > 100% delayed



FINANCE

How are we doing?

The Health Board agreed and submitted its 2020/21 – 2022/23 IMTP to Welsh Government by the end of January 2020 for its consideration. The Welsh Government wrote to the UHB on 19th March 2020 to inform it whilst it had an approvable plan, it had paused the IMTP process for an indefinite period so that organisations could focus on the challenges of COVID 19.

Welsh Government has now set out the resources available to support the COVID 19 response. There is now an expectation that NHS bodies will manage within these resources to deliver their original planned position, which for the UHB was a break even position by year end.

At month 7, the UHB is reporting an underspend of £0.362m against this plan. During the 7 months to the end of October net expenditure of £88.478m arose from the management of COVID 19 which is offset by the same amount of Welsh Government COVID 19 funding leaving an operating surplus of £0.362m.

Reported month 7 position

The Welsh Government amended the monthly financial monitoring returns to capture and monitor net costs due to COVID 19 that are over and above LHB plans. The financial position reported to Welsh Government for month 7 is a surplus of £0.362m and this is summarised in the Table below:

Table 1: Financial Performance for the period ended 31st October 2020

	Cumulative Month 7 £m
COVID 19 Additional Expenditure	94.720
COVID 19 Non Delivery of Savings Plans	10.426
COVID 19 Reductions in Planned Expenditure	(15.390)
COVID 19 Release of Planned Investments	(1.278)
Net Expenditure Due To COVID 19	**88.478**
Welsh Government COVID funding received / assumed	(88.478)
Net COVID 19 Position (Surplus) / Deficit £m	**0.000**
Operational position (Surplus) / Deficit	(0.362)
Financial position (Surplus) / Deficit	(0.362)

The month 7 position represents a significant improvement on the position reported up to month 5 and the key reason for the recovery was the confirmation of further Welsh Government funding in month 6 to cover the additional costs arising from the impact of COVID 19.

The additional COVID 19 expenditure in the 7 months to the end of October was £94.720m. At month 7 additional costs of £47.925m related to the Dragon's Heart Hospital (DHH). There was also £46.795m of other COVID 19 related additional expenditure.

COVID 19 is also adversley impacting on the UHB savings programme with underachievment of £10.426m against the month 7 target of £17.044m. Further material improvement is not anticipated until the COVID 19 pandemic passes.

Elective work has been curtailed during this period as part of the UHB response to COVID 19 and this has seen a £15.390m reduction in planned expenditure. The UHB has also seen slippage as a commissioner of £1.278m on its WHSSC commissioning plan due to impact of COVID 19.

The net expenditure due to COVID 19 was £88.478m and this was matched by an equal amount of additional Welsh Government COVID 19 funding. The UHB also had a small operating underspend of £0.362m leading to a net reported surplus at month 7.

Forecast Year End Position

Whilst the UHB expects the non COVID related operational position to remain broadly balanced as the year progresses, the additional costs arising from plans to manage COVID 19 are expected to continue. The forecast at month 7 of net expenditure due to COVID 19 in 2020/21 was £151.726m and this is offset by additional COVID 19 funding of £151.726m as summarised in table 2 below:

Table 2: Forecast Financial Performance at month 7

	Forecast Year-End Position £m
COVID 19 Additional Expenditure	154.949
COVID 19 Non Delivery of Savings Plans	19.908
COVID 19 Reductions in Planned Expenditure	(20.893)
COVID 19 Release of Planned Investments	(2.238)
Net Expenditure Due To COVID 19	**151.726**
Welsh Government COVID funding received / assumed	(151.726)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**

The UHB is now forecasting a break even position at year end. The improvement is the result of confirmation of additional Welsh Government funding based upon the resource assumptions set out in the NHS Wales Operating Framework 2020/21 for Q3 and Q4.

Underlying deficit position

The underlying deficit position brought forward into 2018/19 was £11.5m. Delivery of the 2020/21 plan would have reduced this to £4m by the year end. The achievement of this is largely dependent upon delivering the £25.0m 2020/21 recurrent savings schemes. The latest assessment is that this will be circa £21.3m less than planned and this will increase the underlying deficit to £25.3m. What is unclear at the moment is whether Welsh Government will provide any recurrent funding to underwrite this. In addition, there is a risk that a small component of the COVID response will have a recurrent costs. These risks are being identified so that mitigating actions can be taken.

Creditor payment compliance

The reported Non-NHS Creditor payment compliance was 96.1% for the 7 months to the end of October and continues to meet the 95% performance target.

Remain within capital resource limit

The UHB had an approved annual capital resource limit of £81.587m at the end of October 2020. Capital expenditure for the first 7 months of the year was £46.860m against a plan of £48.685m. The UHB expects the final 2020/21 capital outturn to be broadly in line with its capital resource limit.

Additional funding has been allocated to support the response to COVID 19 and the UHBs CRL has been updated to reflect this. The UHB has however requested further COVID 19 funding especially to support the provision of elective and routine services through the creation of green zones. The value of this is £2.5m and to date £1.043m of the funding has been confirmed. The UHB is now expecting this to be fully funded which will mitigate risks of delivering the capital programme within budget.

What are the UHB's key areas of risk?

At month 7, following confirmation of additional funding assumptions, the key revenue financial risk is managing the impact of COVID 19 within the additional resources provided and delivering a break even position.

What actions is the UHB taking to improve?

Continue to work with Welsh Government to identify and secure all additional costs of managing COVID 19.

Report Title:	**Intensive Learning Academies (ILAs)** **All Wales Academy for Innovation: Update**								
Meeting:	Board						**Meeting Date:**	26th November 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Executive Director Workforce & Organisational Development								
Report Author (Title):	Director of Transformation & Informatics								

Background and current situation:

Cardiff and Vale have been working with partners at Cardiff University and international partners to secure Welsh Government funding through the call for Intensive Learning Academies that was launched at the beginning of 2020. The process has evolved in response to the feedback provided by Welsh Government and we want to keep the Board up to date. We now have developed a compelling offer, along with our partners in Cardiff University, but also with Swansea University.

The ILA bid is now with the Minister, and if approved will be a memorable joint effort from Cardiff and Swansea, that will enable us to offer innovation training and support to our staff and staff across Wales – subject to Ministerial Approval (due beginning December)

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

Partnership with both Cardiff University and Swansea University
Cardiff the key frontline provider, supporting Len Richards as the Lead CEO for Innovation
This strengthens our aim to develop such innovation in Cardiff and Vale, be seen as a world leader but also as a strong partner sharing and learning across Wales.

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

Not applicable.

Recommendation:

The Board is asked to note the information in the presentation and will be updated once a Ministerial decision is made.

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	x

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

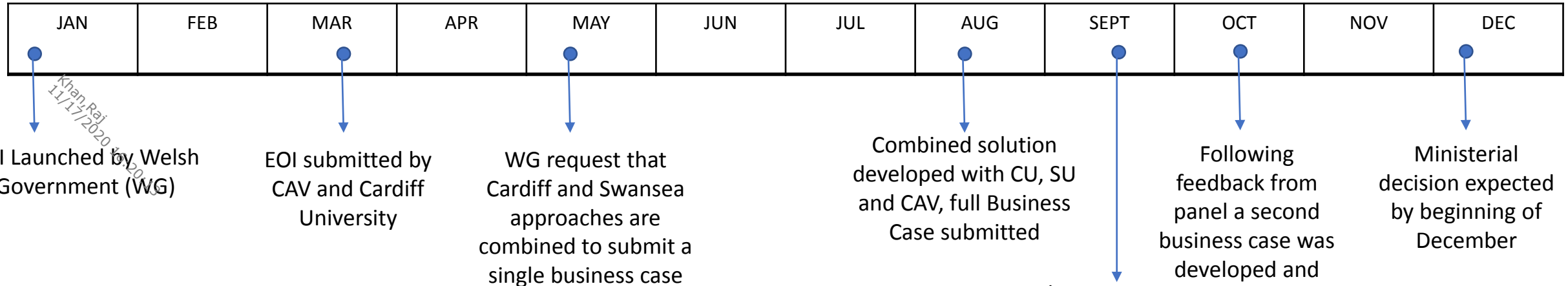
Equality and Health Impact Assessment Completed:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

- All Wales Intensive Learning Academy for Innovation in Health and Social Care:

Our vision is for Wales to be a world leader and global authority in ***the 'scale and spread' of improvement, innovation and transformational change*** *within health and social care. The ILA will;*

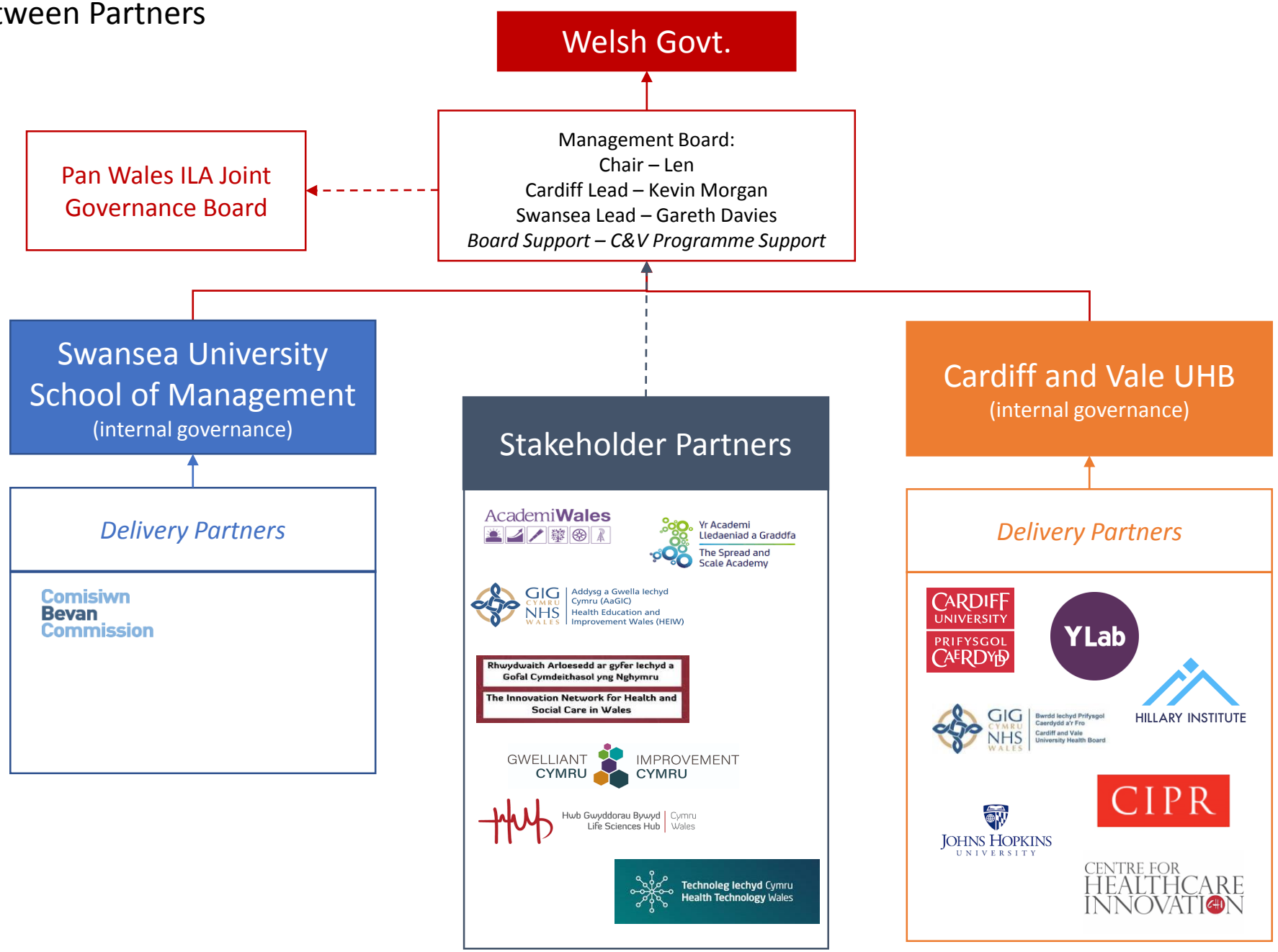
- *Work in collaboration with partners to deliver a world-class learning, research and teaching base that will equip leaders with the confidence, skills and capability to realise innovation in health & care and wellbeing.*
- *Enable Wales to retain and develop engaged and ambitious health and social care leaders that are adept in the knowledge and science of innovation practice needed to deliver the 2028* A Healthier Wales *vision.*
- *Establish the mechanism to develop a combined offer between the partners that will support ongoing development of 'boundaryless learning' in response to current and future innovation challenges and opportunities.*

- Timetable of the process so far:



- Swansea University will be the academic lead partner for the ILA.
- Cardiff University (Y Lab and CIPR) will be sub contractor to CVUHB.
- We have co-developed a solution with Y Lab and CIPR at Cardiff University that enables us to bring their expertise to the programme.
- The revised approach enables each partner to play to their respective strengths.
- This ensures we deliver a sustainable position by Year 4, through developing and delivering a world leading offer and maximising the spread and scale of innovation in Wales.
- The involvement of Y Lab strengthens our relationship with Social Care Wales.

Relationship between Partners



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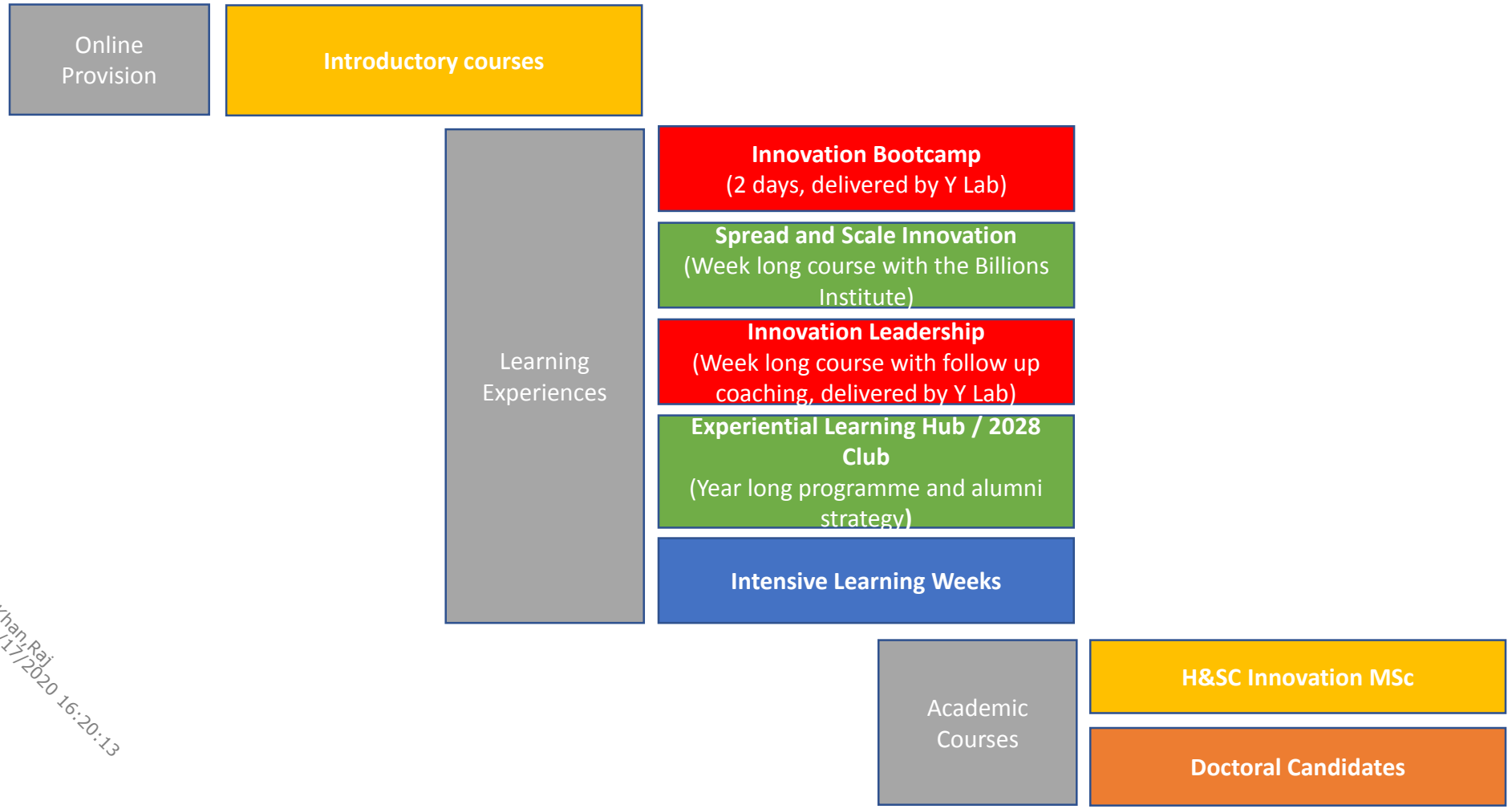
Combined ILA Offer



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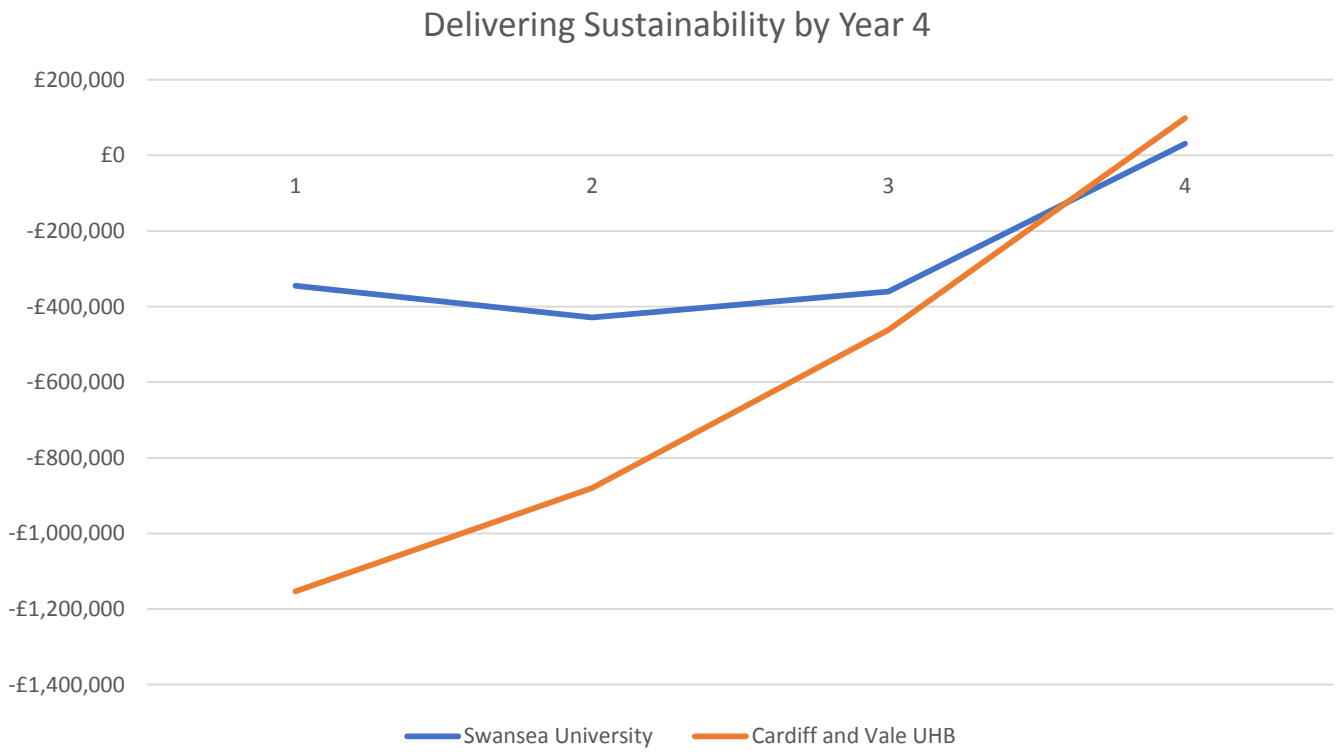
Funding Request and Sustainability

Funding Request	Year 1	Year 2	Year 3	Total
Swansea University	£ 344,622	£ 428,605	£ 360,333	£ 1,133,560
Cardiff and Vale University Health Board	£ 1,153,417	£ 879,752	£ 462,105	£ 2,495,274
			Grand Total	£ 3,628,834



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Report Title:	**The Nurse Staffing Levels for Adult Acute Medical And Surgical Wards following the Bi-annual Calculation**							
Meeting:	**Board meeting**					**Meeting Date:**	**26/11/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	✓	**For Information**	
Lead Executive:	Executive Nurse Director							
Report Author (Title):	Deputy Executive Nurse Director							

SITUATION

The Nurse Staffing Levels (Wales) Act 2016 Statutory Guidance requires the designated person (the Executive Nurse Director) to formally present to the Board the nurse staffing requirements for adult in-patient medical and surgical wards. This report provides the Board with a detailed summary of the nurse staffing level for each ward where Section 25B&C applies that has been agreed by the designated person in consultation with the Clinical Board teams.

REPORT

BACKGROUND

The Nurse Staffing Levels (Wales) Act [2016] became law in March 2016. The Act requires health service bodies to make provision for appropriate nurse staffing levels, and ensure that they are providing sufficient nurses to care for patients sensitively. Section 25A of the Act relates to the Health Boards' overarching responsibility which came into effect in April 2017, requiring Health Boards to ensure they had robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their organisation. Section 25B&C identifies wards where there is a duty to calculate nurse staffing levels using a prescribed methodology and maintain nurse staffing levels.

The process of determining the staffing levels across the Health Board is well established. Wards that are included in 25B&C undertake the bi-annual acuity audit and triangulate that information with their professional judgment of the ward, patient population and staff currently in post and a distinct number of patient outcomes that are generally regarded as being nurse sensitive. In addition, the Executive Nurse Director requests all clinical areas outside of 25B&C to undertake a review of their staffing in line with this timetable to provide assurance of compliance with 25A.

The Act requires Health Boards to undertake calculations in May and November each year. However, the first annual calculation in 2020, which was due to be presented to Board in May 2020 was impacted on by the COVID-19 pandemic. A letter received by the Chief Nursing Officer date 24th March 2020, provided Executive Nurse Directors with clarity and assurances in relation to the Covid-19 pandemic. An exception paper was subsequently presented to Board on 28th May 2020 providing assurance in the changes to nurse staffing calculation aligned to the service and operations reconfiguration required at the time. Throughout the COVID-19 period, the Health Board has recorded the staffing levels on each ward on a monthly basis to provide assurances that they were being monitored and this information was presented to Board in the Annual Assurance paper in September 2020.

ASSESSMENT

Evidence of compliance under Section 25A

The Executive Nurse Director has determined that a review of nurse staffing levels across all clinical areas in line with the requirement in 25A will provide assurance that the principles behind the Act are considered. These considerations are informed by professional judgement and national standards where available.

The agreed process of signing off these establishments within the UHB have been followed within this time period from the Ward Sister/ Charge Nurse to the Director of Nursing for the Clinical Board and includes the Directors of Operations, Head of Finance and Head of Workforce from each Clinical Board. The Clinical Boards and Executive Nurse Director have agreed establishments that they consider will meet all reasonable requirements.

Under 25(A) of the Act, staffing levels for all inpatient areas throughout the UHB have been calculated to ensure that they can provide the level of care sensitive to the patient needs. To ensure that Nurse Staffing levels are maintained all Clinical Boards have a version of a daily safety briefing whereby senior teams determine staffing requirements and manage risk continually over a 24 hour period. Since the COVID-19 period the Nurse Staffing levels have been managed through the COVID-19 Local Control Centers on a 4x daily basis through a dynamic risk managed basis.

Paediatrics Inpatients Nurse Staffing Principles

In December 2019, the Health Minister announced plans to extend the Nurse Staffing Levels (Wales) Act 2016 to include paediatric in patient wards as part of Section 25(B). The purpose of the paediatric work stream is to devise an evidence based - workforce planning tool to determine appropriate nurse staffing levels within paediatric inpatient areas.

Cardiff and Vale UHB continues to have excellent engagement with the All Wales paediatric inpatient work stream. We have worked with the 9 interim principles for nurse staffing on paediatric wards and are now fully compliant. As a health board we are working with the Paediatric Welsh Levels of Care draft document and continuing to score our patients once a day and monitor our compliance. With the Paediatric programme lead we have delivered a comprehensive training package for all staff to help to support the implementation of the methods and tool required to assess and record patient acuity.

Cardiff and Vale UHB has revisited Birthrate Plus through 2020 where we have re-set the Birthrate Plus establishments.

We are also compliant with British Association of Peri-natal Medicine (BAPM) and Paediatrics Intensive Care National Standards (PICNS).

District Nursing Staffing Principles

There has been guidance from the Chief Nursing in terms of District Nursing establishments in place for some time. This guidance has been considered when determining establishments for District Nursing areas and there is an expectation from Welsh Government that the Health Board is working towards full compliance with the principles.

The modelling of DN teams aligning to the DN Principles has been tested during the COVID-19 pandemic. The workforce modelling of the teams has proved effective as the District Nursing teams have been deployed effectively to work in collaboration with other Care home providers; Hospices and the hospital discharges.

Whilst COVID-19 has created challenges to the Nurse Staffing Act Programme, Cardiff and Vale Health Board remains committed to progressing on the delivery of these principles.

Mental Health

Whilst the Clinical Boards and Executive Nurse Director have agreed establishments that they consider will meet all reasonable requirements, the Board should take note of exceptions:

The Mental Health Clinical Board management team and therefore, the Executive Nurse Director have not been able to sign off all the nursing establishments for these areas as they remain non-compliant with section 25(a) of the Act as the professional and service requirements do not meet the financial envelope. The Board will recall this being previously reported. In order to manage this risk the Clinical Board reviews staffing levels on a day to day basis by: formal review of rosters every morning; Out-of-hours requests managed by silver manager on call; Shift coordinators move staff around on a daily basis; Use of temporary staffing when required. The Mental Health Clinical Board provided assurances to the Strategy and Delivery Committee in April 2019 that they are looking to address these issues in line with the IMTP processes with support from the wider UHB. This has not been addressed to date.

Table 1 Wards where establishment has not been signed off in the Mental Health Clinical Board

Hazel	Ash
Elm	Willow
Maple	East 10
Oak	East 12
Beech	East 14
Pine	East 16
East 18	Park Road Houses
Daffodil	Phoenix
Meadow	St Barrucs

A set of draft inpatient Nurse Staffing Principles for mental health inpatients is in development by the All Wales Nurse Staffing Programme. Each Health Board has undertaken an impact assessment against the draft principles which will inform the Health Boards of the implications and resources required to comply with the principles once agreed and implemented. This will be presented in the IMTP.

As part of Section 25A, the Act requires UHB's to secure the provision of nursing services to allow nurses to provide care sensitively. The UHB is therefore currently looking at the

infrastructure to identify how we can move forward with the lead Director for commissioned services to ensure compliance with Section 25(a), in the care we commission both inside and outside of Wales.

Wards Where 25B&C Applies

25B&C require Health Boards to calculate the nurses staffing levels using a prescribed method of calculation. Wards included in this section of the Act are currently acute adult medicine and surgery ward. Following the acuity audit undertaken in July 2020 as part of the Bi-annual recalculation process, all wards under Section 25(B) of the Act were reviewed in order to ensure the prescribed methodology was considered.

Appendix 1 (Annual Presentation of Nurse Staffing Levels to the Board) outlines the wards that are included in Section 25B and 25C by clinical Board and provides assurance to the Board that triangulated approach has been applied to agree nurse staffing levels.

Appendix 2 (Summary of Nurse Staffing Levels for wards where Section 25B applies) outlines the nurse staffing levels i.e. planned roster and required establishment for each ward, and evidences the rationale, purpose and outcome of recalculations undertaken both within and outside the bi-annual calculation cycle. The table attempts to outline the changes have occurred due to a change in case mix/acuity/bed numbers, which has resulted in wards being include or excluded during the reporting period.

Due to the fact that the Executive Nurse Director requests all clinical areas outside of 25B&C to also undertake a review of their staffing in line with this timetable, to provide further assurance of compliance with 25A, all non 25B areas have been included in Appendix 2.

RECOMMENDATION

The Board is asked to:

- **APPROVE** the nursing establishments in compliance with requirements of the Nurse Staffing Levels (Wales) Act [2016]

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.

<table>
<tr><th>APPENDIX 1</th><th>Annual Presentation of Nurse Staffing Levels to the Board</th></tr>
<tr><td>Health board</td><td>Cardiff and Vale University Health Board</td></tr>
<tr><td>Date of annual presentation of Nurse Staffing Levels to Board</td><td>26th November 2020</td></tr>
<tr><td>Period covered</td><td>November 2019 to October 2020</td></tr>
<tr><td>Number and identity of section 25B wards during the reporting period.

• Adult acute <u>medical</u> inpatient wards
• Adult acute <u>surgical</u> inpatient wards
(Ref: paragraph 26-30)</td><td>
<table>
<tr><td>Medicine</td><td>A1, A6 Gastro, B7, A7, C6, C7, East 6, East 7, East 4, CFU, West 6, East 2, East 8, , A1 Link, C4, Heulwen, C5, A1MDU</td></tr>
<tr><td>Specialist</td><td>B4H, TCT, B4N, B1, T4, B5, T5</td></tr>
<tr><td>Surgery</td><td>B6, Duthie, A2, B2N, A5N, West 5, A5S, C7, West 1, West 3,</td></tr>
<tr><td>Children and Women</td><td>C1</td></tr>
</table>
• Please refer to Appendix 2 for details of establishments for 25B wards
</td></tr>
<tr><td>Using the triangulated approach to calculate the nurse staffing level on section 25B wards

(Ref: paragraph 31-45)</td><td>The Nurse Staffing Levels (Wales) Act 2016 requires that all wards included in section 25(B) must calculate the number of Nurses using a triangulated approach utilising three sources of information. The information triangulated is both qualitative and quantitative in nature and must include:

• Professional judgement – the Clinical Board Nurse Director in conjunction with the Ward Sister/ Charge Nurse and Lead and Senior Nurses use their knowledge of the clinical area to inform the levels of nurse staffing. The Operational Guidance for the Act provides detailed descriptions defining professional judgment. Included in this description is a suggestion that data on, compliance with mandatory training, vacancy and sickness rates, temporary staffing usage, bed occupancy and student feedback may be of use in supporting this aspect.

• Patient acuity - use the prescribed evidence-based workforce planning tool to understand the level of acuity and activity that can influence nurse staffing numbers. The tool used to determine the acuity of each</td></tr>
</table>

	patient is the Welsh Levels of Care. • **Quality indicators** –quality indicators that are particularly sensitive to care provided by a nurse are used as part of the calculation. To reduce the burden of measurement, quality indicators that have an established data source have been detailed as a minimum data set within the Act and Statutory guidance. The indicators are: • **Patient falls** - any fall that a patient has experienced whilst on the ward; • **Pressure ulcers** - total number of hospital acquired pressure ulcers judged to have developed while a patient on the ward; and • **Medication errors** - any error in the preparation, administration or omission of medication by nursing staff (this includes medication related never events). A record of this process is documented for each clinical area using an All Wales Recording Template. These record details of the overall findings of the workforce planning tool, any evidence from the quality indicators for that recording period and a summary of the professional judgement of the team. The areas of responsibility in the sign off the nurse staffing levels in wards where Section 25B&C apply are presented to ensure that the professional opinions across the service are considered.
Finance and workforce implications Khan Raj 11/17/2020 16:20:13	The process for managing nurse staffing and ensuring that all reasonable steps are maintained is now well established in Cardiff and Vale: • Daily review of nurse staffing levels through the Local Control Centres. • Daily recording of staffing levels and reasonable steps documented on Healthcare Monitoring System. • Staffing deficits escalated and reviewed to Director of Nursing for Clinical Boards. • Unfilled shifts escalated to bank/agency at the earliest opportunity Clear Divisional escalation procedures to ensure and manage timely escalation of unfilled shifts. • RN and HCSW deployment, as and where required. The Registered Nurse vacancy and ability to attract and recruit, remains the biggest risk within Cardiff and

	Vale. The Health Board continues to have a clear recruitment strategy, targeted and focused nurse recruitment events which are constantly being refreshed and supported by all Clinical Boards and Executive Team. The Deputy Executive Director of Nursing chairs the All Wales Attraction, Recruitment and Retention. Within Cardiff and Vales there are number of initiatives to support the recruitment of nursing workforce, to include, • The development of the Nursing Workforce Hub to oversee both the strategic and operational management of Nursing recruitment and deployment. • Registered Nurses applied for temporary NMC registration during COVID (n=10). • HCSW recruitment continues since December 2019 (n=295) • Positive student streamlining (n=179) • Local recruitment events (n=40) • International recruitment has been maintained throughout early part of 2020 (n=67) Despite the significant changes to Nursing and ward establishments since November 2019, all funding requirements have been met within the Clinical Boards allocated budget. However, due to the significant Registered Nurse vacancies and the merging and sustained impact of the Covid19 Pandemic there has been a significant reliance on temporary staffing to cope with Covid19 and subsequent workforce challenges associated with the pandemic and additional surge capacity requirement.
Conclusion & Recommendations	
Khan Raj 11/17/2020 16:20:13	There have been significant challenges throughout the first 6 months of 2020 with the development of COVID-19, in the tracking, review alignment of nurse staffing. There has been a requirement for a number of wards to repurpose during the period of COVID-19 which has caused further impact on our ability to record and report in line with the Act in a consistent manner. During this time we have seen: • Significant redesign in nursing models of care • Effective mobilisation of nursing workforce to meet the requirements of changing patient and ward demographics. • Successful recruitment strategies to ensure continuous flow of nurses into organisation

	• The formal calculation of nurse staffing levels for July 2020 during unprecedented times • The delivery of the Annual Assurance Paper to provide further assurance to Board of safe Nurse staffing levels within Cardiff and Vale. • Working on All Wales basis to support the development of a reliable data capture system in order to meet our statutory reporting requirements relating to ‘the extent to which the nurse staffing level has been maintained’.

Appendix 2: Summary of Nurse Staffing Levels for wards where Section 25B applies

Health Board/Trust:	Name: Cardiff & Vale UHB	
Period being reported on :	Start date: November 2019	End Date: October 2020
Number of wards where section 25B has applied during the period:	**Medical:18**	**Surgical: 10**
	Speciality: 7	**Children & Women: 1**

To be completed for EVERY wards where section 25B has applied

✓- 25B ward

Medical

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward C7 ✓	E						E	7	4	30.96	17.06	Yes	NA	NA		Yes	Yes	Ward changed from H&N and a Urology ward to red COVID ward
	L						L	7	7									
	LD						LD	7	4									
	TW						TW											
	N						N	4	2									
Ward A5N ENT ✓	E	4	2	15.48	8.53	Yes	E						NA	NA		NA	Choose an item.	Ward closed in reorganisation during COVID
	L	3	2				L											
	LD						LD											
	TW						TW											
	N	2	1				N											
Ward A5 CLOSED	E	4	2	15.48	8.53	Yes	E						NA	NA		NA	Choose an item.	Ward closed in reorganisation during COVID
	L	3	2				L											
	LD						LD											
	TW						TW											
	N	2	1				N											
Ward ASSESS	E	5	3	13.70	7.45	Yes	E	5	3	22.74	11.25	Yes	NA	NA		Yes	Yes	Increased to 7 days during
	L	5	3				L	5	3									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
MENT	LD						LD											COVID
	TW						TW											
	N	2	1				N	3	1									
Ward DUTHIE ✓	E	4	2	15.48	8.54	Yes	E	5	3	21.93	11.37	Yes	NA	NA		Yes	Yes	Increased bed capacity during COVID
	L	3	2				L	4	3									
	LD						LD											
	TW						TW											
	N	2	1				N	3	1									
Ward ANWEN CLOSED	E	1	1	6.80	4.5	Yes	E						NA	NA		NA	Choose an item.	Ward closed during COVID
	L	2	1				L											
	LD						LD											
	TW						TW											
	N	0	0				N											
Ward A1 LINK CLOSED	E	5	2	21.93	8.54	Yes	E						NA	NA		NA	Choose an item.	Ward closed during COVID
	L	5	2				L											
	LD						LD											
	TW						TW											
	N	3	1				N											
Ward B2 NORTH ✓	E						E	5	2	19.09	11.37	Yes	NA	NA		Yes	Yes	Ward opened when A1 moved across during COVID
	L						L	5	2									
	LD						LD											
	TW						TW											
	N						N	3	1									
Ward B2 SOUTH	E	4	2	15.48	8.53	Yes	E	4	2	15.48	8.53	Yes	Yes	No		NA	Choose an item.	
	L	3	2				L	3	2									
	LD						LD											
	TW						TW											
	N	2	1				N	2	1									
Ward A2 ✓ Khan Raj 11/17/2020 16:26:13	E	7	4	32.89	15.48	Yes	E	6	4	28.43	17.06	Yes	NA	NA		Yes	Yes	Ward repurposed from an upper GI ward to a general green area during COVID
	L	7	3				L	6	4									
	LD						LD											
	TW						TW											
	N	4	2				N	4	2									
Ward SSSU	E	11	5	28.4	9.73	Yes	E	8	5	21.35	9.73	Yes	NA	NA		Yes	Yes	Ward repurposed from an
	L	11	5				L	8	5									
	LD						LD											

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
	TW						TW											
	N	3	1				N	3	1									assessment unit to multi-speciality green ward during COVID
Ward WEST 1 ✓	E						E	4	4	19.90	19.90	Yes	NA	NA		Yes	Yes	Ward repurposed from a medical ward to trauma ward during COVID
	L						L	4	4									
	LD						LD											
	TW						TW											
	N						N	3	3									
Ward WEST 3 ✓	E						E	3	2	14.15	11.37	Yes	NA	NA		Yes	Yes	Ward changed from breast ward to trauma ward during COVID
	L						L	3	2									
	LD						LD											
	TW						TW											
	N						N	2	2									
Ward WEST 4 CLOSED	E	3	2	14.69	11.37	Yes	E						NA	NA		NA	Choose an item.	Ward closed during COVID
	L	3	2				L											
	LD						LD											
	TW						TW											
	N	2	2				N											
Ward CAVOC CLOSED	E	8	3	27.21	11.37	Yes	E						NA	NA		NA	Choose an item.	Ward transferred to W1 during COVID
	L	7	3				L											
	LD						LD											
	TW						TW											
	N	3	1				N											
Ward BETHAN CLOSED	E	2	1	10.28	2.84	Yes	E						NA	NA		NA	Choose an item.	Ward closed during COVID
	L	2	1				L											
	LD						LD											
	TW						TW											
	N	2	0				N											
Ward WEST 5 ✓	E	4	2	17.05	12.79	Yes	E	4	2	17.05	12.79	Yes	Yes	No		NA	Choose an item.	
	L	4	2				L	4	2									
	LD						LD											
	TW						TW											
	N	3	1				N	2	2									
Ward B6	E	6	4	26.67	17.05	Yes	E	6	4	26.67	17.05	Yes	NA	NA		NA	Choose	Ward repurposed
	L	5	4				L	5	4									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
	LD						LD										an item.	from a trauma ward to a medical ward during COVID
	TW						TW											
	N	4	2				N	4	2									
Ward A6 NORTH CLOSED	E	4	3	18.32	14.21	Yes	E						NA	NA		NA	Choose an item.	Ward closed during COVID
	L	4	3				L											
	LD						LD											
	TW						TW											
	N	3	2				N											
Ward A5 NORTH ✓	E						E	4	3	18.32	14.21	Yes	NA	NA		Yes	Yes	Ward opened during COVID
	L						L	4	3									
	LD						LD											
	TW						TW											
	N						N	3	2									
Ward A3 LINK CLOSED	E	4	2	19.90	8.54	Yes	E						NA	NA		NA	Choose an item.	Ward closed during COVID
	L	4	2				L											
	LD						LD											
	TW						TW											
	N	3	1				N											
Ward A5 SOUTH ✓	E						E	3	2	14.21	8.53	Yes	NA	NA		NA	Choose an item.	Opened as 19 bed trauma ward
	L						L	3	2									
	LD						LD											
	TW						TW											
	N						N	2	1									

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward EAST 2 ✓	E						E	4	4	20.90	17.06	Yes	NA	NA		Yes	Yes	Ward was opened during COVID
	L						L	4	4									
	LD						LD											
	TW						TW											
	N						N	3	2									
Ward EAST 6 ✓	E	4	4	19.48	18.48	Yes	E	4	4	19.48	18.48	Yes	NA	NA		Yes	No	Ward changed to a Red ward during COVID
	L	3	5				L	3	5									
	LD						LD											
	TW						TW											
	N	3	2				N	3	2									
Ward EAST 7 ✓	E	4	4	20.90	17.06	Yes	E	4	4	20.90	17.06	Yes	Yes	No		NA	Choose an item.	
	L	4	4				L	4	4									
	LD						LD											
	TW						TW											
	N	3	2				N	3	2									
Ward EAST 8 ✓	E	4	4	16.63	21.68	Yes	E	4	4	16.63	21.68	Yes	Yes	No		NA	Choose an item.	
	L	3	4				L	3	4									
	LD						LD											
	TW						TW											
	N	2	3				N	2	3									
Ward SRC	E	5	6	21.44	27.78	Yes	E	5	6	21.44	27.78	Yes	Yes	No		NA	Choose an item.	
	L	4	6				L	4	6									
	LD						LD											
	TW						TW											
	N	3	4				N	3	4									
Ward WEST 2 CLOSED	E	3	4	13.50	15.28	Yes	E						NA	NA		Yes	Choose an item.	Ward closed during COVID
	L	2	3				L											
	LD						LD											
	TW						TW											
	N	2	2				N											
Ward WEST 6	E	4	3	20.90	14.21	Yes	E	4	3	20.90	14.21	Yes	Yes	No		NA	Choose an item.	
	L	4	3				L	4	3									
	LD						LD											
	TW						TW											
	N	3	2				N	3	2									
Ward	E	2	0	11.51	2.78	Yes	E						NA	NA		Yes		Ward closed

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.				

Version 1, Issued March 2020

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
GWENWYN CLOSED	L	2	0				L										Choose an item.	during COVID
	LD						LD											
	TW						TW											
	N	2	1				N											
Ward A1 LINK ✓	E	5	5	26.79	20.71	Yes	E	3	2	13.60	8.90	Yes	NA	NA		Yes	Yes	A4 moved to A1 link and reduced beds during COVID
	L	5	5				L	3	2									
	LD						LD											
	TW						TW											
	N	3	3				N	2	2									
Ward HEULWEN ✓	E			29.43	22.74	Yes	E	3	2	29.43	22.74	Yes	Yes	No		NA	Choose an item.	
	L						L	3	3									
	LD						LD											
	TW						TW											
	N						N	4	4									
Ward EU	E			115.6	40.46	Yes	E	20	7	115.6	40.46	Yes	Yes	No		NA	Choose an item.	
	L						L											
	LD						LD											
	TW						TW											
	N						N	20	7									
Ward AU	E	7	4	40.46	23.12	Yes	E			40.46	23.12	Yes	Yes	No		NA	Choose an item.	
	L	8	4				L											
	LD						LD											
	TW						TW											
	N	7	4				N											
Ward B7 ✓	E	6	4	32.26	17.06	Yes	E	6	4	32.26	17.06	Yes	Yes	No		NA	Choose an item.	
	L	6	4				L	6	4									
	LD						LD											
	TW						TW											
	N	5	2				N	5	2									
Ward WEST 1 CLOSED	E	4	3	20.44	13.89	Yes	E						NA	NA		Yes	Choose an item.	Ward closed during COVID
	L	4	3				L											
	LD						LD											
	TW						TW											
	N	3	2				N											
Ward CFU	E	2	1	12.11	2.78	Yes	E	2	1	12.11	2.78	Yes	Yes	No		NA	Choose an item.	
	L	2	1				L	2	1									
	LD						LD											

E = Early shift	L = Late shift	TW = Twilight shift	LD = Long Day	N = Night duty
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Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
✓	TW						TW											
	N	2	0				N	2	0									
Ward A7 ✓	E	6	4	26.00	19.44	Yes	E	3	2	16.23	11.37	Yes	NA	NA		Yes	Yes	Ward reduced beds during COVID
	L	6	4				L	3	2									
	LD						LD											
	TW						TW											
	N	3	3				N	3	2									
Ward A1 MDU ✓	E	7	4	30.69	17.06	Yes	E	7	4	30.69	17.06	Yes	Yes	No		NA	Choose an item.	
	L	6	4				L	6	4									
	LD						LD											
	TW						TW											
	N	4	2				N	4	2									
Ward C4 SOUTH ✓	E	3	3	16.21	11.37	Yes	E	3	3	16.21	11.37	Yes	Yes	No		NA	Choose an item.	
	L	3	3				L	3	3									
	LD						LD											
	TW						TW											
	N	2	1				N	2	1									
Ward C6 ✓	E	5	5	26.79	20.71	Yes	E	5	5	26.79	19.90	Yes	Yes	No		NA	Choose an item.	
	L	5	5				L	5	5									
	LD						LD											
	TW						TW											
	N	3	3				N	3	3									
Ward C7 SOUTH ✓	E	3	2	15.21	8.33	Yes	E	7	4	27.60	19.90	Yes	NA	NA		Yes	Yes	C7 medical ward repurposed to surgical ward during COVID
	L	3	2				L	6	4									
	LD						LD											
	TW						TW											
	N	2	1				N	3	3									
Ward LANSDOWNE	E	2	4	12.10	13.90	Yes	E	3	4	12.11	19.04	Yes	Yes	No		NA	Choose an item.	
	L	2	4				L	2	4									
	LD						LD											
	TW						TW											
	N	2	1				N	2	2									
Ward SAM DAVIES	E	3	4	12.10	13.90	Yes	E	3	4	12.11	19.40	Yes	Yes	No		NA	Choose an item.	
	L	2	3				L	2	3									
	LD						LD											
	TW						TW											
	N	2	2				N	2	2									

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		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward RHYDLFAR	E	2	5	12.10	19.40	Yes	E	2	4	12.10	19.40	Yes	Yes	No		NA	Choose an item.	
	L	2	5				L	2	4									
	LD						LD											
	TW						TW											
	N	2	2				N	2	2									
Ward ELIZABETH	E	2	5	12.10	19.40	Yes	E	2	4	12.10	19.40	Yes	Yes	No		NA	Choose an item.	
	L	2	5				L	2	4									
	LD						LD											
	TW						TW											
	N	2	2				N	2	2									
Ward EAST 4 ✓	E	4	4	20.90	17.06	Yes	E	4	4	20.90	17.06	Yes	Yes	No		NA	Choose an item.	
	L	4	4				L	4	4									
	LD						LD											
	TW						TW											
	N	3	2				N	3	2									
Ward A6 GASTRO	E	5	3	26.58	19.09	Yes	E			26.58	19.09	Yes				Yes	No	Was A7 prior to move to A6 during COVID
	L	5	3				L											
	LD						LD											
	TW						TW											
	N	3	2				N											
Ward C5	E	5	3	27.6	19.9	Yes	E			27.6	19.9	Yes				Yes	No	Was C7 prior to move to C5 during COVID
	L	5	3				L											
	LD						LD											
	TW						TW											
	N	3	2				N											

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		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward C1	E	4	3	22.08	12.64	Yes	E	3	3	16.86	12.64	Yes				Yes	Yes	Ward reduced bed capacity during COVID
	L						L											
	LD	2	1				LD	2	1									
	TW						TW											
	N	3	1				N	2	1									

Ward	Planned Roster			Required Establishment at the start of the reporting period (October 2019)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Planned Roster			Required Establishment at the start of the reporting period (Sept 2020)		Is the Senior Nurse/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation. If yes, reasons for any changes made		
		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward CITU	E	12	2	63.94	4.06	Yes	E	12	2	63.94	4.06	Yes	Yes	No		NA	Choose an item.	Ward moved to UHLduring COVID
	L	12	2				L	12	2									
	LD						LD											
	TW						TW											
	N	12	0				N	12	0									
Ward T4 NEURO ✓	E	7	2	38.37	8.53	Yes	E	7	2	38.37	8.53	Yes	Yes	No		NA	Choose an item.	
	L	7	2				L	7	2									
	LD						LD											
	TW						TW											
	N	7	1				N	7	1									
Ward B4 NORTH ✓	E	7	4	30.66	19.9	yes	E			30.66	19.9	yes	Yes	No		NA	Choose an item.	
	L						L											
	LD	7	4				LD											
	TW						TW											
	N	4	3				N											
Ward	E	5	7	21.68	23.65	Yes	E	5	7	21.68	23.65	Yes	Yes	No		NA		

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		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
4&5 ROOKWOOD	L	4	3				L	4	3								Choose an item.	
	LD						LD											
	TW						TW											
	N	3	3				N	3	3									
Ward 7&8 ROOKWOOD	E	5	6	20.91	22.39	Yes	E	5	6	20.91	22.39	Yes	Yes	No		NA	Choose an item.	
	L	4	3				L	4	3									
	LD						LD											
	TW						TW											
	N	3	3				N	3	3									
Ward C4 NEURO CLOSED	E	6	6	18.5	20.41	Yes	E						NA	NA		NA	Choose an item.	Ward closed during COVID
	L	3	4				L											
	LD						LD											
	TW						TW											
	N	2	3				N											
Ward TCT ✓	E	3	1	18.22	5.69	Yes	E	3	1	18.22	5.69	Yes	Yes	Yes	Establishment reviewed to increase skill mix on days.	NA	Choose an item.	
	L	3	1				L	3	1									
	LD						LD											
	TW						TW											
	N	3	1				N	2	1									
Ward C3/CCU	E	9	3	35.41	9.54	Yes	E			35.41	9.54	Yes	NA	NA		Yes	No	C3/CCU moved to A4 during COVID
	L	6	3				L											
	LD						LD											
	TW						TW											
	N	5	1				N											
Ward B1 ✓	E	7	3	29.89	10.56	Yes	E	7	3	29.89	10.56	Yes	Yes	No		NA	Choose an item.	
	L	6	3				L	6	3									
	LD						LD											
	TW						TW											
	N	4	1				N	4	1									
Ward B5 ✓	E	7	4	29.89	18.32	Yes	E	7	4	29.89	18.32	Yes	Yes	No		NA	Choose an item.	
	L	6	4				L	6	4									
	LD						LD											
	TW						TW											
	N	4	2				N	4	2									
Ward T5 ✓	E	6	3	29.81	13.35	Yes	E	6	3	29.81	13.35	Yes	Yes	No		NA	Choose an item.	
	L	5	3				L	5	3									
	LD						LD											

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		RN	HCSW	RN WTE	HCSW WTE			RN	HCSW	RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
	TW						TW											
	N	5	1				N	5	1									
Ward B4 HAEM ✓	E	8	3	39.13	15.99	Yes	E	8	3	39.13	15.99	Yes	Yes	No		NA	Choose an item.	
	L	8	3				L	8	3									
	LD						LD											
	TW						TW											
	N	5	2				N	5	2									
Ward C5	E	7	2	31.92	8.53	Yes	E									NA	No	C5 closed during COVID
	L	7	2				L											
	LD						LD											
	TW						TW											
	N	4	1				N											

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Report Title:	**Recognising and Responding to the Climate Emergency - Sustainability Action Plan**						
Meeting:	C&V UHB Board				**Meeting Date:**	26/11/20	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**
Lead Executive:	Executive Director Strategic Planning						
Report Author (Title):	Executive Director Strategic Planning						

Background and current situation:

There is incontrovertible evidence from the scientific community that climate change is taking place due to man-made emissions of greenhouse gases. Like many countries around the world, the Welsh Government has declared a climate emergency and has been taking action as a globally responsible Wales for many years.

In an emergency, we have to behave and act differently and swiftly. Therefore the Health Board needs to take action urgently to accelerate reduction in our carbon impact, and take other action to embed sustainable development into everything that we do.

Without targeted action and a significant and deliberate commitment to responding to the climate emergency, the Health Board will not meet the current targets set by the Welsh Government. This paper sets out targets we can commit to today, whilst further targets presented by Welsh Government representing the glide-path to net zero by 2030 are expected early in the New Year.

This paper is seeking the approval of the Board for the action plan attached to this paper, to engage on it with our staff and reaffirm our collective commitment to improving our impact upon the environment.

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

A full paper presenting the approach to sustainability is attached to this document, entitles 'Sustainability Action Plan'.

In January 2020, Board committed to responding urgently to the climate emergency, confirming a desire to be an exemplar organisation. The Health Board is already taking action in a number of areas and benchmarks well on a number of key measures. External review has confirmed that we are progressing well with embedding the Wellbeing of Future Generations requirements, having adopted the strategic objectives in our ten year strategy (Shaping our Future Wellbeing) as our wellbeing objectives.

Within the UK, many NHS organisations are committing formally to take action to respond to the climate emergency. The Centre for Sustainable Healthcare was set up a number of years ago and is providing advice and evidence to support healthcare organisations respond to the need for urgent action to ensure services are more sustainable in the future. Much of the evidence relates to sustainable models of healthcare which focus on prevention illness and disease, and delivering lean and efficient health care. This is very much in line with Prudent Healthcare Principles and the objectives we have set out in Shaping Our Future Wellbeing.

The Newcastle Upon Tyne Hospitals NHS Trust stands out as a leading the way in England, with a Director of Sustainability charged with overseeing the delivery of an ambitious sustainability improvement programme called SHINE (Sustainable Healthcare in Newcastle).

In order to develop our sustainability action plan, a working party was established, sponsored by the

Executive Director of Strategic Planning, which looked at the evidence from around the UK and world and identified the areas we should focus our actions.

The group endorsed an eight themed action areas using some of the learning from Newcastle's SHINE Programme and also the Centre for Sustainable Healthcare. Cardiff Council released their One Planet Cardiff initiative in October 2020 and alignment on language to ensure consistency with our partner has been built into our eight theme titles.

For each theme, an objective, success measures, actions, a lead, a date and the measurement metrics have been set out. Collectively these are ambitious targets for the level of improvement we aspire to deliver. Given work being undertaken on UHW2 and the Clinical Services Plan, it is anticipated that new targets will be set in co-ordination with the Welsh Government's net zero ambitions in 2021.

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

Proposed Themes and High Level Objectives

1. Energy - Use less energy year on year & increase use of renewable to maintain ISO14001 accreditation
2. Waste & Food - Reduce waste through our operations
3. Water - Reduce water usage, promote the importance of keeping hydrated
4. Procurement - Integrate sustainable & ethical procurement practices into policy
5. People - Staff & patients aware of commitment to sustainability. An Eco-literate organization
6. Built Environment, Green Infrastructure & Biodiversity - Increase sustainable healthcare building design and healthy, green, bio-diverse external spaces
7. Transport - Reduce the number of cars brought to our sites, encourage active travel and homeworking
8. Clinical - Develop low carbon/low waste care for our patients. Sustainability embedded in C&V strategy & investments. Promote prudent health care/self-care/prevent-prehab-rehab

The full action plan is detailed in the attached paper.

Since the working group has been meeting the new actions have been completed or identified and reflected in our plan including:

- **Water**
  - New water fountain in Barry. Health Charity agreed to fund five more: 1 x Rookwood, 1 x Breast Centre, 1 x CRI, 2 x St Davids. Request from clinicians in UHW to be considered on application.
- **Clinical**
  - Reusable device pilot. Video laryngoscope. Is it feasible to trade a single use device for a reusable device? Trade offs between costs and lifecycle value. Fiona Brennan
  - Inhalers. Project setting up to investigate the prescribing of more environmentally friendly inhalers. Simon Barry
  - New Clinical Fellow started with remit for progressing 3 sustainability projects: Inhalers, further transforming anaesthetic practices, educating colleagues (and med school) on Sustainable QI: Amarantha Fennell-Wells (supervised by Dan Morris and Fiona Brennan).

Implementation

In order to ensure delivery of the Sustainability Action Plan, in addition to the energies and enthusiasm of the SAP Working Party, commitment is required to appoint project officer capacity and small capital/revenue budget to enable specific projects to be taken forward.

- Sustainability project officer (band 7)
  - To establish reporting mechanism report progress against targets across the organisation – report to ME and Board on quarterly basis.
  - To lead cross functional sustainability projects, e.g. a swapping to a sustainable clinical device would require support and commitment from multiple stakeholders.
  - To be a point of sustainability co-ordination for the network of sustainability champions across the organisation
  - To secure external funding through identification of funding opportunities and to lead successful bid developments
- Action Plan Delivery
  - £100k to provide secure bike storage at our sites (subject to quotations) to support active travel commitments as a year 1 priority.
  - £150k p/a set aside from discretionary capital/revenue to fund sustainability projects and their operation.
- Welsh Government has a new fund for innovative projects that can be bid into. Particular interest in service change opportunities. The Project Officer would need to liaise with Working Party members and Sustainability Champions to identify projects to put forward for funding.

New Carbon Neutral targets will be set in 2021 from WG and NHS Wales which could require an adjustment in our action planning so the Sustainability Action Plan will be reviewed and if necessary refreshed to ensure challenge and ambition remains articulated.

Engagement

We would like to engage with our staff on the actions in our Sustainability Action Plan. This spreads knowledge that we are tackling the issue and will seek ideas for how the UHB can become more advanced and tackle more deeply our environmental impact.

Recommendation:

It is recommended that the Board approve this Sustainability Action Plan, agree to engage with our staff on it and note that further targets will be set by Welsh Government and NHS Wales in early 2021 in order to have a glide-path towards net zero by 2030.

The Board continues to support our commitment to improving our impact on the environment.

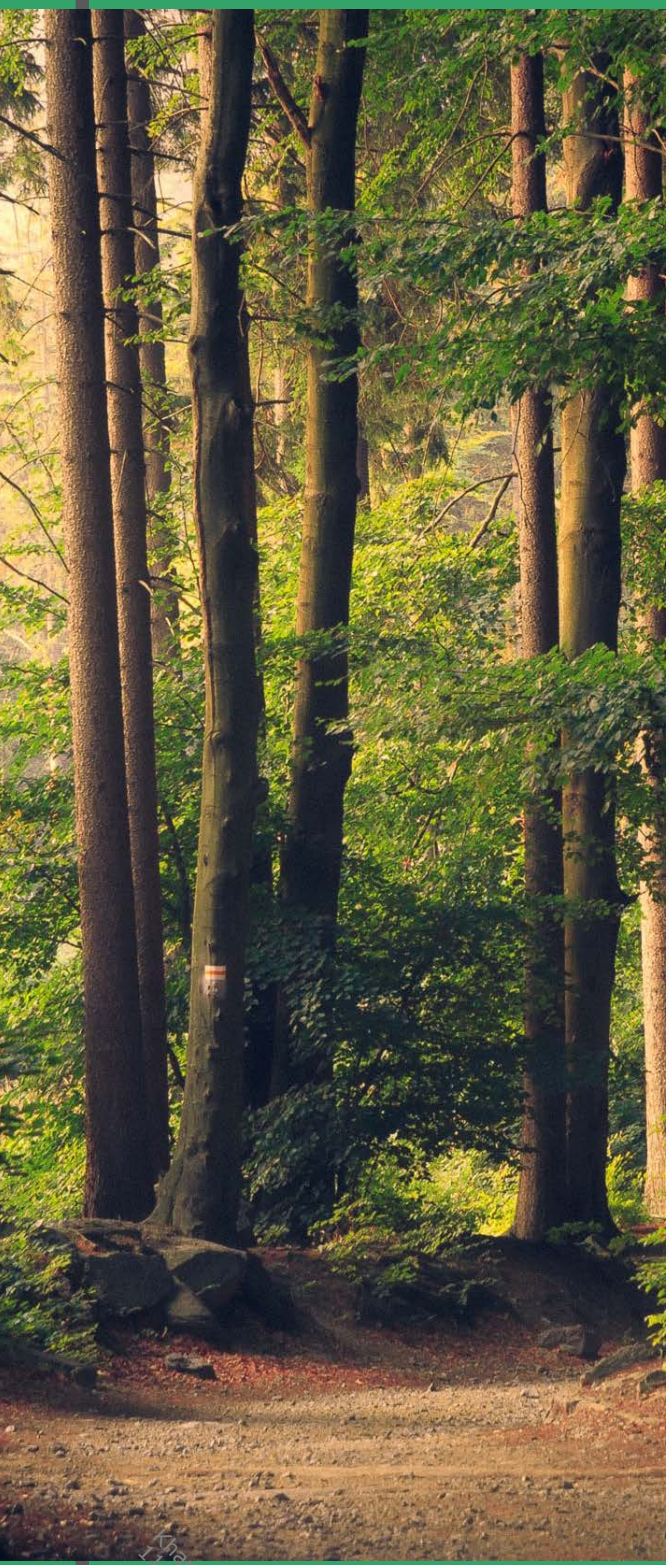
Shaping our Future Wellbeing Strategic Objectives

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	x	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	x	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	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		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	x	Integration		Collaboration	x	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.*



SUSTAINABILITY ACTION PLAN

SUBJECT TO ENGAGEMENT

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Foreword

Climate Change is the is the single biggest issue facing humanity. With a warming earth, rising water levels and increased incidence of extreme weather events leading to flooding, Cardiff is predicted to be impacted heavily as we move towards the end of the century. With the certain health impacts of a more extreme climate, the time to act has run out.

We're pleased that Cardiff & Value UHB has had a strong track record of reducing our environmental footprint and thanks to Welsh Government funding through the Re:Fit programme, have a pipeline of projects planned to make further improvements. We need to build on this and do more however.

It is estimated that 4% of all the UK's greenhouse gases are as a result of healthcare. Whilst we have passionate people who have been pioneering in the adoption of sustainable healthcare practices, we must look at all aspects of our operation as a health system and deliver improvements, whether that is in reducing single use plastics used in clinical care or re-imagining our services in ways that positively impact our patients as well as the environment.

This Sustainability Action Plan sets out what we'd like to achieve in the short term and act as a springboard to going further and faster as we develop our plans to realise our Shaping Our Future Wellbeing aims and re-provide University Hospital Wales. The action plan is necessarily broad and seeks to prove concepts in clinical care in particular which can act as pathfinders for further advancement.

Our Cardiff & Vale UHB colleagues and Board are passionate about our improving our impact on the environment so this plan builds on what has been achieved and we look forward to future iterations which sets the goals and ambitions ever higher.

Charles Janczewski
Chair, Cardiff and Vale University Health Board

Abi Harris
Executive Director of Strategy and Planning

What is sustainability?

Sustainability and sustainable development is most commonly described as 'development that meets the needs and aspirations of the present without compromising the ability of future generations to meet their own needs' (World Commission on Environment and Development 1987).

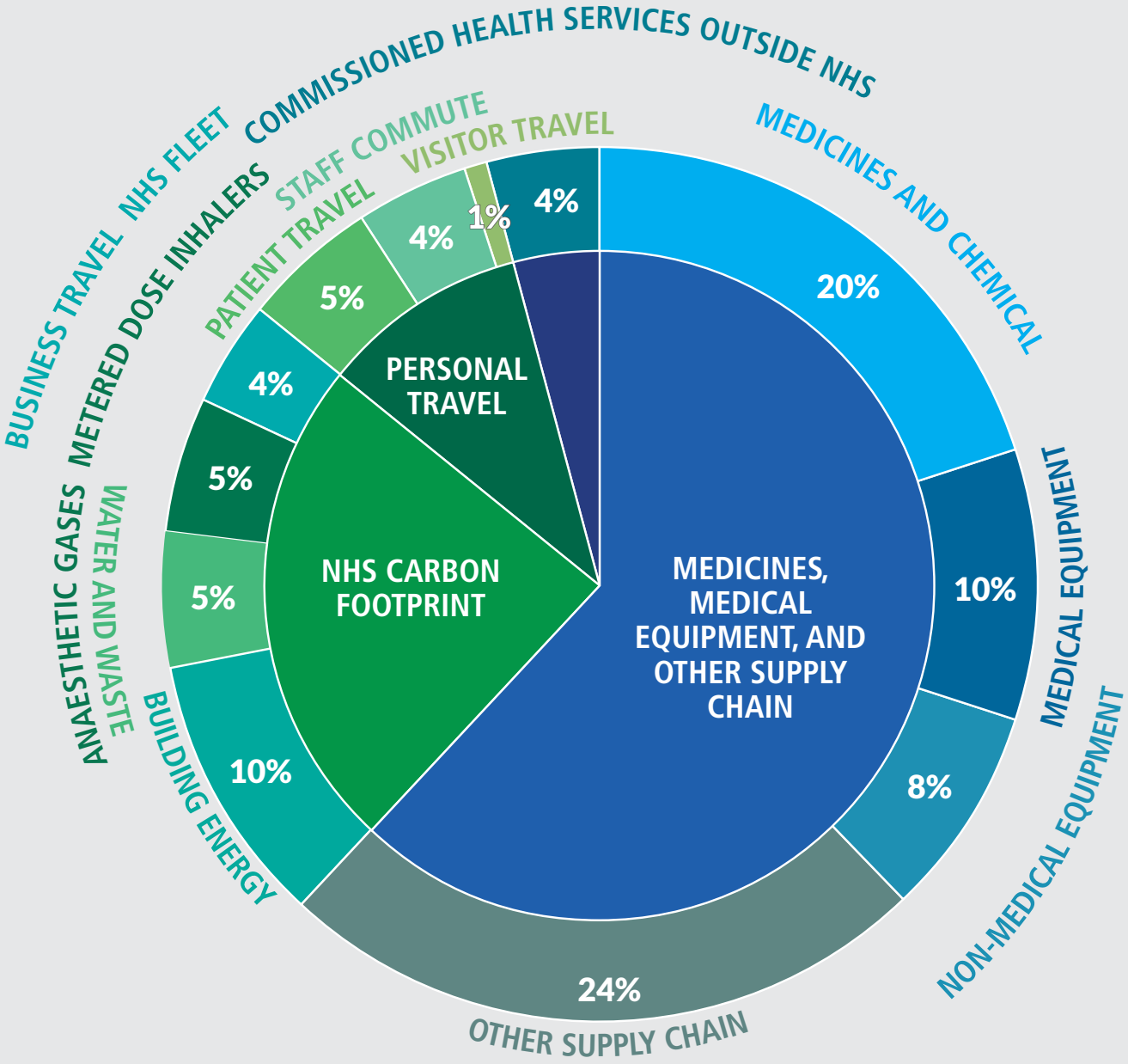
Why take action now?

There is incontrovertible evidence from scientific community that climate change is taking place due to man-made emissions of green hour gases. The impact of climate change is visible already – extreme weather, rising sea levels, mass species loss and extinction – and is impacting on our daily lives.

Like many countries around the world, the Welsh Government has declared a climate emergency and has been taking action as a globally responsible Wales for many years.

In an emergency, we have to behave and act differently and swiftly. Therefore if the Health Board is to meet and exceed the existing requirements, we need to take action urgently to accelerate reduction in our carbon impact, and take other action to embed sustainable development into everything that we do.

In lieu of expected data from NHS Wales, the following diagram depicts the sources of NHS England's carbon emissions to illustrate the extent of the challenge.



NHS England's Sources of Carbon Emissions by Proportion of NHS Carbon Footprint
(Source: "Delivering a Net Zero National Health Service")

Without targeted action and a significant and deliberate commitment to responding to the climate emergency, the Health Board will not meet the current targets set by the Welsh Government, as set out overleaf.

In response to Covid19, we have radically changed the way we delivery services – there is an opportunity to embed and accelerate new ways of working which contribute to a more sustainable future.

What has been done so far in Wales?

In 2015 the Welsh Government enacted the Wellbeing of Future Generations (Wales) Act (2015) – world-leading landmark legislation now being replicated in other countries across the world. This is was followed by a number of other important legal requirements agreed by the Welsh Government including the Environment (Wales) Act (2016) requires Welsh Government to reduce emissions of greenhouse gases (GHGs) in Wales by at least 80% for the year 2050.

In 2019, the Welsh Government published Prosperity For Wales: A Low Carbon Plan for Wales – public sector to be carbon neutral by 2030. The plan is very detailed and sets out the actions required across all sectors in Wales to deliver on the targets set.

What Have We Done So Far

The Health Board is already taking action in a number of areas and benchmarks well on a number of key measures.

External review has confirmed that we are progressing well with embedding the Wellbeing of Future Generations requirements, having adopted the strategic objectives in our ten year strategy (Shaping our Future Wellbeing) as our wellbeing objectives.

In January 2020, Board committed to responding urgently to the climate emergency, confirming a desire to be an exemplar organisation. The Board also agreed the Biodiversity Action Plan at its meeting in January 2020 which commits us to taking action to promote biodiversity on our extensive estate. Some examples of the actions we are already taking are set out below.

- Environment (Wales) Act (2016) requires Welsh Government to reduce emissions of greenhouse gases (GHGs) in Wales by at least 80% for the year 2050
- Welsh Government's Prosperity For Wales: A Low Carbon Plan for Wales (2019)
- The health care sector is a significant consumer of energy and as one of the biggest NHS organisations in the UK, this is true of our Health Board. However we have a proactive energy group and we have already taken significant action to reduce our energy use and we are now the lowest energy usage in Wales.
- Carbon reduction programme in place (Re:fit programme etc.) – although this will not take us the carbon reduction targets set by Welsh Government. This includes participation in the EU Carbon Credit Scheme.
- The NHS is typically a high producer of waste but we have taken a significant amount of action to date to reduce the amount of waste we produce and to eliminate waste going into landfill. To date our Health Board achieves the highest levels of waste reduction of any health board in Wales.

- We are also a big consumer of water, and our ageing estate results in a higher usage of water compared to modern facilities. However, we have taken actions to reduce water usage overall, with the introduction of initiative such as waterless urinals.
- Theatres are a big consumer of energy and potential waste creation. We are leading a Green theatres innovation project looking at how theatres of the future can be designed and run in ways that are carbon neutral and sustainable.
- We are ensure that we are building sustainability the design and build of new infrastructure. We have secured extra capital funding for decarbonisation of Maelfa Wellbeing Hub development.
- We know that promoting active travel is good for the environment and good for our health. We have an Active Travel commitment with PSB partners and active travel plans in place but we are not yet on track to deliver the commitments we have made.
- We have a significant amount of estate we can use for promoting sustainability and biodiversity. Orchard at UHL is one of our biggest initiatives in this area.

What is Happening Elsewhere

Within The UK

Within the UK, many NHS organisations are committing formally to take action to respond to the climate emergency. The Centre for Sustainable Healthcare was set up a number of years ago and is providing advice and evidence to support healthcare organisations respond to the need for urgent action to ensure services are more sustainable in the future.

Much of the evidence relates to sustainable models of healthcare which focus on prevention illness and disease, and delivering lean and efficient health care. The Cochrane also references the impact of harm caused by excess medical interventions to patients. This is very much in line with Prudent Healthcare Principles and the objectives we have set out in Shaping Our Future Wellbeing.

The Newcastle Upon Tyne Hospitals NHS Trust stands out as a leading the way in England, with a Director of Sustainability charged with overseeing the delivery of an ambitious sustainability improvement programme called SHINE (Sustainable Healthcare in Newcastle).

They have created an ambitious action plan which articulates how they're going to make a difference. We have referenced what others including Newcastle are doing as inspiration for setting Cardiff and Vale UHB's direction of travel.

Learning from The USA

There is a very proactive approach to delivering sustainable healthcare in the USA with some specific examples set out below.

Go local with food choices

Cafeterias in hospitals serve hundreds of people per day, and the source of their food can have a dramatic effect on a hospital's environmental impact. By contracting with vendors that rely on locally grown fresh produce, hospitals can minimize gasoline consumption required to ship and refrigerate fruits and veggies from distant locations. Hospitals can also work with local composting companies to haul away food waste that can be used as fertilizer in sustainable farming.

Look into ways to conserve water.

One hospital, Virginia Mason Medical Centre in Seattle, saved over 6 million gallons of water per year by replacing a linear accelerator (used in radiation therapy) with a better model; replacing washroom toilets, faucets and showers with water-efficient alternatives; and purchasing high-efficiency dishwashers. On a large scale, less water per flush or shower can make a big difference in water consumption.

Save energy

Reducing energy use and carbon output is particularly tricky for hospitals, but not impossible. Connecticut's Greenwich Hospital saved over 1.7 million kWh and $303,000 of electricity per year, and reduced its overall energy consumption by 35%. How? The hospital reprogrammed its heating and cooling plants, re-engineered its air handling systems and upgraded its light bulbs, among other changes. And this investment paid for itself – Greenwich Hospital made back its money within six months.

Change waste disposal protocols

Because hospitals produce so much waste, disposing of it in an environmentally friendly way can be challenging. For example, regulated medical waste has to be disinfected before going to the landfill. Disinfection methods like incineration are both energy intensive and known to release noxious fumes. But processes like autoclaving, chemical treatment and microwaving can be more eco-friendly. Ask the company behind your disinfection process about its energy and chemical use, and consider switching if you can find a greener provider.

Practice chemical safety

Dozens of chemicals used in a hospital can be dangerous under the right conditions, but there are some surprising culprits. LCD displays, fluorescent lamps, CRT monitors, flame-retardant mattresses, wheelchair cushions and even baby bottles can contain hazardous chemicals if you buy them from the wrong manufacturer. For your hospital, you can improve

chemical safety by making conscious purchasing decisions and recycling toxic goods, like batteries, properly.

Revamp entire supply chain to be more sustainable

Work with vendors to ensure that all products your hospital purchases are as environmentally friendly as possible, from medical supplies to printer paper.

Making renovations and upgrades greener

There are national Leadership in Energy and Environmental Design (LEED) standards.

Change landscaping techniques

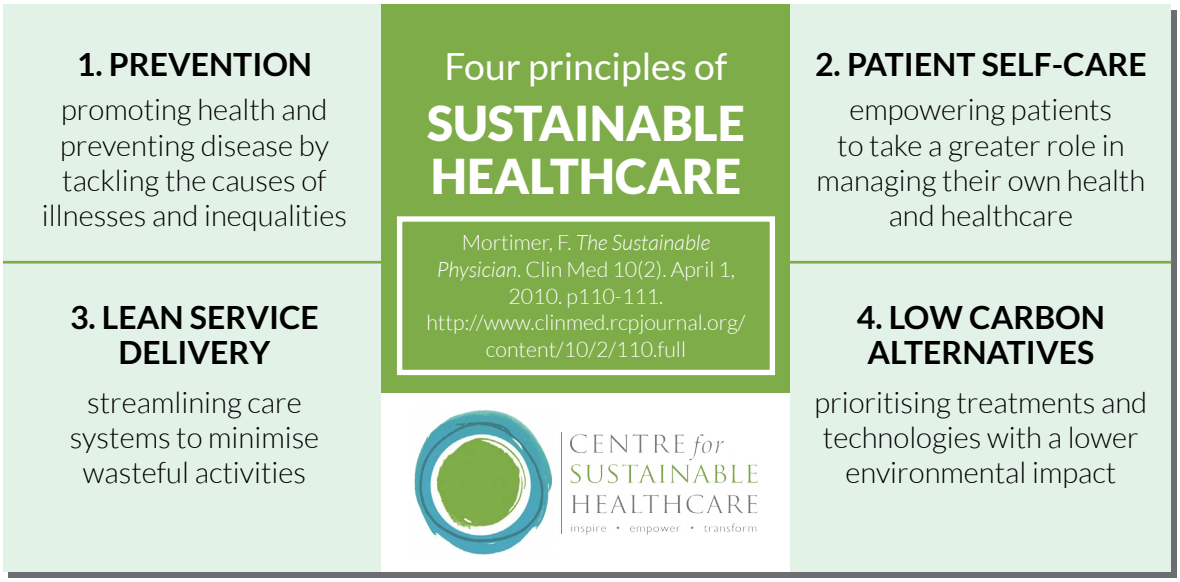
Switching to green landscaping techniques using native plants can help your hospital better manage storm water drainage, reducing waste. Also, incorporating more green space into your hospital's campus is a sustainability practice that can also improve its appearance.

Develop our Sustainability Action Plan (SAP)

Our Sustainability Model

In order to develop our sustainability action plan, a working party was established, sponsored by the Executive Director of Strategic Planning, which looked at the evidence from around the world and identified the areas we should focus our actions. Membership of the Sustainability Action Plan Working Group is set out in Annex 1 – the working group was drawn from people across corporate departments and in clinical areas already acting as champions for climate change and proactively working to deliver sustainable health care.

The group decided to adopt the four pillars advocated by the Centre for Sustainable Development. Linking to these pillars we have aligned our strategic objectives (or wellbeing objectives) and have developed a proposed set of actions against eight themes using some of the learning from Newcastle's SHINE Programme.



Centre for Sustainable Healthcare 4 Pillars

Our Sustainability Action Plan

For each theme, a series of commitments have been set out, with ambitious targets for the level of improvement we aspire to deliver, and confirmation of where the leadership for the action sits within the organisation.

Both Public Service Boards have identified climate change/sustainability as a priority. The proposed areas for action in the Vale of Glamorgan are set out in Annex 2. Cardiff Council has just launched consultation on its response to the Climate Emergency - The One Planet Strategy Consultation (https://www.oneplanetcardiff.co.uk/). Members of the SAP Working Party are attending the launch event.

The Working Party has recognised the opportunities presented by the Covid19 crisis to do things differently as we reset a new normal post C19 and there is a real opportunity to embed sustainability into our 'recovery', reflecting the Welsh Government's signal around a 'green recovery' approach to the reconstruction work.

Lean Service Delivery
✓Home first
✓Sustainable services

Low Carbon
✓Avoid harm, waste and variation

Prevention
✓Outcomes that matter

Patient Self-Care
✓Empower the patient

Proposed Targets

Theme	Objective	Key Success Measures	Actions	Lead	Date	Metrics
Energy	Use less energy year on year increase use of renewable to maintain ISO14001 accreditation	Carbon emissions reduction 3% y/y Maintain consumption 100% renewable electricity.	Implement our pipeline of phase 1a Re:Fit energy saving projects	CEF	31/3/21	tCo2e
			Develop proposal for a combined heat and power plant at UHL by 31/3/21			ISO14001 recertification
Waste Food	Reduce waste through our operations	Zero waste to landfill Reduction in waste generated	Maintain zero waste to landfill	CEF	31/3/21	Total waste in tonnes segregated
			Halve food waste by 2025 from a 2007 baseline			Tonnes waste incinerated with energy recovery
			Maximise waste incinerated with energy recovery			% waste recycled as proportion of total
			Encourage recycling amongst staff and patients/visitors			
Water	Reduce water usage, promote the importance of keeping hydrated	To accurately measure water usage and seek reduction strategies	Increase number of water refill stations across our estate by 5, funded by Health Charity.	CEF	31/3/21	Num new water fountains - 31/3/20 and 31/3/21
			Update water/sewage reporting to reflect use/costs as part of EFPMS returns.			Water use m3
			Encourage service improvement programmes related to waster/sewage.			
Procurement	Integrate sustainable ethical procurement practices into policy	All CV controlled procurement activity > £25k carries out an NHS SS sustainability risk assessment	Apply NHS SS risk assessment to all upcoming new and contract retenders, to ensure all opportunities for maximising sustainability/carbon reduction are included/prioritised	Head Procurement	31/3/21	Number sustainability assessments carried out

Theme	Objective	Key Success Measures	Actions	Lead	Date	Metrics
People	Staff patients aware of commitment to sustainability Eco-literate org	Staff recognise our commitment to sustainable healthcare service delivery and have a role to play	Communicate successes and plans	Sustainability Action Group	31/3/21	Impact measures through staff surveys
Built Environment, Green Infrastructure Biodiversity	Increase sustainable healthcare building design and healthy, green, bio-diverse external spaces	All new builds and major refurbishments include sustainable design features as standard and our external space is healthy, green and biodiverse.	BREEAM Excellent EPC Rating of A for all new builds. Built using 15% of recycled materials.	CEF	31/3/21	Business cases signed off.
			Express the UHW2 opportunity before the end March 2021 with an aspirational set of sustainability characteristics.	PD UHW2	31/3/21	UHW2 Programme Business Case signed off by Management Exec

Theme	Objective	Key Success Measures	Actions	Lead	Date	Metrics
Transport	Reduce the number of cars brought to our sites, encourage active travel and homeworking	Increased use of active travel Increased number of ULEVs in our fleet	Comply with the Cardiff Vale Healthy Travel Charter: reduced car usage to commute, more cycle usage to commute, more staff using ULEVs during the day, increased bus usage.	Dr Tom Porter	31/3/21 31/12/22	Healthy Travel Survey
			Promote home working to reduce commuting journeys in aggregate	ALL CV UHB	31/3/21	
			Consider ULEVs when fleet vehicles need replacing	CEF	2025	All light vehicles to by ULEV
			Increase bike locking facilities across our sites and provide bike maintenance help across our sites.	CEF/Health Charity	31/3/22	Number new bike locking schemes
Clinical	Develop low carbon/ low waste care for our patients. Sustainability embedded in CV strategy investments Promote: Prudent health care/self care/ prevent-prehab-rehab/	To be recognised as a benchmark/case study health system for sustainable health policy and practice Sustainability is embedded into our service planning arrangements.	50% of non f2f consultations by 31/3/21 (using digital platforms)	COO	31/3/22	% of total consultations in March 2022
			Test lean, green pathways as part of the UHW2 PBC and Clinical Services Plan.	Hunt/Le G/ Masani	31/3/21	Developed Clinical Services Plan
			Address metered dose inhaler (MDI) use by using low carbon inhalers	Clinical Fellow (CF)	30/9/21	Mt CO2e
			Searching for further opportunities transforming anaesthetic practices.	Clinical CF	30/9/21	Mt CO2e
			To advocate the work of the Centre for Sustainable Healthcare	CF	30/9/21	Evidence engagement cut through.
			Gather together a community of interested clinicians who are promoting sustainable healthcare and understand their impact. Climate Smart Clinician Network.	Dr Fiona Brennan CF	30/9/21	Community practicing sustainability improvement.
			Explore opportunities to use more sustainable devices and create a framework for further schemes.	Sustainability Action Group	31/3/21	At least 2 business cases created.

Progress Highlights

Since the working group has been meeting the following initiatives have come forward:

Net Zero

- WG and NHS Wales to set new targets to enable to net zero by 2030 to be realised, promote a circular economy and improve air quality– expected in early 2021.

Water

- New water fountain in Barry. Health Charity agreed to fund five more: 1 x Rookwood, 1 x Breast Centre, 1 x CRI, 2 x St Davids. Request from clinicians in UHW to be considered on application.

Journeys

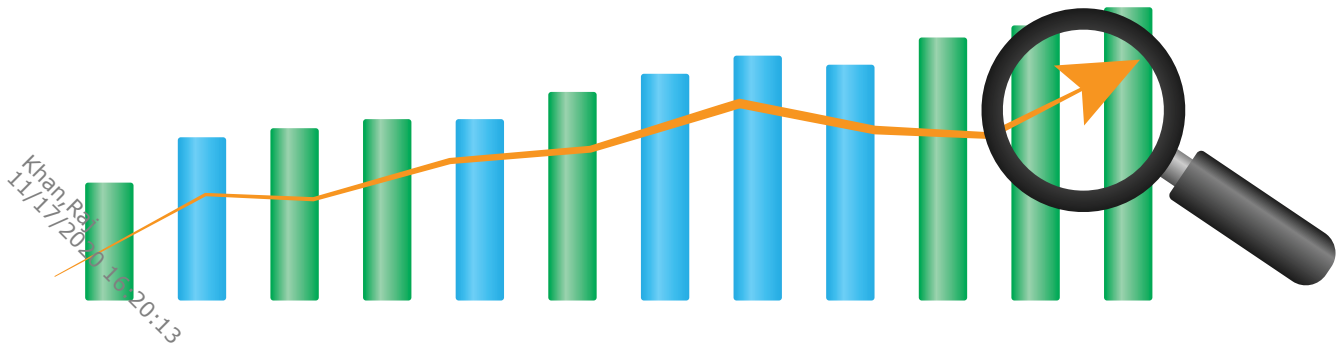
- Application to Health Charity to fund bike maintenance mornings at our sites: basic safety checks and repairs advice
- It is estimated that 85,000 journey miles have been saved as a result of patients receiving video consultations rather than unnecessary face to face visits.

Clinical

- Reusable device pilot. Video laryngoscope. A study where trade offs between costs and lifecycle value need to be assessed. Dr Fiona Brennan
- Inhalers. Project setting up to investigate the prescribing of more environmentally friendly inhalers. Simon Barry
- New Clinical Fellow started with remit for progressing 3 sustainability projects: Inhalers, further transforming anaesthetic practices, educating colleagues (and med school) on Sustainable QI: Amarantha Fennell-Wells (supervised by Dan Morris and Fiona Brennan).

Partnership

- Since producing our action plan, Cardiff Council have commenced a consultation on their One Planet Cardiff vision for a carbon neutral city by 2030. There are ways emerging for the UHB to work with Cardiff council on their ambitious plans. The UHB will respond positively to the consultation.



Implementation

A lot has been achieved so far with robust management of our energy, waste and water through our ISO 14001 accreditation, having been embedded into business as usual practice for a considerable period of time.

It is recognised that opportunities exist to make sustainability gains in the products we use to provide care. To help achieve this, Cardiff and Vale will fund a Sustainability Project officer to lead on trail blazing schemes to question why we use certain products and whether kinder alternatives are holistically better, not just cheaper. £150k p/a of capital and revenue (combined) will be allocated for project delivery.

In addition, Cardiff and Vale in partnership with HEIW have agreed to fund a Clinical Fellow in Sustainable Healthcare between 2020 and 2023. Projects have been allocated for delivery that make inroads into metered dose inhalers, finding further gains in anaesthetic gasses and educating the next generation of clinicians.

The Sustainability Action Group will monitor and control delivery of our action plan and report to The Board progress.

Annex 1 - Vale PSB Climate Emergency Charter (Draft)

Working together across the Vale of Glamorgan we commit to:

Lead by example

- Promote a wider understanding of climate change and how our actions impact on the environment – listen, learn and act
- Embed sustainability within our procurement policies and practices – buy less and buy local
- Value, protect and enhance our natural environment
- Divest from fossil fuel related industries

Take positive action

- Promote the use of public transport, walking and cycling
- Plant more trees and create more woodland and hedgerows
- Increase the number of electric/hybrid vehicles in our fleet and create a network of EV charging points across the Vale
- Make our buildings more energy and water efficient and explore opportunities for renewable energy
- Increase the network of water refill stations
- Restore and enhance peatland and grass lands to increase carbon storage

Reduce our impact

- Reduce the need to travel
- Reduce/eliminate our use of single use plastics
- Reduce the amount of office space we need
- Reduce our paper use

Annex 2 - Sustainability Action Plan Working Party

Abigail Harris	*Executive Director of Strategic Planning*
Jared Torkington	*Consultant Colorectal Surgeon and Associate Medical Director for Clinical Innovation*
Fiona Brennan	*Consultant Anaesthetist*
Dan Morris	*Consultant Ophthalmologist*
Jon McGarrigle	*Head of Energy*
Simone Joslyn	*Head of Arts and Health Charity*
Mike Jones	*Unison Trade Union Conveyor*
Ed Hunt	*UHW2 Programme Lead*
Jonathon Watts	*Head of Strategic Planning*
Claire Salisbury	*Head of Procurement*
Tom Porter	*Public Health Consultant and Active Travel Lead*
Amarantha Fennell-Wells	*Clinical Leadership Fellow (Sustainable Healthcare)*
Nadia DeLonghi	*Natural Resources Wales*
Stephen Allen	*South Glamorgan CHC*
Simon Barry	*Respiratory Consultant*

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Caerdydd a'r Fro

Cardiff and Vale
University Health Board

Report Title:	**Shaping our Clinical Services – Overview paper**								
Meeting:	Board						**Meeting Date:**	26.11. 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Executive Director Strategic Planning								
Report Author (Title):	Victoria LeGrys/Marie Davies								

Background and current situation:

Redesigning the way we deliver our clinical services is fundamental in the delivery of the UHB's vision for future care as set out in our Shaping our Future Wellbeing strategy. The clinical redesign programme – *Shaping our Clinical Services* - to deliver this transformation has been identified as an urgent priority for the organisation.

The learning from having to manage and implement change at pace during the COVID-19 pandemic has reinforced the requirement for the healthcare system to transform as a whole system.

In addition to the extraordinary circumstances in which we are currently operating, there are a number of existing drivers which require the first phase of this programme to be delivered at pace. These include the replacement of UHW as a local, regional and national provider of acute and specialist services with the current ambition for the delivery of the Programme Business Case set for February 2021.

Work on the programme has already begun, with programme leads now in place, a small programme team developing and a plan for initiating both internal and public engagement drafted. The approach to internal and public engagement and delivery of the first phase of the programme has been discussed and supported by both Management Executive and Board Development on 22nd and 29th October respectively.

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

The Board are asked to:

1. Note the contents of the 'Shaping our Clinical Services document'
2. Note and discuss the proposed engagement plan
3. Feedback on the draft content of the phase 1 engagement presentation

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

'Shaping our Clinical Services' document

Throughout 2018/19 the Management Executive alongside corporate and clinical leads have worked together to develop a high level clinical services redesign proposal to identify and describe a vision for the future of clinical services; something which begins to describe the changes required to clinical services to enable the delivery of Shaping our Future Wellbeing. The output of this is a high level draft UHB clinical services document.

This has been refreshed and updated and now requires testing and developing through a period of engagement in order that the feedback can be used to inform the UHW2 Programme Business Case.

Engagement

A detailed engagement plan has been drafted and discussed with Management Executive on 22/10/20 and following this the South Glamorgan Community Health Council (CHC) Chief Officer and Chair on the 26/10/20 and 02/11/20 respectively.

Timescales for engagement were reviewed and both the Management Executive and the CHC leads agree that engagement with our workforce, the public and key stakeholders on our vision for the development and redesign of clinical services is required as soon as the appropriate materials can be produced.

The above discussions led to an outline agreement to run an initial 6-8 week engagement for the first phase. Following review of activities to ensure that both internal engagement can commence and run through the month of December it is proposed that the external public engagement begins in January with key messages from internal and external engagement being incorporated into the UHW Programme Business Case.

Comments and ideas generated in the discussion have been reflected in the attached draft Engagement Plan, including the CHC offer to host Zoom presentation and discussion sessions for the public. There was agreement that we would continue to work with the CHC to develop the public facing resources and engagement plan, for consideration by the CHC Service Planning Committee in December.

A key area of importance is to ensure that our approach does not signal any inappropriate predetermination of significant service change prior to engagement. This is critical in terms of how we describe our long term ambitions for two acute hospital sites in having different roles going forward. This must be framed appropriately in our engagement resources to reassure our workforce, partners and the wider public that any future changes to our acute unscheduled care pathways will not disadvantage particular communities – particularly in the context of the reaction to last year's engagement on the future of Frail Older People's services in Barry.

It is therefore important to revisit and check both staff and public opinion on the challenges and opportunities provided within the materials before working through detail on how clinical services will change and ensure that the Heath Board is clear in its intention to engage and formally consult, where appropriate, on a number separate components of the redesign programme.

Programme

Programme leads are now in place. In light of the engagement and UHW2 PBC timescales there is a need to work quickly and intensively to develop the Programme scope and structure as well as key interdependencies and enabling projects and initiatives.

This was supported by the Management Executive and following this a plan for phase 1 of the programme has been set out below.

1. **Programme Definition and Management:**

- Objectives
- Scope, exclusions
- Dependencies
- Stakeholder map
- Timeline
- Benefits & consequences of not undertaking a 1-year plan
- Programme management approach & governance

2. **Future Care pathway transformation**

- Developed formula for a series of redesign workshops
- Map of our services, understanding where to place redesign effort first & why in order to sequence
- Selected exemplar pathways for initial redesign workshop (1st one to be held by January 21)
- Collaboration with Lightfoot & learning from best practice and experts available to us

Phase 1 of the programme will be supported by the UHB Change Hub and will deliver the above outputs over 8 weeks and by the middle of January 2021 these will be recorded and captured within a Programme Initiation Document which will be brought back to Management Executive for approval and Board for information.

Recommendation:

The Board are asked to:

(a) Note the contents of the 'Shaping our Clinical Services document'
(b) Note and discuss the proposed engagement plan
(c) Feedback on the draft content of the phase 1 engagement presentation

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.*

Cardiff and Vale UHB Shaping Our Clinical Services 2020 – 2030

1

Foreword

Cardiff and Vale University Health Board is one of the largest and most complex NHS organisations in the UK. The Health Board provides local healthcare services for over 500,000 people in Cardiff and the Vale of Glamorgan and we are the main provider of over 100 specialist services for the people of south Wales and for some services the whole of Wales and the wider UK. Working with many different stakeholders, we promote health and wellbeing whilst planning and providing healthcare in people's homes, community facilities and hospitals. Our responsibilities however go beyond the immediate delivery of NHS services. Working in partnership with our University partners we are a major teaching and research organisation and we play a significant and growing role in the Welsh economy as part of the network of organisations driving forward the life sciences sector in Wales. In everything we do we are cognisant of the aims of the Wellbeing of Future Generations Act as we seek to influence the factors that determine the health and wellbeing of our population and to minimise the impact of our activity on the environment. We are very proud of this triple role as a local NHS organisation, as a provider of specialised services and as an organisation working to deliver a healthier and more prosperous Wales. This role, however, creates unique challenges for us in the way we use our resources (our staff and our buildings) to deliver on our ambitions in the future.

The demand on the services provided by the health board will increase in the short, medium and long term partly because of population growth (particularly within our catchment) but also because of the changing age distribution within the population both locally and nationally. An increasing proportion of our population will be both older (particularly over 85) or younger (under 16), and both groups have a high reliance on healthcare. For these reasons alone, we cannot sit still in the way we provide our services. When we factor in the impact of medical innovation, changing workforce requirements, the impact of new health threats such as COVID 19 and broader policy and legislative changes we have a degree of change that we have to adapt to meet and which needs to be carefully planned for. We are therefore developing a Strategic Clinical Services Plan for the next ten years (and probably beyond) which brings together a number of existing and emerging programmes of work to make us fit for the future.

Our Shaping Our Future Wellbeing Strategy 2015 – 2025 provides the context for everything we do: for healthcare increasingly being provided away from hospitals and nearer to people's homes, delivering outcomes that are important to the patient, providing standardised treatment where appropriate, delivered efficiently, and finally, supporting our population to lead healthy lifestyles and self-manage conditions where appropriate. Included in this programme is an ambitious plan to build community facilities which will give easier access to health and wellbeing services closer to home. On top of this come other projects to improve day to day operational efficiency and to change the way we work. We also want our patients, from our local population and the wider regional and national population, to receive the specialist hospital care they need in the most appropriate setting. To this end, we want to seek your views on our ideas for ensuring that we have the right model for our hospital-based services currently at the University Hospital of Wales (UHW) and at University Hospital Llandough (UHL) for the medium and long term. We want to continue to develop the right facilities for our hyper acute tertiary centre and our less acute, planned surgical centre, ambulatory care site. Our working hypothesis is that this will be best achieved by further developing the functional separation between the current two sites, but this requires further exploration and testing.

Furthermore, these plans provide a foundation for a renewed UHW, a 'UHW2' that will be state of the art and offer care suitable for the mid-21st Century. UHW has served us well since 1971 but it was conceived around a model of care designed in the 1950s and the current buildings are nearing the end of their design life. The hospital is no longer able to provide the space and facilities required by modern medicine. A UHW2 would not only see further improvements for patients and staff but will also be a more sustainable and energy efficient facility. This will also enable UHW to play its role as a major trauma centre, emergency department and home for acute services accessed by the people of Wales.

The aim in this phase of engagement is to share our vision for how we see community and hospital services developing over the next decade as part of a transformed system. We want to test our thinking, particularly in relation to how we see key service areas develop including emergency and acute care, planned care and tertiary services. Whilst it may take a number of years to fully realise our clinical model, we are already starting to make changes to support the delivery of Shaping Our Future Wellbeing. Our programme 'shaping our clinical services' will develop the framework for changes which have already begun and decisions which will be taken in the short, medium and long term. This framework will be integrated with the 'shaping our future wellbeing: In the community' programme and also key service plans including Mental Health, Children's and Women and learning disability services. We will need to develop an overarching Health Board workforce plan, informed by the workforce drivers and service changes, to ensure that we are able to support and implement our ambitions. Specific service changes may require further engagement and/or consultation. We believe that by implementing our final plans, we will deliver better patient outcomes, better patient satisfaction, better value, better satisfaction for the teams of people working for the Health Board and a better deal for Wales.

Len Richards	**Charles Janczewski**	**Stuart Walker**	**Abigail Harris**
Chief Executive	**Interim Chair**	**Medical Director**	**Director of Strategic Planning**

Contents

1. Shaping our Clinical Services – Setting the Scene

1.1 Our long term vision

As a Health Board, our overarching mission is *caring for people and keeping people well.* In order to achieve, our overarching vision is *that a person's chance of leading a healthy lifestyle should be the same wherever they live and whoever they are*. Our *Shaping our Future Wellbeing Strategy 2015 - 2025* sets out how we intend to deliver this vision. Our strategy was developed with four core principles at its heart, which are set out below, and these remain key guiding principles as we set out how we see our clinical services developing over the next decade.

We are now at the midpoint of our strategy and we have reviewed our plan in relation to the developing policy environment in Wales. *Shaping Our Future Wellbeing* is very much in line with the aspiration set out in the Welsh Government's ten-year plan for health and social care services, *A Healthier Wales (2018)*. The plan sets out our commitment to increase our focus on the determinants of health through the promotion of healthier lifestyles, by facilitating people to adopt healthier lifestyles and by using our agency as a major organisation to shape the conditions within society that underpin health and wellbeing.

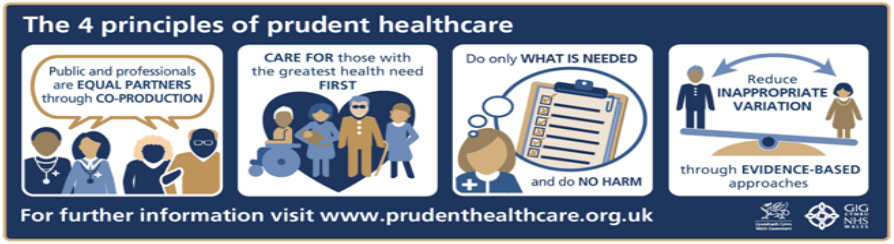
If we are successful in meeting these objectives, we would expect the nature of service delivery to change with major hospital sites focussing on more complex and specialist work and by delivering the majority of services people need most frequently through local provision, through new digital services and in the home.

In addition to providing comprehensive services for our local Cardiff and Vale population, we are the largest provider of tertiary (highly specialist) services in Wales and we treat patients with complex, specialised needs from around Wales. This means that we are at the forefront of cutting-edge, new and innovative

treatments and therapies. This, coupled with our extensive research activities, enables our patients to have access to many of the new treatments and therapies available, some of which are only accessible through participation in clinical trials. Our national reach means that these benefits are not only experienced by local people but will support the diffusion of ideas and new services across the whole of Wales.

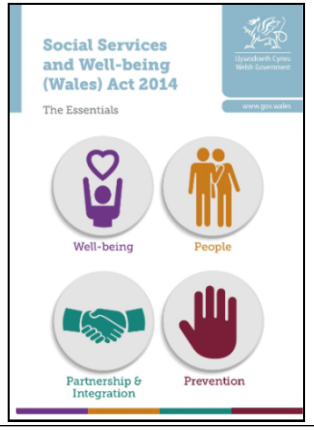
1.2 National Planning Context

Planning within the health board is influenced by national policies, underpinned by speciality/professional standards and regulatory requirements.



We have been working on the practical implementation of **prudent healthcare** principles since spring 2014. Our approach has also encompassed the findings from the Parliamentary Review endorsing the **"**one system" vision with four aims – the Quadruple Aim – that health and care staff, volunteers and citizens should work together to deliver clear outcomes, improved health and well-being, a cared for workforce, and better value for money, describe the foundation blocks on which we have developed our approach to prudent healthcare planning and delivery. The prudent principles are strongly reflected in our Shaping our Future Wellbeing strategy, which has at its core '*caring for people, keeping people well'* and are at the heart of our Transformation and Improvement Programmes**.**

	The **Wellbeing of Future Generations (Wales) Act 2015** came into force on 1st April 2016. It requires public bodies to set and publish wellbeing objectives that are designed to maximise its contribution to achieving each of the seven national wellbeing goals, through the five ways of working (prevention, collaboration, involvement, integration and long-term). We have a webpage describing our contribution to achieving the Act's goals. Our ten year Shaping Our Future Wellbeing strategy was developed through co-production with our citizens and patients, placing a strong emphasis on prevention and care closer to home.

	This strategy provides a joined-up framework to enable all organisations in Wales to work across boundaries, putting the citizen at the heart of our collaborative planning and service delivery. It provides a clear context within which Shaping Our Future Wellbeing directly fits. The five priorities that have emerged from this strategy as having the greatest potential contribution to long term prosperity and wellbeing provide a helpful focus for the UHB and partner stakeholders. The four themes within the strategy align with Shaping Our Future Wellbeing and our Public Service Board Wellbeing Plans. The long-term aim is to build a Wales that is prosperous and secure, healthy and active, ambitious and learning, and united and connected. Our Plan needs to contribute to the overall Healthy and Active aim to improve health and well-being in Wales and in particular in Cardiff and the Vale of Glamorgan, for individuals, families and communities, with significant steps to shift our approach from treatment to prevention.
	Our plan must contribute to the delivery of improved wellbeing outcomes and shift the focus of care from hospital to community. The Social Services and Wellbeing (Wales) Act 2014 came into force on 6th April 2016. The Act provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and for transforming social services in Wales. This means that we must work with our Local Authority colleagues through the Regional Partnership Board to drive integration, innovation and service change. We are doing this though our Integrating Health and Social Care Programme.
	**A Healthier Wales** sets out a long-term future vision of a whole system approach to health and social care, focused on health and wellbeing, and on preventing illness. It emphasises the creation of a 'wellness system' over the next 10 years, with prevention increasing in importance; and describes the quadruple aim for NHS Wales – specifically, improved population health and wellbeing, better quality and more accessible services, higher value health

1.3 Healthcare is changing

The population we serve and its needs are changing and we need to continually adapt and develop our services in order to provide the very best outcomes for the people. The growth of our local population and the changing demographic requires a very different model of service delivery and supporting modern physical and digital infrastructure. Our population is changing in a number of ways:

- The main increases in local demands for health care services will be from our increasingly older population who will continue to require support to manage one or a combination of chronic conditions and to reduce and manage the risks associated with increasing frailty, including dementia. Local demand for palliative care support will also increase due to this changing demographic.
- There are currently almost 65,500 children under the age of 15 living in Cardiff and 23,600 living in the Vale – 89,100 in total. 74% live in Cardiff and 26% are in the Vale. By 2029, this total population will increase by 20% to 107,200. This compares to a Wales average of 0.2% increase over the same period. The demand will arise from the increased incidence and diagnosis of mental ill health in young people, and advancements in the early diagnosis and personalised treatment regimes for rare diseases. Major trauma experienced by children is also increasing.
- In adults, the main causes of premature death and disability remain cancer and circulatory diseases, areas where unhealthy lifestyle behaviours have a significant contributory factor. Survival rates for cancer in Wales remain amongst the worst in Europe due to a number of factors, and our clinical services plan reflects the need to ensure our system is able to support earlier cancer identification and intervention, alongside the work we are doing to support healthy lifestyle choices and delivery of care pathways that optimise people's chances of recovery following a cancer (or other disease) diagnosis and treatment. As we have seen recently with the emergence of COVID 19, we need to be able to respond to novel infectious diseases, and continue to work through what the long-term legacy of the current pandemic means for our clinical model in the future. We continue to evaluate the implications of the COVID 19 pandemic for the future planning of services for infectious diseases.
- Health inequality and the gap in healthy life expectancy is worsening, and urgent action is required to reverse this trend. This requires action outside the health system, but the Health Board is well placed to support broader action.
- When developing Shaping Our Future Wellbeing, people told us that being able to stay living well at home was really important to them. The UHB's ambition is to develop whole system pathways for all services in order to optimise the provision of care at home or within the community. The demand for local secondary care should be at least partially if not wholly offset by the provision of more care and support in the community.
- For those patients who live outside of the UHB's resident catchment population the demand for care will be very different. Most community and local secondary care will be provided by the patients' host health board. However, for the wider population of the south central and south east regions it is anticipated that the UHB will play an increasing role in the provision of specialist emergency or complex services that can only be provided from one

geographical central place due to the relatively low volume of patients requiring a critical service mass in one centre, or where there is a requirement for very specialist clinical skills or equipment. We will increasingly work in networks, where clinicians may work in a regional networked service, with clinicians forming part of a regional workforce for particular specialist services, where patients are seen locally for all pre and post-operative care, and the specialist intervention being provided in the tertiary/regional specialist centre.

- The UHB will continue to deliver and develop its tertiary services to meet the health needs of the regional, supra-regional and national populations. This includes the establishment of new services, such as the Major Trauma Centre and the Gender Identity Service, as well as progressing ongoing and future developments, such as Advanced Therapeutic Medicinal Products and the Genomics Strategy for Wales.
- The Health Board will continue to act as a commissioner of local services and will work with neighbouring Health Boards to enable appropriate access to local services in other health board areas and vice versa if that is in the interests of particular patients or local communities.

New Treatments and Technology

Healthcare is a rapidly developing and evolving industry with huge investments worldwide in health care research and innovation. Our research and innovation activities, and tertiary services, keep us at the forefront of these developments. In the last year, novel cell and gene therapy treatments have been introduced, with the health board being one of the first accredited centres for new CAR-T therapies (chimeric antigen receptor T-cell), where therapy is specifically developed for each individual patient and involves reprogramming the patient's own immune system cells which are then used to target their cancer. It is a highly complex and potentially risky treatment, but it has been shown in trials to cure some patients, even those with quite advanced cancers and where other available treatments have failed. These treatments will increasingly present the possibility of curing patients with a cancer or rare genetic disease diagnosis or providing therapies that significantly slow the rate at which a disease progresses.

Precision and personalised medicine will radically change the way many services are currently delivered. Through increased research and technology, these new medical models help cliniciansunderstand the environment, lifestyle and heredity — that play a role in a patient's health, disease, or condition and therefore more accurately predict which treatments and prevention initiatives will be most effective and safe. They also shift the emphasis to prevention.

Point of care testing (POCT) allows for the rapid turnaround of testing and results meaning quicker intervention and treatment by bringing the testing closer to the patient and care provider. It may also help reduce inequalities by increasing our reach out to certain segments of our population that are difficult to contact.

Medical IT (information technology) is evolving quickly with a single electronic patient record, where a single, one system view of the patient's details and medical information (including diagnostics) will shortly be easily accessible by all clinicians involved with their care and treatment. Modernisation of our

information technology infrastructure is needed to provide an appropriate digital platform to support service transformation and enable clinicians to work in very different ways. Situated in the right environment allows clinicians to network, share practice, share research and avoid professional isolation.

Technology is also developing at a rapid rate with a significant proportion of the population now using smart phones to conduct many aspects of their daily lives. There are already many healthcare systems taking advantage of this technology to support patient-initiated contact with services, as we are doing through the introduction of Patient Knows Best, and introduction of virtual on-line consultations, though Skype type contacts. The Kaiser Permanente healthcare system now provides more than 50% of its outpatient appointments via this mode of delivery. Many homes now have Amazon Echo type devices which connect to the voice-controlled intelligent personal assistant service such as Alexa. There are many trials being undertaken about the role these devices can play in supporting people to remain living well and independently in their own homes. Our response to Covid 19 has seen a significant acceleration in the adoption of digital solutions and we expect this development to continue apace. The Health Board is however mindful of the risks of digital exclusion and will work to ensure services remain universally accessible.

In order to provide the best outcomes for patients, we need to ensure that there is appropriate access to specialist services and equipment which means that the careful co-location of critical services and equipment will be essential in the redesign of our clinical services.

The Importance of Environment

There is now considerable evidence that the physical environment within healthcare buildings can have a significant impact on patient outcomes and wellbeing. Modern hospital building standards dictate access to natural light, privacy, quietness, access to fresh air, minimal environmental impact and the right facilities to ensure modern infection control requirements with sufficient space to allow people to be active and speed up recovery or prepare better for surgery (prehabilitation/rehabilitation). In Wales we can see new standards being delivered in the latest developments including the new Grange University Hospital in Cwmbran and it is right that we should be ambitious to meet those standards for our communities as well.

In addition, healthcare generally and hospitals more specifically can have a significant environmental impact including land use, energy consumption, waste management, noise and the use of hazardous substances. In redesigning our facilities we need to aim to be world leaders in sustainability minimising our ecological footprint and developing facilities in sympathy with the largely residential settings in which our main sites currently sit.

Workforce Changes

Securing the workforce of the future will be one of the biggest challenges facing the Health Board but this will be greatly facilitated by the development of leading-edge clinical services delivered in first class facilities. We recognise that in order to provide sustainable specialist services, clinicians must be able to

work and train within a professional environment which is compliant with national clinical and educational standards – this is absolutely critical to providing the best outcomes for patients and key to recruiting and retaining essential clinicians.

Our workforce is also key to transforming our system. We will see the continued expansion of multi-disciplinary and multi-agency teams where the most appropriate professional takes the lead in the co-ordination and delivery of care, with the necessary inputs from all team members. We will also see the further development of interprofessional education and will require the right facilities for clinical placements and clinical simulation training. The changing demographics of our workforce and scarce skills will also influence how we deliver services, supported by increasing opportunities presented by artificial intelligence for example the newly introduced FIT testing (faecal immunochemical test, a screening test for bowel cancer) is using an automatic analysis process.

Supporting and Growing the Wider Economy

The life science sector is a key contributor to the economy in Wales and has the potential to grow significantly over the next decade. Welsh Government has prioritised the development of the Life Science Sector within its plan, *Prosperity For All*. Cardiff and the Vale University Health Board is closely linked to the work of the Welsh Government's Life Science Hub and the two City Regional Deals (Cardiff and South East Wales and Swansea and South West Wales). As a health board providing a significant contribution to the research, teaching and innovation activity in Wales, we will have a key role to play in realising this potential. In the medium term, this will bring better jobs and more wealth to Wales and we need to clearly articulate the contribution of our clinical services plan to this broader agenda in our detailed business cases

1.4 What does this mean for the health board?

In order to deliver our strategy and clinical services plan, we will work with a wide range of partners, both at a local level, and across Wales, who make up the health and care system and transform, over time, how we support people to live well in their local communities. We have acknowledged that our model for primary care in particular will need to change over time, and the Welsh Government's emerging model for primary care signals the changes we need to make over the next decade. With our partners, we are working on setting out our integrated model for local, place based, health and care which reflect the needs of the local populations.

Our partnership with Cardiff University enables us to collaborate with partners across Europe for the benefit of patients in Wales. Clinical innovation and teaching the next generation of clinicians (doctors, nurses, health scientists and therapists) form the other key parts of our relationship with Cardiff University, University of South Wales and Cardiff Metropolitan University. We have numerous clinicians who undertake a dual role as academics involved in research and teaching and deliver front line patient care services. We currently deliver over 50% of the research activity in Wales and we need to continue to build our partnerships and ensure that the right infrastructure is in place to enable expansion of our research capability so that a significant proportion of our patients benefit directly from clinical research.

Given the progress we have made in developing our model of local services this next iteration of our clinical services plan needs to focus on how we see hospital services developing over the next decade as part of a transformed system that provides the necessary support to primary care to enable people to remain living independently at home, and that provides timely access to both emergency and planned hospital treatment.

We know that the way our hospital system is designed is not delivering the best experience or outcomes for patients. We know that compared with the best healthcare systems in the world our system is unbalanced, and we continue to provide too much of our care in hospital settings. Patients wait too long to access the advice, diagnosis or treatment they need, and often the system makes it difficult for people to return home quickly from a spell in a hospital. Achieving this shift of emphasis can only be done if we work in partnership with Local Authorities and the Third Sector to support the delivery of social care.

It is important however to recognise that overall our outcomes benchmark well with other similar NHS providers across the United Kingdom, and our patient experience feedback is very positive overall. But we know that there is a lot more we need to do to deliver the services required into the future. Over the next decade we will see continued growth in the number (and as a proportion of total population) of older people living in our communities. We will also see the total population in Cardiff and Vale growing rapidly (including those under 16 and students) as a result of Cardiff being one of the fastest growing cities in the UK. We also know that unhealthy lifestyles are contributing significantly to what is known as 'the burden of disease' – people being diagnosed with chronic conditions, such as diabetes and heart disease or cancer where an unhealthy lifestyle was likely to have been a contributory factor.

We are also continuing to evaluate the impact of the ongoing response to the COVID 19 pandemic which has had a profound impact on the way our services are delivered in the short term. This has been a sharp reminder of the devastating consequences for every one of major outbreaks of infectious diseases and how our systems need to adapt in response.

We know that the facilities we will need to provide transformed services will need to be very different. In 2018 we developed an estates strategy which set out the condition, utilisation and functional suitability of our current infrastructure, and the outline plans for developing our estate over the next decade. The detailed plans will be informed by our clinical services programme, and the detailed service models that will follow. We know that we will need significant investment in our infrastructure, including replacing or redeveloping our major sites the University Hospital of Wales (UHW) and University Hospital Llandough (UHL). Both sites have developed significantly over their lifetime. UHL was opened in 1933, originally as an infectious disease hospital, in a rural setting outside Cardiff. UHW is nearly 50 years old and is also nearing the end of its original design life. UHL reflects the inherited pre-NHS legacy brought together in 1948 and UHW the planning thinking of the 1950s and early 1960s. We celebrate the contribution both hospitals have made and continue to make but it is time for a significant step forward.

The scale of capital investment needed to deliver what we need will be unprecedented in recent times but the cost of not changing would be greater. UHW is not only a hospital for our local population but also a specialist facility serving the whole of Wales. A redeveloped facility will provide the opportunity to create a flagship of international standing. As the needs of the local, regional, supra-regional and national populations increase, our estate needs to react accordingly.

Our business cases to secure the resources needed will need to clearly demonstrate the added value and benefit to patients, communities and the wider economy locally and across Wales. We also need to plan creatively to ensure that our final design solutions are capable of flexibility and adaptation to deliver new services over the next 50 years.

Our shaping our clinical services programme and resulting plan will not attempt to describe how we see each individual service develop over the next decade - it provides a framework around which we can see the key service areas develop. It will be integrated with our Shaping our Future Wellbeing in the community programme and closely linked with service plans for the development of services such as mental health, children and womens services and Learning Disabilities. The rest of this document sets out the background and requirements for change in more detail and outlines briefly our next steps.

2. Background

2.1 About the Health Board

Cardiff and Vale University Health Board (UHB) was established in October 2009 as part of the wider reforms of NHS organisations in Wales. Those changes brought together the commissioning functions of the former Local Health Boards and the service delivery function of NHS Trusts. At the core of those changes was the desire to simplify organisational arrangements around a fully integrated model which for the first time brought primary care, and hospital-based services together in the same organisation. Cardiff and the Vale University Health Board is one of the largest NHS organisations in the UK, and provides services at a local, regional, supra-regional and national level. Our clinical services strategy reflects our continued effort to deliver on the vision that underpinned the creation of the Health Board as we move to the next phase in our development of a citizen centred, local first, model of care.

As a Health Board, we have a responsibility for planning, commissioning and providing services for over 500,000 people living in Cardiff and the Vale of Glamorgan (from Trowbridge/St Mellons in the east to Llantwit Major/St Bride's Major in the west). This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres, community health teams and mental health services. Together, these provide a full range of health services for our local residents.

As a provider of 100+ specialised tertiary services we have a responsibility to deliver care at a regional, supra-regional and national level, for around 3,200,000 people.

Many of our specialist services are commissioned by the Welsh Health Specialised services Commission (WHSSC). WHSSC is a joint committee of the Health Boards in Wales and the Boards effectively pool resources to fund the provision of specialist services on behalf of their resident populations. WHSSC commissions highly specialised services from across the UK and we are working in partnership with WHSSC and the other Health Boards to develop the long-term strategy and strengthen the provision of specialised services in Wales.

The cost of delivering this extensive range of services is around £1.4 billion annually and we employ around 14,000 staff who work across a range of sites and delivering care in people's homes and other community settings.

2.2 About the local people we serve

The Population We Serve

Understanding the needs of our population is essential for robust and effective planning. Our Population Needs Assessment, undertaken by our Local Public Health Team and developed with our regional partners provides a collective view of the population challenges on which we must build our plans. It is important we look beyond simply understanding the health needs of our citizens but look at the wellbeing of our population which encompasses environmental, social, economic, and cultural wellbeing. We recognise the wider impact we have as an organisation on these matters and that working with our partners, we can impact on some of the factors shaping health need and demand across our communities. We also acknowledge that our needs assessment is for Cardiff and Vale of Glamorgan populations only and it does not cover all the regions from which patients come to access our services as a tertiary provider. We work with the other Health Boards and WHSSC to understand the wider health needs of the Welsh population.

Population growth: Cardiff is one of the fastest growing cities in the UK. The population of Cardiff is growing rapidly at nearly 1% per year, or around 36,000 people over the next 10 years. While overall numbers in the Vale are relatively static, the total population of Cardiff and Vale has now exceeded 500,000 for the first time.

Ageing population: The average age of people in both Cardiff and the Vale is increasing steadily, with a projected increase in people aged 85 and over in the Vale of 15% over the next 5 years and nearly 40% over 10 years. An ageing population is evident in other areas across Wales, with some seeing an accelerated increase in growth of older people numbers. Older people tend to be the greatest users of healthcare associated with diseases associated with ageing, such as dementia, and the impact of multi-morbidities resulting from chronic conditions.

Health inequalities: There is considerable variation in healthy behaviours and health outcomes in our area and a clear understanding of the link between deprivation and poorer health outcomes. For example, smoking rates vary between 12% and 34% in Cardiff, with similar patterns seen in physical activity, diet and rates of overweight and obesity. Uptake of childhood vaccinations is also lower in more disadvantaged areas. Life expectancy is around ten years lower in our most deprived areas compared with our least deprived, and for healthy life expectancy there is a difference of 22 years. Deprivation is higher in neighbourhoods in South Cardiff, and in Central Vale. Many people in our communities have lifestyles that have a contributory factor in the development of a number of diseases – such as diabetes, cancer, heart disease and respiratory diseases - and premature death. The number of people with more than one long-term illness is increasing.

Tobacco: One in six adults (15%) in our area smoke. While this number continues to fall, which is encouraging, tobacco use remains a significant risk factor for many diseases, including cardiovascular disease and lung cancer, and early death.

Food: Poor diet is a major influence on poor health outcomes. Over two thirds of people in our area don't eat sufficient fruit and vegetables, and over half of adults are overweight or obese. In some disadvantaged areas access to healthy, affordable food is more difficult and food insecurity is becoming more prevalent due to increasing living costs and low wages.

Physical activity: Over 40% of adults in our area don't undertake regular physical activity, including a quarter (27%) who are considered inactive. Even modest changes to levels of activity can make a big difference and the solutions often lie outside the NHS for example active travel plans.

Emotional health and wellbeing:

Social isolation and loneliness: Around a quarter of vulnerable people in our area report being lonely some or all of the time. Social isolation is associated with reduced mental well-being and life expectancy.

Welsh language: The proportion of Cardiff and Vale residents of all ages who have one or more language skills in Welsh is 16.2%, with around 1 in 10 people in Cardiff (11.1%) and the Vale (10.8%) identifying themselves as fluent. Over one in four young people aged 15 and under speak Welsh in our area (26.7% in Cardiff and 29.6% in the Vale of Glamorgan). Many of our specialist services draw people from areas of Wales where Welsh is the principal language. The Health Board is committed to meeting and indeed going beyond its legal responsibilities in promoting and facilitating the use of the Welsh Language.

Cardiff has one of the most ethnically diverse populations in Wales, with one in five people from a black or minority ethnic (BME) background. 'White other' and Indian ethnicities are the second and third most common ethnic groups after White British.

2.3 Our current service configuration

Although the health board is a huge organisation, the reality is that our core service provision is highly localised. We are responsible for ensuring that our Cardiff and Vale of Glamorgan citizens have access to high quality primary care services, which include: General Medical Services (GPs) General Dental Services, Community Optometry Services (Opticians) and Community Pharmacy Services to support the delivery of high quality, responsive and sustainable services to meet local need. As an example, on average there is a pharmacy for every 5,000 residents and GP practice for under 10,000 residents. Based within the heart of the community, they work with hospitals and other community-based healthcare staff to provide health advice, assessment, treatment and care. We have recently launched Primary Choice and CAV 24/7 to help people find the right health advice, care and treatment for their needs, so that they see the right person, first time in their local communities or in A&E if that's the right place for their care. Services are provided across the whole of Cardiff and Vale of Glamorgan within three Localities: Cardiff North and West, Cardiff South and East, and the Vale of Glamorgan. Each Locality has three Primary Care Clusters in which individual practices and their registered patients remain the bedrock of service provision. Clusters allow services to work together in planning and delivering a wider range of services for local communities (around 50,000 residents, responsive to their local health and well-being needs. Since April, in response to COVID19 GP practices have moved a significant proportion of these appointments to virtual forms of delivery – telephone or video calls – with face to face appointments only for those who need a physical examination or for whom a virtual consultation isn't appropriate.

Alongside our primary care services, we deliver of wide range of services directly into people's homes (district nursing, podiatry, health visiting, children's community nursing services), in local health community settings including a wide range of clinic assessments and treatments in our health centres and community hospitals (St Davids and Barry) – baby clinics, child health clinics, community mental health services, children and young people's mental health services and sexual health services. We also deliver services in other community facilities – school nursing in schools and colleges, rehabilitation clinics in local leisure centres, mental health services in local settings, such as community hubs, prison health services, homeless health services in hostels and on our city's streets and night time city emergency unit outreach to support the safe delivery of the night time economy in Cardiff. Many of these services we deliver on a multi-agency basis with a number of other partners – particularly local authority and third sector partners.

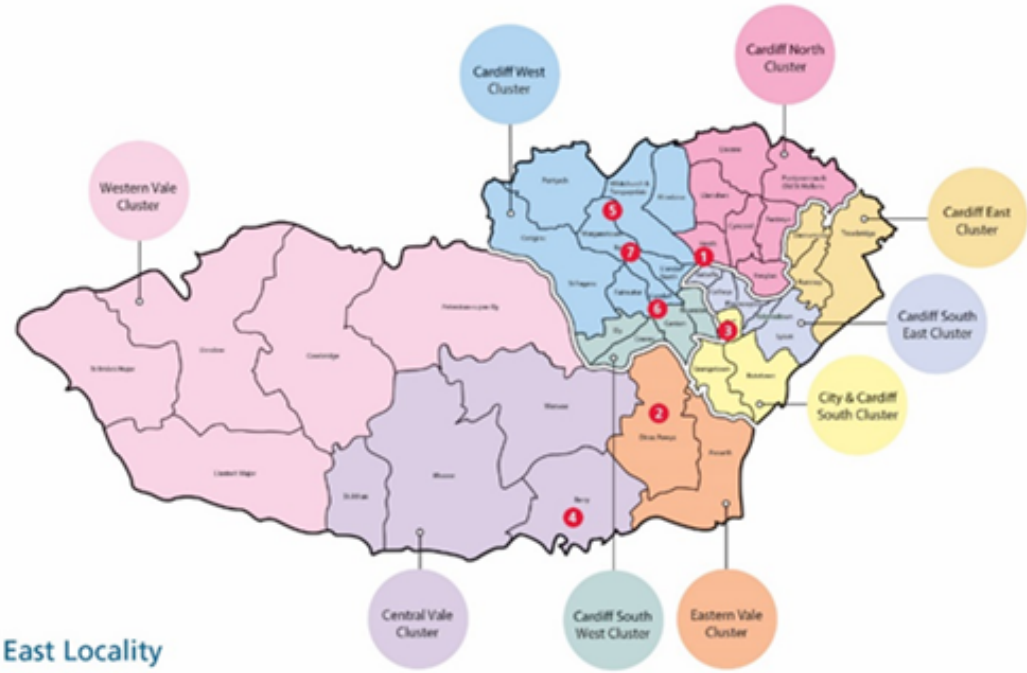
Area	Current Population	Main GP Surgery Premises	GP Branch Surgery Premises located in cluster	Community Health Premises	Dental practices	Optometrists	Pharmacies
NORTH & WEST LOCALITY							
Cardiff North Cluster	102,687	10	3	Llanishen Health Centre Pentwyn Health Centre Rhiwbina Health Centre	14	14	19
Cardiff West Cluster	55,488	8	2	Radyr Health Centre 200 Fairwater Road	8	8	13
Cardiff South West	66,445	11	1	St David's Hospital Riverside Health Centre Parkview Clinic (not operational due to storm damage)	9	9	10
NORTH & WEST LOCALITY TOTALS	**224,620**	**29**	**6**	**8**	**31**	**31**	**42**
SOUTH & EAST LOCALITY							
City and South Cluster	40,985	7	1	Grangetown Health Centre Wellbeing Hub @ Loudoun	8	8	10
Cardiff East Cluster	54,857	4	1	Rumney Medical Centre Llanederyn Health Centre Llanrumney CELT Cardiff East Locality Team Llanrumney Medical Centre	7	3	10
Cardiff South East Cluster	63,414	8	4 (including branch sites of Practices based in other clusters)	Cardiff Royal Infirmary Roath Clinic HMP Cardiff Health Centre	5	6	16
SOUTH & EAST LOCALITY TOTALS	**159,256**	**19**	**6**	**9**	**20**	**17**	**36**
VALE OF GLAMORGAN							
Central Vale Cluster	64,297	7	7 (including 3 branches from Western Vale practices)	Barry Hospital Broad Street Clinic	9	8	14
Eastern Vale Cluster	36,677	4	0	Penarth Health Centre Dinas Powys Medical Centre Avon House	5	5	9
Western Vale Cluster	28,785	3	1	Llantwit Major Health Centre Cowbridge Health Centre	6	6	6
VALE OF GLAMORGAN TOTALS	**129,759**	**14**	**8**	**7**	**20**	**19**	**29**
HEALTH BOARD TOTAL	**513,635**	**62**	**20**	**24**	**71**	**67**	**107**

*colours to cross match to map on page 10.

Map of our Services

Hospitals

1. University Hospital of Wales (UHW)
2. University Hospital Llandough (UHL)
3. Cardiff Royal Infirmary (CRI)
4. Barry Community Hospital
5. Whitchurch Hospital (decommissioned)
6. St David's Community Hospital
7. Rookwood Hospital (decommissioning in 2023)



North & West Locality

Cardiff North Cluster
Current population size: 103,221
No. GP practices: 10

Cardiff West Cluster
Current population size: 56,515
No. GP practices: 8

Cardiff South West Cluster
Current population size: 66,445
No. GP practices: 11

South & East Locality

City & Cardiff South Cluster
Current population size: 40,985
No. GP practices: 7

Cardiff East Cluster
Current population size: 57,493
No. GP practices: 4

Cardiff South East Cluster
Current population size: 63,559
No. GP practices: 8

Vale of Glamorgan

Western Vale Cluster
Current population size: 28,785
No. GP practices: 3

Central Vale Cluster
Current population size: 64,297
No. GP practices: 7

Eastern Vale Cluster
Current population size: 36,677
No. GP practices: 4

Our hospital services are currently provided from five sites across Cardiff and the Vale of Glamorgan: the University Hospital of Wales (UHW– for Cardiff & Vale and Wales)/ Noah's Ark Children's Hospital for Wales (CHfW – for Cardiff & Vale and South Wales), University Hospital Llandough (UHL – for Cardiff & Vale and South Wales), St David's Hospital (SDH – for Cardiff & Vale), Barry Community Hospital (for Vale) and Rookwood Hospital (for Cardiff & Vale and South East Wales).

University Hospital of Wales (UHW)

The University Hospital of Wales is the largest hospital in Wales. The hospital was planned in the 1950s, construction began in 1963 and it opened in 1971. Significant defects in the original build required extensive remedial work to be undertaken in 1978. The hospital has been subject to a number of redesign and changes over the years as additional and more complex and specialised services have been provided and other hospitals have closed, including the transfer of A&E from the former Cardiff Royal Infirmary in 1999. Due to the changes and advances in medical care it is no longer fit for purpose nor does it have the right infrastructure or capacity within its buildings. It delivers a range of highly specialised and complex inpatient, outpatient and day-case services such as Cardiac surgery, a major Emergency Department and Major Trauma Centre service, 26 Operating Theatres, Level 3 Critical Care, organ transplantation, acute oncology and birthing for mothers and babies at high risk. Complex investigations and tests using the full range of diagnostic facilities such as all types of blood and tissue tests, CT and MRI scanning are available 24 hours a day, 365 days a year. It has 934 beds across a full range of specialities and is co-located with the Noah's Ark Children's Hospital for Wales, University Dental Hospital and Cardiff University School of Health Sciences.

It is also the largest provider of specialist tertiary services in Wales. As a tertiary service centre, we are responsible for providing services of a specialised nature or for rare conditions to the people of Wales. These services are typically provided on an inpatient basis following referral from their local GP or hospital consultant, with outpatient services provided locally where possible, or delivered virtually where they can to prevent un-necessary travel. The full detail of these services will be outlined in our Tertiary Services Strategic Plan.

Regional (South East Wales)	Supra-Regional (South and West Wales, and South Powys)	National (All Wales)
Cardiac surgery	Clinical immunology	All Wales Medical Genetics Clinical Service
Specialised neurology	Cystic fibrosis	Orbital prosthetics
Vascular surgery	Neurosurgery	Neuropsychiatry

Noah's Ark Children's Hospital for Wales

Phase One of the Children's Hospital for Wales opened in 2005 as a purpose designed and built facility with an entrance for children's medical and cancer services separate to the main hospital. In 2015, Phase Two opened with the full spectrum of paediatric services including purpose designed wards, Paediatric Intensive Care Unit, Neonatal Intensive Care, operating theatres, radiology department (MRI and x-ray), hydrotherapy pool, therapy and play areas. It has 137 beds. It will remain on the same site as UHW and no changes are envisaged.

University Dental Hospital (UDH)

The University Dental Hospital (UDH) is a stand-alone building on the main University Hospital of Wales site. It has strong links with Cardiff University School of Dentistry and provides dental care for patients who are screened as suitable for treatment by undergraduate dental students. The School of Dentistry is the only dental school in Wales and provides unique and important leadership in dental research, training the next generation of dentists and dental therapists, and patient care. As part of Cardiff University Biomedical and Life Science College Campus developments a new Dental Hospital will be designed to reflect more teaching and training out in community settings.

University Hospital Llandough (UHL)

The University Hospital Llandough was originally proposed before the first world war. It was finally opened in 1933 as an infectious disease hospital and with significant refurbishment and development over time has developed into a hospital providing a wide range of District General Hospital services. It has 661 beds across a range of specialities including the Hafan y Coed Mental Health Unit, Older People's services, the Breast Unit and regional specialist Cystic Fibrosis Unit. It has the full range of diagnostic facilities such as blood tests, CT and MRI scanning, but these are available 24/7 for existing inpatients and during routine working hours for outpatients and clinics. The new regional spinal and neuro-rehabilitation unit will be commisisoned in 2021 to provide accommodation for these services, transferring from Rookwood Hospital.

Rookwood Hospital

Rookwood Hospital, orginally a home for gentry, became a convalescent home for Welsh paraplegic pensioners in 1918 and subsequently a hospital for people with spinal and neurological injuries and their rehabilitation, a site for elderly care assessment and Day Hospital, the Artifical Limb and Appliance Service (ALAS), the Electronic Assisted Technology Service (EATS) and the Wales Mobility and Driving Assessment Service (WM&DAS, non NHS service). It currently has 48 beds which will transfer to UHL in 2021. Elderly care services will relocate to St David's Hospital in 2020. This hospital will close in 2021 although there are currently no plans to relocate ALAS, EATS or the WM&DAS from its current location.

St David's Hospital (SDH)
St David's Hospital opened in 2002 and was one of only a few hospitals in Wales to be funded via the Private Finance Initiative (PFI) programme. It has 72 beds and provides inpatient reablement, rehabilitation and step up services of older people, a range of outpatient services including dental clinics, therapies, the Children and Adolescent Mental Health Service, a children's centre and the Gender Identity Clinic/Service. There are no diagnostic facilities on this site.

Barry Community Hospital
Barry Community Hospital opened in 1995 and provides a range of primary and secondary care services, including a rehabilitation ward for older people, outpatient clinics including blood tests, Minor injuries unit (08:30 – 15:30 Monday to Friday), Radiology Department (plain x-rays only), outpatient therapies, GP Out of Hours service, dental clinics and a Young Onset Dementia Ward. It has 39 beds. As part of Shaping our Future Wellbeing: In Our Community programme it will become a Health and Wellbeing Centre for the Vale Locality. Barry Community Hospital has a rich history as a centre of the community, in October 2020 the hospital will turn 25 and we want to mark this anniversary by having a clear plan in place to launch the hospital into the next 25 years. We will be working with partners, staff, communities and service users to explore what could be included in the Health and Wellbeing Centre for the Vale.

3. Delivering our strategy - five years in

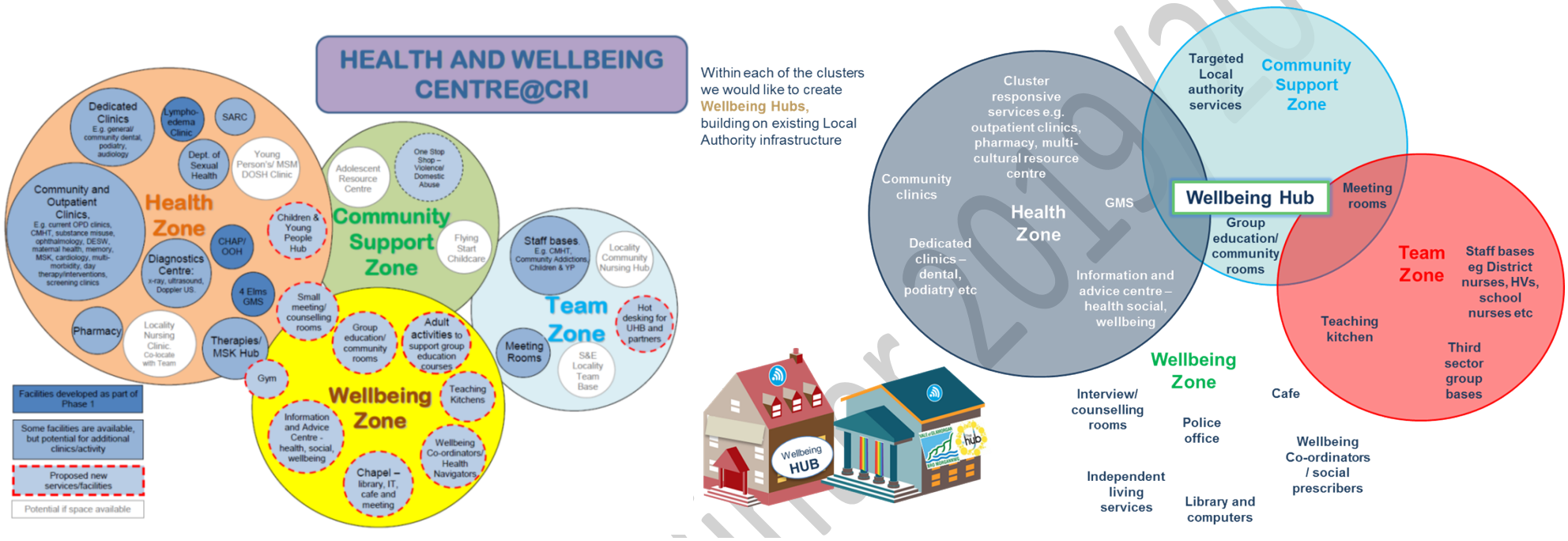
3.1 Designing a single integrated system
To develop our strategy, we worked with staff, people who use our services and partner organisations to shape our strategic direction. The strategy sets out how we intend to deliver our strategic objectives. It describes the challenges we face, the principles which underpin the development of our services and the steps we intend to make to bring about the change required to achieve our vision. It recognises the need to take a balanced approach to achieving change for **our population**, **our service priorities**, **our sustainability** and **our culture**. At its heart are the key principles of 'Home First' and 'Empower the Person', to help people to live well in their communities, with better emotional and physical wellbeing and when help is necessary, services are targeted to those most in need.

As part of delivering the strategy we have already set out a whole system service model which was developed with our partners and our Perfect Locality specification sets out how we see services in the community developing and how we make best use of the wide range of public, independent and third sector community assets and resources that are available to support health and wellbeing.

The whole system model describes how services will integrate with local authority, third and independent sectors in relation to caring for people in the community. As technology continues to develop access to services will be available from other sites than the main hospital bases. This includes outpatient appointments and reviews being undertaken virtually, with test results and monitoring via Apps or smartphone technology. Services will integrate across the traditional primary/secondary care interface to ensure that a prudent approach to healthcare is delivered by the most appropriate person/team. Health pathways for the majority of conditions, developed collaboratively by GPs and hospital-based clinicians, will set out how patients will access information, diagnosis and treatment, ensuring that, where possible, care is provided at or as close to home as possible. Over time, services will increasingly be based in the community to support this model of care, with only those services that require either a critical mass, access to critical care or theatres, or specialist diagnostic or medical equipment, provided in acute hospital settings.

We are already several years into our *Shaping our Future Wellbeing: In Our Community* programme which is developing detailed plans for a number of new community facilities (buildings) to give easier access to health and wellbeing services closer to home. Our plan is to develop a Health and Wellbeing Centre in each of the three localities (Cardiff Royal Infirmary, Barry and North Cardiff) and a Wellbeing Hub in each of the Primary Care Clusters (nine in total). Engagement with local communities and clinicians who will be delivering services in our Health and Wellbeing Centres and Wellbeing Hubs has informed our services model, which will be tailored to the needs of each locality and cluster.

Outline model for services within Health and Wellbeing Centre's and Wellbeing Hubs



The Programme is being rolled out in three phases over the coming 10 years. Phase 1 is underway. In July 2018, Welsh Government received the overarching Programme Business Case which describes our local needs, what services should change and how we want to go about doing it. In August 2019 this was formally endorsed by Welsh Government allowing us to move forward with our plans.

3.2 Changing how we work - improvement and implementation enablement programmes

To support the delivery of our strategy and to underpin our the development of our clinical services, we have established an internal change programme to create the right organisational environment and conditions to create a step change in the way we undertake our activities, and to ensure we continue to deliver the best services for all our patients. Our five Enabler Programmes are summarised below. They have been carefully selected to make big improvements in four key priorities: optimising length of stay (better outcomes for patients), reducing unnecessary outpatient appointments (better patient

satisfaction, better staff satisfaction), improving theatre productivity (better value) and lastly reducing waste, harm and variation (better value, better patient outcomes, and better staff satisfaction).

HealthPathways™	Designed by clinicians for clinicians, HealthPathways ™is a digital director of patient pathway information. Launched on 14th February 2019 the system now has 40 live pathways with a further 20 expected to become available soon. Since launch, HealthPathways™ pages have been visited over 10,000 times. I THOUGHT WE HAD LOADS MORE THAN THIS
Digitally Enabled Organisation	This programme aims to improve efficiency through greater digital support reflecting best practice, by reducing duplication and increasing accuracy of patient records. The three elements of the programme include embracing technology, enabling our workforce and implementing a digital change model to deliver a refreshed digital vision.
Leadership and Culture	We have introduced a new Leadership and Development Programme supporting our top 80 leaders to enable them to be the leaders and champions of change within the organisation. The programme has been informed by our Learning Alliance Partnership has resulted in a comprehensive programme of activity which commenced in July 2019 #Amplify 2025.
Accessible Information	The ability to use data and information to improve decision making is a key part of the UHB's transformation approach. Data from Lightfoot, Signals from Noise has already enabled a reduction in Length of Stay over the winter period. Plans for the National Data Resource (NDR) and the business case for Clinical Data Repository (CDR) are progressing well and the team are in an excellent position for effective local implementation of this National Programme to provide accurate clinical information in a usable format.
Alliancing (working together to achieve a common goal)	Working in a multi-agency environment initially focussing on Falls Prevention, the Alliancing Programme has made excellent progress. Funding from The Health Foundation has been secured, a number of productive sessions have been undertaken and proposals have been agreed with CEDAR (Research Organisation) to support the evaluation of the approach.

Alongside these programmes, many other initiatives and activities are being undertaken throughout the organisation that are increasingly aligned to Shaping our Future Wellbeing and designed to achieve our key priorities. These are some examples:

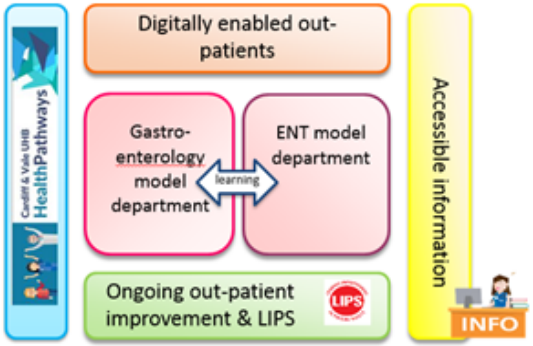
Improvement and Implementation: The Cardiff and Vale Way

A new approach to Transformation is being developed to support the widespread change that the organisation is currently undertaking. A focus on benefits is key, along with a streamlined and accessible change methodology supported by a restructured team, and the development of a Visual Management System. Procurement of a Collaboration Hub will bring all transformation and Improvement information into one central place for improved governance and decision making.

Patient Knows Best

Enabling patients to have access to their electronic health record is a key part of empowering our patients about their health and wellbeing. A roll-out in ENT as part of the 'Valuing our Patient's Time' programme has demonstrated that the time saved via unnecessary appointments and improved processes has allowed specialist nurses to target elderly and isolated patients for treatment.

Valuing our Patient's Time



Outpatient transformation is being undertaken through the lens of valuing our patient's time. Service changes to outpatient processes are focussing on two departments - Gastroenterology and ENT, taking on board the outcomes from the many small projects taking place.

The programme help to support patients in a primary care setting, however, during the COVID-19 pandemic virtual outpatients clinics have been rapidly rolled out across specialist areas to reduce attendance at our hospital sites and keep our patients safe.

3.3 The next steps

In the next phase of the delivery of our strategy a key step forward is the design of our shaping our clinical services programme, ensuring it is designed with the patient at the heart and alongside key partners and stakeholders to ensure the redesign of our clinical services are fit for the future and can be delivered effectively and collaboratively. We will also continue tobuild on a number of key service changes that have been implemented in the last two years including a regional approach to neonatal and obstetrics services, interventional radiology services and major trauma services.

3.4 Our Planning and Design Principles

To turn our vision into reality we have worked with clinicians and wider stakeholders to develop this strategic overview and describe the major service changes and critical enablers required to reshape our clinical services in order to meet the future needs of our population. This includes the redesign of our hospital-based services around a very different model of care and the need to re-provide the University Hospital of Wales. The majority of care will be provided based on personalised care plans following standardised clinical pathways with improved digital information systems, electronic communication and more flexible community-based support enabling the provision of more care at home or closer to home. The focus for the acute intervention element of care and treatment will be on providing those services that can only be delivered in a hospital environment.

The principles on which we are redesigning and developing our clinical services are as follows:

- We will work collaboratively with our neighbouring UHBs, Local Authority and other public and third sector partners to provide care through a connected health and social care system to improve health and wellbeing.

- Citizens should receive care at home or as close to home as possible – hospitals should only provide assessment or care that cannot be provided in the community.
- Patients requiring hospital admission should receive high quality, high value, evidence-driven, safe and compassionate care.
- Hospital care should provide the appropriate package of sustainable, specialist care co-ordinated to meet the needs of the patient and focussed on improving outcomes.
- Innovative workforce models, new technologies and a flexible digital platform across clinical and wider care providers will support new models of care.
- Redesigned clinical pathways and services will deliver improved outcomes and value-based healthcare.

As we change our local healthcare system to a fully integrated whole system seamless service model, work through the finer details of our urgent unscheduled care and surgical service models and deliver on our transformation programme, we expect the number of beds and how each of our hospital sites function as a part of that system to change. The configuration at UHW in particular, will also be influenced by the tertiary services strategic plan and the highly complex and specialised services that it provides for the rest of Wales. The development of Health and Wellbeing Centres and Wellbeing Hubs will enable more Cardiff and Vale citizens to access assessment and treatment in the community, closer to home

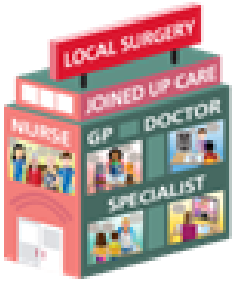
4. What services will be delivered where and how will they be delivered?

4.1 The future configuration of healthcare services

As outlined previously our population is changing. To meet these changing needs we must change how our services are provided. Where possible our services will be delivered predominantly in patients' homes or from facilities in the community.

- In citizens' **homes** – either accessed online through developing e-services on new digital platforms or delivered by increasingly integrated locality and cluster-based health and social care community teams to maintain citizens' independence and wellbeing at home. Our aim is to enable people to remain independent and well, living in their own home.

- In **primary care and community facilities** such as GP practices, community pharmacies, optometrists and dental practices. General medical services (GP primary care services) are currently delivered by 62 independent practices. Increasingly services are being planned and delivered on a primary care cluster or locality basis, in line with the emerging primary care model. Increasingly multi-disciplinary and multi-agency teams will provide a greater range of services in local communities, supporting the timely discharge of patients home following acute care.



- In **Wellbeing Hubs**. These will be focused on delivering a social model of health, either through the development of existing assets e.g. health centres, leisure centres, and local authority community hubs or through new builds in areas of extensive new residential development or in newly developed facilities such as those under development at Maelfa. There will be at least one Wellbeing Hub per cluster.

Core Services Proposed for Each Wellbeing Hub

- ✓ GP services
- ✓ Community midwifery services
- ✓ Health Visiting
- ✓ Primary Mental Health Services
- ✓ Community Children's services
- ✓ Some specific outpatient services to meet cluster health priorities
- ✓ There will be a range of additional services that will be developed with cluster leads and stakeholders to provide a tailored service model to respond to individual cluster needs

In each of our three localities there will be a **Health and Wellbeing Centre (H&WBC)**. These will provide the infrastructure to support the services for the locality that cannot be provided in the wellbeing hubs due to the dependence of service on equipment, facilities or critical mass. Patients will be able to access locality the following range of services:

- diagnostic and clinical support for ambulatory patients (care/treatment/tests provided on an outpatient basis)
- point of care testing
- plain film x-ray
- outpatient services
- a range of integrated health and social care services that will be tailored to reflect the specific needs of the locality.

- *Cardiff Royal Infirmary* (CRI) – will become the Health and Wellbeing Centre for the South and East Locality
- *Barry Hospital* – will become the Health and Wellbeing Centre for the Vale Locality
- *North Cardiff* – a small part of the Whitchurch Hospital site is proposed for redevelopment to provide the Health and Wellbeing Centre for the North and West Locality.

Core Services Proposed for Each H&WBC

- Ambulatory care for rapid assessment of patients with specific conditions without the need for emergency admission
- Range of point of care testing services and plain film x-ray
- Enhanced enablement services
- Range of outpatient services
- Community Mental Health Teams
- Community Children's Services

There will be a range of additional services that will be developed with locality leads and stakeholders to provide tailored service models to respond to individual locality needs or enhance/develop existing regional service e.g. Sexual Assault Referral Centre (at CRI) Younger Onset Dementia Centre (Barry)

This work is being taken forward via the Shaping Our Future Wellbeing: In Our Community programme. We are currently in Tranche 1 with a full separate development and engagement programme.

Hospital based services

Our hospital-based services need to be reshaped to support the future healthcare service needs of our local, regional and tertiary population within modern and fit-for-purpose infrastructure. The redesign of clinical pathways and development of cluster and locality based integrated care capacity will enable the capacity for hospital delivered care to be optimised. The ambition for the two major acute hospital sites in Cardiff and Vale UHB is to clearly define their future roles in ensuring that patients are admitted for the shortest time for the provision of care that can only be delivered in a hospital environment. Our clinical services plan will require these two hospitals to operate differently in the longer term. Our current working assumption is that we will continue to provide services across 2 sites with the functional separation as set out in this paper. We do fully recognise however that there are other options that will need further exploration. A single site solution for Cardiff encompassing the full range of clinical and teaching services would be a formidable undertaking though not without precedent. There would be advantages to the colocation of services and potential economies of scale but equally there are risks associated with colocation of routine and complex care. There are also practical considerations that need to be worked through including site availability in the right location and the practicality of redeveloping on the UHW site whilst it still functions as a hospital.

Given the extended lead time for any major new development to happen our outline model is based on the reality that a two-site solution will be needed to sustain services and deliver our new model for at least the next decade irrespective of any different long-term solution.

Working with our clinicians we have agreed the outline model for our two major hospital sites:

- UHW will be the major acute site (highly specialised tertiary centre, high acuity, complex medical/surgical patients, training/research and innovation); and
- UHL will be the ambulatory care/low acute site (ill but stable – not dependent on critical care or 24/7 acute medical care).

In order to develop these models fully and to inform the design and functionality of the new hospital to replace UHW and provide the strategic clinical direction and context for the ongoing development of services and infrastructure across the other UHB sites, including the Health and Wellbeing Centres, work is ongoing to clarify the future configuration of:

1. Tertiary service provision across the UHB;
2. Urgent unscheduled care model (front door emergency admissions at UHW and 24/7 Primary Care urgent unscheduled care non-admission model services); and
3. Elective surgery (Surgical Centre of Excellence at UHL for non-complex surgery).

Barry Community Hospital

As described above, there is already agreement to the development of a Health and Wellbeing Centre in Barry for the Vale of Glamorgan Locality to support more care to be delivered by the integrated locality team and primary care through cluster working, and integrated health pathways. This will mean expanding and changing the focus of some of the services provided there, building on developments we have already progressed. Barry Hospital is now the locality base for both the Community Mental Health Team and the Community Resource Team (although the latter has been temporarily relocated to provide more bed capacity to support the COVID19 response for increase rehabilitation and reablement following acute hospital care. We have already started work to improve the facility in the shorter term to ensure services are better co-ordinated and to improve the environments for patients and staff. The next stage, which has also commenced, is to ensure that there is a coherent vision to develop a facility the community is proud of and which is aligned to the urgent unscheduled care medicine model and vision for Health and Wellbeing Centres. This work is being led by the Joint UHB and Local Authority Vale Locality Team and forms part of the *Shaping Our Future Wellbeing: In Our Community* programme.

St David's Community Hospital

A key part of the integrated locality model of care, we want to develop St David's Hospital as a centre of excellence for rehabilitation, aimed at supporting people not quite ready to go home or who need care short term care that cannot be delivered at home but who do not need to be in an acute hospital. As part of this we have already created an additional rehabilitation ward, resulting in more people being discharged from acute care at the right time, reducing overall demand for acute hospital beds. Our plan is to provide community hospital rehabilitation services following an acute episode of care at St David's Hospital with the full range of specialist rehabilitation staff and all members of the multi-agency disciplinary team present on site. This will include assessment, day hospital, therapies and inpatient services. The approach will be based on the model of 'discharge to assess' where we work with our local authority partner to ensure that patients are discharged from acute hospital care as soon as they no longer need this level of care. Assessment of recovery, rehabilitation and reablement needs – both short and longer term - can then be undertaken at home or in a community facility such as a step down residential home bed, or a community hospital bed.

University Hospital Llandough (UHL)/Llandough Campus – Our low acuity site for specialist care not requiring intensive care support, recovering patients, elective care and mental health inpatient and day care services for working age adults and older people

Clinical Approach for UHL

- ✓ Site for ill but stable individuals (post-acute/step down, rehabilitation)
- ✓ Surgical Centre of Excellence - non-complex planned surgery
- ✓ Specialist services that are not dependant on critical care or 24/7 on-site acute medical admissions

Diagnostics & Ambulatory Care

- Daytime imaging services – x-ray, Ultrasound, CT, MRI.
- Hot pathology/diagnostic daytime service.
- Routine endoscopy – screening, planned and follow up.
- Where patients in the community become unwell and unstable and require a specific clinical assessment, diagnostic investigation or short-term clinical intervention that is not deliverable within the community services, then the ambulatory acute medicine pathway will support the referral of triaged patients to a daytime Acute Ambulatory Medicine (AAM) service. The pathways for this service are under development and will necessarily require clear links into the community based and specialist-based service provision to ensure that care can be quickly stepped up or down based on the patients' clinical needs. The opportunity to provide this AAM support within the H&WB centres will be tested to optimise local access to community-based care.

Medicine

- Services to support the step-up and step-down care for patients that are not well enough to be cared for in the community but do not require immediate or 24/7 access to critical care or specialist clinical services or who require intensive specialist rehabilitation. This care could be delivered based on condition specific pathways and include Day Hospital and an Elderly Care Assessment Service. The selected acute medical intake would be centralised at the new UHW.
- 24/7 cover for all patients on UHL site (Mental Health, surgery, palliative care, medicine.)
- General rehabilitation and ongoing medical inpatient care – stepped down from UHW or local residents repatriated from other regional acute hospitals.

Mental Health Services

- Inpatient and hospital based mental health services (as currently provided).

Surgery

- Surgical Centre of Excellence – Clinical colleagues have been involved in the development of an expanded elective surgery service to optimise the capacity for non-complex elective surgical care for high volume, low risk short stay surgery based on the successful CAVOC model. This will be supported through the development of additional theatre and Post Anaesthetic Care Unit, anaesthetic daytime capacity and a comprehensive pre-assessment model including prehabilitation/rehabilitation.

Tertiary Services

- Specialist neuro and spinal rehabilitation services (transfer in 2021) and Cystic Fibrosis delivered from new purpose-built facilities.

Other

- Partnership *palliative care model.*

New University Hospital of Wales-our hyper acute site, tertiary centre for complex medical/surgical patients (24/7,365 dependency on critical care)

Clinical Approach for UHW

- ✓ Site for emergency care for acutely ill and complex medical/surgical patients including major trauma
- ✓ Regional, Supra-regional and national Tertiary services
- ✓ Acute services dependant on co-location with 24/7
- ✓ People supported back to the appropriate care location when no longer requiring high intensity/ specialist care

The new hospital will provide a modern and fit-for-purpose facility that will be optimised to provide the capacity and capability for the range and volume of high acuity and specialist services. Ward and service configuration will be aligned to reflect clinical interdependencies. It will be developed collaboratively with Cardiff University to support their medical and life sciences hub and to enhance the innovation, research and development opportunities with wider stakeholders. There will be immediate access to all essential diagnostic, critical care and specialist clinical services on a 24/7 basis for acutely unwell patients requiring an emergency admission or a complex, specialist or high-risk elective procedure.

- Those acute services currently provided at UHL that would deliver a benefit to patients from co-location with critical care, specialist clinical support services or those services that are not clinically safely sustainable in the long term will transfer to the new UHW e.g. 24/7 urgent unscheduled care medical intake, critical care services.
- Major Trauma Centre for South Wales.
- Emergency Department (A&E) for Cardiff and the Vale of Glamorgan catchment.
- Full 24/7 diagnostics – all imaging, interventional radiology, full regional pathology laboratory services, radio-pharmacy, endoscopy and cardiac catheter laboratory services.
- All levels of critical care.
- Unselected acute medical intake for Cardiff and the Vale of Glamorgan catchment.
- 24/7 emergency theatre capacity including dedicated major trauma theatre.
- All acute emergency care and inpatient beds for all specialty emergencies – e.g. acute medicine, surgical specialties, acute oncology, cardiology, respiratory, acute stroke (HASU), acute gerontology and gastrointestinal.
- Complex elective surgery – including cancers, spinal, maxillofacial, vascular, robotic surgery.
- A co-located consultant and midwifery-led birthing centre.
- Specialist tertiary services including cardiac and neurosurgery, blood and marrow transplant, renal surgery, nephrology and transplant, thrombectomy, advanced gene and cell therapies and All Wales Genomics service.
- Noah's Ark Children's Hospital for Wales and all paediatric emergency, intensive care (PICU) and inpatient services.
- Neonatal intensive care – all levels.

It will provide this level of care for some regional patients and South Wales patients for new services either:

- commissioned through Welsh Health Specialised Services Committee and planned collaboratively with Swansea Bay UHB, or through
- regional collaboration with partner UHBs in South Central and South East Wales i.e. Cwm Taf Morgannwg and Aneurin Bevan UHBs.

4.2 Workstreams in development

- **Enablement and Rehabilitation**
  A Rehabilitation Framework has been developed with full clinical and local authority involvement, led by the Director of Therapies and Health Sciences. The overarching aim is 'helping people to live longer, healthier lives'. The focus of the framework is 'closer to home' so the emphasis is on delivery in primary care and the community as well as supporting the clinical models at each of our sites. The model as outlined in the diagram below has been tested with the Stakeholder Reference Group and will be published early 2021 and shared widely. This work links to our work on the 'discharge to assess' approach we are taking to ensure people move on from their acute episode of care, and plans for rehabilitation, reablement or longer term care and support needs can be assessed once someone is back in their own home, or in their local community health or care facilities.

- **Urgent Unscheduled Care Model**
  There is strong clinical support for an urgent unscheduled care model which combines no front door medical admission at UHL with pathways for rapid assessment, diagnostics and monitoring in primary care/community, recognising that there will be a need to provide 24/7 cover for all patients on UHL site (Mental Health, surgery, palliative care, medicine). The elective surgical services model, general medical model and the rehabilitation model will influence how this is provided. There is ongoing work to develop the 24/7 Primary Care urgent unscheduled care non-admission model services recognising that sometimes it is social care support which will prevent people from being admitted to hospital and facilitate early discharge; we will need to look at how this can be provided. Once outlined, the model will be tested with our stakeholders.

- **Planned Surgery @ UHL – Surgical Centre of Excellence (non-complex surgery)**
  The provision of planned surgical services is already well-developed at UHL and the vision for the future described at a high level. The sustainability of existing and further development of additional planned, surgical services is being tested through the development of a surgical service model specification. This defines the service model in the context of the key clinical standards alongside the service, workforce and infrastructure dependencies to deliver a sustainable service model across the elective surgical specialties. Following positive feedback from a period of engagement, the initial focus is on moving planned day case and 23-hour surgery to UHL for non-complex patients building on the surgical models already established at UHL, to develop UHL as a Surgical Centre of Excellence for non-complex, routine planned surgery. This will shape progression through the full spectrum of specialities.

- **Tertiary Services**
  The planning work on developing the strategic plan for tertiary services has commenced, with a baseline assessment of current service delivery. The aim is to develop a clear, compelling, and coherent vision for tertiary services with our partners across Wales, including Local Health Boards, WHSSC, Local Government, Universities, and Welsh Government. This work is proceeding in parallel and is aligned with the broader strategic, clinical service planning such that it informs the Programme Business Case for the re-provision of UHW. There will be a full engagement programme on the model. It is expected that an agreed Tertiary Services Strategic Plan will be published early in 2021.

4.3 What this mean for the new UHW and UHL/Llandough Campus

University Hospital of Wales 2 (UHW2)

Based on our emerging, early proposal for a new University Hospital of Wales (UHW2) would be a state-of-the-art hospital for the acutely ill patient for Cardiff and the Vale of Glamorgan and the largest provider of highly specialised tertiary services in Wales. It would be built with and have, the latest design and technology for the full spectrum of specialities available 24/7 for local, regional, supra-regional and national services. It would be part of the proposed Heath Park Health Science Quarter, developed in partnership with Cardiff University, Welsh Government, Cardiff City Regional deal partners and Life Science industry partners.

To complement the service change described in this document, a new UHW would be required to provide modern healthcare in line with clinical pathways, service models, standards and regulations. In undertaking such a major investment, the following results must be achieved:

- *Better Patient Outcomes:*
    - World leading health outcomes for high acuity patients delivered from the new UHW but which is part of a system that empowers people to live healthy lives.
    - Reduction in health inequalities within Cardiff and the Vale.
    - Reduced length of stay through pathway management and latest prehabilitation and rehabilitation techniques, and strong repatriation agreements when patients come from other health boards.
    - Reduced admissions as care delivered closer to home.

- *Better Patient Satisfaction*
    - A highly accessible site reflecting both local and national access requirements and linked to the developing South Wales Metro transport infrastructure.
    - A healing environment with the latest medical techniques, better adjacencies of services and departments.

- *Better Staff Satisfaction*
    - Optimum capacity meeting the need of Cardiff, Vale of Glamorgan, South Wales and Wales.
    - Benefitting from closer relationships with Cardiff University where innovation is shared.

- More Environmentally Sustainable

- Reducing carbon consumption.
- Sustainable transport options.
- Green space.
- Wider benefits for the local communities.
- Based on sustainable supply chains.
- A design for the local community to enjoy and in harmony with the local environment.
- Flexible to react and anticipate the changes seen in 21st Century healthcare.
- Create high value local employment.

- *Better Value*
  - Lower running costs.
  - Through better design more efficient for the workforce
  - Increased income from commercial activity.
  - Research and Development activity directly benefitting patients though more clinical trials.

- *Wider macro benefits*: Cardiff and Vale UHB is one of the largest employers in Wales and a major part of the local and national economy. The development of the new clinical model will bring both short and long-term economic advantage through the build process and the delivery of long-term benefits including additional years of employment for a healthier population and the wider social value of healthy life years gained.

University Hospital Llandough/Llandough Campus

UHL will be a thriving and active fit for purpose Cardiff and Vale hospital site for ill but stable individuals who are not dependent on critical care for their admission or inpatient stay. A range of services based on condition-specific pathways, would support earlier assessment, treatment and rehabilitation such that length of stay is as short as possible and as much assessment, treatment and care as possible is provided in the community at Health and Wellbeing Centres, primary care or Wellbeing Hubs. It would be a Surgical Centre of Excellence for non-complex planned surgery providing day case and 23 hour stays for a range of specialities. In 2021 the specialist neuro and spinal rehabilitation services will transfer from Rookwood Hospital into new purpose-built facilities. It would remain the prime site for inpatient Mental Health Services for the UHB.

4.4 What does this mean for Wyn?

Scenario 1: Wyn lives on his own and has family and friends close by with whom he meets up regularly. Wyn's daughter was worried that Wyn was looking less steady on his feet so referred him to the falls prevention service provided from the local wellbeing hub. Wyn learnt regular exercises to help with his muscle strength and balance. During his visits to the hub, Wyn met the independent living team who came to do an assessment at his house. Following this some technology was installed in Wyn's home, with remote monitoring which made him feel safer at home and to reassure his family.

Whilst out walking his dog, Wyn had a nasty fall when he slipped on ice. Following a 999 call, Wyn was taken to the University Hospital of Wales as a major trauma patient where he received scans to rule out damage to his brain or internal bleeding, and to confirm that he had fractured his hip. The next morning Wyn was transferred to University Hospital Llandough for surgery to fix his broken hip. The cluster team was notified of Wyn's admission to hospital and started to co-ordinate his plan for discharge following surgery with the hospital team. The community connector in the cluster team also arranged for Wyn's neighbour to look after his dog.

Wyn stayed in UHL for four days for the acute phase of his care. In discussion with the locality resource team and based on this need for more time for recovery, Wyn was transferred to his St David's Hospital where the team were able to provide an intensive rehabilitation programme delivered mainly by the therapies team. Here the locality team were able to spend time to assess Wyn's ongoing care needs. Wyn was discharged home with short term support to help with getting showered and dressed in the morning and to ensure that Wyn was able to continue with the rehabilitation exercises prescribed on discharge. The cluster team called Wyn every few days over the next few weeks to check that he was doing ok, and arranged for Wyn to join the local gardening group in the wellbeing hub to get Wyn out of the house a bit more as he was feeling a bit isolated and lonely. The neighbours continued to walk Wyn's dog until he was able to do so and ensured that he what he needed from the shops.

Wyn made a full recovery and continues to go to the gardening group and has got to meet more people who live in his community. This has helped him regain some of the confidence he lost when he fell.

Scenario 2: Wyn lives on his own and has family and friends with whom he meets up regularly. Wyn noticed that his bowel habits had changed recently and he was getting tummy ache more regularly. Wyn accessed the patient inform portal and having looked up the relevant information made an appointment to see his GP, having completed the online GP assessment. The GP referred Wyn for rapid diagnostic assessment following the suspected cancer pathway and Wyn was seen a week later in the rapid access diagnostic clinic in the Locality Health and Wellbeing Centre. Here Wyn was diagnosed as having cancer and the following week he met through a virtual clinic with the multi-disciplinary team to discuss the treatment that would best suit Wyn. A member of the cluster team was able to join Wyn at home to help him with the virtual consultation as his daughter wasn't able to join Wyn for this. The treatment plan was tailored to Wyn's genetic profile in order to give him the best outcome. It was agreed that Wyn would have surgery following by chemotherapy. Wyn had put on a bit of weight over the last few years and hadn't done much exercise. Wyn was advised that his recovery from surgery and the cancer would be quicker and have better outcomes if he lost a bit of weight before the surgery. Wyn was referred to the prehabilitation team who helped Wyn lose over a stone in the six weeks that he waited for his surgery. He really enjoyed the treadmill at the local leisure centre where the team helped by with a programme of exercises jointly with the prehab team, who also provided him with psychological support as Wyn had become convinced his wasn't going to survive the cancer.

Wyn's surgeon knew that the surgery might be complex due to the position of the cancer, so the surgery was undertaken at UHW as it was likely that he might need intensive care following the surgery. The surgery went as planned and the surgeons were very pleased with the outcome. Wyn was discharged home after four days and the locality team visited him regularly over the first couple of weeks to support Wyn's recovery. They also undertook an assessment to look at whether Wyn had any longer term care needs. During this process, Wyn disclosed that he often felt lonely and really struggled to look after the house – the house in which he had raised his kids with his wife, who had sadly dies several years ago. Wyn took the decision to move into a housing complex which provided care onsite should he need it, and with a restaurant where he could eat everyday if he wanted to and make new friends. He didn't want to put on weight again and thought this would help him with a healthy diet too.

Wyn's chemotherapy started a few weeks later following his recovery from surgery and the plans were progressed for him to move into his new home. The chemotherapy was delivered at home by the Team from Velindre Cancer centre. Wyn had also consented to be part of a research trial so the chemotherapy drug used was the very latest treatment available. It also meant that Wyn was had move regular follow up, most of which was done virtually through video appointments. Wyn's treatment is going well – but he wants to plan ahead and has asked the cluster team to help him draw up his advanced care plan, so when the time comes (which he hopes is many years away) he can be supported to die peacefully in his new home.

5. Helping us shape our clinical services - engagement and consultation

This vision for clinical services has been shaped by conversations we have had with a range of stakeholders over the last two years and we have tested our thinking through the imagined experience of our model patient, Wyn. We want to test the direction of travel with Health Board staff and colleagues in local primary care, as key partners in delivery of the vision. We want to hear your views on our ambitions for UHW and UHL as a part of the wider implementation of the UHB's Shaping Our Future Wellbeing strategy and to explore how our plans can contribute to the wider aspirations of Welsh Government for the country as a whole.

We will be conducting a continuing conversation with our local community, our workforce and wider stakeholders as part of our continuous engagement. We are canvassing feedback on our high-level plans in particular around the development of the concept of:

- A hospital that will provide the complex, acute care for those patients that are acutely unwell and require either an acute emergency assessment or admission who will potentially require immediate access to specialist or critical care. It is important that these services are co-located on one site to provide the best outcomes for our patients with appropriately trained and skilled clinical teams and access to the full range of critical care and diagnostic services, all available 24/7.

- An elective hospital service focussed on delivering routine, protected planned surgery and condition-specific care for patients whose conditions or needs are non-life threatening but who will benefit from an environment of hospital care that is not impacted by or dependant on the high acuity and emergency care service.

As part of our engagement exercise we will be holding a wide range of discussion sessions that will be available to all interested stakeholders as well as through our usual social media platforms. In addition to this general engagement we also anticipate that we will hold a number of specific engagement and also formal consultation exercises as our high-level plan takes shape. Some of these more formal engagement and consultations exercises will be around:

- ***how*** our service provision will be changing e.g. the proposed centralisation of some specialist surgery for the wider region in Cardiff (UHW) e.g. current arterial (vascular) surgery proposals,
- whereas other engagement and consultation exercises will be focussed on the ***where*** the service provision will be changing i.e. emerging proposals to move the remaining selected acute medical emergency admissions from UHL to UHW.

Report Title:	**Development of Genomics Partnership Wales – Outline Business Case**							
Meeting:	**Cardiff and Vale UHB Board**					**Meeting Date:**	**26/11/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**	
Lead Executive:	**Executive Director of Strategic Planning**							
Report Author (Title):	**GPW Project Director & Director of Capital Estates & Facilities**							

Background and current situation:

This paper sets out a summary of proposals and associated capital and revenue implications for further development of the Genomics for Precision Medicine Strategy through the co-location of the following Genomics Partnership Wales organisations – All Wales Medical Genomics Service (national service hosted by C&VUHB), Wales Gene Park (hosted by Cardiff University) and Pathogen Genomics Unit (part of Microbiology, PHW). It is provided to the Board to agree the submission of the Outline Business Case (OBC) to Welsh Government (WG) for £15.3m capital funding to proceed to FBC development. The Executive Summary is attached (and the full OBC is available on request).

The Board is asked to authorise the submission of Development of Genomics Partnership Wales – Outline Business Case to Welsh Government as part of the process to access capital funding to proceed to develop the FBC.

This business case seeks approval to enable the further development of the Welsh Government's Genomics for Precision Medicine Strategy through Cardiff and Vale UHB providing increased delivery capability for Genomics Partnership Wales' partner services. This will permit the continued and improved provision of genomics services and research from facilities that are safe, fit for purpose and of sufficient size to provide the required capacity for the future. The co-location of these genomics partners will also provide additional benefits to patients and the population of Wales.

This co-location of key Genomics Partnership Wales partners is critical to meeting the vision and aims of the Genomics for Precision Medicine Strategy. Current estates occupied by the partners, especially the laboratory facilities, are not fit for purpose in terms of space available and also lack the flexibility to meet the new service and technological needs. In order for the genomic services to be developed and to continue to guarantee the quality of services delivered, additional space is required to house new equipment, and to accommodate the expanding workforce and the increasing portfolio of new genomics services to improve patient care.

The Genomics Partnership Wales Governance Board has received regular progress reports on the project throughout the development of this scheme.

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

- The UHB have recognised the inadequacy of the existing genomics facilities at UHW and are committed to providing a new, fit for purpose building.
- The Welsh Government recognise the advantages of co-locating the key Genomics Partnership Wales partners and highlighted the development of the required business case as a key deliverable from the programme.
- The current facilities for the All Wales Medical Genomics Service at UHW has been expanded with some refurbishment, however the laboratories and location of the service across several buildings poses a serious risk to service delivery and quality.

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

The Genomics for Precision Medicine Strategy was launched by Welsh Government in July 2017. New genetic and genomic technologies have the potential to revolutionise medicine and public health. This strategy sets out the Welsh Government's plan to create a sustainable, internationally competitive environment for genetics and genomics to improve health and healthcare provision for the people of Wales.

The Strategy outlines the key initial actions, as part of a 5-10 year plan that will:

- Develop internationally-recognised medical and public health genomics services in Wales – that are innovative, responsive and well-connected to the major genetics and genomics initiatives that are evolving worldwide;
- Develop internationally-recognised research in genomics and excellent platforms for precision medicine, with All-Wales leadership and coordination and strong links to clinical genetics;
- Be outward-looking, and actively seek out partnerships that can strengthen genomics and precision medicine services and research in Wales, with a focus on those partnerships that will bring the biggest benefits for patients;
- Develop the NHS and research workforce in Wales, in recognition that this investment will have the biggest impact.

The plan aims to make Wales an international leader in precision medicine, with experts working closely together to make genomics and genetics part of everyday medicine. Genomics Partnership Wales was established in 2018 to represent all of the key stakeholders involved in the delivery of the Strategy. Based on the key themes highlighted in the Strategy, the following high level investment objectives were agreed:

Co-production - Demonstrate a commitment to work in an open and transparent manner with patients and the public, using their collective experiences to shape and add value to the work of the Genomics Partnership and future genomics services in Wales

Clinical and Laboratory Services - Develop internationally-recognised medical and public health genomics services with strong collaboration across NHS and academia to ensure equity of access to sector-leading genomics services for the citizens of Wales

Research and Innovation - Create an internationally competitive genomics research environment through investment in genomic research technologies and Precision Medicine platforms, collaborative infrastructures and ambitious training portfolios

Workforce - Nurture an enthused and highly skilled workforce that can serve as ambassadors for genomics within the NHS, ensuring that our services evolve at pace - can increase their throughput whilst remaining reliable, equitable and progressive

Strategic Partnerships - Establish Wales as an outward-looking, collaborative and reputable

home for business development, promoting the genomic services in Wales to attract the best partnership opportunities
As part of the Clinical and Laboratory Services theme and investment objective, there is this specific aim:
Genomics Partnership Wales will seek to understand the key dependencies and infrastructure requirements of both human and pathogen genomics services to enable the delivery of excellent patient services in Wales. A business case will be prepared for the urgent short- term accommodation needs for the human genomics laboratory, and long-term accommodation solutions for a genomics laboratory suite, research and clinical services with sufficient capacity for future growth and collaboration

The co-location of All Wales Medical Genomics Service, Pathogen Genomics Unit and Wales Gene Park is to meet this specific need, and support the broader aims of this transformational strategy.

The impact of not submitting the OBC
The services would be maintained at their current levels in terms of activity and technology, and the implementation of new techniques would not be possible.

The main disadvantages for all partner services would be:

- The existing service issues experienced as a result of lack of laboratory and office space are not resolved;
- Current issues with existing facilities arrangements for AWMGS staff who are spread across various locations at UHW site making efficient and cohesive working very difficult are not resolved;
- The development of national-level services or increased research activities (the laboratory space and facilities arrangements are not fit for purpose) will not be facilitated;
- Current quality (ISO) accreditation of AWMGS and PenGU laboratories could be jeopardised;
- The introduction of new technologies and services would be extremely restricted;
- Services would not meet future demand or patient needs;
- Significant efficiencies in use of genomics technologies and expertise to improve patient care would not be realised;
- The introduction of new laboratory and digital equipment would not be facilitated;
- The aims of an integrated genomics facility outlined in the Genomics for Precision Medicine Strategy would not be met

This is considered phase one of a much wider precision medicine proposal in Wales

Service Scope and Vision

Below describes the services and vision for each of the three partners; co-location in appropriate facilities is required to meet both the aims of the Genomics for Precision Medicine Strategy and each of the individual partner organisations.

All Wales Medical Genomics Service (AWMGS)

The laboratory service receives, analyses and reports approximately 40,000-50,000 samples for genomic analysis per year. Samples are received from Clinical Genetics, cardiology, paediatrics, neurology, antenatal clinics, oncology, and many other disciplines. These samples require specialist analysis with a turnaround of 3 days – 8 weeks and full interpretative advice is given to

referring clinicians.

The clinical service receives, triages and assesses approximately 10,000 referrals each year (likely to increase). Referrals are received from primary and secondary care and (occasionally) from patients themselves. Some referrals are time-critical because they relate to a pregnancy or sick newborn, or because the outcome of genetic investigations is expected to alter patient management (e.g. breast cancer surgery).

The team provide an on-call service during normal working hours to give advice to known patients and other healthcare professionals with genetic/genomic queries. This also involves visits to a ward (most often the neonatal unit) to assess inpatients with a potential genetic condition.

The AWMGS must be able to grow with the demands for the service and have the capacity and capability to deliver the future (many unknown) required services for Welsh patients. This includes the development and delivery of new genomic technologies for introduction into the NHS. The service will need to form partnerships with external stakeholders to enhance the delivery of patient services, utilising staff experience and skills, and the technologies available in Wales.

Pathogen Genomics Unit (PenGU)

PenGU provides a range of genomics services delivered through three main service areas - testing and diagnostics; enhanced outbreak support; surveillance.
To consolidate and enable the above core activity, a number of key business support aspects have been provided including bioinformatics and IT infrastructure development.
The specific services are as follows – Influenza; diagnostics services for HIV resistance; diagnostic services for Mycobacteria; C. difficile; antimicrobial resistance; SARS CoV-2

Public Health Wales will have a genomic-focused health protection and infection prevention control service within 5 years and beyond. To achieve this ambition, the plans are centred on five key objectives that will guide activity and actions over the life of the project, as follows:

- **Delivering infectious disease services that are equitable, consistent and reflective of the needs of patients in Wales – fulfilling the prudent healthcare principle to work with patients and healthcare professionals to improve outcomes so that patients have a greater control of their own health.**
- **Driving an efficient research and innovation base – prioritising support for investigation and research to promote coproduction and cross discipline work**
- **Initiating economic growth – using NGS to instigate productivity, transform the service and create commercial opportunities**
- **Facilitating partnership in developing and adopting new approaches in public health – capitalising on existing collaborative work and research strengths to foster collaboration and enhance contributions to future development**
- **Building capacity, training, educating and developing staff in NGS – developing and investing in staff to build biomathematics, bioinformatics and bench-level capability in the Wales workforce**

Wales Gene Park (WGP)

Within the WGP genomics facility a wide variety of research projects are supported across a number of genomic technologies.

The WGP education and engagement team offer a large portfolio of events that have thousands of participants for professional and public engagement and education around genetics and genomics.

WGP's vision is to harness genetics and genomics to advance research, healthcare, education and innovation. The WGP genomics facility strive to continue to provide the best and most cost effective NGS technologies at affordable pricing to researchers within Wales, and to incorporate new genomic technologies as they become required by healthcare researchers in Wales. A major strength of WGP genomics facility is the ability to capitalise on the multiple types of sequencing instruments within Cardiff to provide affordable NGS and bioinformatics support for the research community within Wales. The WGP genome editing facility supports researchers to generate new models of disease, expanding provision to include collaborations incorporating genome editing within human IPS cell lines.

The WGP education and engagement facility focus on enhancing awareness and understanding of genetics and genomics, engaging with health and science professionals, schools, colleges and the public.

A summary of the projected capital costs is shown below:

Capital Costs at PUBSEC 250	**Option 0** Do nothing: addressing backlog maintenance only	**Option 1** New build on the GE site	**Option 2** Extensive refurbishment of CD1 on the GE site	**Option 3 Preferred:** Partial refurbishment of CD1 on the GE site
	£000	**£000**	**£000**	**£000**
Works Costs	1,402	23,987	12,777	6,701
Fees	14	3,751	1,978	1,107
Non-Works	0	4,510	2,985	2,960
Equipment	0	1,232	982	582
Costs				
Planning	0	3,348	1,872	1,828
Contingency				
Subtotal excluding VAT	**1,416**	**36,828**	**20,594**	**13,178**
VAT @ 20% less reclaimable	280	6,615	3,212	2,146
Total Capital Cost	**1,696**	**43,443**	**23,806**	**15,324**

A summary of expected Revenue costs is shown below:

Expenditure type	Do nothing Option 0 £	All 3 areas on new build GE SITE Option 1 £	All 3 areas full refurb CD1 on GE SITE Option 2 £	Preferred option All 3 areas partial refurb CD1 on GE SITE Option 3 £
Floor space sq. metres	3,484	5,119	4,969	4,969
Business rates	47,980	121,660	121,660	121,660
Energy	88,877	109,000	106,000	106,000
Estates maintenance	85,960	126,289	122,589	122,589
Domestic services	62,651	87,243	87,243	87,243
Security	8,966	13,173	12,787	12,787
Waste	10,805	15,874	15,408	15,408
Digital/IT	0	100,111	100,111	100,111
Building lease charge/rent (Capital)	0	0	0	0
Insurance	0	13,694	13,694	13,694
Service charge – landlord	0	195,128	195,128	195,128
Transport costs		9,464	9,464	9,464
Total	**305,238**	**791,636**	**784,084**	**784,084**
Assumed releasable costs		(152,619)	(152,619)	(152,619)
Net additional revenue	**305,238**	**639,017**	**631,465**	**631,465**

The above assumes that 50% of the current Capital, Estates and Facilities costs from existing estate occupied by Genomic services will be releasable.

Additional Capital Requirements:

The annual lease/rental cost for CD1 of **£0.600m** per annum (£0.500m + VAT), will be classified as an annual capital cost under IFRS 16 (International Financial Reporting Standard 16 – Leases). As a consequence, there will be an **annual capital funding requirement of £0.600m.** To note that before the introduction of IFRS 16, such lease costs would be classified as revenue expenditure.

In line with IFRS 16, the lease will need to be capitalised on the UHB balance sheet to reflect the total liability over the 15 years of the lease. Taking account of rent review periods at years five and ten as set out in the lease, with a maximum 3% indexation increase, the total liability would be **£9.524m**. This will require agreement with WG and an uplift to the UHB's Capital Resource Limit (CRL), commencing in 2021/22.
In addition, against the £15.324m capital cost of the preferred option, there will be a non re-current impairment to the asset value of £10.317m as determined by the Valuation Office. This

will require agreement by WG.

Furthermore, it is assumed that all capital charges associated with this development will be funded by WG. This relates to depreciation on tenants improvements to the lease and right of use of the asset, together with interest charges.

Key Benefits
A summary of the main benefits is provided below:

- Build reputation as Centre of Excellence for genomics and precision medicine
- Create a united partnership in genomics
- Maximising patient access to genomics services
- Improved strategic fit of services
- Maintaining the clinical quality of services
- Provide sustainable and flexible facilities to meet future needs
- The development of national services to provide support for non-infectious and infectious disease diagnostics
- Introduction of new technologies, equipment and clinical services
- Development of specific, appropriate environment for laboratory services for both clinical and research purposes
- Development of clinical areas which meet patient needs
- Co-location of laboratory and clinical genetics services is essential for the increasing requirement for joint working and interpretation of genomic medicine services
- Improved turnaround times for services
- Reduced waiting lists
- Increased research activities that translate to clinical care
- Equipment being fully utilized and capacity managed across partners
- Increased efficiencies in use of the facilities
- Improvements in adjacencies of staff providing cross working opportunities
- The provision of population-level activities to help tackle health inequalities
- Improved staff retention
- Ability to attract and recruit high calibre staff
- An increase in the number of partnerships established
- A higher level of engagement activities with various parties
- Increased patient involvement in genomics research and service development
- New research studies undertaken
- Increasing workforce can be accommodated

Assurance is provided by:

- Continuous monitoring of the project and OBC development by the Project Team whose membership includes all relevant Stakeholders
- Regular reporting of progress, risks etc to the Genomics Partnership Governance Board

Recommendation:

The Board is asked to **approve** the submission of Development of Genomics Partnership Wales – Outline Business Case to Welsh Government for capital funding to proceed to develop the FBC.

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. EHIA included as an appendix to the OBC

Development of Genomics Partnership Wales

Outline Business Case: Executive Summary

November 2020 – Final v4

Document Information

Status	Final
Date	10th November 2020
Authors	Adcuris/CVUHB
Circulation	CVUHB Project Team

Version	Date Issued	Summary of Change	Document Owner
Draft v1	13th August 2020	Draft strategic case issued for review	Geoff Walsh
Draft v2	23rd October 2020	Updates to commercial case and management case	Geoff Walsh
Draft v3	6th November 2020	Financial case drafted	Geoff Walsh
Final v4	10th November 2020	Updated following review comments	Geoff Walsh

1.1 Introduction

This business case seeks the approval for a capital investment of £15.3m to permit further development of Genomics for Precision Medicine Strategy to enable to the Cardiff and Vale University Health Board (CVUHB) to provide increased delivery for the following Genomics Partnership Wales organisations:

- All Wales Medical Genomics Service (AWMGS - Clinical and Laboratory)
- Pathogen Genomics Unit (PenGU, Microbiology, PHW)
- Wales Gene Park (Cardiff University).

1.2 Strategic Case

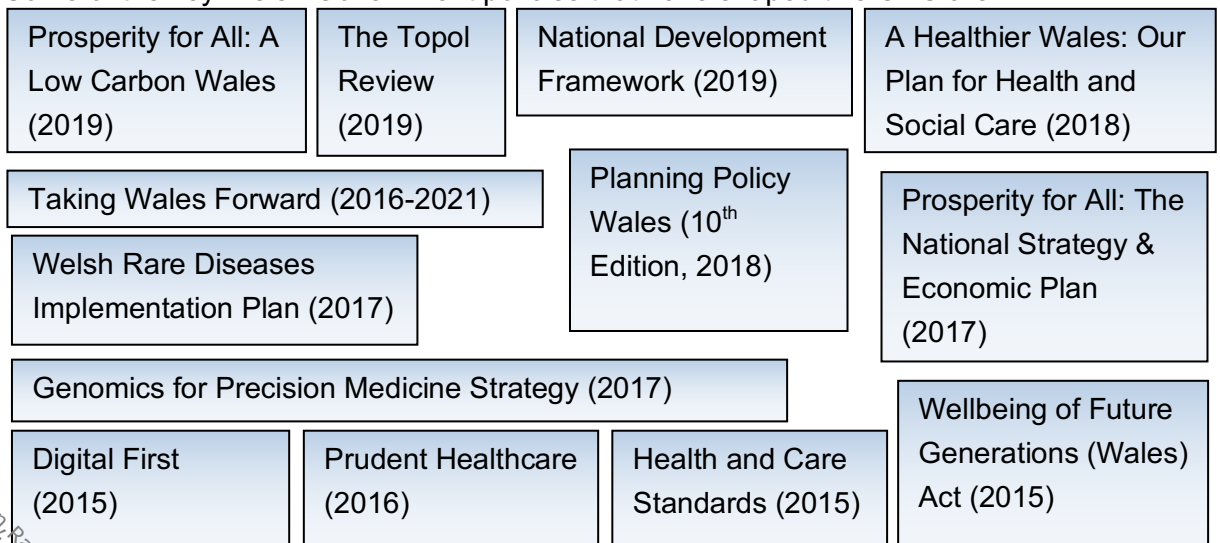
1.2.1 The Strategic Context

Throughout the development of this OBC, the Health Board has been mindful to ensure it continues to consider and take account of local and national drivers for the health and wellbeing of the community.

Cardiff and Vale UHB is responsible for planning and delivering health services for its local population of around 485,000, which represents 15.5% of the country's residents. This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres, community health teams and mental health services. The Health Board employs approximately 14,500 staff and has an annual budget of £1.4 billion.

The Health Board is confident that the strategic drivers for this investment and associated strategies, programmes and plans are consistent with national, regional and local strategy and policy documents.

Some of the key Welsh Government policies that have shaped this OBC are:



Executive Summary Figure 1: Overarching National Policies considered within this OBC

Key local strategies taken into consideration within this OBC are:

- Strategic Clinical Services Plan 2019 – 2029;
- Shaping Our Future Wellbeing Strategy (2015 – 2025);
- Integrated Medium Term Plan 2019 / 2022;
- Cardiff and Vale UHB Estates Strategy;
- Cardiff and Vale UHB Delivering Digital: a Five Year Strategy – Building a learning health and care system (July 2020);
- Cardiff and Vale UHB Informatics Strategy (2017/18 – 2019/20).

There are three key partners involved in the development of the proposals within this business case. These are:

- All Wales Medical Genomics Service;
- Pathogen Genomics Unit (PenGU);
- Wales Gene Park.

1.2.2 The Case for Change

1.2.2.1 Service Vision

All Wales Medical Genomics Service (AWMGS)

The AWMGS must be able to grow with the demands for the service and have the capacity and capability to deliver the future (many unknown) required services for Welsh patients. This includes the development and delivery of new genomic technologies for introduction into the NHS.

The service will need to form partnerships with external stakeholders to enhance the delivery of patient services, utilising staff experience and skills, and the technologies available in Wales.

Pathogen Genomics Unit (PenGU)

Public Health Wales will have a genomic-focused health protection and infection prevention control service within 5 years and beyond. To achieve this ambition, the plans are centred on five key objectives that will guide activity and actions over the life of the project, as follows:

- Delivering infectious disease services that are equitable, consistent and reflective of the needs of patients in Wales – fulfilling the prudent healthcare principle to work with patients and healthcare professionals to improve outcomes so that patients have a greater control of their own health.
- Driving an efficient research and innovation base – prioritising support for investigation and research to promote coproduction and cross discipline work.
- Initiating economic growth – using NGS to instigate productivity, transform the service and create commercial opportunities.
- Facilitating partnership in developing and adopting new approaches in public health – capitalising on existing collaborative work and research strengths to foster collaboration and enhance contributions to future development

- Building capacity, training, educating and developing staff in NGS – developing and investing in staff to build biomathematics, bioinformatics and bench-level capability in the Wales workforce.

Wales Gene Park (WGP)

To harness genetics and genomics to advance research, healthcare, education and innovation. The WGP genomics facility strive to continue to provide the best and most cost-effective NGS technologies at affordable pricing to researchers within Wales, and to incorporate new genomic technologies as they become required by healthcare researchers in Wales. A major strength of WGP genomics facility is the ability to capitalise on the multiple types of sequencing instruments within Cardiff to provide affordable NGS and bioinformatic support for the research community within Wales.

The WGP genome editing facility supports researchers generate new models of disease, expanding provision to include collaborations incorporating genome editing within human IPS cell lines.

The WGP education and engagement facility focus on enhancing awareness and understanding of genetics and genomics, engaging with health and science professionals, schools, colleges and the public.

1.2.2.2 Key requirements

The need for additional space

Current estates occupied by the partners, especially the laboratory facilities, are not fit for purpose in terms of space available and lack of flexibility to meet the new service and technological needs. In order for the genomic services to be sustained and developed at pace, additional space is required to house new equipment, and to accommodate the expanding workforce and the increasing portfolio of new genomics services to improve patient care. Services have historically been designed around the limited space available, which results in inefficiencies across the delivery pathways.

The need to improve the quality of services

In order for Wales to compete with the Genomic Medicine Service in England, premises should be developed around the workflow of the laboratories and needs of patients, if we are going to continue to guarantee the quality of services delivered. Some efficiencies will be found through co-locating NHS, Public Health and research laboratories, where the same equipment can be used by multiple organisations. This will benefit all co-located organisations in terms of access to new technologies as they emerge and management of resources to meet changing and at times unpredictable demand (such as virus outbreaks). The NHS and Public Health services need quality laboratories and infrastructure to sustain their UKAS accreditation (ISO 15189).

The need to better integrate research and clinical activity

For the translation of research into clinical practice to be seen as a priority and given the best chance of succeeding, close working on a day-to-day basis is essential. Not only from the perspective of sharing equipment and expertise, but to facilitate discussions between both communities to ensure that areas of clinical priority, also align with research priorities. Where gaps exist, these can then be identified easily and strategically developed.

The need to form a critical mass in order to attract top talent and high-value partnerships

Competing with the likes of Oxford, Cambridge and London to attract high-value, UK-national and international partnerships is very difficult when the skills, expertise and physical footprint is fragmented. Being able to host public as well as professional engagement meetings and events to showcase our work and enable networking with many organisations simultaneously, will undoubtedly position genomics in Wales in a stronger position.

In line with Welsh Government guidance, the scope of this business case has been assessed against a continuum of need ranging from:

- A minimum – essential or core requirements/outcomes;
- An intermediate – essential and desirable requirements/outcomes;
- A maximum – essential, desirable and optional requirements/outcomes.

This business case takes forward the maximum scope and will include the following services:

- All Wales Medical Genomics Service (AWMGS - Clinical and Laboratory)
- Pathogen Genomics Unit (PenGU, Microbiology, PHW)
- Wales Gene Park (Cardiff University).

A summary of the investment objectives together with the main benefits associated with each objective is provided below:

Investment Objective	Main Benefits
Investment Objective 1: An All-Wales state-of-the-art genomic medicine facility that benefits both patients and the wider Welsh population	▪ The development of national-level services to provide support for non-infectious disease diagnostics ▪ Introduction of new technologies and services ▪ Development of specific, appropriate environment for laboratory services for both clinical and research purposes ▪ Development of clinical areas which meet patient needs

Investment Objective	Main Benefits
Investment Objective 2: An integrated facility to develop both NHS and Public Health genomic services, as well as an environment to grow the genomic research portfolio in Wales	▪ Co-location of laboratory and clinical genetics services is essential for the increasing requirement for joint working and interpretation of genomic medicine services. ▪ Improved turnaround times for services ▪ Reduced waiting lists ▪ Increased research activities that translate to clinical care
Investment Objective 3: A facility that supports the translation of genomic medicine from the bench to the clinic, enabling the rapid evaluation and adoption of new genomic technologies to benefit patients	▪ Introduction of new technologies and services ▪ Provision of new clinical services
Investment Objective 4: Capacity for integrated working from both an equipment and infrastructure, and staff resource perspective	▪ Equipment being fully utilized and capacity managed across partners ▪ Increased efficiencies in use of the facilities ▪ Improvements in adjacencies of staff providing cross working opportunities
Investment Objective 5: A hub to attract top talent to the Welsh genomics workforce, with the facilities to train, develop and retain our staff for the good of the services and citizens of Wales	▪ The provision of population-level activities to help tackle health inequalities ▪ Improved staff retention ▪ Ability to attract and recruit high calibre staff
Investment Objective 6: An outward-facing hub that competes on a global stage, attracting new high-value partnerships to Wales that in turn, expedite the mainstreaming and understanding of genomics for the benefit of our citizens	▪ An increase in the number of partnerships established ▪ A higher level of engagement activities with various parties ▪ Increased patient involvement
Investment Objective 7: Capacity for future growth, to accommodate the advancement of new genomic technologies and workforce expansion	▪ Introduction of new services ▪ New research studies undertaken ▪ Increased workforce being accommodated ▪ New laboratory and digital equipment implemented

Executive Summary Table 1: Investment Objectives and Main Benefits

1.3 Economic Case

1.3.1 The Long List

The long list of options was generated in accordance with best practice contained in the Infrastructure Investment Guidance. The evaluation was undertaken in accordance with how well each option met the investment objectives and critical success factors (CSFs).

An options framework to generate the long list of options was utilised. By systematically working through the available choices for what, how, who, delivery timescale and funding. Some options were discounted, others carried forward as possible to then provide the recommended approach to identify the preferred way forward.

The table below provides a summary of the findings of the long list option appraisal:

Option	Finding
1.0 Scope	
Option 1.1 – do nothing	Discounted (carried forward for comparative purposes)
Option 1.2 – do 'minimum' – provide facilities for the Pathogen Genomics Unit	Discounted
Option 1.3 – 'intermediate' - provide facilities for the Pathogen Genomics Unit and the Wales Gene Park	Discounted
Option 1.4 – 'maximum' - provide facilities for the Pathogen Genomics Unit, the Wales Gene Park and the All Wales Medical Genomics Service	Preferred
2.0 Service Solutions	
Option 2.1: Refurbish the existing facilities	Discount
Option 2.2: New build on the UHW site	Discount
Option 2.3: New build on the GE site	Possible
Option 2.4: Extensive refurbishment of CD1 on the GE site	Possible
Option 2.5: Partial refurbishment of CD1 on the GE site	Preferred
Option 2.6: Refurbishment of CD1 for Pathogen Genomics Unit and the Wales Gene Park and upgrade buildings 19 and 20 for the All Wales Medical Genomics Service	Discount
3.0 Service Delivery	
3.1 In House	Discounted
3.2 Partial Outsource	Discounted
3.3 Strategic Partnership	Preferred
4.0 Implementation	
4.1 Big Bang	Preferred
4.2 Phased	Discounted
5.0 Funding	
Only public funding has been considered as it has been agreed with Welsh Government that this project will be supported	

Executive Summary Table 2: Summary of Inclusions, Exclusions and Possible Options

1.3.2 The Short List

The 'preferred' and 'possible' options identified in the table above have been carried forward into the short list for further appraisal and evaluation. All the options that were discounted as impracticable have been excluded at this stage, with the exception of the Do Nothing option which has been carried forward for comparative purposes only.

On the basis of this analysis, the recommended short list for further appraisal is as follows:

	Scope	Service Solution	Service Delivery	Implementation	Funding
Option 0	Do nothing				
Option 1	Pathogen Genomics Unit, the Wales Gene Park and the All Wales Medical Genomics Service	New build on the GE site	Strategic Partnership	Big Bang	Public
Option 2	Pathogen Genomics Unit, the Wales Gene Park and the All Wales Medical Genomics Service	Extensive refurbishment of CD1 on the GE site	Strategic Partnership	Big Bang	Public
Option 3	Pathogen Genomics Unit, the Wales Gene Park and the All Wales Medical Genomics Service	Partial refurbishment of CD1 on the GE site	Strategic Partnership	Big Bang	Public

Executive Summary Table 3: Short Listed Options

1.3.3 Qualitative Benefits Appraisal Key Findings

The evaluation of the qualitative benefits associated with each of the shortlisted options was taken to the Project Team.

Benefit Criteria	Weighted Scores			
	Option 0	Option 1	Option 2	Option 3
1. Build Reputation as Centre of Excellence	14	140	126	112
2. Create a United Partnership in Genomics	12	120	108	96
3. Maximising Patient Access to Genomics services	50	100	90	90
4. Improved Strategic Fit of Services	20	50	50	50
5. Maintaining the Clinical Quality of Services	84	140	126	126
6. Optimising the Quality of Facilities	9	90	81	72
7. Ease of Access to the Site	20	20	20	20
8. Making more effective Use of Resources	45	54	63	72
9. Sustainable in the Long Term	18	48	36	36
10. Providing Flexibility for the Future	7	70	56	49
11. Practicality and Timeliness of Delivery	100	40	60	90
TOTALS	**379**	**872**	**816**	**813**
RANK (weighted)	**4**	**1**	**2**	**3**

Executive Summary Table 4: Summary Results of Option Appraisal

1.3.4 Preferred Option

The preferred option is the partial refurbishment of the existing CD1 building on the GE site to provide integrated laboratories and support accommodation for:

- All Wales Medical Genomics Service (AWMGS - Clinical and Laboratory)
- Pathogen Genomics Unit (PenGU, Microbiology, PHW)
- Wales Gene Park (Cardiff University).

1.4 Commercial Case

1.4.1 Procurement Strategy

The construction will be procured through the NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) established NHS 'Building for Wales' Framework. The Supply Chain Partner (SCP) Interserve Construction has been appointed under the framework to develop both the design and construction of the proposed facility.

Contractual Arrangements have been entered into with all parties for the OBC stage using the NEC contract as prescribed under the Framework..

It is anticipated that the total construction duration will run for 12 months (including enabling works) although the start date for this is dependent on the approvals process.

1.4.2 Required Services

The scope of services required is for the project management, cost advice and the design and construction of integrated laboratories for the following services, via a refurbishment of the existing CD1 building on the GE site:

- All Wales Medical Genomics Service (AWMGS - Clinical and Laboratory)
- Pathogen Genomics Unit (PenGU, Microbiology, PHW)
- Wales Gene Park (Cardiff University).

1.4.3 Community Benefits and Procurement

The Health Board are working with the Supply Chain Partner as part of the Considerate Construction Strategy to measure the identified benefits extended from this scheme.

1.5 Financial Case

1.5.1 Capital Costs

A summary of the capital costs and impairment for the preferred option is as follows:

	£000
Works costs	8,042
Fees	1,328
Non-works costs	3,552
Equipment	698
Contractor Quantified Risk provision	2,193
VAT Reclaim	-489
Total Gross	**15,324**

Executive Summary Table 5: Capital Costs for the Preferred Option

Year	DEL Impairment £m	AME Impairment £m	TOTAL £m
2020/21	0	0	0
2021/22	0	0	0
2022/23	0	10.317	10.317
2023/24	0	0	0

Executive Summary Table 6: Impairment for the Preferred Option

This OBC assumes all capital charges and depreciation will be funded by WG in each of the years as per the above.

1.5.2 Revenue Costs

The table below shows the total revenue costs including showing the difference from the current revenue costs (excluding capital charges, depreciation and impairment):

The following is a summary of the total impact of capital charges and depreciation by year until the planned opening of the new facility:

Expenditure type	£
Business rates	121,660
Energy	106,000
Estates maintenance	122,589
Domestic services	87,243
Security	12,787
Waste	15,408
Digital	98,111
Building lease charge/rent	600,000

Expenditure type	£
Insurance	13,694
Service charge	162,607
Transport costs	TBC
Total	**1,340,099**
Assumed releasable costs	(152,619)
Net additional Costs	**1,187,480**

Executive Summary Table 7: Revenue Costs

Assumptions:

- Business rates is an estimate supplied by Deloittes, so can go up or down;
- Energy costs have been costed by the energy team;
- Maintenance, security and waste are calculated on EFPMS(estates and facilities benchmarking system) price per SQM. The other areas are based on actual costs provided by the department however these costs are estimates and further work will need to be undertaken to validate the costs identified by reviewing the new building and its service needs;
- Cleaning costs have been calculated based on current hours cleaned for the current services and pro rata up for the new Genomics site. However Facilities will need to review the building and the split of clinical to office space to calculate an accurate figure;
- The rent is £500k plus vat and is free for the first year and will apply from Year 2;
- Digital cost have been costed by IT;
- Insurance cost have been provided by GE estates;
- The service charge is included at £3.5 per sq. foot and will be capped at this cost but go up each year with RPI;
- Assumes VAT is recoverable on the service charge;
- No assessment is currently being made of the potential impact on the SLA with Cardiff University as a result of the University vacating space at UHW due to this development.

1.5.3 Overall Affordability

It is assumed the impairment and recurrent charges for depreciation will be funded by WG. The net additional revenue costs and funding are summarised in the table below:

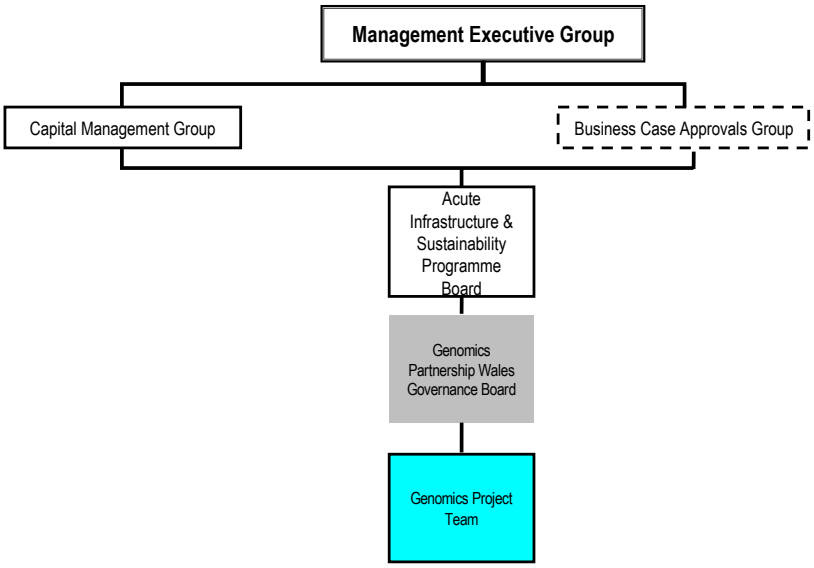
	£m
Impairment WG impairment funding	10.317
Depreciation WG Strategic Capital charge funding	0.999
Other Additional Revenue Costs	1.187

Executive Summary Table 8: Overall Affordability

1.6 Management Case

1.6.1 Project Management Arrangements

The reporting organisation and the reporting structure for the project is shown below:



Executive Summary Figure 2: Project Reporting Structure

The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
OBC submission to WG	November 2020
FBC submission to WG	March 2021
Design completion and commence construction	August 2021
Construction completion	August 2022
Facility operational	October 2022

Executive Summary Table 9: Key Milestones

1.6.2 Benefits Realisation and Risk Management

A draft benefits realisation plan has been developed that outlines the key objectives, benefits and measures, which will be used to evaluate the project, it also shows who has the accountability for its realisation. This benefits realisation plan will be finalised during the development of the FBC.

The risk management strategy has been integrated into the project management procedures, with responsibility for implementation of the strategy resting with the Project Director. The key risks of the preferred option have been assessed and strategies for managing them outlined. An initial risk register has been developed for the preferred option which includes all risks identified to date.

1.6.3 Post Project Evaluation Arrangements

The Health Board is committed to ensuring that positive lessons are learned through full and effective evaluation of key stages of the project. This learning will be of benefit to the Health Board in undertaking future projects, and potentially to other stakeholders and the wider NHS.

1.7 Recommendation

It is recommended that approval be given for the Cardiff and Vale University Health Board to develop this project to Full Business Case stage.

The preferred option is the construction of integrated laboratories for the following services, via a refurbishment of the existing CD1 building on the GE site:

- All Wales Medical Genomics Service (AWMGS - Clinical and Laboratory)
- Pathogen Genomics Unit (PenGU, Microbiology, PHW)
- Wales Gene Park (Cardiff University).

The project will enable Health Board to meet the requirements for improving the quality of services and improvements in efficiencies through better workflow and co-location with Public Health and research laboratories and ensure the laboratories continue to meet the UKAS accreditation (ISO 15189).

Report Title:	**Cardiff and Vale COVID-19 Mass Vaccination Programme Summary Update**								
Meeting:	Cardiff and Vale University Health Board Board Meeting					**Meeting Date:**	26 November 2020		
Status:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**	**X**	
Lead Executive:	**Executive Director of Public Health**								
Report Author (Title):	**Consultant in Public Health**								

Background and current situation:

Introduction:
The long term response to the COVID-19 pandemic requires a safe and effective vaccine to be available to all who need it.

Cardiff and Vale University Health Board (CVUHB) has overall responsibility for the protection of public health within the Cardiff and Vale of Glamorgan area. This includes responsibility for planning the response to a pandemic, a key part of which over the next 12 months is the delivery of vaccinations to large numbers of people in a short timescale.

This paper outlines the proposal for the delivery of the COVID-19 Mass Vaccination programme. It is recognised that this proposal will change as operational and service plans are developed and further clarity on vaccine type, priority groups, and timescale for delivery is understood.

Current Situation:
Every Health Board in Wales was tasked with submitting preliminary plans for the delivery of the COVID-19 vaccination programme locally by 3 September 2020 to the Chief Medical Officer for Wales. Cardiff and Vale UHB submitted a strategic level plan, approved by the CVUHB Chief Executive Officer. A more detailed operational plan for mass vaccination in Cardiff and the Vale of Glamorgan is currently being developed. A Programme Manager is now in place to oversee the coordination and development of the programme plan.

A Cardiff and Vale COVID-19 Vaccine Programme Board (Chaired by the Executive Director of Public Health) provides the strategic leadership for the programme. A wider Stakeholder Group brings key representatives from partner agencies together to provide support for the planning and delivery of the Covid-19 mass vaccination programme and ensure that the quality and safety of care is the highest priority during the programme. Six work streams have been identified (Workforce & Training; Venues & Logistics; end-to-end person journey; Vaccine Considerations, Digital, and Communications), each with multi-agency membership, working across the programme to ensure a joined up, collaborative approach. Each work stream reports weekly to the Programme Board

Delivery of mass vaccination will encompass a blended model, according to the different priority groups. This will include a combination of mass vaccination centres, mobile vaccination teams and vaccination in workplace settings. The identified mass vaccination centres are:

- Holm View Leisure Centre, Barry (Vale)
- Pentwyn Leisure Centre, Pentwyn (Cardiff North and West)
- Cardiff and Vale Therapy Centre, Splott (Cardiff South and East). This will be dual-use with the current Community Testing Unit.

In addition to the mass vaccination centres, the programme also requires the establishment of a booking line / call centre for eligible individuals to make vaccination appointments. The location for the booking centre has been scoped and will be Cardiff and Vale Therapy Centre, Splott. Holm View Leisure Centre in Barry will be prepared for use as a business continuity plan for the booking centre should it be required. The intention will be for at least 50% of the booking centre workforce to be remotely based. The necessary work will be undertaken at both venues for this purpose.

The vaccination programme in Cardiff and the Vale of Glamorgan, as per the rest of Wales, is planned to be delivered over a 9-12 month period, starting from mid December 2020, when the first delivery of vaccines is expected. This will coincide with the delivery of the seasonal flu vaccination programme which takes place from Sept to March 2020. However, it is anticipated that the bulk of flu vaccination will be delivered by 31 December 2020. There are several planning assumptions which have been made around the development of the programme, listed in Appendix 1.

Approximately 265,000 people across Cardiff and Vale UHB will be eligible for Covid-19 vaccination, according to the Joint Committee on Vaccination and Immunisation (JCVI) interim advice on priority groups. Please note, this figure includes all in Priority Groups 1-10 as set out below and not Group 11 (rest of the population - priority to be determined). This figure does not account for all the overlap between the groups (e.g. a person could be aged 50-65 years and also in a high risk group) and the final number is likely to be lower due to uptake being less than 100%. The total figure of those eligible is likely to change once the final priority groups are agreed by JCVI.

The interim ranking of priorities is a combination of clinical risk stratification and an age based approach, which should optimize the vaccination programme according to need, and deliverability. A provisional ranking of prioritisation for persons at risk by the JCVI is set out below:

1. older adults resident in a care home and care home workers
2. all those 80 years of age and over and health and social care workers
3. all those 75 years of age and over
4. all those 70 years of age and over
5. all those 65 years of age and over
6. high-risk adults under 65 years of age
7. moderate-risk adults under 65 years of age
8. all those 60 years of age and over
9. all those 55 years of age and over
10. all those 50 years of age and over
11. rest of the population (priority to be determined)

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

The delivery of a mass vaccination programme for Cardiff and Vale will be a significant undertaking and will require substantial resources in order to achieve the level of vaccination that is needed. A major cost implication will be the recruitment of the relevant workforce to run the mass vaccination events as well as the need for suitably equipped venues with the appropriate IT infrastructure. A national digital solution is being developed by NWIS (the *Welsh Immunisation System* or WIS), to be made available by the end of November. The UHB's Director of Digital and Health Intelligence is currently working through the assumptions and specification required for the most effective solution for Cardiff and Vale UHB.

A further, major implication will be the establishment of a booking centre which will manage the call/recall process and receive incoming calls from individuals for appointments. The booking centre approach has been agreed to reduce Did Not Attend (DNA) rates and to prevent wastage of the vaccine. There is an urgency to prepare a venue for this service, develop the IT infrastructure and to commence staff recruitment and training. Various estate options have been explored including in-house "physical" venues as well as a virtual booking centre. It has been agreed to use Cardiff and Vale Therapy Centre as the booking centre due to the space available and the ability to co-locate with the clinical vaccination team. Holm View Leisure Centre is to be prepared as a business continuity solution should it be required.

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

Assessment

As this is a key area of work which needs to be delivered and as such will require substantial resources. There is a need to urgently agree funding to enable the planning and delivery to be developed at scale.

Risk and Mitigations

Risk	Mitigation
CVUHB does not produce a costed, operational delivery plan in the timescales required.	Employment of Programme Manager to move plans forward at pace has been undertaken.
If CVUHB cannot get required workforce, pace of vaccination will be reduced	Use of Flu Champion Peer Vaccinators and Occupational Health staff for vaccination of frontline UHB staff. Work stream currently working through sourcing options including voluntary sector and Local Authorities for non-clinical roles.

Funding source needs to be clarified. This affects workforce, venues and pharmacy distribution and storage.	Health Board lead identified (Lynne Aston). Financial plan worked up.
National IT solution will not be available in required timescales and/or does not meet local requirements	Head of Digital/IT working with NWIS. Local plan for digital solution being considered.

Recommendation:

- **NOTE** the content of this 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	X	Long term	X	Integration		Collaboration	X	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.*

APPENDIX 1: Planning Assumptions

Vaccine availability

It is assumed:

- vaccine will be available mid Dec and training for staff will commence mid-November and costs incurred from then.
- The costs of the vaccine will be met by UK Government or Welsh Government.

Numbers to be considered for vaccination

The numbers identified for vaccination are as identified in Table 1 of the Health Board's delivery plan. The total of this population is 265,000, each requiring 2 vaccinations 28 days apart, total 530,000. This does not take account of overlap between the priority groups and is currently based on 100% uptake.

Vaccination venues

Vaccinations will be carried out in 3 venues in each of the Cardiff and Vale localities with the following number of stations (vaccination points):

- Splott (Cardiff South): 20 stations
- Holm View (Vale): 10 stations
- Pentwyn (North Cardiff): 10 stations

It is assumed operating times will be 7 days per week and operating times will be 7.30am – 8.00pm with opening times 8.30am – 7.30pm.

Where vaccinations are carried out in care homes or where vaccine is delivered to those with underlying comorbidities who cannot visit a vaccination site, this will be delivered by a mobile team who will work 9.00am to 5.00pm.

Workforce requirements

Staffing requirements are based on delivering the program within 9-12 months and based on the number of stations identified. It is assumed that legislation will be amended to permit unregistered nurses to undertake the vaccination, although that decision is currently unconfirmed. The skill mix and supervisory arrangements have been agreed with the professional nurse lead. Administrative support will be required at each venue.

Digital / IT infrastructure

A large scale digital infrastructure is required to implement the programme, and a national Welsh Immunisation Service is being developed to support this. The resources required for digital and IT input includes support staff, networking, configuration, repair, telecommunications, reporting etc.

Vaccine delivery / storage

Central vaccine delivery costs will be provided by shared services at no cost in line with current arrangements. Storage of vaccine (frozen vaccine) at Welsh Blood service is assumed at no cost. Vaccines will be delivered to the sites through a coordinated programme.

Communications / Advertising

It is assumed that responsibility for advertising / communications will be with the Health Board and will not be undertaken centrally. A comprehensive communications plan will be put in place, based on national messages but with local information where needed.

Report Title:	**Stakeholder Reference Group Nomination of Chair and New Members**								
Meeting:	**UHB Board**						**Meeting Date:**	**26th November 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**X**	**For Information**	
Lead Executive:	**Executive Director of Strategic Planning**								
Report Author	**Strategic Partnership and Planning Manager**								

BACKGROUND AND CURRENT SITUATION

The Stakeholder Reference Group (SRG), a statutory Advisory Group to the Board, is currently without a substantive Chair. This report seeks the Board's approval of the SRG's nomination for Chair and approval of two other new members, in accordance with the process set out in Standing Orders.

EXECUTIVE DIRECTOR OPINION/KEY ISSUES TO BRING TO THE ATTENTION OF THE BOARD/COMMITTEE

The previous SRG Chair, Richard Thomas, left the Group in March 2020 having reached the end of his extended term of office. Since that time Vice-Chair, Geoffrey Simpson has fulfilled the role of interim Chair. Members of the SRG were subsequently invited to put forward nominations for the role of Chair. On 23 September, SRG member Sam Austin put her name forward as the new Chair. Sam provides a third sector perspective to SRG in relation to working with children and young people and is the Deputy Chief Executive of Llamau. The SRG membership has been canvassed and is now formally nominating Sam Austin as its Chair. The Chair of SRG is also an Associate Member of the Board.

In addition we have two new nominations to the SRG, replacing previous members: Cllr Janice Charles who has been nominated by the Vale of Glamorgan Council; and Siva Sivapalan who has been nominated via an open invitation process facilitated by the County Voluntary Councils (CVCs), to provide a third sector perspective in relation to older people. Siva is a member of the Cardiff 50+ Forum and a committee member of the Hindu Council of Wales.

The SRG carer member reluctantly decided to step down over the summer for personal reasons. The CVCs led a process to recruit a new member but this was unsuccessful and following advice about the pressures currently faced by carers, an interim arrangement has been agreed for a member of staff from the Carers Trust SE Wales which provides the Cardiff and Vale Carers Gateway service, to attend SRG to provide a carer perspective.

ASSESSMENT AND RISK IMPLICATIONS (SAFETY, FINANCIAL, LEGAL, REPUTATIONAL etc.)

The Board must appoint a substantive Chair to this Advisory Group.

RECOMMENDATION

The Board is asked to:

- **APPROVE** the appointment of Sam Austin as Chair of the SRG and seek the necessary formal approval from Welsh Government.

- **APPROVE** the nomination of Cllr Charles and Siva Sivapalan to the SRG
- **NOTE** the interim steps taken to provide a carer perspective to the SRG

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								

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Report Title:	**Corporate Meeting Schedule 2021-22**								
Meeting:	Board						**Meeting Date:**	26.11.20	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		**x**
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Corporate Governance**								

Background and current situation:

Each year the Corporate Meeting Schedule is developed to plan out the Board and Committee meeting dates for the following year. This exercise has been completed for 2021-22 and the resulting schedule is being presented to Board for sign off; this is the first time the schedule has come to Board with the aim of strengthening this governance process and ensuring full engagement.

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

The proposed Corporate Meeting Schedule for 2021-22 is attached at Appendix 1. It is planned to ensure key reporting requirements are met such as end of year reporting / sign off of annual accounts and also to provide adequate run in time for the publishing of papers to comply with Standing Orders.

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

It is crucial that the dates set out in the Corporate Meeting Schedule are adhered to and therefore where Committee Chairs or Executive Leads are not able to attend agenda settings, arrangements should be made for their relevant Vice Chairs / Executive Deputies to step in. This will ensure smooth running of the process and provide report authors with the requisite time to prepare their reports in advance of the deadlines.

Where there is a requirement to set an additional "special" meeting, this will be facilitated by the Corporate Governance Team and the schedule updated to reflect the same.

Recommendation:

The Board is asked to:

- Note and approve the attached Corporate Meeting Schedule for 2021-22.

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	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		Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

CORPORATE MEETING SCHEDULE 2021 - 22											
Dates	**Audit**	**Board / Board Development**	**Board of Trustee**	**Charitable Funds**	**Digital & Health Intelligence**	**Finance**	**Health & Safety**	**Mental Health Capacity Legislation**	**Quality, Safety & Experience**	**RaTs**	**Strategy & Delivery**
Mar-21											
Agenda Setting		03 February 2021		09 February 2021							02 February 2021
Deadline for Papers		08 March 2021		02 March 2021			16 March 2021				23 February 2021
Date of Meeting		**25 March 2021**		**16 March 2021**		**24 March 2021**	**30 March 2021**			**26 March 2021**	**09 March 2021**
Apr-21											
Agenda Setting	15 February 2021	31 March 2021						08 March 2021	09 March 2021		
Deadline for Papers	23 March 2021	12 April 2021						06 April 2021	30 March 2021		
Date of Meeting	**06 April 2021**	**29 April 2021**				**28 April 2021**		**20 April 2021**	**13 April 2021**		
May-21											
Agenda Setting		14 April 2021									29 March 2021
Deadline for Papers		10 May 2021									27 April 2021
Date of Meeting	***18TH MAY WORKSHOP***					**26 May 2021**					**11 May 2021**
Special Meeting		***27 May 2021***									
Jun-21											
Agenda Setting	17 May 2021	02 June 2021		26 April 2021	19 April 2021				03 May 2021		
Deadline for Papers	15 June 2021	07 June 2021		25 May 2021	18 May 2021				01 June 2021		
Date of Meeting		**24 June 2021**		**08 June 2021**	**01 June 2021**	**23 June 2021**			**15 June 2021**		
Special Meeting	**29 June 2021**										
Jul-21											
Agenda Setting	14 June 2021	16 June 2021	02 June 2021					07 June 2021			31 May 2021
Deadline for Papers	13 July 2021	12 July 2021	01 July 2021				22 June 2021	06 July 2021			29 June 2021
Date of Meeting	**27 July 2021**	**29 July 2021**				**28 July 2021**	**06 July 2021**	**20 July 2021**			**13 July 2021**
Special Meeting		**AGM 29 July 2021**	***15 July 2021***								
Aug-21											
Agenda Setting		04 August 2021									
Deadline for Papers		09 August 2021									
Date of Meeting		**26 August 2021**				**25 August 2021**					
Sep-21											
Agenda Setting	09 August 2021	18 August 2021	11 August 2021	26 July 2021					30 July 2021		02 August 2021
Deadline for Papers	07 September 2021	13 September 2021	09 September 2021	24 August 2021					14 September 2021		31 August 2021
Date of Meeting	**21 September 2021**	**30 September 2021**	**23 September 2021**	**07 September 2021**		**29 September 2021**			**28 September 2021**		**14 September 2021**
Oct-21											
Agenda Setting		06 October 2021			23 August 2021			06 September 2021	13 September 2021		
Deadline for Papers		11 October 2021			21 September 2021		28 September 2021	05 October 2021	12 October 2021		
Date of Meeting		**28 October 2021**			**05 October 2021**	**27 October 2021**	**12 October 2021**	**19 October 2021**		**21 October 2021**	
Special Meeting									**26 October 2021**		
Nov-21											
Agenda Setting	18 October 2021	13 October 2021									04 October 2021
Deadline for Papers	16 November 2021	08 November 2021									02 November 2021
Date of Meeting	**30 November 2021**	**25 November 2021**				**24 November 2021**					**16 November 2021**
Dec-21											
Agenda Setting		08 December 2021		25 October 2021					01 November 2021		
Deadline for Papers		13 December 2021		23 November 2021					30 November 2021		
Date of Meeting		**30 December 2021**		**07 December 2021**		**29 December 2022**			**14 December 2021**		
Jan-22											
Agenda Setting		15 December 2021	08 December 2021					06 December 2021			29 November 2021
Deadline for Papers		10 January 2022	06 January 2022				11 January 2022	04 January 2022			28 December 2021
Date of Meeting		**27 January 2022**	**20 January 2022**			**26 January 2022**	**25 January 2022**	**18 January 2022**			**11 January 2022**
Feb-22											
Agenda Setting	20 December 2021	02 February 2022			20 December 2021				10 January 2022		
Deadline for Papers	25 January 2022	07 February 2022			18 January 2022				08 February 2022		
Date of Meeting	**08 February 2022**	**24 February 2022**			**01 February 2022**	**23 February 2022**			**22 February 2022**		
Mar-22											
Agenda Setting		16 February 2022		17 January 2022							31 January 2022
Deadline for Papers		14 March 2022		15 February 2022							01 March 2022
Date of Meeting		**31 March 2022**		**01 March 2022**		**30 March 2022**					**15 March 2022**
Apr-22											
Agenda Setting	07 March 2022	06 April 2022						14 March 2021	28 February 2022		
Deadline for Papers	05 April 2022	11 April 2022					22 March 2022	12 April 2021	29 March 2022		
Date of Meeting	**19 April 2022**	**28 April 2022**				**27 April 2022**	**05 April 2022**	**26 April 2021**	**12 April 2022**		

2021

April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday	DHIC	1	Thursday	HSMB	1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
2	Friday		2	Sunday		2	Wednesday		2	Friday		2	Monday		2	Thursday	HSMB	2	Saturday		2	Tuesday		2	Thursday	HSMB
3	Saturday		3	Monday		3	Thursday	HSMB	3	Saturday		3	Tuesday		3	Friday		3	Sunday		3	Wednesday		3	Friday	
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6	Tuesday	Audit	6	Thursday	HSMB	6	Sunday		6	Tuesday	Health & Safety	6	Friday		6	Monday		6	Wednesday		6	Saturday		6	Monday	
7	Wednesday		7	Friday		7	Monday		7	Wednesday		7	Saturday		7	Tuesday	CFC	7	Thursday	HSMB	7	Sunday		7	Tuesday	CFC
8	Thursday	HSMB	8	Saturday		8	Tuesday	CFC	8	Thursday		8	Sunday		8	Wednesday		8	Friday		8	Monday		8	Wednesday	
9	Friday		9	Sunday		9	Wednesday		9	Friday		9	Monday		9	Thursday		9	Saturday		9	Tuesday		9	Thursday	
10	Saturday		10	Monday		10	Thursday		10	Saturday		10	Tuesday		10	Friday		10	Sunday		10	Wednesday		10	Friday	
11	Sunday		11	Tuesday	Strategy	11	Friday		11	Sunday		11	Wednesday		11	Saturday		11	Monday		11	Thursday		11	Saturday	
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13	Tuesday	QSE	13	Thursday		13	Sunday		13	Tuesday	Strategy	13	Friday		13	Monday		13	Wednesday		13	Saturday		13	Monday	
14	Wednesday		14	Friday		14	Monday		14	Wednesday		14	Saturday		14	Tuesday	Strategy	14	Thursday		14	Sunday		14	Tuesday	QSE
15	Thursday		15	Saturday		15	Tuesday	QSE	15	Thursday	BOT Special	15	Sunday		15	Wednesday		15	Friday		15	Monday		15	Wednesday	
16	Friday		16	Sunday		16	Wednesday		16	Friday		16	Monday		16	Thursday		16	Saturday		16	Tuesday	Strategy	16	Thursday	
17	Saturday		17	Monday		17	Thursday		17	Saturday		17	Tuesday		17	Friday		17	Sunday		17	Wednesday		17	Friday	
18	Sunday		18	Tuesday	Audit workshop	18	Friday		18	Sunday		18	Wednesday		18	Saturday		18	Monday		18	Thursday		18	Saturday	
19	Monday		19	Wednesday		19	Saturday		19	Monday		19	Thursday		19	Sunday		19	Tuesday	MHCL	19	Friday		19	Sunday	
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21	Wednesday		21	Friday		21	Monday		21	Wednesday		21	Saturday		21	Tuesday	Audit	21	Thursday	RATS	21	Sunday		21	Tuesday	
22	Thursday		22	Saturday		22	Tuesday		22	Thursday		22	Sunday		22	Wednesday		22	Friday		22	Monday		22	Wednesday	
23	Friday		23	Sunday		23	Wednesday	Finance	23	Friday		23	Monday		23	Thursday	BOT	23	Saturday		23	Tuesday		23	Thursday	
24	Saturday		24	Monday		24	Thursday	Board + Dev	24	Saturday		24	Tuesday		24	Friday		24	Sunday		24	Wednesday	Finance	24	Friday	
25	Sunday		25	Tuesday		25	Friday		25	Sunday		25	Wednesday	Finance	25	Saturday		25	Monday		25	Thursday	Board	25	Saturday	
26	Monday		26	Wednesday	Finance	26	Saturday		26	Monday		26	Thursday	Board + Dev	26	Sunday		26	Tuesday	Special QSE	26	Friday		26	Sunday	
27	Tuesday		27	Thursday	Special Board	27	Sunday		27	Tuesday	Audit	27	Friday		27	Monday		27	Wednesday	Finance	27	Saturday		27	Monday	
28	Wednesday	Finance	28	Friday		28	Monday		28	Wednesday	Finance	28	Saturday		28	Tuesday	QSE	28	Thursday	Board + Dev	28	Sunday		28	Tuesday	
29	Thursday	Board + Dev	29	Saturday		29	Tuesday	Special Audit	29	Thursday	Board + AGM	29	Sunday		29	Wednesday	Finance	29	Friday		29	Monday		29	Wednesday	Finance
30	Friday		30	Sunday		30	Wednesday		30	Friday		30	Monday		30	Thursday	Board	30	Saturday		30	Tuesday	Audit	30	Thursday	Board + Dev
			31	Monday					31	Saturday		31	Tuesday					31	Sunday					31	Friday	

2022

Jan			Feb			Mar			Apr			May			Jun		
1	Saturday		1	Tuesday	DHIC	1	Tuesday	CFC	1	Friday		1	Sunday		1	Wednesday	
2	Sunday		2	Wednesday		2	Wednesday		2	Saturday		2	Monday		2	Thursday	HSMB
3	Monday		3	Thursday	HSMB	3	Thursday	HSMB	3	Sunday		3	Tuesday		3	Friday	
4	Tuesday		4	Friday		4	Friday		4	Monday		4	Wednesday		4	Saturday	
5	Wednesday		5	Saturday		5	Saturday		5	Tuesday	Health & Safety	5	Thursday	HSMB	5	Sunday	
6	Thursday	HSMB	6	Sunday		6	Sunday		6	Wednesday		6	Friday		6	Monday	
7	Friday		7	Monday		7	Monday		7	Thursday	HSMB	7	Saturday		7	Tuesday	DHIC
8	Saturday		8	Tuesday	Audit	8	Tuesday		8	Friday		8	Sunday		8	Wednesday	
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10	Monday		10	Thursday		10	Thursday		10	Sunday		10	Tuesday		10	Friday	
11	Tuesday	Strategy	11	Friday		11	Friday		11	Monday		11	Wednesday		11	Saturday	
12	Wednesday		12	Saturday		12	Saturday		12	Tuesday	QSE	12	Thursday	BOT	12	Sunday	
13	Thursday		13	Sunday		13	Sunday		13	Wednesday		13	Friday		13	Monday	
14	Friday		14	Monday		14	Monday		14	Thursday		14	Saturday		14	Tuesday	QSE
15	Saturday		15	Tuesday		15	Tuesday	Strategy	15	Friday		15	Sunday		15	Wednesday	
16	Sunday		16	Wednesday		16	Wednesday		16	Saturday		16	Monday		16	Thursday	
17	Monday		17	Thursday		17	Thursday		17	Sunday		17	Tuesday	Strategy	17	Friday	
18	Tuesday	MHCL	18	Friday		18	Friday		18	Monday		18	Wednesday		18	Saturday	
19	Wednesday		19	Saturday		19	Saturday		19	Tuesday	Audit	19	Thursday	Board	19	Sunday	
20	Thursday	BOT	20	Sunday		20	Sunday		20	Wednesday		20	Friday		20	Monday	
21	Friday		21	Monday		21	Monday		21	Thursday		21	Saturday		21	Tuesday	
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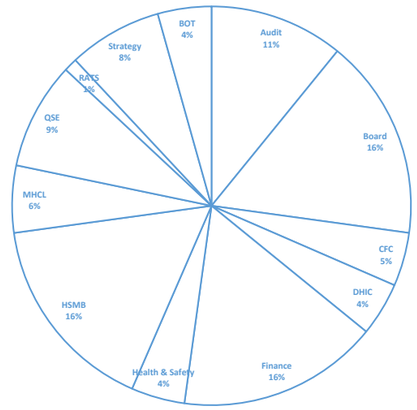
24	Monday		24	Thursday	Board + Dev	24	Thursday		24	Sunday		24	Tuesday		24	Friday	
25	Tuesday	Health & Safety	25	Friday		25	Friday		25	Monday		25	Wednesday	Finance	25	Saturday	
26	Wednesday	Finance	26	Saturday		26	Saturday		26	Tuesday	MHCL	26	Thursday	Audit Workshop	26	Sunday	
27	Thursday	Board	27	Sunday		27	Sunday		27	Wednesday	Finance	27	Friday		27	Monday	
28	Friday		28	Monday		28	Monday		28	Thursday	Board + Dev	28	Saturday		28	Tuesday	Audit Special
29	Saturday					29	Tuesday		29	Friday		29	Sunday		29	Wednesday	Finance
30	Sunday					30	Wednesday	Finance	30	Saturday		30	Monday		30	Thursday	Board Special
31	Monday					31	Thursday	Board				31	Tuesday				



Audit	10
Board	15
CFC	4
DHIC	4
Finance	15
Health & Safety	4
HSMB	15
MHCL	5
QSE	8
RATS	1
Strategy	7
BOT	4

2021

April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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17	Saturday		17	Monday		17	Thursday		17	Saturday		17	Tuesday		17	Friday		17	Sunday		17	Wednesday		17	Friday	
18	Sunday		18	Tuesday	Audit workshop	18	Friday		18	Sunday		18	Wednesday		18	Saturday		18	Monday		18	Thursday		18	Saturday	
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28	Wednesday		28	Friday		28	Monday		28	Wednesday		28	Saturday		28	Tuesday		28	Thursday		28	Sunday		28	Tuesday	
29	Thursday		29	Saturday		29	Tuesday	Special Audit	29	Thursday		29	Sunday		29	Wednesday		29	Friday		29	Monday		29	Wednesday	
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			31	Monday					31	Saturday		31	Tuesday					31	Sunday					31	Friday	

2022

Jan			Feb			Mar			Apr			May			Jun		
1	Saturday		1	Tuesday		1	Tuesday		1	Friday		1	Sunday		1	Wednesday	
2	Sunday		2	Wednesday		2	Wednesday		2	Saturday		2	Monday		2	Thursday	
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8	Saturday		8	Tuesday	Audit	8	Tuesday		8	Friday		8	Sunday		8	Wednesday	
9	Sunday		9	Wednesday		9	Wednesday		9	Saturday		9	Monday		9	Thursday	
10	Monday		10	Thursday		10	Thursday		10	Sunday		10	Tuesday		10	Friday	
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18	Tuesday		18	Friday		18	Friday		18	Monday		18	Wednesday		18	Saturday	
19	Wednesday		19	Saturday		19	Saturday		19	Tuesday	Audit	19	Thursday	Audit Workshop	19	Sunday	
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21	Friday		21	Monday		21	Monday		21	Thursday		21	Saturday		21	Tuesday	
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26	Wednesday		26	Saturday		26	Saturday		26	Tuesday		26	Thursday		26	Sunday	
27	Thursday		27	Sunday		27	Sunday		27	Wednesday		27	Friday		27	Monday	
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29	Saturday					29	Tuesday		29	Friday		29	Sunday		29	Wednesday	
30	Sunday					30	Wednesday		30	Saturday		30	Monday		30	Thursday	
31	Monday					31	Thursday					31	Tuesday				

Audit	10
Board	0
CFC	0
DHIC	0
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Health & Safety	0
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MHCL	0
OSE	0
RATS	0
Strategy	0
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2021

April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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21	Wednesday		21	Friday		21	Monday		21	Wednesday		21	Saturday		21	Tuesday		21	Thursday		21	Sunday		21	Tuesday	
22	Thursday		22	Saturday		22	Tuesday		22	Thursday		22	Sunday		22	Wednesday		22	Friday		22	Monday		22	Wednesday	
23	Friday		23	Sunday		23	Wednesday		23	Friday		23	Monday		23	Thursday		23	Saturday		23	Tuesday		23	Thursday	
24	Saturday		24	Monday		24	Thursday	Board + Dev	24	Saturday		24	Tuesday		24	Friday		24	Sunday		24	Wednesday		24	Friday	
25	Sunday		25	Tuesday		25	Friday		25	Sunday		25	Wednesday		25	Saturday		25	Monday	Board	25	Thursday		25	Saturday	
26	Monday		26	Wednesday		26	Saturday		26	Monday		26	Thursday	Board + Dev	26	Sunday		26	Tuesday		26	Friday		26	Sunday	
27	Tuesday		27	Thursday	Special Board	27	Sunday		27	Tuesday		27	Friday		27	Monday		27	Wednesday		27	Saturday		27	Monday	
28	Wednesday		28	Friday		28	Monday		28	Wednesday		28	Saturday		28	Tuesday		28	Thursday	Board + Dev	28	Sunday		28	Tuesday	
29	Thursday	Board + Dev	29	Saturday		29	Tuesday		29	Thursday	Board	29	Sunday		29	Wednesday		29	Friday		29	Monday		29	Wednesday	
30	Friday		30	Sunday		30	Wednesday		30	Friday		30	Monday		30	Thursday	Board	30	Saturday		30	Tuesday		30	Thursday	Board + Dev
			31	Monday					31	Saturday		31	Tuesday					31	Sunday					31	Friday	

2022

Jan			Feb			Mar			Apr			May			Jun		
1	Saturday		1	Tuesday		1	Tuesday		1	Friday		1	Sunday		1	Wednesday	
2	Sunday		2	Wednesday		2	Wednesday		2	Saturday		2	Monday		2	Thursday	
3	Monday		3	Thursday		3	Thursday		3	Sunday		3	Tuesday		3	Friday	
4	Tuesday		4	Friday		4	Friday		4	Monday		4	Wednesday		4	Saturday	
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6	Thursday		6	Sunday		6	Sunday		6	Wednesday		6	Friday		6	Monday	
7	Friday		7	Monday		7	Monday		7	Thursday		7	Saturday		7	Tuesday	
8	Saturday		8	Tuesday		8	Tuesday		8	Friday		8	Sunday		8	Wednesday	
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14	Friday		14	Monday		14	Monday		14	Thursday		14	Saturday		14	Tuesday	
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22	Saturday		22	Tuesday		22	Tuesday		22	Friday		22	Sunday		22	Wednesday	
23	Sunday		23	Wednesday		23	Wednesday		23	Saturday		23	Monday		23	Thursday	
24	Monday		24	Thursday	Board + Dev	24	Thursday		24	Sunday		24	Tuesday		24	Friday	
25	Tuesday		25	Friday		25	Friday		25	Monday		25	Wednesday		25	Saturday	
26	Wednesday		26	Saturday		26	Saturday		26	Tuesday		26	Thursday		26	Sunday	
27	Thursday	Board	27	Sunday		27	Sunday		27	Wednesday		27	Friday		27	Monday	
28	Friday		28	Monday		28	Monday		28	Thursday	Board + Dev	28	Saturday		28	Tuesday	
29	Saturday					29	Tuesday		29	Friday		29	Sunday		29	Wednesday	
30	Sunday					30	Wednesday		30	Saturday		30	Monday		30	Thursday	Board Special
31	Monday					31	Thursday	Board				31	Tuesday				

Audit	0
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Health & Safety	0
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Khan Raj
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2021

April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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1	Saturday		1	Tuesday		1	Tuesday		1	Friday		1	Sunday		1	Wednesday	
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20	Thursday	BOT	20	Sunday		20	Sunday		20	Wednesday		20	Friday		20	Monday	
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Khan Raj
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2021

April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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			31	Monday					31	Saturday		31	Tuesday					31	Sunday					31	Friday	

2022

Jan			Feb			Mar			Apr			May			Jun		
1	Saturday		1	Tuesday		1	Tuesday	CFC	1	Friday		1	Sunday		1	Wednesday	
2	Sunday		2	Wednesday		2	Wednesday		2	Saturday		2	Monday		2	Thursday		
3	Monday		3	Thursday		3	Thursday		3	Sunday		3	Tuesday		3	Friday		
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7	Friday		7	Monday		7	Monday		7	Thursday		7	Saturday		7	Tuesday		
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29	Saturday					29	Tuesday		29	Friday		29	Sunday		29	Wednesday		
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31	Monday					31	Thursday					31	Tuesday					

Audit	0
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2021

April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday	DHIC	1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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Jan			Feb			Mar			Apr			May			Jun		
1	Saturday		1	Tuesday	DHIC	1	Tuesday		1	Friday		1	Sunday		1	Wednesday	
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20	Thursday		20	Sunday		20	Sunday		20	Wednesday		20	Friday		20	Monday	
21	Friday		21	Monday		21	Monday		21	Thursday		21	Saturday		21	Tuesday	
22	Saturday		22	Tuesday		22	Tuesday		22	Friday		22	Sunday		22	Wednesday	
23	Sunday		23	Wednesday		23	Wednesday		23	Saturday		23	Monday		23	Thursday	
24	Monday		24	Thursday		24	Thursday		24	Sunday		24	Tuesday		24	Friday	
25	Tuesday		25	Friday		25	Friday		25	Monday		25	Wednesday		25	Saturday	
26	Wednesday		26	Saturday		26	Saturday		26	Tuesday		26	Thursday		26	Sunday	
27	Thursday		27	Sunday		27	Sunday		27	Wednesday		27	Friday		27	Monday	
28	Friday		28	Monday		28	Monday		28	Thursday		28	Saturday		28	Tuesday	
29	Saturday					29	Tuesday		29	Friday		29	Sunday		29	Wednesday	
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April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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1	Saturday		1	Tuesday		1	Tuesday		1	Friday		1	Sunday		1	Wednesday	
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4	Tuesday		4	Friday		4	Friday		4	Monday		4	Wednesday		4	Saturday	
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6	Thursday		6	Sunday		6	Sunday		6	Wednesday		6	Friday		6	Monday	
7	Friday		7	Monday		7	Monday		7	Thursday		7	Saturday		7	Tuesday	
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April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday		1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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April			May			June			July			Aug			Sep			Oct			Nov			Dec		
1	Thursday		1	Saturday		1	Tuesday		1	Thursday	HSMB	1	Sunday		1	Wednesday		1	Friday		1	Monday		1	Wednesday	
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MHCL	0
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RATS	1
Strategy	0
BOT	0

Report Title:	**Velindre Radiotherapy Satellite Centre – Outline Business Case**							
Meeting:	**Cardiff and Vale UHB Board Meeting**					**Meeting Date:**	26 Nov 2020	
Status:	**For Discussion**	✔	**For Assurance**		**For Approval**	✔	**For Information**	
Lead Executive:	**Executive Director of Strategic Planning**							
Report Author (Title):	**Assistant Director of Finaince – Financial Management and Strategy Head of Outcomes-Based Commissioning**							

Background and current situation:

Aneurin Bevan UHB (ABUHB) has submitted its Outline Business Case (OBC) for the Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital (NHH) for commissioner approval. The business case has been developed in conjunction with Velindre NHS Trust and will need to be considered by the relevant Boards, including Cardiff and Vale UHB to support ABUHB's submission of the case to Welsh Government for capital funding and progression to Full Business Case. The main implication for C&V UHB is the consideration of the associated Velindre LTA revenue proposals associated with the capital OBC.

The OBC for the Radiotherapy Satellite Centre forms part of the plans to transform cancer services (TCS) in South East Wales. The TCS programme has been agreed in principle by all health boards and Welsh Government. The TCS programme includes the development of a new Velindre Cancer Centre (nVCC) on land adjacent to the existing Velindre Cancer Centre (VCC). The decision regarding the nVCC proposal is due from Welsh Government by the end of the calendar year. Currently all radiotherapy for the south-east Wales population is delivered from VCC in Cardiff. Demand for radiotherapy treatment is growing at an average rate of 2% per year, through a combination of population growth, earlier diagnosis and increasing numbers of suitable indications for treatment. There are also a number of new techniques that require longer treatment time, such as Deep Inhaled Breath Holding (DIBH) to achieve better outcomes. This increases demand for radiotherapy service time irrespective of increase in the number of patients.

The required capacity for radiotherapy is modelled over 10 years for this business case. Radiotherapy is currently delivered from 6 Linear Accelerator (linac) machines at VCC which are all reaching the end of their useful life and will need to be replaced for the move to the nVCC. The strategic long term plan is to have 8 linacs at nVCC and 2 at the RSC at NHH to deliver the required capacity for South East Wales. The case has been presented at the Collaborative Cancer Leadership Group, Directors of Planning and the Collective Commissioning Group.

The new facility would primarily be used by residents within the Aneurin Bevan Health Board area, but this would free up capacity within the existing VCC facilities for Cardiff and Vale residents. There would be qualitative benefits for AB patients in terms of reduced travelling times and convenience and for C&V patients in terms of reduced waiting times. The current Joint Council for Oncology (JCO) standard for maximum referral to treatment time is 28 days, but the Welsh Single Cancer Pathway aims to reduce this to 21 days. Currently radiotherapy

demand is lower than predicted due to reduced referral rates during COVID, however Velindre is forecasting the demand to increase significantly from December, reaching pre-COVID levels by the end of the 2020/21 financial year.

The existing facilities at Velindre are being utilised near to capacity, with some linacs currently over their expected life span, with enhanced maintenance required to extend their utility to the completion timescale for nVCC. Radiotherapy demand will exceed supply before the completion of the nVCC if the proposed facility at NHH does not proceed. In this scenario, additional radiotherapy capacity would need to be outsourced from private facilities, such as the Rutherford Cancer Centre in Newport, or further afield in Swansea or Bristol. This would be at a higher unit cost and there is no guarantee that sufficient capacity would be available to meet demand, with increased travel times for Cardiff and Vale patients.

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

The main consideration for C&V UHB is the availability and cost of additional capacity at the existing or nVCC site to meet anticipated future increased demand. It is not anticipated that that there will be material patient flows from the C&V UHB area to the Nevill Hall satellite centre. The creation of the satellite centre at Nevill Hall improves access for AB, Powys and Cwm Taf patients as part of the overall required increase in radiotherapy capacity for South East Wales.

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

The OBC provides forecast funding requirements of £30.286m for capital expenditure and £2.547m recurrent annual revenue costs. Velindre is requesting that £0.712m of the £2.547m recurrent funding requirement is provided early to enable lead costs to for early recruitment and training to supported.

The current Long Term Agreement with Velindre is based upon a longstanding financial framework that Velindre NHS Trust and commissioners have recognised does not reflect current costs of radiotherapy delivery. Finance leads from Velindre and commissioning health boards have developed and agreed a new financial framework based on updated costs and financial principles. It was planned to shadow run the new financial framework in 2020-21 with a view to full live implementation in 2021-22. Covid 19 has caused some of these plans to be delayed as block contracts have been operated to ensure stable fund flows across the NHS Wales system. The financial assessment of the revenue proposals by Velindre has been conducted alongside the context of the new financial framework and what would be paid to Velindre under the new financial framework.

The proposed revenue costs are based on the assessed staff and non-staff resources required to operate to run two linacs at full capacity the Nevill Hall site. These costs have been benchmarked against the financial framework and alternative providers to assess value for money :-

Table 1 – Alternative radiotherapy provision cost

Benchmarked Equivalent Costs	£s
Private Provider Fee	10,866,325
English Tariff (Bristol)	2,698,212
English Tariff (Christie)	2,565,508

NHH Satellite Centre Preferred Option Comparison	2,546,607

The benchmarked cost assessment support the cost proposal as being reasonable within a market context.

The proposed costs have also been assessed against the cost had the two linacs been commissioned and run from the nVCC. This highlights a diseconomy of scale by running a satellite centre remotely from the main centre of £0.183m. Some diseconomy of scale would have been expected in operating a radiotherapy service from two different geographic locations. Commissioners are making enquiry with Velindre to better understand the justification for this value.

Table 2 – Cost of provision from a one site delivery model

	nVCC £s	NHH £s	**Diseconomy of scale £s**
TOTAL COST	2,363,884	2,546,607	182,723
C&V Estimated impact through the financial framework			50,797

The proposed revenue investment represents 89% of the cost of activity had Velindre been financed for the full cost of the profiled additional radiotherapy activity under the new financial framework. This demonstrates that Velindre are not inappropriately recovering corporate overheads as a result of the revenue proposal.

The proposal to C&V UHB is to invest in additional radiotherapy capacity that it is forecast C&V UHB residents will require over the next ten year period based on a 2% annual increase assumption. In reality, radiotherapy activity will be more volatile from year to year but has broadly followed a 2% average increase in recent years.

The request for C&V UHB is contained in Table 3.

It is important to note that, under the new financial framework for Velindre, the variable cost liability will materialise for C&V UHB irrespective of any decision to support the two site radiotherapy model if patient demand increases and can be met by Velindre NHS Trust. The key component is the request to fund the additional fixed cost in Velindre NHS Trust, starting in 2022-23 partially recognising increased activity already delivered and partly to meet the recruitment and training required for the new two-site model. This investment would then be sustained to support new demand and capacity requirements from 2023-24 onwards.

Velindre NHS Trust has agreed that the non-recurrent lead in funding will be capped at £0.712m (for all commissioners) but limited to actual costs incurred according to the ability to recruit in advance of opening the RSC.

Table 3 – Projected additional radiotherapy requirement and cost for C&V UHB

		Cost that varies with performance £	Fixed Capacity Investment £	Total Projected Investment £	Fractions Purchased
	2020/21 Projection	53,259		53,259	576
	2021/22 Projection	53,259		53,259	576
Transition Costs	2022/23 Projection	53,259	204,443	257,702	576
Opening	2023/24 Projection	35,506	82,379	117,885	384
	2024/25 Projection	35,506		35,506	384
	2025/26 Projection	35,506		35,506	384
	2026/27 Projection	35,506		35,506	384
	2027/28 Projection	35,506		35,506	384
	2028/29 Projection	35,506		35,506	384
	2029/30 Projection	35,506		35,506	384
	2030/31 Projection	35,506		35,506	388
	Total Investment	**443,825**	**286,822**	**730,647**	**4,804**

The additional radiotherapy capacity is profiled over the following treatment areas. In reality this will vary as capacity and demand come online.

Table 5- Profiled additional radiotherapy treatments for C&V UHB residents

Treatment Type	Cardiff & Vale
Prostate Fractions	2,133
Breast non-DIBH	928
Breast DIBH	928
Palliative Treatment	487
Radiotherapy - Planning Palliative/Single Point	98
Radiotherapy - Planning Breast	62
Radiotherapy - Planning Breast Advanced	62
Radiotherapy - Planning Abdominal & Thoracic	107
TOTAL ACTIVITY	**4,804**

Discussions continue with Velindre NHS Trust colleagues and other commissioners to consider adjustment to investment values if the anticipated radiotherapy demand does not materialise.

Velindre NHS Trust has issued a paper stating :-

"a proposal of a tolerance for marginal rates was discussed, the essence of which was to establish a mechanism for recognising significant fluctuations against the planned growth. The intent being that both Commissioner and VCC are commensurately funding activity /resourced to deliver activity, with funding returned to commissioners for fixed costs where activity is significantly below the planned growth"

This consideration requires further discussion between Velindre NHS trust and commissioners but provides assurance that Velindre NHS Trust recognises the need to review the additional fixed cost investment for additional radiotherapy capacity at an appropriate time.

In conclusion, the AB/Velindre proposal is for C&V UHB to support Welsh Government investment in additional radiotherapy infrastructure based on a two-site model. The direct ask of C&V UHB is to invest in additional radiotherapy activity to be provided by Velindre over the next decade in anticipation of increased demand.

Recommendation:

The Cardiff and Vale Board is asked to;

1. Approve the OBC in principle to proceed to Welsh Government for the consideration of investment in radiotherapy infrastructure.

2. Agree in principle to support the revenue costs associated with increased demand for radiotherapy for Cardiff and Vale residents, subject to:

    - Further engagement to understand the underlying principles and assumptions for the radiotherapy demand modelling
    - An agreement to the timescales to review actual demand and re-assess respective commissioner investments in fixed cost capacity
    - An agreement of the mechanism by which the review would be conducted

3. Agree to support 'lead in' implementation costs as they are incurred for recruitment and other necessary advance service commissioning costs.

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Our Ref JP/SH/np/cj

9 October 2020

Carol Shillabeer, Chief Executive, Powys tHB
Paul Mears, Chief Executive, Cwm Taf Morgannwg UHB
Len Richards, Chief Executive, Cardiff & Vale UHB

Dear Colleague

Radiotherapy Satellite Centre (RSC) Outline Business Case (OBC)

Please find attached the RSC OBC for the consideration and approval of your Health Board. The OBC is the product of significant multi-disciplinary and inter-organisational working at a time of particular disruption caused by COVID-19. The work has also been supported by the Project Supply Chain Partner and Advisors. You can see from the information provided, specifically in the Economic Case, that the preferred option is identified as a Satellite Unit at Nevill Hall Hospital. An Executive Summary of the RSC OBC is also attached.

You will recall that the development of an RSC has been a core element of the TCS Programme for a number of years. It applies the principle of care closer to home that is central to the clinical model. The OBC identifies the benefits that will accrue from this investment and the risks that will be mitigated by the expansion of radiotherapy capacity for the population of South East Wales. We can confirm to you that the Case for the RSC, although aligned and complimentary to the Case for the nVCC, stands independently of that other decision.

The Case identifies that this Unit can be operational in the summer of 2023 on the proviso that the OBC is approved in December 2020 to enable the FBC to commence and, critically, the enabling works to commence in January 2021. This is a critical dependency on the Project Timeline. The Case also identifies a forecast revenue funding requirement of commissioners totalling £2.547m recurring and £0.712m required to support the development based on current projections of activity. This forecast funding requirement primarily relates to the cost of meeting the predicted radiotherapy demand growth for South East Wales population that would be required irrespective of the various options considered. We can advise you that Aneurin Bevan Health Board approved its contribution of £1.0m recurring and £0.279m non-recurring at its Health Board meeting

on 23rd September 2020. I can also confirm to you that the OBC was approved by the Velindre Trust Board on 24th September.

With regard to progressing the case, the Project Finance Team have already engaged with commissioners through the Collective Commissioning Group (CCG) and the professional scrutiny of the financial aspects of the OBC undertaken to date is presented in the Financial Case. You will note that the Financial Case also requests capital resources of £30.286m from the Welsh Government to fund the infrastructure development.

Aneurin Bevan University Health Board and Velindre University NHS Trust are jointly seeking the formal support of the OBC by partner Commissioners in South East Wales including Cardiff & Vale University Health Board, Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board. We are progressing scrutiny dialogue with the Welsh Government in parallel with your organisations review process.

The joint Project Board has also requested the RSC OBC be placed on the agenda of the Collaborative Cancer Leadership Group at its meeting on the 14th October in order to continue the collective commissioner dialogue in relation to this regional Case.

We shall contact you shortly to discuss the opportunity and provide any further information required by your organisation to achieve approval.

We are grateful for your support in this matter.

Yours sincerely

Judith Paget

Judith Paget
Prif Weithredwr/
Chief Executive

Steve Ham
Prif Weithredwr/
Chief Executive

Encs

cc Powys tHB, Cwm Taf Morgannwg UHB and Cardiff & Vale UHB:
Finance Directors
Directors of Planning
Medical Directors
Board Secretaries

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Transforming Cancer Services In South East Wales

Radiotherapy Satellite Centre (RSC)

Outline Business Case

RSC 0BC
Sept 2020

Outline Business Case: 2020

Radiotherapy Satellite Centre (RSC)

Executive Summary

EXECUTIVE SUMMARY

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1 INTRODUCTION

1.1 Velindre Cancer Centre (VCC) is a centre of excellence for the non-surgical treatment of cancer. It is one of the ten largest regional clinical oncology centres in the United Kingdom and the largest of the three centres in Wales.

1.2 VCC serves the 1.5 million people who live in South East Wales, providing services at Velindre Cancer Centre in Cardiff and at a number of other sites in its catchment area and in patients' own homes. The Centre, however, is fast approaching the point where our skilled workforce will be unable to meet the needs of patients

1.3 To ensure that Cancer Services meets the needs of the population into the future, the Welsh Government requested that Commissioners and Velindre University NHS Trust (VUNHST) develop a Transforming Cancer Services (TCS) Programme Business Case for South East Wales. This work, that commenced in 2015 and provided a PBC in 2017 established a Clinical Model for Cancer Services in South East Wales. This was actioned through extensive engagement and consultation with partner organisations including Third Sector and, importantly, patients and their families.

1.4 After significant stakeholder and patient engagement, the Clinical Model within the PBC required the development of Regional Radiotherapy Satellite Centre to serve the North of the South East Wales catchment population. An option appraisal, independently led, was undertaken and Nevill Hall Hospital in Abergavenny was identified as the preferred location for the Regional Radiotherapy Satellite Centre (RSC).

1.5 In parallel with this work on the RSC OBC, an nVCC OBC has been developed, approved by Commissioners and submitted to Welsh Government on 8th July 2019. In this context, the Trust has received Outline Planning Permission to build the new Velindre Cancer Centre (nVCC) in Whitchurch, Cardiff. The nVCC Project Approval timeline is shared below:

Table 1-1: nVCC OBC Approval Timelines

Description	Planned Completion Date	Status
nVCC OBC approved by commissioners	April 2018	Completed
nVCC OBC approved by Trust Board	July 2019	Completed
Submission of nVCC OBC to the Welsh Government	July 2019	Completed
nVCC Commercial Approval Point (CAP) 1	TBC	Ongoing
Ministerial approval of nVCC OBC	TBC	Ongoing

1.6 There is a key relationship between the nVCC and RSC Project, and between both these Projects and the Integrated Radiotherapy Solution (IRS) procurement. These relationships relate to demand management, workforce development, clinical effectiveness and commissioning optimisation. The rationale for an RSC has been made in the TCS PBC and the selection of Nevill Hall Hospital as the preferred site in a separate option appraisal. The OBC focuses on the deliverability, affordability and VFM of that solution as compared to the expansion of the nVCC beyond the SOA contained within its current OBC.

1.7 Further, the Welsh Government approved resources in August 2019 to enable the development of an OBC for the RSC. The Project Advisors were appointed in October and November 2019 and support the RSC Project Board and Project Team established by Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) to develop the OBC. The RSC OBC was approved by both VUNHST and ABUHB on 24th September and 23rd September respectively.

1.8 The OBC identifies that the preferred RSC option is deliverable, affordable and offers VFM.

1.9 It should be noted that significant additional revenue costs will be required in excess of the revenue cost of the preferred option to provide additional Radiotherapy capacity to meet forecast demand if the proposed satellite unit does not progress. The majority of that activity will need to be provided via other Providers.

2 OVERVIEW OF THE OBC

2.1 The provision of a Radiotherapy Satellite Centre (RSC) has been identified within the Transforming Cancer Services (TCS) Programme as a key development to facilitate timely and effective services to the South East Wales population.

2.2 The case for an RSC is further articulated within the Strategic Case. The Strategic Case also sets the policy context within which the RSC Project is being undertaken and the role of the Project in improving cancer services for the people of South East Wales in the years' ahead. Specifically, the Strategic Case clearly sets down the deficiencies of the current Model of Service and the capacity limitations to meeting service demand.

2.2 The Economic Case identifies a Preferred Option. The Preferred Option develops an RSC on land under the ownership of the Health Board. The Preferred Option provides a modern, fit for purpose, environment that can evolve to meet future demands and developments as they emerge. The Economic Case sets down the Economic Appraisal that has been undertaken to identify the Preferred Option that offers the best Value for Money to NHS Wales.

2.3 The Commercial Case sets down the approach to the procurement of the solution and the commercial approach to be adopted within the Project. The Partnership arrangements between ABUHB and VUNHST are also presented. Shared Services Technical Team have contributed to the Commercial Case, given the importance of the RSC to the TCS Programme.

2.4 The Financial Case demonstrates the affordability of the Preferred Option. The Case sets down the Financial Framework used for the development of the OBC. The Financial Case also sets down the approach to the establishment of the revenue and capital costs set down in the Business Case. It presents the methodology for capital cost development, identified by our Technical Advisors, and scrutinised by NWSSP Shared Services Property Division. The methodology for revenue cost development, identified by the Financial Scrutiny Group (FSG), is also presented, along with the agreed model for cost distribution between Health Boards and Welsh Government.

2.5 The Management Case provides assurance to decision makers on the arrangements in place to support the effective delivery of the Project. It sets down the governance and management processes identified to effectively deliver the Preferred Option. The RSC Project Board and the RSC Project Team, established to deliver the procurement and associated commercial arrangements, and the supporting Project Management arrangements are presented. In addition, the External and Internal Advisors, that are integral to the delivery process, are described along with the mechanisms to be deployed for their effective utilisation and management. The Management Case also addresses the governance interface between the Health Board and the Trust.

3 STRATEGIC CASE

3.1 The Strategic Case sets out the case for the development of an RSC. It does this by articulating the deficiencies of the current Clinical Model and Service Capacity. The RSC OBC can be viewed as a partner Business Case to the nVCC OBC in terms of the sizing of the nVCC. It is important, however, to emphasise that the RSC OBC also stands alone and separate from the nVCC OBC in terms of the Solution proposed. The case is made for local provision regardless of the nVCC being progressed.

3.2 The limitations and challenges related to the current Clinical Model and Service capacity are impacting the Trust's ability to deliver effective high quality, patient centred services are presented.

3.3 It is widely accepted that the current patient travel distances are sub-optimal and does not sufficiently promote access, patient well-being and recovery. It is also widely accepted that improving the Clinical Interface and relationship between VCC and Local Cancer Services will improve patient care.

3.4 As well as the sub-optimal patient model, it is evidenced within the Strategic Case that the current Radiotherapy Service capacity (8 treatment machines) does not meet current and projected patient demand.

3.5 To demonstrate the level of future demand at the existing VCC, the Trust has undertaken a detailed demand modelling exercise. This involved comparing the current hospital capacity to meet demand in any new infrastructure. This analysis has been presented to, and supported by Commissioners, NHS Wales Shared Services and WG Officers.

3.6 There is also no space to expand on the existing VCC site. This represents a high risk to patients given the anticipated growth timeline in demand for services. While planning is underway to mitigate as far as possible capacity limitations in the short term, it is imperative that a substantive term solution is urgently established. The timeline for the nVCC, currently being projected to open in 2025 is a significant concern.

3.7 Essentially, the Strategic Case presents the case for additional capacity to be built at the RSC in support of the following Project Spending Objectives:

Table 3-1: RSC Project Spending Objectives

Project Spending Objective	Description
Project Spending Objective 1	To build new hospital infrastructure that supports **quality** and **safe** services.
Project Spending Objective 2	To provide sufficient **capacity** to meet future **demand** for services.
Project Spending Objective 3	To **improve patient, carer** and **staff experience.**
Project Spending Objective 4	To provide **capacity** and **facilities** to support the delivery of high quality **education**, **research**, **technology** and **innovation.**

3.8 The overall objective is to deliver an RSC that will provide excellent care for cancer patients from across the North of the region, closer to their homes. The RSC will provide a range of radiotherapy services for patients across South East Wales. In addition the RSC will support the VCC, and in due course the nVCC, to be an international focal point for research and education.

4 ECONOMIC CASE

4.1 The purpose of the Economic Case is to identify and appraise the potential options for the delivery of the RSC Project and identify the option (the Preferred Option) that provides the best value for money.

4.2 The RSC Project Board followed the Options Framework approach, as recommended in the Welsh Government's Better Business Case guidance, to identify the options for delivering the nVCC Project. These options were set in the context of the previous work of the TCS Programme in identifying the preferred location for any Regional Satellite Centre. This earlier work was approved by the TCS Programme Board and the sponsoring Commissioners, in 2017. Accordingly, the identified options for the OBC were agreed with the Welsh Government at the outset of the process. The options were evaluated and appraised by the RSC Project Board against the Project Spending Objectives (PSOs) and CSFs. The RSC Project Board used the outputs of this evaluation to identify the Preferred Way Forward for the Project.

4.3 The options appraised by the RSC Project Board are presented below:

- **The Status Quo Option 'Do Nothing':** This option provides a benchmark for assessing the value for money of all options. It is limited to the Operational Optimisation of existing arrangements as far as possible in order to improve the organisation's capability to meet current demand for core services and the provision of outsourced capacity to meet forecast additional demand.

- **RSC Option (Preferred Way Forward) 'Intermediate':** This option provides the development of a purpose built RSC. This option offers an early implementation which increases radiotherapy capacity in South East Wales and will be funded through NHS Capital.

- **nVCC Expansion 'Do Minimum':** This option offers the same capacity solution as the RSC Option with the feature of incorporating this capacity within an expanded nVCC. This option requires a delayed implementation which will be funded through a mix of private and public funding. It will also maintain the 'Status Quo' in terms of service location for the residents of the Northern catchment of South East Wales

4.4 The shortlisted options were then subjected to a robust Economic Appraisal. Table 4-1 summarises the output of this Appraisal.

Table 4-1: Net Present Cost of the Short Listed Options

Expenditure Heading	Do Nothing	Do Minimum (nVCC Extension)	RSC
Initial capital costs	0	-2,299	-27,086
Lifecycle capital costs	0	0	-3,349
Total capital costs	**0**	**-2,299**	**-30,435**

Transitional costs	0	-712	-712
Outsourcing during transitional period	0	-14,488	0
Recurring revenue costs	-616,664	-199,563	-144,520
Total revenue costs	**-616,664**	**-214,763**	**-145,232**
Quantified risks - capital costs	0	0	-1,707
Optimism bias	0	0	-1,358
Revenue expected risk value	0	-5,569	-3,147
Total risk costs	**0**	**-5,569**	**-6,212**
Total costs	**-616,664**	**-222,632**	**-181,880**
Benefits	0	0	582,733
Total benefits	**0**	**0**	**582,733**
Net Present Cost (undiscounted)	**-616,664**	**-222,632**	**400,854**
Total costs (discounted)	-242,925	-96,158	-83,589
Total benefits (discounted)	0	0	374,190
Net Present Cost (discounted)	**-242,925**	**-96,158**	**290,601**
Rank	**3**	**2**	**1**
Benefit Cost Ratio (discounted)	**0.00**	**0.00**	**4.48**
Rank	**2**	**2**	**1**

4.5 The Economic Appraisal demonstrated that the RSC Option offered the lowest Net Present Cost (NPC) of the two *'do something'* options and offers best value for money in terms of whole life costs.

4.6 It also offered the best benefit cost ratio at 4.48 suggesting that it offers best value for money in terms of the relationship between benefits and costs.

4.7 The Intermediate RSC Option, is, therefore, identified as the Preferred Option for the Project.

5 COMMERCIAL CASE

5.1 The Commercial Case sets out the basis on which the Project will deliver a commercially viable procurement and deals with:

- The procurement strategy for construction and equipment, and intended procurement route;
- The key project specific contractual arrangements and risk apportionment between the public and private sector;
- The funding mechanism for services over the duration of the Project;
- Any anticipated personnel implications; and
- The accountancy treatment of the Project.

5.2 The Commercial Case outlines the Welsh Government intention to deliver funding from NHS Capital.

5.3 The Commercial Case describes how the Project is a design and build Project. Project operated by the Health Board and the Trust in partnership. The clinical service and equipment will be provided, managed and maintained by the Trust.

5.4 The Health Board will be required to provide Hard FM services for planned building maintenance (including lifecycle replacement), reactive building maintenance and hard landscaping. The cost of providing these services will be charged to the Trust as part of the agreed Service Payment. All Soft FM services will be provided by the Health Board.

5.5 The Commercial Case confirms the expected accountancy treatment and the Project will be accounted for as “on balance sheet” for the Health Board.

6 FINANCIAL CASE

6.1 The purpose of the Financial Case is to demonstrate the affordability of the Preferred Option.

6.2 A Financial Framework has been developed to support the RSC Project. The scope of the Financial Framework is focused on costs directly attributable to this investment decision.

6.3 The Financial Case has been constructed and scrutinised in partnership with the Collective Commissioning Group (CCG) on behalf of the Commissioning Health Boards. The Financial Case provides detail on the costing methodology employed and reflects a professionally and technically recognised approach to determining OBC cost information.

6.4 The Financial Case outlines the capital requirements of the RSC Project. These costs are to be funded from the All Wales Capital Programme. These capital costs are presented in the table below.

Table 6-1: Capital Requirements

Cost category	Funding requirement £	Source of Funding
Project capital expenditure	30,285,532	Welsh Government

6.5 The Financial Case identifies the capital requirements of the Preferred Option for radiotherapy treatment machines and digital resources that are being procured via the Integrated Radiotherapy Solution (IRS) procurement currently going through Competitive Dialogue managed by the TCS Digital and Equipment Project Board.

6.6 The Financial Case outlines the recurring revenue costs requirement of the Preferred Option.

Table 6-2: Recurring Revenue Costs

	NHH RSC Preferred Option £
Workforce	
Radiotherapy Delivery	1,276,039
Medical Physics Delivery	526,394
Facilities	72,858
IT	16,223
Pharmacy	8,738
Pay	**1,900,252**
Non Pay	
Utilities	95,276
Hard FM	69,207
Rates	62,536
Soft FM	9,137
Consumables	75,000
Patient Transport	5,000
Equipment Maintenance	264,390
IM&T Maintenance	27,097
Pharmacy	708
Travel	38,005
Non Pay	**646,355**
TOTAL COST	**2,546,607**

6.7 The Financial Case outlines the Balance Sheet impact of the arrangements for the Trust and the Welsh Government as “on balance sheet”. It also provides details on the annual depreciation requirements of the Project which are planned to be resourced by the Welsh Government in the usual way.

6.8 The Financial Case outlines the agreed methodology for the distribution of revenue costs between Commissioners. It also outlines the approach to risk sharing and cost inflation. The table below sets down the agreed Commissioner shares and the distribution of the recurring revenue costs of the Project over Commissioners.

Table 6-3: Indicative Split of Commissioner Costs

Commissioners	Split %	Recurring Revenue Costs £
Swansea Bay UHB	0.64%	16,298
Aneurin Bevan UHB	39.25%	999,543
Cardiff & Vale UHB	28.69%	730,622
Cwm Taf Morgannwg UHB	27.78%	707,447
Hywel Dda UHB	1.51%	38,454
Powys THB	2.14%	54,497
WHSSC	0.00%	0
Total Recurring Revenue Costs	**100%**	**2,546,607**

6.9 The Financial Case outlines the non-recurring revenue requirements for Project pre-commissioning that will be funded by Commissioners. These non-recurrent costs total £0.712m in 2022/23.

6.10 The Financial Case also outlines the new approach to LTA arrangements, that will support the Projects financial arrangements which have been recently agreed by the Trust and Commissioners.

7 MANAGEMENT CASE

7.1 The Management Case describes the Project Governance, Assurance and Management Arrangements to successfully deliver the RSC Project, to time, cost and quality. It describes the role of the TCS Programme Delivery Board, Project Board, Project Team, the External and Internal Advisors and how their contribution will be integrated within the delivery of the RSC Project.

7.2 The Project Structure will ensure the RSC Project has the ability to seek timely approvals, can be effectively reported on, and has the effective escalation of risks and issues leading to effective decision making.

7.3 The Management Case further describes how it will use Project Management methodologies to effective manage the Project. This also includes the effective oversight and management of benefits and risks.

7.4 Given the NHS capital route for the Project, the Management Case sets out how it will manage the procurement of the RSC. This includes the specification of the role of External and Internal Advisors that will also contribute to the process.

7.5 The proposed approach to change control, procurement and contracts management is also presented.

7.6 The Management Case also sets out important estimated timelines, for the procurement and the construction of the RSC, based on industry benchmarks. These are summarised in Table 7-1.

Table 7-1: Project Plan Key Milestones

Milestone	Dates
Submission of OBC to Commissioners and Welsh Government	September 2020
Welsh Government Approval / FBC Commencement	January 2021
Enabling Works Commencement	January 2021
Submission of FBC to Welsh Government	September 2021
Welsh Government Approval / Start-on-site	November 2021
Completion	August 2023 (subject to confirmation of IRS Preferred Partner and commissioning period)

8 PREFERRED OPTION

8.1 The Preferred Option delivers an RSC at Nevill Hall Hospital, Abergavenny. The ambition is to deliver a world-class facility that will provide specialist care for cancer patients from that locality. The RSC will provide a range of radiotherapy services for patients across the northern catchment population of South East Wales. In addition the RSC will support the nVCC to become an international focal point for research, learning, technology and innovation. A summary of the key requirements and features of the Preferred Option are provided below.

Activity

Table 8-1: Activity Casemix

Treatment Type	No of Fractions
Prostate Fractions	7,434
Breast non-DIBH	3,234
Breast DIBH	3,234
Palliative Treatment	1,699
	15,600

Footprint

8.2 The proposed 'footprint' of the new Preferred Option is 2,528m^2. The proposed current 'footprint' of the Preferred Option has been sized in line with Health Building Notes, best practice guidance and statutory compliance requirements. In addition the RSC will be able to accommodate forecast activity projections.

Flexibility for Future Expansion

8.3 It is important to highlight that there is planned expansion space (equivalent to accommodation for 2 additional treatment machines plus supporting equipment) on the identified site for the RSC. This expansion capacity is important to the TCS Programme Risk Management Strategy in the event that the clinical growth assumptions prove to be understated.

Major Medical Equipment Requirements

8.4 The delivery of non-surgical Cancer Services is dependent upon having access to two treatment machines which will be essential to support the safe

and effective delivery of patient treatments. These treatment machines are being procured via the Integrated Radiotherapy Solution (IRS) Project.

Cost

8.5 The RSC costs of £30.28m in Capital and £2.547m in Revenue on a recurring basis is in addition to £0.712m of transitional costs.

Benefits

8.6 For the purposes of the economic appraisal, we have quantified benefits which differentiate between the options, are measurable and evidence-based, and can be monetised using recognised methodology. This includes the following:

- Additional capacity available to meet forecast demand
- Reduced travel time for patient and carers
- Improved access to treatment and clinical trials leading to better clinical outcomes

8.7 In addition, there are a number of benefits which are relevant to the case but are difficult to quantify in monetary values and/or do not differentiate between the options and so have not been incorporated within the economic appraisal. These include:

- Patients have access to seamless pathway of care in a single place
- Improved patient and carer experience
- More resilient and flexible workforce
- Improved staff satisfaction (although may be disbenefit for some staff members - additional travel)
- Improved safety and compliance with standards
- Better sustainability, resilience and future proofing
- Opportunities to attract further investment

9 CONCLUSION

9.1 The Case for a nVCC has been made within the OBC. The deficiencies and challenges of the current infrastructure in supporting the delivery of high quality patient care have been clearly presented. The constraints of the current site to meet future demand and technological change have also been clearly set down.

9.2 A rigorous Economic Appraisal, following HM Treasury guidance and Welsh Government Better Business Case guidance, has been undertaken and this robust and transparent appraisal process has identified a clear Preferred Option. The Preferred Option has been approved by the Velindre University NHS Trust Board and Aneurin Bevan University Health Board.

9.3 The delivery of the Preferred Option is to be executed through the Commercial arrangements set down in the Commercial Case, as required by the Welsh Government. The development of the RSC supports the VCC and the development of a nVCC which is a key commitment in the Welsh Government's Programme and will be delivered as one of three pathfinders' Projects under the Welsh Government's innovation MIM Programme which has been established to support investment in capital infrastructure in Wales

9.4 The Financial Case has been developed in partnership with Commissioners, taking the advice of the Welsh Government, and the Financial Framework adopted has delivered a robust assessment of the overall capital and revenue consequences of the Preferred Option. The Financial Case clearly demonstrates the affordability of the Preferred Option and presents the distribution of cost shares between Commissioners.

9.5 The Management Case provides assurance on the delivery process for the Preferred Option. It describes the clear Project Management arrangements developed to deliver the RSC Project. The role of External and Internal Advisors have been clearly established. Change Control and Risk Management has been detailed and set down. The Project Plan to deliver the RSC by August 2023 meets the objectives set by the TCS Programme. The capital costs of Project delivery are to be resourced by the Welsh Government.

9.6 The Preferred Option, and the delivery approach described within the RSC OBC is presented to the Welsh Government for support and approval.

9.7 It should be noted that significant additional revenue costs will be required in excess of the revenue cost of the preferred option to provide additional Radiotherapy capacity to meet forecast demand if the proposed satellite unit does not progress. The majority of that activity will need to be provided via other Providers.

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Outline Business Case: 2020

Radiotherapy Satellite Centre (RSC)

Strategic Case

STRATEGIC CASE

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1 INTRODUCTION

1.1 The scope of the Project is limited to the building of a Radiotherapy Satellite Centre (RSC). In taking forward this scope, Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) will be seeking formal approval from Partner commissioners and from the Welsh Government in relation to the Outline Business Case (OBC) for an RSC. In seeking approval, the OBC must provide assurance in relation to:

- The need for an RSC;
- The Preferred Option identified within the OBC;
- The building footprint of the RSC;
- The additional costs directly attributable to the RSC; and
- The Project Management and Governance arrangements for delivering the RSC Project.

1.2 The purpose of this strategic case section is to:

- Provide an overview of Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) and their relevant Service Hospitals
- Provide an overview of Cancer Services in South East Wales and the whole system leadership arrangements
- Provide an overview of the Transforming Cancer Services (TCS) Programme
- Describe the Project partnership arrangements between ABUHB and VUNHST
- Describe the existing arrangements and the business needs for this business case
- Set out the project scope including objectives, benefits and risks
- Describe how the Project will support the delivery of sustainable radiotherapy services across South East Wales

2 BACKGROUND

2.1 Radiotherapy is the use of ionising radiation, usually high energy x-rays to treat disease and is usually used to treat malignant disease (cancer) and some benign indications. It has an important role in treatment of cancers as 50% of all cancer patients will benefit from receiving radiotherapy as part of their cancer management. Developments in radiotherapy techniques and the increasing incidence of cancer indicate that the demand for radiotherapy will continue to rise and require sufficient and resilient capacity to be made available. Work to date by VUNHT indicates the service will be unable to deliver a high, quality, reliable and sustainable service without an expansion in capacity.

2.2 This need to meet the demand of non-surgical cancer services, together with the poor condition of the estate at Velindre cancer Centre (VCC) led to the Transforming Cancer Services program (TCS), which developed with partners a clinical model for non-surgical cancer services. This model included a satellite Radiotherapy centre (RSC) and this business case focuses on the RSC and its role to secure radiotherapy capacity for the population of South East Wales. The capacity needs to be in place ahead of the new VCC as demand is already exceeding capacity but also to enable medical physics staff to be available to commission the equipment in RSC but also in the new VCC.

2.3 In addition to the lack of capacity, a key factor supporting the case is the benefit of care being delivered closer to home, especially as there is evidence that update of radiotherapy in Wales is below best practice and there is evidence that availability of services closer to patients leads to increased uptake of treatments – which in turn will lead to improved outcomes and better experiences for patients.

2.4 Following agreement on the TCS clinical model, the process for determining the best site for the RSC was established with partner organisations through an evaluation exercise. This led to the selection of Nevill Hall Hospital as a site for the RSC and as such this is a joint project between the 2 organisations.

2.5 The remainder of this Strategic Case will provide more detail on the above issues to support the case for change for this service development.

3 ORGANISATIONAL OVERVIEW

3.1 This section will provide an overview of Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) and their relevant Service Hospitals and an overview of Cancer Services in South East Wales and the whole system leadership arrangements.

Aneurin Bevan University Health Board (ABUHB)

3.2 Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013.

3.3 It serves an estimated population of over 639,000, approximately 21% of the total Welsh population.

3.4 With a budget of **£1.281 billion the HB** delivers healthcare services to people in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen and also provide some services to the people of South Powys.

3.5 The Health Board covers diverse geographical areas and had to take account of a mix of rural, urban and valley communities. The valleys experience high levels of social deprivation, including low incomes, poor housing stock and high unemployment.

3.6 The Health Board employs over 11,000 staff and is the largest employer in Gwent.

Services

3.7 The Health Board provides a comprehensive range of acute hospital based, Community based, Mental Health and Primary Care services via a large and complex estate consisting of the following:

- Acute Hospitals - Royal Gwent, Neville Hall, Ysbyty Ystrad Fawr
- Community Hospitals - County, Ysbyty Aneurin Bevan, St Woolos, Chepstow and Monnow Vale
- Mental Health Hospitals - St Cadoc's, Llanfrechfa, Maindiff Court, Ysbyty'r Tri Chwm
- 8 Locality based Mental Health Units and 1 Residential Unit on LGH site, 4 unoccupied units across Gwent.
- 30 Locality based Community clinics

3.8 In addition to the above the new Grange hospital, Specialist Critical Care Centre (SCCC) is due to open in November 2020.

Velindre University NHS Trust (VUNHST)

3.9 The Trust has evolved significantly since its establishment in 1994 and is operationally responsible for the management of the following two divisions:

- Velindre Cancer Centre; and
- Welsh Blood Service.

3.10 The Trust is also responsible for hosting the following organisations on behalf of the Welsh Government (WG) and NHS Wales:

- National Wales Information Services (NWIS)*;
- NHS Wales Shared Services Partnership (NWSSP); and
- Health Technology Wales (HTW).

** NWIS will be transferred to a SHA 2020/21*

Velindre Cancer Centre (VCC)

3.11 Velindre Cancer Centre is located in Whitchurch on the North-West edge of Cardiff and is one of the ten largest regional clinical oncology centres in the United Kingdom and the largest of the three centres in Wales. The Trust is the sole provider of non-surgical specialist cancer services to the catchment population of 1.5 million across South East Wales, from Chepstow to Bridgend and from Cardiff to Brecon. Addiotnally it provides more specialist radiotherapy services across the whle of South Wales. Velindre Cancer Centre employs around 700 members of staff and has approximately 70 volunteers who provide a range of 'added value' roles across the centre. The Trust also works in partnership with a wide range of third sector, charities, Higher Education Institutions (HEIs) and Industry/Commercial Partners to deliver high quality cancer care and undertake clinical research.

3.12 Velindre Cancer Centre is responsible for the delivery of non-surgical treatment including Radiotherapy and SACT, recovery, follow-up and specialist palliative care. Following their specialist cancer treatment, Velindre Cancer Centre supports patients during their recovery and through follow up appointments.

3.13 Specialist teams provide care using a well-established multi-disciplinary team (MDT) model of service for oncology and palliative care, working closely with local partners and ensuring services are offered in appropriate locations in line with best practice standards of care. The range of services delivered by Velindre Cancer Centre includes:

- Radiotherapy
- Systemic Anti-Cancer Therapies (SACTs) and chemotherapy
- Inpatients
- Ambulatory care
- Outpatient services
- Pharmacy

- Specialist radiology/imaging
- Nuclear Medicine
- Specialist Palliative care
- Acute Oncology Service (AOS)
- Living with the impact of cancer
- Education and Learning
- Research, Development and Innovation.

3.14 The following patient services are delivered in outreach settings in Health Board (HB) locations across South East Wales from Velindre Cancer Centre:

- SACT delivery;
- Outpatient appointments;
- Inpatient reviews; for patients receiving care and treatment in HBs
- Health Board MDTs; and
- Research and Education.

3.15 However, all Radiotherapy activity is currently delivered at the Velindre Cancer Centre.

Overview of Cancer Services in South East Wales

3.16 The planning and delivery of cancer services in South East Wales is the responsibility of the four Health Boards (HBs) as part of their statutory responsibility to meet the health needs of the populations they serve. The HBs are supported by the Welsh Health Specialist Services Committee (WHSSC) which commissions specialist cancer services on their behalf.

3.17 The four HBs in South East Wales are:

- Aneurin Bevan University Health Board;
- Cardiff and Vale University Health Board; and
- Cwm Taf Morgannwg University Health Board.
- Powys Teaching Health Board

Figure 3-1: Map of Local Health Boards across South East Wales

3.18 The HBs also work in partnership with the All Wales Cancer Network, NHS Trusts, Community Health Councils, Voluntary and Charitable Organisations and Public Health Wales.

3.19 The four Health Boards, in conjunction with VUNHST and other stakeholders e.g. Wales Cancer Network (WCN), have formed the South East Wales Collaborative Cancer Leadership Group (CCLG). The purpose of the *South East Wales CCLG* is to provide effective system leadership for Cancer Services across South East Wales and deliver improvements in outcome and service experience for the catchment population. It aims to achieve this through the building and nurturing of a sustainable, collaborative cancer community across the region to align change across the whole cancer system.

3.20 The CCLG oversees all Collaborative Cancer Programmes of work within the region, ensuring clear leadership and coordination with a focus on benefits delivery for patients, putting into practice the national policies, standards and procedures for the benefit of patients. The CCLG functions at a regional level

in support of the work of the CIG, other groups including the SCP Strategic Groups, on an All Wales level.

3.21 The CCLG also looks beyond health to ensure its ways of working embed the Well-being and Future Generations (Wales) Act 2015 and contribute to the seven Well-being goals and the sustainability principles.

3.22 The CCLG's remit is also to coordinate commissioning decisions and investments and facilitate the realignment of pathway resources within and between organisations. As such the CCLG will oversee the scrutiny and approval of the RSC OBC and its alignment with other regional developments.

The Cancer Pathway

3.23 The delivery of cancer services across Wales generally conforms to a well-defined pathway of care which includes the following five key stages:

Table 3-1: The Cancer Pathway

Cancer Prevention: Enhancing public awareness and education to make informed decisions about lifestyle choices that promote a healthy, cancer free population.
Cancer Diagnosis: Cancer can be identified through a National Screening Programme or where cancer symptoms are identified by the patient/health care professional. If cancer is suspected the patient is assessed by a multi-disciplinary team in the Health Board (often supported by Velindre Cancer Centre staff) and cancer may be diagnosed.
Treatment: The treatment options for every patient are discussed and considered by multi-disciplinary teams (MDTs). The treatment options include surgery, non-surgical treatment e.g. Radiotherapy or Systemic Anti-Cancer Therapy (SACT), a combination of these treatments and supportive care. Care often straddles organisational boundaries.
Recovery/Follow Up: Regular follow up appointments are important to monitor recovery, manage and reduce the after effects of treatment and to ensure any signs of cancer relapse/recurrence are identified at their earliest stage.
End of Life Care: Sadly, not all patients survive cancer – openness about the need to plan end of life care is essential. A focus on living and dying well, early identification of needs and access to fast, effective palliation are important to reduce distress for both the patient and their family.

The Single Cancer Pathway (SCP)

3.24 The Single Cancer Pathway (SCP) Strategic Leadership Group has been established to co-ordinate and align the all Wales activities of partners, and align the needs of local organisations, to drive the transformation of patient outcomes through the implementation of a SCP.

3.25 The SCP will replace the current Urgent Suspected Cancer (USC) and non-Urgent Suspected Cancer (nUSC) pathways. The aim of the new pathway is to ensure that patients begin a first definitive treatment no later than 62-days after

the point of suspicion of cancer. Such an ambition necessarily presents capacity challenges at all points of the patient pathway, not least in relation to treatment delivery.

3.26 The Wales Cancer Network's (WCN) Cancer Site Groups (CSGs) have developed a suite of optimal, site-specific, pathways describing road maps for how the SCP might be successfully implemented. The optimal pathways which are currently available, which include those for all common cancers, almost exclusively allow a maximum 21-day period for post-diagnosis planning and scheduling before treatment must begin.

3.27 Currently, time to radiotherapy performance at VCC and the other Welsh cancer centres is monitored relative to a series of targets previously recognised as defining best practice standards by the Joint Collegiate Council for Oncology (JCCO), the co-ordinating, inter-collegiate body for non-surgical oncology in the United Kingdom. These measures require that the large majority of patients undergoing treatment with radiotherapy begin that treatment within 28-days of referral. This is at odds with the ambition of the SCP and it is inevitable that the development of revised treatment pathways locally will pose further capacity management challenges for VCC.

3.28 A related development in the field of radiotherapy, more specifically, will see the adoption of a revised suite of time to treatment measures in the near future in Wales. These measures, developed by the Clinical Oncology Sub-Committee (COSC), will replace the extant JCCO measures. The COSC performance measures are supported by definitions which better reflect the ever increasing complexity of radiotherapy planning and will require the great majority of patients referred for radiotherapy treatment to begin their treatment within 21-days of referral. This is in step with the overarching ambition of the SCP, but again will pose significant capacity challenges.

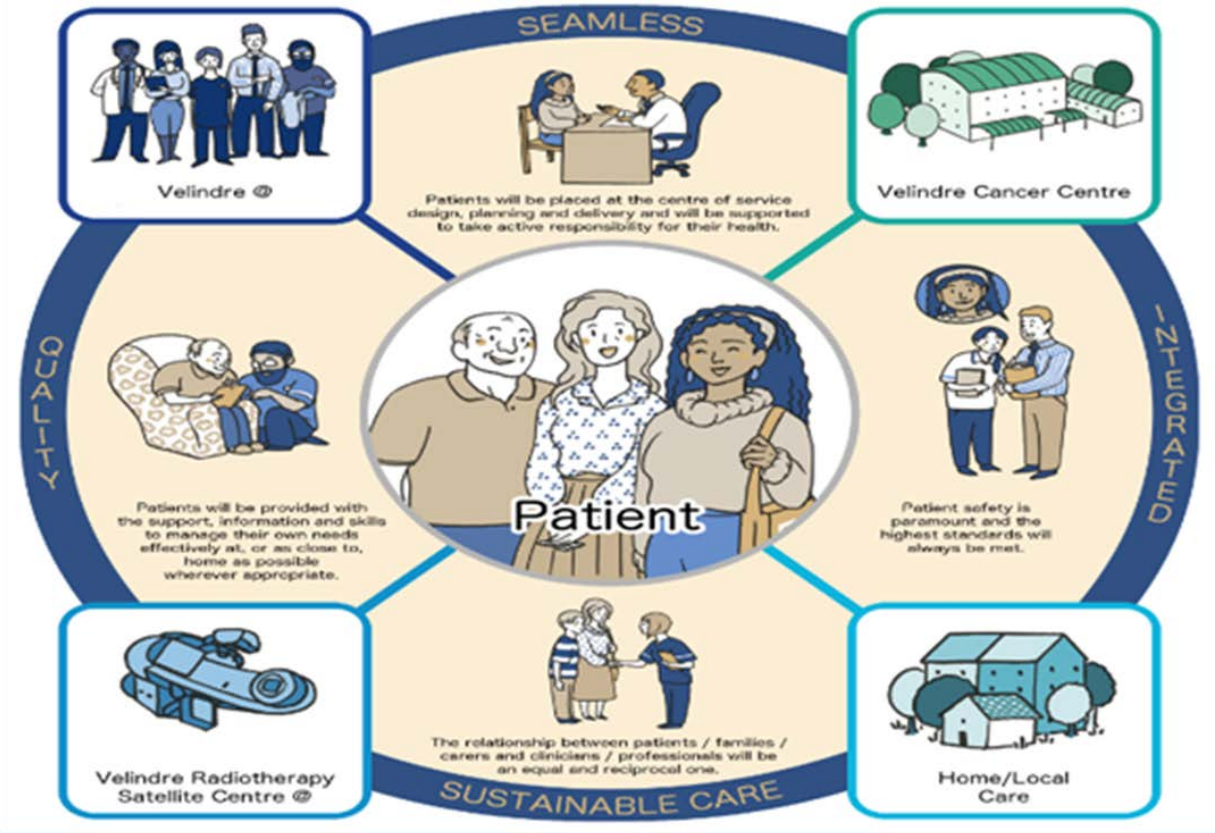
3.29 It is obvious that efforts to support the implementation of the SCP and the adoption of the new COSC time to radiotherapy measures will exacerbate issues associated with the availability of treatment capacity at VCC due to rising demand.

Transforming Cancer Services (TCS) Programme

3.30 It is important to understand where this OBC sits in the context of the overall TCS Programme. The TCS Programme is an ambitious Programme which aims to deliver transformed Tertiary non-surgical Cancer Services for the population of South East Wales.

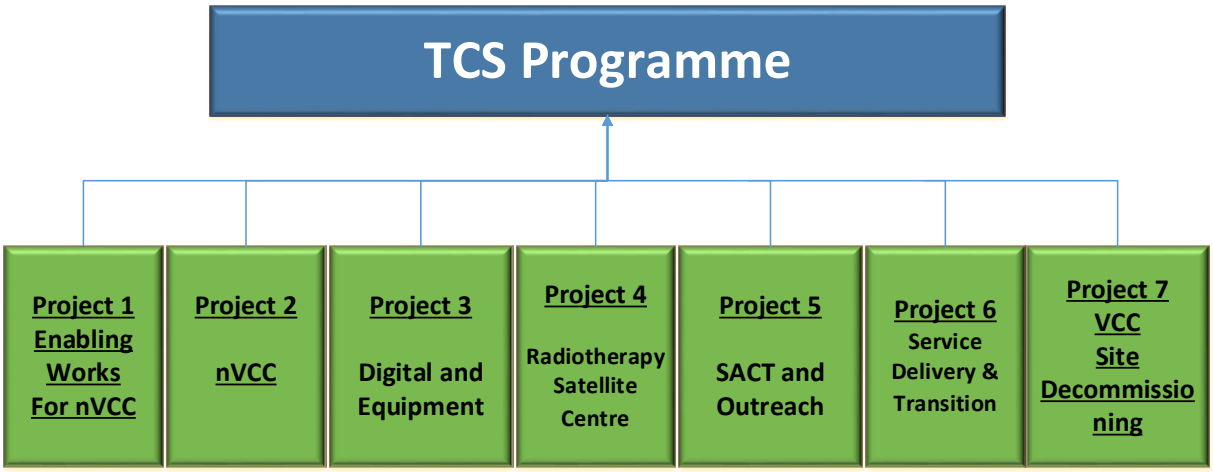
3.31 The detailed clinical model was developed through over 70 workshops/events/meetings involving more than 1000 people – professionals, patients and public from a range of organisations including HBs, Third Sector, and CHC. The clinical model is shown below:

Figure 3-2: Clinical Model



3.32 Following agreement on the proposed clinical model 7 programmes of work/projects were developed to deliver the TCS programme:

Figure 3-3: Seven Programmes of Work



3.33 The Strategic Case for the TCS Programme, its links to Welsh Government Strategy and Velindre's own Cancer Strategy, are made in the TCS Programme Business Case (PBC). It is not the intention of this OBC to restate these, more to show alignment with this wider Programme's aims and objectives.

3.34 This OBC is also related to the Outline Business Case (OBC) for the new Velindre Cancer Centre (nVCC) and the OBC for the Integrated Radiotherapy Solution (IRS). The latter project aims to deliver the Trust decision to seek one prime vendor to deliver a fully integrated Radiotherapy solution and move away from the current situation of dual vendors of Radiotherapy equipment. The Integrated Radiotherapy Solution Procurement OBC is being developed from a Digital and Equipment Procurement De-coupling PBC submitted to and approved by the Welsh Government on 5th June 2019.

3.35 The Clinical Model within the TCS PBC, and as outlined in diagram above describes how services will be delivered in the future and is predicated on the following principles:

- The service model seeks to promote a new set of relationships which work in partnership to improve the way we collectively design and deliver services around patients' needs and to achieve these improvements in a truly sustainable way
- The patient will be central to plans with an integrated network of services organised around them. The organising principle seeks to 'pull' high quality care towards the patient that is accessible in their preferred location and will support them achieving their personal goals during treatment and subsequently living with the impact of cancer
- Patient safety is paramount and the highest standards will always be met;
- The relationship between patients / families / carers and clinicians / professionals will be an equal and reciprocal one.
- Patients will be provided with the support, information and skills to manage their own needs effectively at, or as close to, home as possible wherever appropriate
- Patients will be treated at theirclosest centre where appropriate and safe to do so (removal of HB boundaries)
- Optimising information technology, quality improvement systems, patient involvement, education and embracing innovative approaches to healthcare will all be essential to achieve high levels of service quality in a sustainable way

3.36 To deliver the principles of the new clinical model, care will be delivered differently and at different locations. This will require a number of infrastructure and technology projects as well as service change projects to be established.

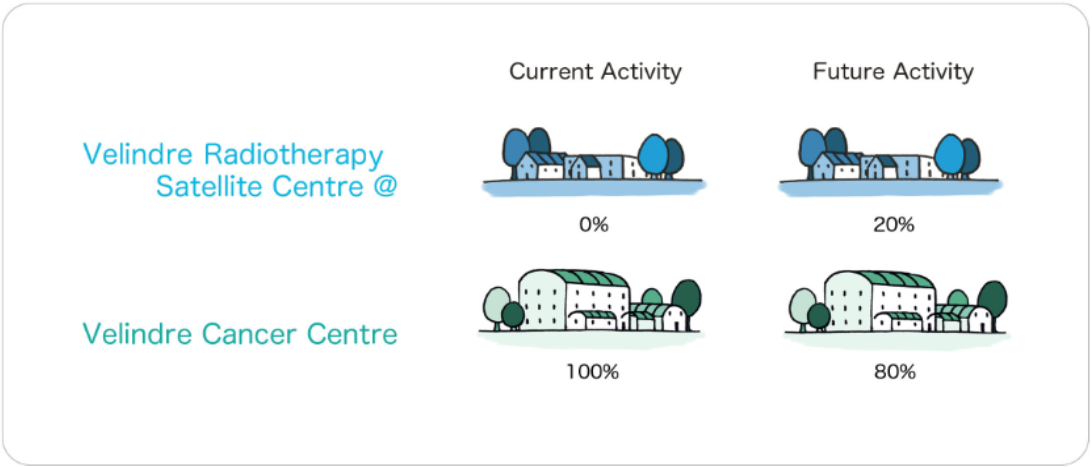
3.37 These locations and their functions are described briefly below:

- **Health Boards**: A range of cancer care occurs within the Local Health Boards (LHB's), with a proportion of patients having all their care

delivered by the Local Health Board (LHB) teams. For other patients who need non-surgical treatment, their care needs to be seamlessly planned with the non-surgical aspects of the pathway, as patient care can often transition from one team to another. The **Velindre@ Outreach facilities** and collaborative working will support this approach

- **Velindre Outreach Centres:** These facilities will provide SACT, outpatient services, education and information provision and ambulatory care procedures within HBs
- **New Velindre Cancer Centre:** The new Velindre Cancer Centre will provide specialist and complex cancer treatment including SACT, radiotherapy (including brachytherapy and unsealed sources) and specialist palliative care, inpatient facilities (being open for admission 24 hours/day, 7 days/week), a specialist acute oncology assessment unit and outpatient services, radiology and nuclear medicine. Due to its geographical location (i.e. within the Cardiff and Vale University Health Board area) it will also form part of the system providing local care to patients for whom it forms the nearest non-surgical cancer facility. Patients will only have to travel to the nVCC if we cannot deliver their care more locally
- **Radiotherapy Satellite Centre:** The Radiotherapy Satellite Centre (RSC) will provide radiotherapy treatment for approximately 20% of our patients (provided by 2 new linear accelerators).

Figure 3-4: Current & Future Activity



3.38 This means better access for patients, reduced travel for patients, associated improved outcomes, and less use of transport services. This will mean that fewer patients need to travel to VCC for their radiotherapy. These Benefits are the focus of this business case.

Preferred Operational Model

3.39 The TCS Programme undertook an appraisal of a wide range of operational delivery models for all its services. The primary objective of this appraisal was to identify the option which provided best value for money.

3.40 Eight different operating scenarios, including extended working hours as well as five, six and seven-day operational models, were evaluated by a multidisciplinary group which was externally facilitated. The assessment was undertaken based upon:

- A non-financial assessment of options against the Projects Spending Objectives and Critical Success Factors; and
- A financial (capital and revenue) assessment of options.

3.41 The preferred operating scenario (Scenario 8) scored the highest based on a combined non-financial and financial score. This scenario included the following components for radiotherapy services:

Table 3-2: Preferred Operating Scenario

Radiotherapy Service	5 days a week, 9.5 hours a day at both NVCC and RSC 7-day Radiotherapy service for emergency patients and for urgent palliative patients who are treated at VCC

3.42 Following the determination of the clinical model and the preferred operating model it was necessary to determine an appropriate location for the satellite center.

Process for Identifying a Preferred Site

3.43 In determining the preferred location of the Velindre RSC the TCS Programme requested all Health Boards in South East Wales in 2017 for expressions of interest in hosting the RSC. This resulted in two University Health Boards, Aneurin Bevan and Cwm Taf (now Cwm Taf Morgannwg University Health Board), expressing an interest and subsequently offering up a range of possible locations on the Nevill Hall Hospital and Prince Charles Hospital sites respectively. Following an estate-based assessment, two potential sites for each Health Board were identified and subjected to more detailed scrutiny.

3.44 To assist the Trust in undertaking the evaluation, support has been provided from a range of specialist sources with the overall process being overseen by Capita Business Services Ltd who were appointed by the TCS Programme to provide Health Care Planning advice for the RSC Project.

3.45 The approach, criteria and weightings within the evaluation methodology were developed by Velindre in partnership with each Health Board and CHCs through the establishment of joint planning groups. There has been positive engagement between Velindre and the Health Boards throughout the process.

The methodology was approved by the Velindre Trust Board in April 2017; and it was agreed at the Joint Planning Group with Aneurin Bevan and Cwm Taf UHBs on 26th April and 20th April respectively.

3.46 Subsequently, on 20th June 2017 the Transforming Cancer Services Programme Evaluation Panel met to review all elements of the "Radiotherapy Satellite Site Selection Evaluation Review" taking into consideration all the evidence received during the evaluation process. The Evaluation Panel:

- Approved the evaluation report;
- Approved the key findings and results outlined within the report;
- Approved the 'preferred' site location option to host the Radiotherapy Satellite Centre as being Nevill Hall Hospital (site 8) based upon the analysis presented.

3.47 This OBC is based on this Site Selection Evaluation as set down by the Joint Leadership Team at the IIB Meeting 24 July 2019 and the Projects response to the Welsh Government approval letter to proceed dated 28th November 2019.

Project Partnering Arrangements

3.48 Following the selection of ABUHB as the site for the RSC the 2 organizations developed project partnering arrangements:

3.49 ABUHB and VUNHST are proposing to develop and operate the RSC as a partnership with clearly defined roles and responsibilities for each organization within the partnership agreement

3.50 ABUHB will build and provide the landlord services and facilities for the RSC building.

3.51 VUNHST will provide the clinical services and own the associated clinical equipment within the RSC

4 STRATEGIC POLICY CONTEXT

Introduction

4.1 This section of the Outline Business Case (OBC) summarises the strategic context for the Radiotherapy Satellite Centre (RSC) Project.

Strategic Context in Wales

4.2 The Welsh Government has published a wide range of national strategies which provide the framework for the planning and delivery of public services in Wales. These are supported by a range of policies, frameworks and guidance which relate more specifically to health and social care.

4.3 In addition, the TCS Programme and its partner organisation continually scans the environment at a population, national, regional and local level to develop our knowledge and intelligence on key issues which we need to take account of in the strategic planning and delivery of services. We use the Sustainable Development Principles as the basis for our horizon scanning.

Figure 4-1: A Summary of the Strategic Context for the TCS Programme

4.4 The core themes running through the strategic framework within NHS Wales are summarised as:

- Sustainability as the fundamental principle of public services;
- Putting citizens and patients at the centre of service design and delivery;

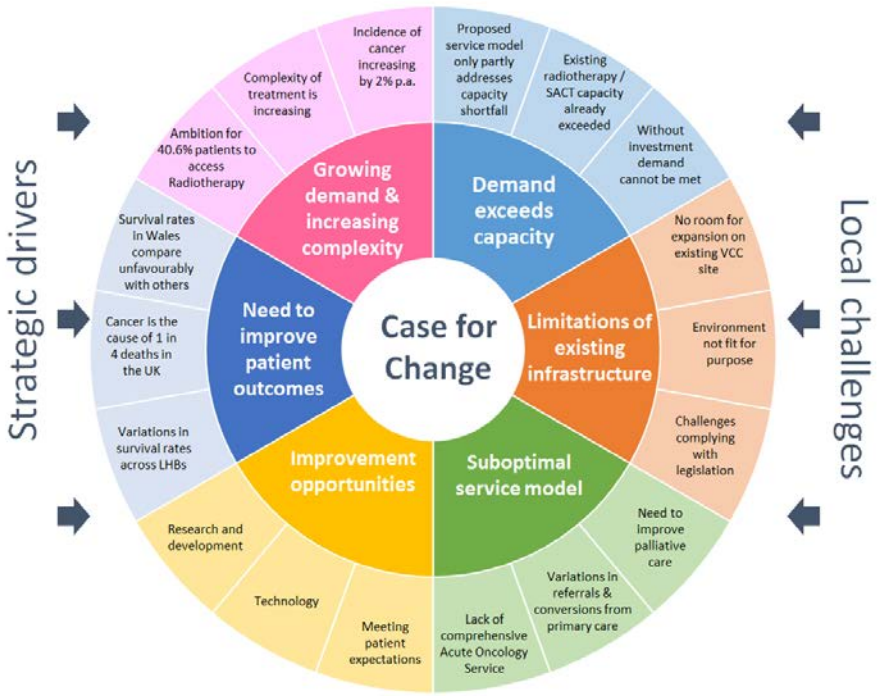
- Developing a new relationship with citizens and patients based upon the principles of prudent health and co-production;
- Providing services of the highest quality which meet the needs of individuals consistently;
- Improving the quality of services;
- Delivering outcomes which are comparable with the best elsewhere;
- Reducing all avoidable waste, harm and variation;
- Providing care at home or within the local community wherever and whenever possible;
- Using resources in a sustainable way;
- Treating people individually with dignity and respect;
- Ensuring that every Welsh pound is spent efficiently and effectively; and
- Providing a first-class experience for everyone who uses services.

4.5 The TCS Programme Business Case (PBC) outlines the strategic context for the Transforming Cancer Services Programme and describes how the Programme is central to VUNHST's ability to deliver key national and local strategic objectives, especially in relation to those outlined in the following strategic documents:

- Well-being of Future Generations (Wales) Act (2015);
- A Healthier Wales: Our Plan for Health and Social Care;
- Prudent Healthcare: Securing Health and Well-being for Future Generations;
- Together for Health – Cancer Delivery Plan;
- The Velindre University NHS Trust Cancer Strategy; and
- Velindre Cancer Centre Strategy for Radiotherapy

Note: It has been agreed with commissioners, through the collaborative scrutiny process, that the PBC is extant and for contextual understanding only. However, the PBC will remain a 'live' document which will be updated at key milestones in the Programme and is currently being updated.

Figure 4-2: Strategic Drivers and Local Challenges



National context Together for Health – Cancer Delivery Plan 2016 – 2020

4.6 Clinical outcomes for cancer patients in Wales compare unfavourably with other countries.

4.7 The Welsh Government's '*Together for Health – Cancer Delivery Plan*' provides a clear strategy for cancer care in Wales and sets out the key drivers for improvement between 2016 and 2020:

- **Preventing cancer**: people to live a healthy lifestyle, make healthy choices and to minimise risk of cancer;
- **Detecting cancer earlier**: cancer is detected earlier where it does occur or recur;
- **Delivering fast, effective treatment and care**: people receive fast, effective treatment and care so they have the best chance of cure;
- **Meeting people's needs**: people are placed at the heart of cancer care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of cancer;
- **Caring at the end of life**: people approaching the end of life feel well cared for and pain and symptom free;
- **Improving information**: providing improved analysis and information which is available at the right time to the right person; and
- **Targeting research**: to support improvements in cancer treatment.

4.8 All the HBs within SE Wales, and within the remit of this business case, along with VUHNST have used these pillars as the basis for their local Cancer Delivery plans to meet the needs of their local population. The key, and consistent, themes from these documents are:

- Improve cancer outcomes in Wales through improved prevention, early detection and better treatments
- Work across the whole healthcare systems to deliver seamless and integrated care for cancer patients
- Deliver care closer to home where safe and appropriate to do so
- Address inequalities for cancer patients
- Equitable access to radiotherapy
- Improve Research, development and learning
- Improve patient experience through patient centred model

Local Strategic Context in VUNHST and ABUHB

4.9 As mentioned above both VUNHST and ABHB have Cancer Strategies and delivery plans which have shared ambitions.

4.10 ABUHB Cancer Strategy *Cancer Services: Delivering a Vision 2020-2025* has the following ambition:

Figure 4-4: ABUHB Vision

ABUHB Vision:

Improve prevention, optimise treatments, patient outcomes and reduce health inequalities for our population and those we serve.

4.11 Velindre cancer strategy - '*Shaping our Future Together'* sets the following vision for cancer services for the next ten years:

Figure 4-4: VUNHST Vision

VUNHST Vision:

To lead in the delivery and development of compassionate, individualised and effective cancer care to achieve outcomes comparable with the best in the world

4.12 At the heart of the TCS Programme is the delivery of a patient centred service model that will allow Commissioners to provide sufficient capacity to deal with growing and changing demand for services, whilst improving clinical outcomes for the population of South East Wales.

4.13 Both ABUBH's Cancer Strategy and its plans for Nevill Hall Hospital (NHH) after the opening of the Grange include the development of the RSC as a key

driver to deliver its ambitions. In the HB's plan the RSC at NHH will operate alongside key other cancer services including local SACT treatments, Acute Oncology Services (AOS) and specialist palliative care.

4.14 This Outline Business Case (OBC) will provide the case for the RSC to support the existing, and in due course new, Velindre Cancer Centre in its provision of Radiotherapy services for the population of South East Wales. The nVCC will provide a hub to deliver the many of specialist non-surgical cancer services for South East Wales but with radiotherapy services closer to home for a proportion of the catchment population delivered via a Satellite Centre. As such it is critical to the delivery of the overall TCS Programme and is therefore aligned to the wider healthcare strategic context, at both a local and national level.

5 EXISTING ARRANGEMENTS RADIOTHERAPY

5.1 The purpose of this section of the business case is to describe the current service delivery arrangements for the services covered within the scope of the RSC Project;

Service Delivery Arrangements, including equipment

5.2 VUNHST delivers specialist non-surgical cancer services to a catchment population of 1.5million people using a hub and spoke service model. For some specialist Radiotherapy treatments the catchment population is all of Wales.

5.3 Services are currently provided across South East Wales from one of two main treatment locations:

- **Velindre Cancer Centre:** The hub of the Trust's specialist cancer services is a specialist treatment, training, research and development Centre for non-surgical oncology; and
- **Outreach Centres:** outpatient and SACT treatments are delivered on an outreach basis within facilities across South East Wales, including District General Hospitals and from patients' own homes.

5.4 Currently all radiotherapy treatments are provided at VCC hub**.**

5.5 Patients are referred to Velindre Cancer Centre for treatment by the following routes:

- Following referral by a GP to the relevant HB; or
- Following presentation as an emergency at an A&E department.

5.5 Prior to referral to Velindre Cancer Centre, all patients will have been investigated and diagnosed with a solid tumour. Some patients may have already undergone surgery. Velindre Cancer Centre's role is to deliver specialist and tertiary cancer treatment, including Radiotherapy, until the patient can be referred back to their host Health Board for ongoing treatment, management, and follow-up.

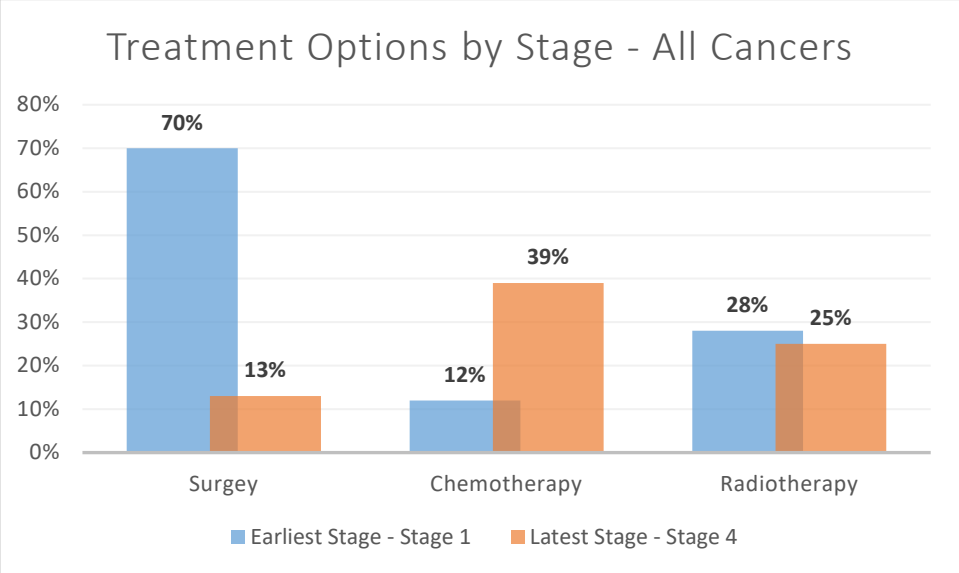
5.6 Radiotherapy plays a vital role in the treatment of cancers with:

- 40% of all patients cured of cancer are cured by radiotherapy
- It also can offer patients the choice of organ preservation and avoid the need for major or disfiguring surgery.

5.7 With rapid developments in the technology the role of Radiotherapy continues to expand in the treatment of cancers.

5.8 Radiotherapy is a flexible treatment modality which is used with a curative or palliative intent, at a consistent rate, regardless of cancer staging as shown by the following graph:

Figure 5-1: Treatment Options by Stage



5.9 Overall the Radiotherapy servicehas a number of specific functions:

- Supports diagnosis
- Undertakes pre-treatment planning
- Outlining – identifying what should be treated
- Undertakes on-going treatment planning and review
- Delivers external radiotherapy using Linear Accelerators (Linacs) and a superficial treatment area as well as Brachytherapy.
- Supports training and education (undergraduate and post graduate) including medical and radiologist training
- Supports the wider VCC and LHB cancer teams and specialists through participating in multi-disciplinary, multi-agency meetings and discussions at a patient and service-wide level.
- Undertakes radiotherapy research

5.10 The current radiotherapy department is based on a single site at the Velindre Cancer Centre (VCC) with the following facilities and equipment include:

- 8 x Linear accelerators;
- 1 x superficial treatment area;
- A brachytherapy suite (with theatre area);
- Pre-treatment planning areas which is supported by 2 CT Simulators, each with a small number of consulting rooms to support on-treatment review and consultation.
- Physics planning areas;
- An electronics and computing workshop that supports the medical physics function i.e. basic repair and PAT testing.

- An engineering workshop/machine shop, electronics workshop, dosimetry & metrology laboratories

5.11 Recent years has seen an increase in the complexity of linear accelerators which impacts on repair, QA and maintenance time to safeguard the reliability and high accuracy of the machines, which is particularly important given the increasing trend of higher doses over less fractions.

5.12 The life expectancy of a Linac is 10 years and it is important that the linacs are fit for purpose and not beyond their life expectancy which leads to increased risks about breakdowns and failures, which in turn affects the sustainability of a safe and reliable radiotherapy service.

5.13 The linacs at VCC are ageing with an average age of 9.6 as at 2020; with a peak age of 15 years which is well beyond the expected lifespan. The table below show the aging profile of machines at VCC:

Table 5-1: Aging Profile of Machines at VCC

			Planning Scenario - No Early Replacement of linacs - No RSC - Wait to nVCC																										
	Type	Location	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2020	2021	2021	2022	2023	2023	2024	2024	2025	2026
																		Transition YR		Transition YR			Transition YR		Transition YR			
LA10	Std	VCC / nVCC																										
LA9	Std	VCC / nVCC																										
LA8	Std	VCC / nVCC							0	1	2	3	4	5	6	7	8	9	9	10	10	11	12	12	13	0	1	2
LA7	Std	VCC / nVCC						0	1	2	3	4	5	6	7	8	9	10	10	11	11	12	13	13	14	0	1	2
LA6	Std	VCC / nVCC	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	15	16	16	17	18	18	19	0	1	2
LA5	Std	VCC / nVCC								0	1	2	3	4	5	6	7	8	8	9	9	10	11	11	12	0	1	2
LA4	Stereo	VCC / nVCC										0	1	2	3	4	5	6	6	7	7	8	9	9	10	0	1	2
LA3	Std	VCC / nVCC			0	1	2	3	4	5	6	7	8	9	10	11	12	13	13	14	14	15	16	16	17	0	1	2
LA2	Stereo	VCC / nVCC												0	1	2	3	4	4	5	5	6	7	7	8	0	1	2
LA1	Std	VCC / nVCC				0	1	2	3	4	5	6	7	8	9	10	11	12	12	13	13	14	15	15	16	0	1	2
Total											6	7	7	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Avg Age											4.17	4.43	5.43	5.63	6.63	7.63	8.63	9.63	9.63	10.63	10.63	11.63	12.63	12.63	13.63	0.00	1.00	2.00
Peak Age											8	9	10	11	12	13	14	15	15	16	16	17	18	18	19	0	1	2

5.14 The RSC is an important development to ensure VUNHST is able to continue to deliver safe and effective Radiotherapy services.

Benchmarking

5.15 As part of the development of TCS programme we have taken the opportunity to benchmark the efficiency of our service. Whilst benchmarking data is routinely captured in many sectors of the health service there is no established benchmarking framework within UK for tertiary cancer services which has made it challenging for VCC to routinely benchmark it performance against other cancer centres. Similarly, in light of fact that operating models, adherence to practice guidelines, etc., vary greatly outside the UK a comparison with non UK radiotherapy centres is not the most appropriate benchmark. In recognition of this, VUNHST has undertaken benchmarking itself.

5.16 Benchmarking exercises were undertaken during 2016/17 and 2019/20 with a number of leading Cancer Centres from across the UK including:

- The Beatson West of Scotland Cancer Centre;
- The Clatterbridge Cancer Centre NHS Foundation Trust;
- Leeds Teaching Hospital NHS Trust; and
- The Royal Marsden NHS Foundation Trust.

5.17 These benchmarking exercises indicated that VUNHST compares favourably with other UK Radiotherapy centres in respect of throughout and efficiency and, therefore, additional capacity cannot be fulfilled by improved efficiency with the current service.

6 BUSINESS NEEDS

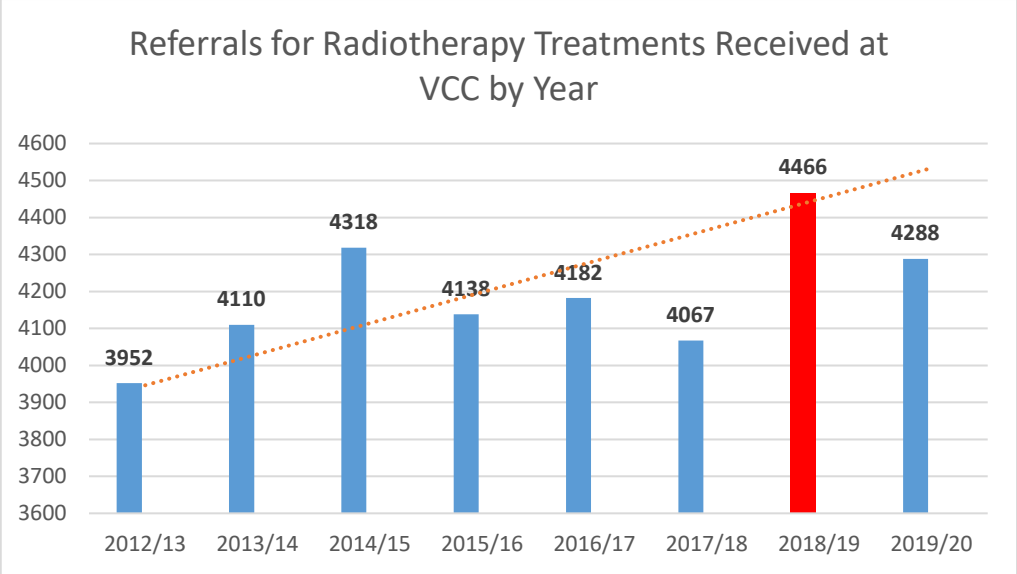
6.1 This section will review the clinical growth assumptions and demonstrate that additional capacity is required to meet the forecast increases in demand for Radiotherapy.

6.2 Earlier sections outlined the role radiotherapy plays in the treatment of cancers. Regardless of the future delivery of systematically more rapid diagnosis, increased screening capacity and public health initiatives, radiotherapy will remain a valid and effective clinical option for the treatment of a large proportion of all patients with cancer.

6.3 There are challenges inherent in attempting to forecast future demand for radiotherapy services given changes in clinical indications, incidence and changing treatment complexity. The TCS Programme has developed clinical growth assumptions which in turn have informed the development of this Outline Business Case. It is estimated that demand for radiotherapy services in south-east Wales will increase at a rate of 2% per annum to 2030/31.

6.4 It is apparent that demand for specialist cancer treatment is increasing. This demand is represented in the most immediate sense by the receipt of increasing numbers of patient referrals. Such an increase has been observed by the radiotherapy service at Velindre Cancer Centre in recent years.

Figure 6-1: Referrals for Radiotherapy Treatments



6.5 The graph above details the number of individual patient referrals for treatment with radiotherapy received at Velindre Cancer Centre from 2012/13 to 2019/20, inclusive. The dotted line overlaid on the graph describes an increase in referrals of 2% per annum from a base in 2012/13. Although there are year on year fluctuations, the graph serves to illustrate that the actual historical growth in referrals has been in step with the 2% clinical growth assumption for radiotherapy within TCS plans.

6.6 The 4,466 referrals received in 2018/19 represent the largest number of referrals received for the radiotherapy treatment at Velindre Cancer Centre in any given year. This follows an earlier peak in 2014/15 (4,318 referrals). Such marked increases in demand present stark capacity challenges which will become more acute as the clinical growth assumption underpinning the TCS Programme materialise.

6.7 There are a number of factors that influence the demand for Radiotherapy including:

1) Increasing incidence of cancer

It is recognised that the rate of cancer incidence in the United Kingdom and Welsh populations has been increasing over time. Cancer incidence in the United Kingdom increased by 12% between the early 1990s and the late 2010s and is expected to increase by a further 40% by 2035. This would represent 514,000 new cases of cancer in the United Kingdom compared to the 359,960 reported in 2015. Within Wales it is forecast incidence will increase by 2% pa over the next 10 years.

As mentioned earlier in this case the Wales Cancer Delivery plan has a focus on earlier detection and diagnosis of cancer. These patients will then require treatments including Radiotherapy. It is also likely to shift the balance towards a higher number of radical treatments as cancers get detected earlier.

2) Increasing population

The increased rate of incidence is driven, in part, by the fact that the population is growing and ageing. Welsh Government's most recent *Future Trends Report* forecasts that the population of Wales will increase by 5% between the mid-2010s and the mid-2030s. Although population level estimates of future changes in incidence take some account of forecast changes in population level and demographic, the anticipated increase to the population of certain areas in south-east Wales in the coming decades are marked. For example local authority population projections, prepared by *Statistics for Wales* on behalf of Welsh Government in 2016, indicate that the population of Newport will increase by approximately 12,000 by 2039 and that of Cardiff will be 26% larger in 2019 than in 2014, an increase which would represent more than 90,000 extra residents.

It is acknowledged that cancer incidence is higher among the over 65s and the same report predicts that the overall proportion of the Welsh population aged 65 and over will increase from 20% to 25% over the same period.

3) **Increasing complexity of treatments**

New techniques and developments are impacting on cancer treatments, including radiotherapy.

New techniques in the planning and delivery of Radiotherapy are improving accuracy of treatments for example to avoid critical organs which helps reduce long term side effects which can be debilitating, but also improves survival.

Developments continue to lead to growth in complexity and create an increase demand on resources including pre-treatment and treatment capacity, increased time to plan, treat and an increase in the rate of re-planning.

One new technique is hypo fractionation which involves high volumes but over shorter fractionation regimes. Whilst this enables fewer visits by patients it requires an increase in accuracy and specification of planning and dosimetric delivery of treatments. This demands more high quality treatment planning but also longer set up time and imaging at the time of treatments. Thus it is predicted that the throughput of treatments per hour will reduce. These, together with the commensurate increase for Quality assurance checking to ensure treatments are delivered in an optimum and safe manner, are having an impact on demand for radiotherapy.

Another example of developments is in chemo radiation with the potential for combination drug therapies that may provide opportunity for enhanced update of radiation by cancer cells or to protect healthy tissues during Radiotherapy.

4) Current uptake levels of RT

Analysis of the update rates of Radiotherapy in Wales show it to be about 37% against best practice of approximately 41% which suggest there are people in Wales who could benefit from Radiotherapy that are not currently receiving it.

It is acknowledged that the proximity of the population to specialist services assist in ensuring greater access and uptake of these services. There is evidence that the uptake of RT treatment by patients diminishes with the distance travelled by patients to reach radiotherapy centres. The provision of a satellite will provide improved access to patients as their travel time will be reduced. The Royal College of Radiologists indicate a journey time of less than 45 minutes is appropriate

Previous work analysing potential sites has shown that a satellite centre will improve the number of patients who live within 45 minute drive of a radiotherapy treatment centre in SE Wales. As the population ages too this should ensure that as many patients as possible can access the relevant treatments. Therefore it is anticipated that a Radiotherapy satellite centre in South East Wales will also lead to an increase in the update of Radiotherapy treatments.

5) Rapid developments in techniques

Velindre Cancer Centre has always had an excellent reputation for delivering high quality radiotherapy to it patients. It has been instrumental in delivering practice changing clinical research and has always been an early adopter of new technologies such as IMRT and stereotactic radiotherapy. The pace of innovation, clinical and technological change and complexity in cancer services is rapid. It is important that the radiotherapy service at Velindre Cancer Centre be at the forefront of cancer treatment, delivering a range of high quality, people centred services, which can benefit the Welsh population, whilst balancing innovation and research with accurate, timely, effective, efficient use of resources.

6.8 Within these demand increases it is projected that the most prevalent tumour types will remain as now. In 2035, approximately a third of all cancers reported in men are anticipated to be cancers of the prostate and a similar proportion of all cancers reported in women will be cancers of the breast.

6.9 These drivers and demographic developments strongly indicate that over the coming years the demand for RT will continue to rise and require sufficient and resilient capacity to be made available. The need for this increased capacity for Radiotherapy services in South East Wales is shown in graphs below and it is this which underpins the development of this OBC.

Figure 6-2: Radiotherapy Activity

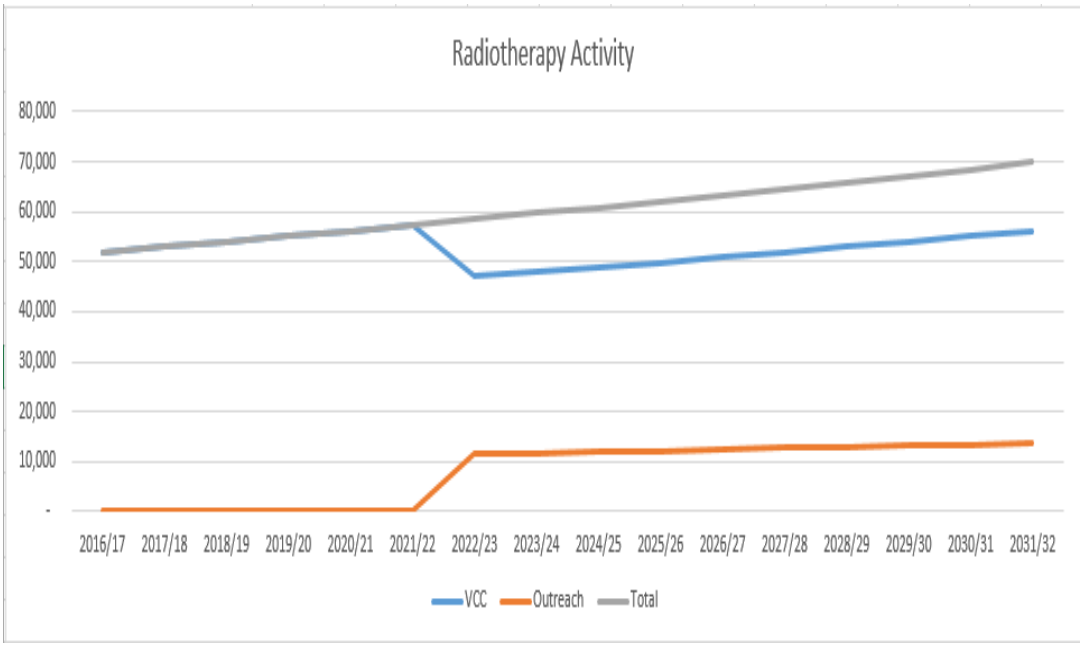
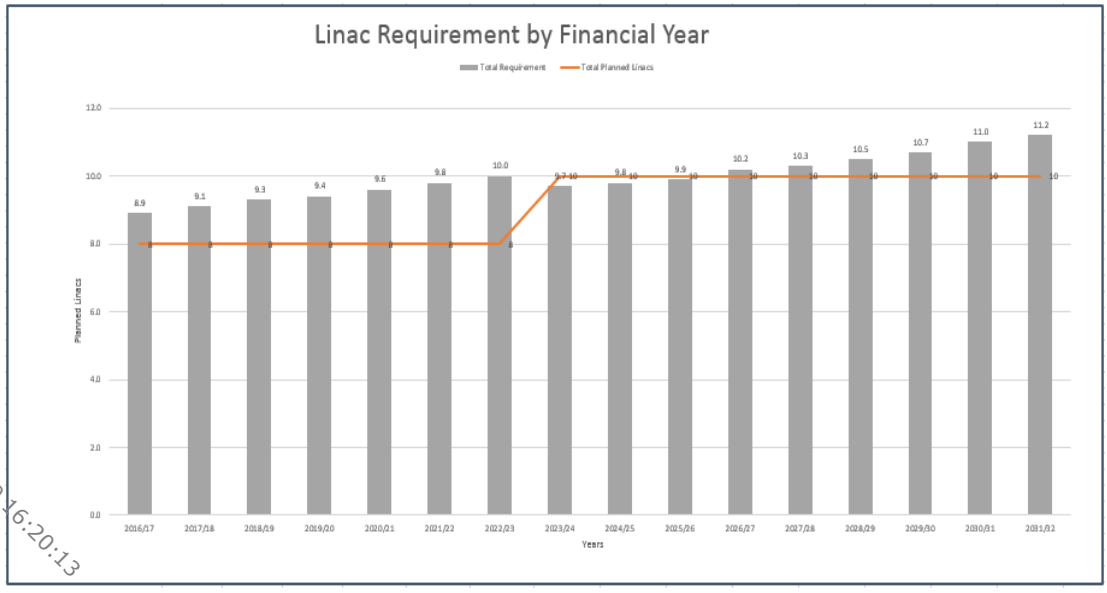


Figure 6-3: Linac Requirement by Financial Year



6.10 In summary the key drivers for the drivers for a RSC are:

- Improve access rates for Radiotherapy treatments, as rates are low in Wales compared to best practice and 50% of all cancer patients will benefit from receiving radiotherapy as part of their cancer management and in 40% of cases it contributes to a cure.
- Currently there is a poor patient experience for patients who travel significant distance for radiotherapy, often every weekday for many weeks.
- A RSC will contribute to the National policy: Healthier Wales –as it delivers care at home/locally where possible
- This type of networked model is used by leading cancer centres around the world delivering good outcomes
- Both Organisations are keen to increase access to research and trials and it is planned that local access to radiotherapy will increase availability and update of Radiotherapy trials

7 KEY RADIOTHERAPY SERVICE AND CAPACITY REQUIREMENTS

7.1 The purpose of this section is to:

- Summarise the methodology which has been applied for forecasting future capacity requirements of South East Wales Cancer Services;
- Provide an overview of the service and capacity requirements and functional requirements; and the Major Medical equipment requirements.

7.2 It is important to highlight the relationship between the nVCC OBC and the RSC OBC in terms of whole system capacity and delivery.

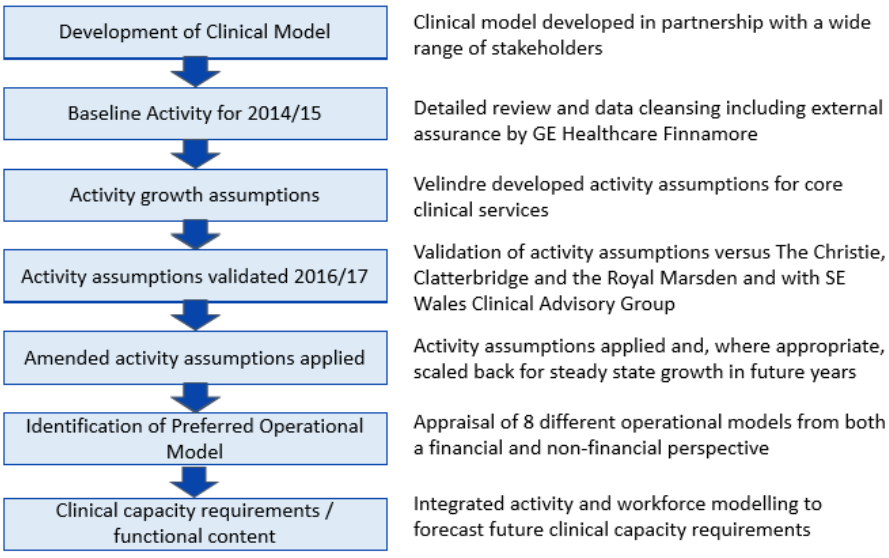
Modelling Future Capacity Requirements

7.3 The TCS Programme has developed a comprehensive activity model to forecast future capacity requirements for as set down in the nVCC OBC South East Wales Cancer Services. 2016/17 has been used as the baseline activity year for the model. The 2016/17 data set has been subject to rigorous review, including external validation, to ensure the accuracy of the data.

7.4 The functionality of the model has been subjected to quality assurance tests by the Trust's Technical Advisors, by GE Healthcare Finnamore and by the TCS Programme Team.

7.5 A summary of the process followed in forecasting future capacity requirements is shown in Figure 7-1.

Figure 7-1: Methodology for Forecasting Future Capacity Requirements



Clinical Growth Assumptions

7.6 The TCS Programme has developed a set of clinical growth assumptions for its core services. These clinical growth assumptions have been developed in partnership with clinical colleagues from across South East Wales and are informed by cancer incidence projections provided by the Welsh Cancer Intelligence and Surveillance Unit (WCISU).

7.7 The assumptions, following the availability and validation of 2016/17 activity data, have been reviewed by the VCC Senior Management Team and by the VCC service and clinical leads respectively. The main output of this review was a reduction in assumed growth rate for Radiotherapy from 4% to 2% between 2016/17 and 2030/31.

7.8 The clinical growth assumptions have been approved by the TCS Programme Management Board and by the TCS Programme Clinical Advisory Board.

Table 7-1: Clinical Growth Assumptions for Radiotherapy Services

Service	Annual Clinical Growth Assumption
	2016/17 – 2030/31
Radiotherapy	2%

7.9 In addition a validation exercise has been undertaken to compare the Trust's clinical growth assumptions against the following Cancer Centres from across the UK.

- The Beatson West of Scotland Cancer Centre;
- The Clatterbridge Cancer Centre NHS Foundation Trust;
- The Christie Cancer NHS Foundation Trust;
- Leeds Teaching Hospital NHS Trust; and
- The Royal Marsden NHS Foundation Trust.

7.10 This validation exercise demonstrated that the clinical growth assumptions were in line with those from other Cancer Centres across the UK, where comparable data is available. It can also be that radiotherapy services at Velindre Cancer Centre has observed growth in recent years in keeping with the assumption.

Forecast Capacity Requirements

7.11 Following the activity and capacity modelling process outlined above, the TCS Programme has been able to establish its core capacity requirements. For Radiotherapy these equate to 10 Linear Accelerators by 2022.

7.12 Given the above activity projections, and based on the agreed operating model referred to above the following planning assumptions were developed for the RSC:

- Radiotherapy Satellite with 2 x operational Linacs. However, there is expansion space to support the installation of two more linacs if required in the future.
- 2 x Operational bunkers on day of opening
- On-treatment review and education
- 1 x CT Simulator
- Good effective and integrated radiotherapy and clinical information systems, for example to enable panning and delivery of treatments.

7.13 There will be a phased clinical implementation at the RSC:

- Phase 1 – Less complex / high volume tumour sites
- Phase 2 – Transition to a wider range of tumour sites

Table 7-2: Phased Implementation

Initial Activity	Proposed Activity	Exclusions
Breast Prostate & SABR Planned & unplanned Palliative Emergency	Urology Upper & Lower GI Lung & SABR Gynae Lymphoma Head & Neck Thyroid Neuro Electrons Chemo-radiation Research	Stereotactic Paediatrics Superficial (DXR) Brachytherapy TBI Sarcoma Benign Conditions Whole CNS Research (Early Phase)
	Research (subject to risk assessment)	

7.14 To deliver the required service model the RSC will requires access to service provided by ABUHB including pharmacy to enable the delivery of chemo-

radiation treatments and emergency medical cover. An SLA will be established for the delivery of these.

Workforce

7.15 A workforce plan to deliver the service outlined above at the Satellite centre has been developed.

8 SPENDING OBJECTIVES

8.1 The purpose of this section is to outline the Spending Objectives for the RSC Project. The Project Spending Objectives (PSOs) provide a basis for appraising potential options and for post-project evaluation.

Project Spending Objectives

8.2 The following RSC PSOs were developed in partnership at a stakeholder workshop, which was attended by representatives with a broad range of service views. In presenting the RSC PSOs it is important to emphasise that:

- The scope of the OBC is limited to the development of the RSC to support the existing, and in the future, a new VCC; and
- The OBC for the RSC will focus on the additional infrastructure costs directly attributable to the RSC and the variable clinical and facilitate costs that result of a step up in radiotherapy capacity to meet modelled demand.

Table 8-1: Project Spending Objectives

Project Spending Objective	Description
Project Spending Objective 1	To provide access to **quality** and **safe** radiotherapy services that optimises patient **outcomes.**
Project Spending Objective 2	To provide sufficient **capacity** to meet future **demand** for services.
Project Spending Objective 3	To **improve patient, carer** and **staff experience.**
Project Spending Objective 4	To provide **capacity** and **facilities** to support the delivery of high quality **education**, **research**, **technology** and **innovation.**

8.3 The PSOs were approved by the RSC Project Board who provided assurance to the Health Board and Trust Board that they were:

- Aligned with the national context for healthcare developments in Wales;
- An alignment with the TCS Programme;
- Aligned with the scope and strategic context of the nVCC Project;
- Specific, measurable, achievable relevant and time-constrained (SMART); and
- Focused on business needs and vital outcomes rather than potential solutions.

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Performance Metrics

8.4 To support the delivery of these objectives a number of key performance metrics have been developed and mapped against the five drivers for investment outlined within the Welsh Governments Business Case guidance.

Table 8-2: nVCC OBC Project Spending Objectives – Key Performance Metrics

Project Spending Objective	Performance Metrics
PSO1 - To provide access to **quality** and **safe** radiotherapy services that optimises patient **outcomes**	• Percentage compliance with Health Building Notes • Compliance assessment against BREAM • Percentage assessment against WHTM Estate Code (Category A Condition of Buildings) • PROM outcome measures • Access rate to Radiotherapy treatments
PSO2 – To provide sufficient **capacity** to meet future **demand** for services	• Percentage of patients receiving radical radiotherapy treated within 21 days • Percentage of patients receiving palliative radiotherapy treated within 7 days • Percentage of patients receiving emergency radiotherapy treated within 2 days • Percentage utilisation of equipment / accommodation: o Linear accelerator utilisation o Non-clinical accommodation utilisation
PSO3 – To **improve patient, carer** and **staff experience**	• Percentage of patients rating their experience as excellent • Percentage staff satisfaction • Percentage recruitment of workforce • Percentage retention of workforce • PREM measures • Reduced travel times for patients and carers with resultant better experience and reduction in carbon footprint
PSO4 - To provide **capacity** and **facilities** to support the delivery of high quality **education**, **research**, **technology** and **innovation**	• Percentage of patients who have the opportunity to participate in clinical radiotherapy research trials • Percentage of patients for each cancer site entered into radiotherapy clinical trials each year • Increased integrated and cross organisation MDT learning and education

9 SCOPE OF THE RADIOTHERAPY SATELLITE CENTRE PROJECT

9.1 As previously described the scope of the Project is limited to the building of an RSC and the following is outside of the scope of the RSC Infrastructure Project:

- All other variable clinical costs of modelled demand growth (excluding radiotherapy which is included within the OBC) which will be considered through the commissioning LTA framework and, therefore, excluded from the RSC OBC;
- All other service development Projects e.g. Prehabilitation which will be subject to separate Business Cases and therefore excluded from the RSC OBC;
- All other outreach capital Projects e.g. SACT services, which will be subject to separate Business Cases and therefore excluded from the RSC OBC; and
- All Digital Projects which the Trust needs to complete irrespective of the RSC Project. These will be the subject of separate Business Cases.

Potential Business Case Options

9.2 The scope of the Project is well defined. There are two potential options for delivering the objectives of the Project apart from the Status Quo:

- Do Nothing;
- Option 1: 10 Linear Accelerators at nVCC
- Option 2: 8 Linear Accelerators at nVCC and 2 Linear Accelerators within the RSC.

9.3 As outlined earlier, the location of the RSC has been previously determined through an independently led options appraisal.

Capacity and Functional Requirements

9.4 As outlined earlier the activity and capacity analysis has demonstrated the following Functional Content requirements is 10 linacs i.e. 2 additional linacs from current levels and when compared to the planned nVCC.

Building Footprint for RSC

9.5 The activity and capacity analysis has demonstrated that the required building footprint for the RSC, is based on the clinical model plan that 2,528 m^2.

10 PROJECT RISKS, CONSTRAINTS, DEPENDENCIES AND ASSUMPTIONS

Risks

10.1 Identifying, mitigating and managing the key risks is crucial to successful delivery. Without effective management of the key risks it is likely that the Project would not deliver its intended outcomes and benefits within the anticipated timescales and spend.

10.2 A full risk register for the RSC Project has been developed which includes the following categories:

11 **Business risks:** Risks that remain 100% with the Health Board and Trust and include political and reputational risks;
12 **Service risks:** Risks associated with the design and build and operational phases of the Project and may be shared with other organisations; and
13 **External Non System risks:** Risks that affect all society and are not connected directly with the proposal. They are inherently unpredictable and random in nature.

10.3 The RSC risk register is managed by the Project Team. The role of the Project Team in managing risks is described within the Management Case.

Constraints

10.4 The main constraints in relation to the RSC Project are outlined in Table 10-1.

Table 10-1: Main Constraints of the RSC Project

Constraint	Overview
Financial Constraints	The infrastructure solution for the RSC must be deliverable within the (including VAT but excluding equipment) capital funding agreed with the Welsh Government and the revenue resources agreed with Commissioners.
Timescale Constraints	The RSC must be operational in line with the Programme requirements and as agreed with the Welsh Government.
Service Continuity	Delivery of patient services must be maintained during the period of construction.
Compliance with Statutory Requirements	The RSC must be fully compliant with all relevant statutory compliance requirements.

Dependencies

10.5 A number of dependencies have been identified in relation to the RSC Project. These are provided in Table 10-2.

Table 10-2: Main Dependencies of the RSC Project

Dependency	Overview
Capital Funding Availability	Access to capital funding is critical to deliver the Project, including the procurement of Major Medical equipment and IM&T and essential Enabling Works.
Revenue Funding Availability	Access to revenue funding is essential to support the recurring revenue implications associated with the RSC Project.
Welsh Government Approval	The Outline Business Case must be approved by Commissioners and the Welsh Government.
Partnership Working	Co-production in the design and implementation of the Project that involves all stakeholders is essential to the Project's success.
Wider Health Strategy and Governance	It is important that general health strategy and governance in Wales, that underpins the RSC Project remains broadly consistent over the period of change.

Assumptions

10.6 The key assumptions underpinning the RSC Project are provided in Table 10-3.

Table 10-3: Main Assumptions for the RSC Project

Assumption	Overview
Implementation of the wider TCS programme	It is assumed that the following capital Projects identified within the TCS Programme are funded and the RSC has been 'sized' on the basis of this assumption. • VCC (and nVCC) at Whitchurch; and • Non-surgical cancer Outreach centres across South East Wales delivering SACT and Outpatient services.
Clinical Growth Assumptions	The RSC has been 'sized' on the basis of a number of clinical growth assumptions (in conjunction with the nVCC OBC), summarised below:

Assumption	Overview
	• Radiotherapy activity will increase by 2% per annum through to 2031

Flexibility for Expansion on the Site of the Radiotherapy Satellite Centre

10.7 It is important to highlight that there is planned expansion space (equivalent to accommodation for 2 additional linear accelerators plus supporting equipment etc.) on the identified site for the RSC. This expansion capacity is important to the TCS Programme Risk Management Strategy in the event that the clinical growth assumptions prove to be understated.

11 CONCLUSION

11.1 The Strategic Case has demonstrated the compelling case for investment to support the development of an RSC. The key factors supporting the case for investment are:

- Demand for Radiotherapy is forecast to increase over the forthcoming years and there is currently insufficient capacity to meet this demand;
- There is no expansion space on the existing Velindre Cancer Centre to, for example, install any additional linear accelerators, which limits the Trust's ability to expand its capacity in response to increasing demand for clinical services;
- Patient access to radiotherapy services in Wales is lower than in the rest of the United Kingdom and location of radiotherapy centres have been identified as a contributing factor; and
- The new Velindre Cancer Centre, has been sized on the basis that an RSC would be delivered in advance of its opening in accordance with the TCS Clinical Model.
- The RSC provides additional radiotherapy service capacity to the patients of South East Wales to meet demand significantly in advance of any other potential service development.

12 APPENDICES

For Information

No appendices are detailed to support this chapter**.**

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Outline Business Case: 2020

Radiotherapy Satellite Centre

Economic Case

ECONOMIC CASE

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1 INTRODUCTION

1.1 The case for a Radiotherapy Satellite Centre (RSC) has been clearly articulated within the Strategic Case.

1.2 The purpose of the Economic Case is to identify and appraise the potential options for the delivery of the Project Spending Objectives (PSOs).

1.3 The Economic Case outlines the option appraisal undertaken to identify the Preferred Option by the following Processes:

- Identification of the Critical Success Factors (CSFs) for the Project;
- Development of a shortlist of options in response to the case for change and the proposed clinical service model;
- Evaluation of the shortlist of options against the CSFs and the PSOs;
- An economic appraisal of the shortlist of the options; and
- A recommendation of the preferred way forward in the form of a Preferred Option.

1.4 The outcome of the option appraisal supports and justifies the decision to proceed with the Project. It does this by identifying a Preferred Option which is expected to demonstrate that the Project will deliver the benefits required and provide the best value for money.

Context

1.5 The Welsh Government approved the Trust's Strategic Outline Programme (SOP) in 2015 for the delivery of Cancer Services in South East Wales.

1.6 The SOP was followed by a Transforming Cancer Services (TCS) Programme Business Case in October 2017 that developed the clinical model underpinning service development in South East Wales.

1.7 The Project parameters set out above are important as they restrict the range and scope of options which could be considered as part of the Economic Case.

2 CRITICAL SUCCESS FACTORS

2.1 As outlined in the Welsh Government's Better Business Case Guidance, the Critical Success Factors (CSFs) are the attributes essential for successful delivery of the Project.

2.2 The Project Group developed the CSFs for the Project and in doing so considered the Welsh Government priorities as outlined in the NHS Infrastructure Investment Criteria. The criteria is outlined below:

Table 2-1: NHS Infrastructure Investment Criteria

- **Health gain:** improving patient outcomes and meeting forecast changes in demand;
- **Affordability:** given the long term revenue assumptions, there should be an explicit reference to reducing revenue costs;
- **Clinical and skills sustainability:** reducing service and workforce vulnerabilities, and demonstrating solutions that are flexible and robust to a range of future scenarios;
- **Equity:** where peoples highest health need are targeted first; and
- **Value for money:** optimising public value by making the most economic, efficient and effective use of resources.

2.3 The CSFs that were identified are as follows:

- Strategic fit;
- Potential value;
- Supplier capacity and capability;
- Potential affordability; and,
- Potential achievability.

2.4 The CSFs are used to assess each option and they have also been aligned to the infrastructure investment criteria, as outlined in the table overleaf.

Table 2-2: Critical Success Factors

Critical success factor	The option will be assessed in relation to how well it:	Alignment to infrastructure investment criteria
Strategic fit	• Meets agreed Project Spending Objectives, related business needs and service requirements; and • Provides holistic fit and synergy with other strategies, programmes and projects.	• Health gain
Potential value for money	• Optimises public value (social, economic, environmental) in terms of potential costs, benefits, and risks.	• Value for money • Equity
Supplier capacity and capability	• Matches the ability and capacity of potential suppliers to deliver the required services; and • Is likely to be attractive to potential suppliers.	

Critical success factor	The option will be assessed in relation to how well it:	Alignment to infrastructure investment criteria
Potential affordability	• Can be funded from available sources of finance; and • Aligns with sourcing constraints.	• Affordability
Potential achievability	• Is likely to be delivered given the Health Board and Trust's and partner organisations' ability to respond to the changes required; • Matches level of available skills required for successful delivery; • Facilitates the continued delivery of services throughout the duration of the project; and • Delivers an operational RSC in line with the Programme agreed with the Welsh Government.	• Clinical and skills sustainability

2.5 The CSFs are used alongside the PSOs and the infrastructure investment criteria to evaluate possible options for the delivery of the Project.

2.6 The possible options for the delivery of the Project will be identified using the Options Framework presented in the next section.

3 THE OPTIONS FRAMEWORK

3.1 The Options Framework, as outlined in the Welsh Government's Better Business Case Guidance, provides a systematic approach to identifying and filtering a broad range of options for operational scope, service solution, service delivery, implementation and the funding mechanism for a Project. An overview of these key dimensions is provided in the following table:

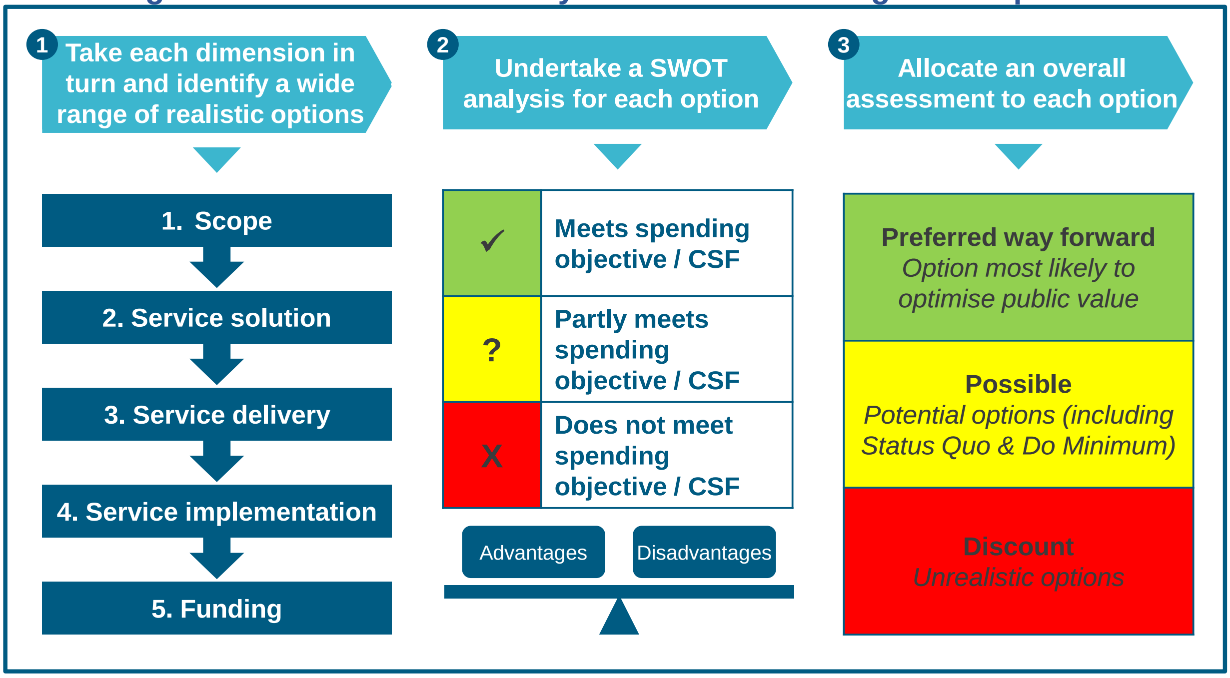
Table 3-1: Options Framework

Dimension	Description
Scope	What is the potential coverage of the project?
Service solution	How the preferred scope of the project can be delivered?
Service delivery	Who can deliver the preferred scope and service solution for the project?
Implementation	The timing and phasing of project delivery in relation to the preferred scope, service solution and delivery arrangements for the project.
Funding	Potential funding requirements for delivering the preferred scope, solution, service delivery and implementation arrangements for the project.

3.2 The process for identifying and assessing options takes each of the key dimensions in turn and undertakes the following steps (as illustrated in Figure 3-1):

- Identification of a wide range of realistic potential options within that dimension.
- An analysis for each option to:
  - Assess how well the option meets the Programmes spending objectives and CSFs; and to
  - Identify the main advantages and disadvantages of the option.
- Using the outputs of the analysis to determine whether the option will be carried forward as the preferred way forward, carried forward as a possible solution, or discounted at this stage.

Figure 3-1: Process to identify and assess the long list of options



3.3 The Programme Delivery Board has identified a wide range of realistic and possible options for the delivery of the project using the options framework.

3.4 A range of potential options were identified in relation to the range of services that the Trust is required to deliver. These options are presented below in Table 3-2:

Table 3-2: Project scope options

Ref	Option	Description
1.1	**Do Nothing**	Continue with existing arrangements
1.2	**Do minimum**	Provide additional capacity at nVCC (increase nVCC LINACs from 8 to 10) with no satellite provision
1.3	**Intermediate**	Develop a new satellite radiotherapy unit at Nevill Hall with 2 LINACs

3.5 The advantages and disadvantages of each of the longlisted options were identified. A summary of this is provided in Table 3-3.

Table 3-3: Project Scope- advantages and disadvantages of options

Advantages	Disadvantages
1.1 Do Nothing	
• Does not require any capital investment	• Service will be unable to accommodate forecast demand in the future

Advantages	Disadvantages
	• Does not increase access closer to home so reduces programme benefits associated with reduced patient travel and improved uptake of services • Does not align with the TCS strategy concerning improving the overall cancer pathway and so will impact on delivery of programme benefits
1.2 Do minimum: Provide additional capacity at nVCC with 2 LINACs	
• Potentially reduces capital costs by negating the need to develop an additional facility	• Does not increase access closer to home so reduces programme benefits associated with reduced patient travel and improved uptake of services • Physical challenges of accommodating 2 additional LINACs on nVCC site • Reduces expansion capacity on nVCC site • Does not provide additional capacity during development of nVCC so significant risk that demand will exceed capacity during this time • Does not mitigate risks associated with recruiting and retaining staff in one geographical location • Requires an increase in revenue service payment cost.
1.3 Intermediate: Develop a satellite radiotherapy unit at Nevill Hall with 2 LINACs	
• Improves access to care closer to home, leading to increased uptake of treatment which will result in improved patient outcomes • Ability to provide additional capacity during the nVCC transitional period. • Flexibility of workforce working, larger recruitment pool and flexibility between sites	• Increased capital due to the introduction of an additional building

3.6 Each option was assessed against the spending objectives and CSFs. The results of this, including the overall assessment of each option, are presented in Table 3-4 overleaf:

Table 3-4: Project Scope - Assessment of Options

		1.1 - Do nothing	1.2 - Additional capacity at nVCC	1.3 - Develop SRU at Nevill Hall
SO1	To provide access to quality and safe radiotherapy services that optimises patient outcome	X	?	✓
SO2	To provide sufficient capacity to meet future demand for services	X	?	✓
SO3	To improve patient, carer and staff experience	X	✓	✓
SO4	To provide capacity and facilities to support the delivery of high quality education, research, technology and innovation	?	✓	✓
CSF1	Strategic fit	X	?	✓
CSF2	Potential value for money	X	?	✓
CSF3	Supply side capacity / capability	✓	✓	✓
CSF4	Potential affordability	✓	✓	✓
CSF5	Potential achievability	X	?	✓
Assessment		Baseline	Possible - Carry forward	Preferred way forward

3.7 Following the assessment of the longlisted options associated with the scope of services to be delivered, it is concluded that:

- Development of a Satellite Radiotherapy Unit at Nevill Hall (Option 1.3) is identified as the preferred way forward because it best meets the spending objectives and the critical success factors, by providing increased capacity, greater workforce resilience and access to care closer to home which will lead to improved patient outcomes. This option offers a significant advantage in terms of providing additional capacity in advance of the nVCC opening.

- Option 1.1 – Do nothing is carried forward as a baseline only to allow comparison of the options. It is not a feasible option as it does not provide enough capacity to meet growing demand and since it will not achieve spending objectives, is not likely to represent value for money.
- Option 1.2 – Providing additional Radiotherapy capacity at nVCC only partly meets spending objectives in terms of additional capacity but creates some risks in terms of timescales and access to care closer to home. It is carried forward as a possible option for evaluation as part of the economic appraisal.

3.8 The outcome of this process determined the longlist of options for the Project. These options were then evaluated and appraised by the RSC Project Board against the PSOs and CSFs.

3.9 The detailed exercise of identifying and assessing the longlist of options is outlined in Appendix OBC/EC1.

4 THE SHORTLISTED OPTIONS

4.1 As outlined in the previous section, the TCS Programme Delivery Board determined the shortlist of possible options that would be appraised.

4.2 The RSC Project Board reviewed the shortlist of options by testing the following:

- Was the option likely to deliver the spending objectives and CSFs?
- Was the option likely to deliver sufficient benefits?
- Was the option practical and feasible?
- Was the option deliverable within the constraints of the project?
- Was the option deliverable without incurring an unacceptable degree of risk?

4.3 Following this review, the shortlist of options were approved by the RSC Project Board and notified to Welsh Government in a letter to Rob Hay dated 28th November 2019.

4.4 The final shortlist of **three** options are presented below:

- **The Do Nothing Option:** This option provides a benchmark for assessing the value for money of all options. It attempts to optimise existing arrangements as far as possible in order to improve the organisation's capability to meet current and some future demand for core services. It requires investment in outsourcing services to meet demand beyond that available from internal capacity.

- **The Do Minimum Option:** This option offers a realistic way forward to meet future demand for core services through the expansion of a purpose built nVCC. This option requires single stage implementation which will be funded through a Public Private Partnership (Building) and NHS Capital Funding (Equipment).

- **The Intermediate Option (Preferred Way Forward):** This option requires the development of a purpose built RSC operating in partnership with Aneurin Bevan University Health Board. This option offers a phased implementation which will be funded from NHS Capital Funding (Building and Equipment).

4.5 The appraisal, in financial and non-financial terms, of the shortlisted options is presented in Sections 5 to 8.

5 FINANCIAL COSTS AND QUANTIFIED BENEFITS

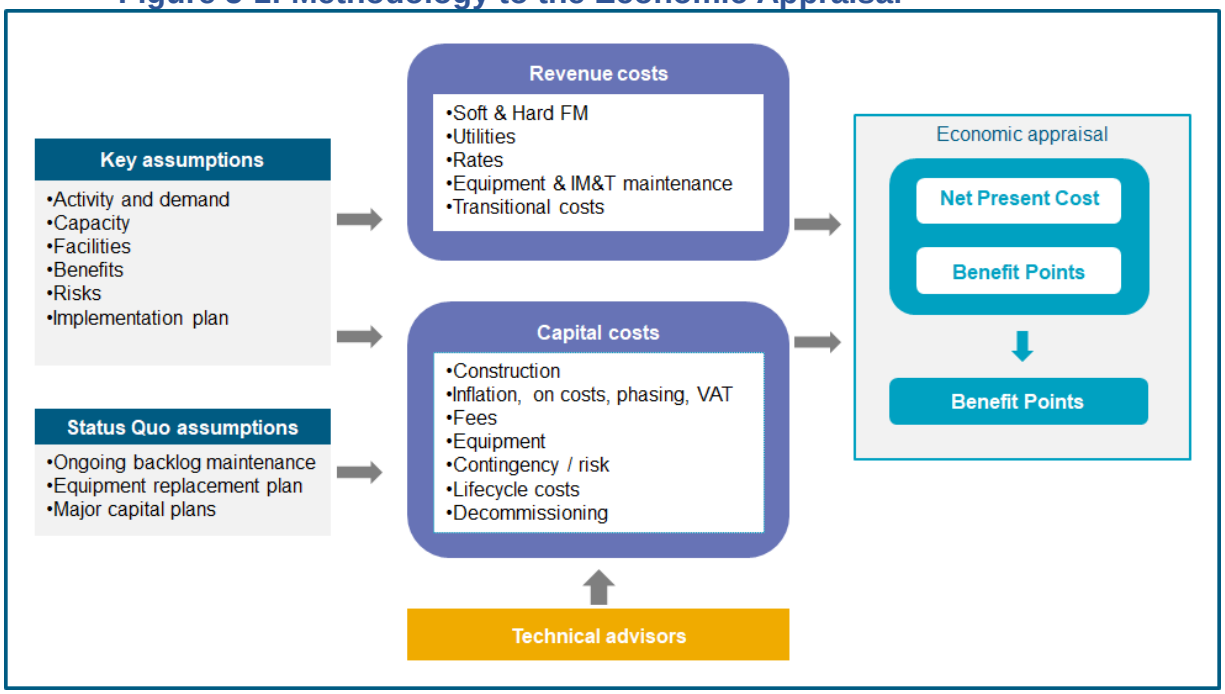
Estimating Costs for the Economic Appraisal

5.1 The treatment of costs and benefits within the Economic Appraisal is in line with current Welsh Government's Better Business Case Guidance.

5.2 The Economic Appraisal process utilises key outputs from other parts of the OBC process, in particular the required outputs and Project Plans, in establishing the capital and revenue (recurring and non-recurring) implications of each option.

5.3 The general approach to the economic appraisal is summarised below:

Figure 5-1: Methodology to the Economic Appraisal



Capital Costs

5.4 The Health Board and the Trust, and their Technical Advisors, in partnership with NHS Wales Shared Services (Shared Services), has prepared the capital costs based on an appraisal of the capital requirements of each option.

5.5 These are derived primarily from the Schedules of Accommodation (see Appendix OBC/EC2) with appropriate adjustments to reflect the costs of delivering the options at the time when the new facilities become operational. The capital requirements differ for each of the three shortlisted options and include:

- **Do Nothing Option:**
  - Requires some outsourcing of services to address demand requirements;
  - Assumes the nVCC will be built be commissioned in 2025.

- **Do Minimum Option:**
  - Construction of an extended nVCC to replace the existing Velindre Cancer Centre and meet the additional capacity required across the South East Wales Region.
  - nVCC designed and sized in line with additional service scope and in line with relevant Health Building Notes; and
  - Expansion zones identified through the design of the nVCC to facilitate the potential future introduction of new services.

- **Intermediate Option (The Preferred Way Forward):**
  - Construction of a RSC to supplement the existing (and new) Velindre Cancer Centre;
  - nVCC designed and sized in line with existing service scope and in line with relevant Health Building Notes; and
  - Expansion zones identified through the design of the RSC and nVCC to facilitate the potential future introduction of new services.

5.6 The capital cost calculations and assumptions have been developed by the Health Board and Trust and their Technical and professional Advisors, and have been shared and agreed with NHS Wales Shared Services. For further details refer to the Capital Cost Forms (Appendix OBC/EC3). The assumptions used to calculate the costs are provided below.

Table 5-1: Main Capital Cost Assumptions

- Construction costs have been calculated by the Project's Technical Advisors (Kier) and the nVCC Project Team based on PUBSEC 250.
- Capital cost forms (OBC forms) are completed using Departmental Cost Allowances Guides (DCAGs), using the Schedule of Accommodation information that outlines the clinical and non-clinical areas in sqm. These costs reflect the detailed Technical costs stage 1.
- The phasing of the capital costs is based on the Project plan.
- Appropriate on-costs have been applied to cover capital expenditure associated with utilities, communications, external building works, and auxiliary buildings.
- Appropriate fees have been determined by the Trust's technical advisors, based on industry norms.
- Equipment estimates cover IM&T, medical and non-medical equipment as provided by the technical advisors. Other equipment (Group 3 and 4 items) has been determined, by the technical advisors based on industry norms.
- Contingencies reflect the capital risks within each of the shortlisted options and are based on an assessment by the Project and their Technical and Professional Advisors. These have been quantified either based on a detailed risk quantification exercise.
- VAT is allowed for at the 20% rate. However, there has been an element of VAT reclaim assumed in developing the construction costs which has been informed by the Trust's VAT advisors.

- It is assumed that the Do Minimum option (nVCC extension) will be delivered via the MIM funding model and so only equipment related costs are included within capital (all building-related costs included within revenue costs).

5.7 The total capital costs for the Project are at 2019/20 prices and include VAT. At this stage they do not include an allowance for optimism bias. The breakdown of capital costs for each option is outlined in the following table:

Table 5-2: Breakdown of Capital Costs (£'000)

	Do Nothing	Do Minimum (nVCC Extension)	RSC
Construction costs	0	0	15,338
Fees	0	0	2,752
Non works costs	0	0	2,859
Equipment costs	0	2,299	2,723
Quantified risk	0	0	1,707
Total costs excl. VAT	**0**	**2,299**	**25,379**
VAT	0	0	4,907
Total costs incl. VAT	**0**	**2,299**	**30,286**

5.8 The capital costs (exc. VAT) have been phased in accordance with the profile of costs as outlined in the Capital Cost Forms (Appendix OBC/EC3). An analysis of the phasing of total capital costs for the Project is outlined in the following table:

Table 5-3: Capital Costs by Financial Year (£'000)

Financial year	Do Nothing	Do Minimum (nVCC Extension)	RSC
2019/20	0	0	529
2020/21	0	0	3,863
2021/22	0	0	4,392
2022/23	0	0	12,432
2023/24	0	2,299	3,933
2024/25	0	0	231
Total capital costs excluding VAT	**0**	**2,299**	**25,379**

5.9 Following the upfront capital investment, the Trust will continue to require an annual capital allocation to finance new and replacement items of equipment. These costs are not included within the cost summarised in Table 5-4.

5.10 In addition to the upfront capital investment, the Trust and its appointed Technical Advisors have estimated the lifecycle cost associated with each of the shortlisted options. The assumptions used to calculate the costs are provided below.

Table 5-4: Lifecycle Cost Assumptions

- Lifecycle costs are calculated over the full 60 year appraisal period in line based on average cost per m2 in line with similar projects. It is assumed to commence in 2023/24 following completion of the project.
- All lifecycle costs for the Do Minimum option (nVCC extension) are assumed to be included within the annual MIM charge.

5.11 An analysis of the annual lifecycle costs of the project is provided in the following table:

Table 5-5: Total Lifecycle Costs (£'000)

Cost category	Do Nothing	Do Minimum (nVCC Extension)	RSC
GIFA m2			2,533
Annual lifecycle costs			59

5.12 The figures provided in this section are consistent with the Capital Cost Forms prepared by the Health Board and Trust's Technical Advisors provided in Appendix OBC/EC3. For the purposes of the economic appraisal these will be adjusted to:

- Include an allowance for optimism bias;
- Exclude VAT; and
- Re-base to a consistent price base where required.

Non-Recurrent Costs

5.13 The Trust requires non-recurring revenue funding to ensure the delivery of the Project and to cover the commissioning phase.

5.14 The Trust has calculated commissioning costs based on the assumptions set out as follows:

Table 5-6: Main Transitional Cost Assumptions

- Non-recurring costs are to be incurred to facilitate Pre Commissioning in 2022/23

5.15 The resulting Project running costs and commissioning costs are outlined in the table below:

Table 5-7: Transitional Costs (£'000)

Cost category	Do Nothing	Do Minimum (nVCC Extension)	RSC
Pre-commissioning costs	0	712	712
Total Costs	**0**	**712**	**712**

Recurring Revenue Costs

5.16 The recurring revenue costs reflect the investment that will be required for each of the options.

5.17 Costs will differ for the three shortlisted options in relation to the operational requirements of each, the main elements of which are described below:

- **Do Nothing option:** Includes the costs to source additional demand outside of the capacity of the facility;
- **Do Minimum (nVCC Extension) option:** Includes the costs associated with operating additional capacity within an extended nVCC;
- **RSC option:** Includes the costs associated with operating the service remotely from the VCC.

5.18 The assumptions used to calculate the costs associated with these features are outlined below:

Table 5-8: Recurring Revenue Cost Assumptions

- Costs are at 2019/20 prices with no inflation included.
- Costs are based on forecast workforce and operating requirements to provide Radiotherapy services for the level of demand that is expected to exceed current/future nVCC capacity, depending on the option:

  Do Nothing
  - Since this option does not address the capacity constraints, costs to outsource unmet demand to an external provider have been estimated.

  Do Minimum
  - For the nVCC Extension option, costs have been estimated for the additional workforce and operating costs required to provide increased capacity on the nVCC site.
  - In addition, an estimate has been made of the increased annual charge associated with the MIM delivery vehicle. This has been calculated based on the estimated capital costs of nVCC extension, on a proportional basis (i.e. the estimated annual charge for the main nVCC scheme in relation to estimated capital costs) and is on a like-for-like basis (including quantified risk but excluding Groups 2, 3, and 4 equipment).

  RSC Option
  - For the RSC option, costs have been estimated based on the workforce and operating costs required to deliver services from a Radiotherapy Satellite Centre at Nevill Hall.

5.19 Annual recurring revenue costs have been estimated for each of the options from 2023/24 onwards following the commissioning of the new facilities under the RSC option. It is anticipated that costs will continue at these levels from that point forward.

5.20 The summary of the annual recurring revenue costs from 2023-24 are outlined in the following table:

Table 5-9: Future Recurring Revenue Costs 2023/24 (£'000)

Cost category	Do Nothing	Do Minimum (nVCC Extension)	RSC
Pay costs	0	1,716	1,900
Non-pay costs	0	648	646
Cost of outsourcing	10,866	0	0
Additional MIM charge for nVCC extension	0	1,237	0
Annual recurring revenue costs	**10,866**	**2,364**	**2,547**

5.21 In addition, the Do Minimum option includes the cost of outsourcing unmet demand has been included for the period from July 2023 to October 2024 to reflect the capacity constraints during the additional construction period required to deliver this option.

Assessing the Cost of Risk

5.22 A range of risks have been identified for the Project, some of which can be quantified and a financial value determined. Other risks are either qualitative or cannot be attributed to specific aspects of the Project, such as revenue risks, the impact of which is excluded from this economic appraisal.

5.23 For the purposes of assessing the costs of risk for the Project the following capital risks have been calculated including:

- Quantified capital risks: which are included in the capital cost contingencies; and
- Optimism bias: the approach used to calculate this is outlined below.

Optimism Bias

5.24 The Health Board and Trust and their cost advisors have calculated an adjustment for optimism bias. This is a requirement of HM Treasury guidance and is intended to redress the demonstrated and systematic tendency for Project appraisers to be optimistic when estimating costs, benefits and timings.

5.25 The optimism bias adjustment is in addition to the calculation for Project specific risk and reflects the current level of uncertainty within the Project. Adjustments for optimism bias will be reduced as more reliable estimates of relevant costs are built up.

5.26 The optimism bias calculation has been prepared in accordance with current HM Treasury guidance following the steps below:

- **Step 1** decide which Project type to use;
- **Step 2** start with the upper limit;
- **Step 3** consider whether the optimism bias factor can be reduced; and
- **Step 4** apply the optimism bias factor to the NPV calculation.

5.27 Given the degree of complexity associated with the construction elements of the Project, it was agreed that a 'non-standard' Project type will be used.

5.28 In line with current guidance, the upper bound level for optimism bias for this type of construction Project is 24%. This was therefore used as the starting point for the optimism bias calculation.

5.29 An analysis is provided below of the main factors and how they contribute to the upper bound level before and after mitigation.

Table 5-10: Optimism Bias Contributory Factors

	% contribution to upper bound	% after mitigation
Procurement	40.0%	6.0%
Project specific	5.0%	1.2%
Client specific	37.0%	10.7%
Environment	4.0%	1.4%
External factors	14.0%	3.0%
Total	**100.0%**	**22.3%**

5.30 Applying this mitigation to the upper bound level of optimism bias results in an optimism bias factor of 5.35% for the RSC Option.

5.31 No optimism bias has been included for the nVCC option.

5.32 The resulting optimism bias factor has been applied to the capital costs within the Economic Appraisal. Further details of the optimism bias calculations is provided at Appendix OBC/EC5.

Expected risk value

5.33 In addition, an expected risk value has been calculated to reflect the risk of delays to the programme for each of the option.

5.34 The impact of any delay is increased outsourcing costs which is estimated to cost £10,866k p.a.

Table 5-11: Expected risk value assumptions

	Do Nothing	Do Minimum (nVCC Extension)	RSC
High impact	N/A	12-month delay (25% probability)	9-month delay (25% probability)
Medium impact	N/A	6-month delay (40% probability)	4.5-month delay (25% probability)
Low impact	N/A	3-month delay (25% probability)	1-month delay (10% probability)
No impact	N/A	No delay (10% probability)	No delay (45% probability)
Expected risk value (£'000)	-	5,569	3,146

Estimating the Value of Benefits

5.35 As outlined in the Strategic Case, the Project delivers benefits in a variety of areas some of which can be quantified and valued financially.

5.36 For the purposes of the economic appraisal, we have focused on quantifying benefits which differentiate between the options, are measurable and evidence-based, and can be monetised using recognised methodology. This includes the following:

- Additional capacity available to meet forecast demand
- Reduced travel time for patient and carers
- Improved access to treatment and clinical trials leading to better clinical outcomes

5.37 The approach used to calculate a monetary value for each of these benefits is outlined below.

Additional capacity

5.38 The additional capacity provided in both the Do Minimum (nVCC extension) and the RSC options, avoid the need to outsource activity to external providers in the long term, resulting in lower revenue costs when compared to the Do Nothing option. The RSC option also avoids the need to outsource activity to external providers in the short term as this can be delivered 16 months earlier than the Do Minimum option.

5.39 Since these costs and savings are accounted for within recurring revenue costs they are not stated as separate benefits in the table below.

Reduced travel time

5.40 It is estimated that around 6,343 attendances p.a. will benefit from closer proximity to the RSC at Nevill Hall, saving patients and carers around 2,957 hours of travel time each year.

5.41 Applying a value of time travelled of £6.26 per hour (Based on Department for Transport's (DfT) Transport Appraisal Guidance (TAG) – specifically, other travel not related to business or commuting at 2020 price base) results in a societal benefit equivalent to £18.5k p.a.

5.42 In addition, the reduced travel time will result in a reduction in carbon dioxide emissions. Assuming an average speed of 30-miles per hour and based on the forecast emissions associated with average fuel consumption and vehicle type applying the economic value of carbon emissions of £75.38 per tonne (Using DfT's TAG 2023 assumptions at 2020 price base), this creates a societal benefit equivalent to £12.8k p.a.

Improved access

5.43 It is estimated that current uptake of Radiotherapy services in Wales is 37% (Based on MALTHUS modelling). Given that best practice guidance is uptake of 41% and there is evidence to suggest that distances of over 45 minutes to access services is a barrier to treatment, it is reasonable to assume that the introduction of a satellite radiotherapy centre at Nevill Hall will increase uptake to at least 39%, equating to an estimated 231 referrals each year (based on average referrals for the last 3 years and ignoring any impact of growing demand related to demographic growth or increased incidence rates).

5.44 The increased uptake of treatment is expected to have a direct impact on clinical outcomes, including cancer survival rates. Applying current survival rates of 49.9% (Based on assumptions within the TCS Programme Benefits Paper) would result in 115 additional cancer survivors each year. It should be noted that this is likely to increase in line with improvements to survival rates, for instance if the target survival rate of 71% was achieved (as outline in the TCS Programme Benefits Paper), this would equate to 164 additional cancer survivors. However, for the basis of the RSC business case, current survival rates have been applied.

5.45 The social value of the life years gained by cancer survivors as a result of the improved access can be quantified by using the concept of Quality Adjusted Life Years (QALYs). QALYs are widely used in health, transport and welfare policy domains. Although there is a limited evidence-base to draw on reasonable assumptions can be made as follows:

- Average QALY for cancer survivors is difficult to establish but the TCS Programme Benefits Paper identified a paper which suggested that a reasonable assumption is 0.3 per year of survival.
- Based on TCS Programme Benefits paper it is estimated that average 5 life years gained for each survivor.
- Value of QALY is based on standard NHS assumption of £60k per QALY.

5.46 This results in a societal benefit equivalent to £10,375k p.a.

5.47 The resulting values of the quantified benefits expressed in cash terms is summarised below for each option. These have been subsequently been incorporated within the Economic Appraisal over the 60-year appraisal period.

Table 5-12: Quantified annual benefits value (£000)

Benefits category	Do Nothing	Do Minimum (nVCC Extension)	RSC
Reduced travel time	0	0	18
Reduced carbon emissions	0	0	12
Improved access	0	0	10,375
Total annual benefits	**0**	**0**	**10,406**

5.48 The approach and methodology used to estimate the monetary value of these Project benefits are outlined in Appendix OBC/EC6(a).

5.49 An analysis of quantified Programme Benefits is provided in Appendix OBC/EC6(b).

5.50 In addition, there are a number of benefits which are relevant to the case but are difficult to reasonably quantify in monetary values and/or do not differentiate between the options and so have not been incorporated within the economic appraisal. These include:

- Patients have access to seamless pathway of care in a single place
- Improved patient and carer experience
- More resilient and flexible workforce
- Improved staff satisfaction (although may be disbenefit for some staff members - additional travel)
- Improved safety and compliance with standards
- Better sustainability, resilience and future proofing
- Opportunities to attract further investment

6 ECONOMIC APPRAISAL

6.1 A discounted cash flow for each of the options has been undertaken over 60 years using a discount rate of 3.5% for years 0 to 30 and 3.0% for the remaining period in line with the requirements of HM Treasury. The key assumptions used in this analysis are summarised below:

Table 6-1: Key Assumptions Used in the Economic Appraisal

- Costs and benefits are calculated over a 60 year appraisal period.
- Baseline (Year 0) will be 2019/20
- Costs and benefits use real base year prices – all costs are expressed at 2019/20 prices in line with the baseline costs.
- The following costs are excluded from the economic appraisal:
  - Exchequer 'transfer' payments, such as VAT;
  - General inflation;
  - Sunk costs; and
  - Non-cash items such as depreciation and impairments.
- A discount rate of 3.5% is applied to the economic appraisal for years 1-30 and 3.0% for years 31 onwards, with the exception of QALY benefits which are discounted at 1.5% in line with HMT Green Book guidance.
- No financial benefits are incorporated.
- Quantified risks including Quantified Capital Risk and Optimism Bias are included based on the approach outlined above.

6.2 The results of the discounted cashflow are outlined in the following table:

Table 6-2: Net Present Cost of the Short Listed Options

Expenditure Heading	Do Nothing	Do Minimum (nVCC Extension)	RSC
Initial capital costs	0	-2,299	-27,086
Lifecycle capital costs	0	0	-3,349
Total capital costs	**0**	**-2,299**	**-30,435**
Transitional costs	0	-712	-712
Outsourcing during transitional period	0	-14,488	0
Recurring revenue costs	-616,664	-199,563	-144,520
Total revenue costs	**-616,664**	**-214,763**	**-145,232**
Quantified risks - capital costs	0	0	-1,707
Optimism bias	0	0	-1,358
Revenue expected risk value	0	-5,569	-3,147
Total risk costs	**0**	**-5,569**	**-6,212**
Total costs	**-616,664**	**-222,632**	**-181,880**
Benefits	0	0	582,733
Total benefits	**0**	**0**	**582,733**
Net Present Cost (undiscounted)	**-616,664**	**-222,632**	**400,854**
Total costs (discounted)	-242,925	-96,158	-83,589
Total benefits (discounted)	0	0	374,190
Net Present Cost (discounted)	**-242,925**	**-96,158**	**290,601**

Rank	**3**	**2**	**1**
Benefit Cost Ratio (discounted)	**0.00**	**0.00**	**4.48**
Rank	**2**	**2**	**1**

6.3 The Economic Appraisal demonstrates that the RSC option offers the lowest Net Present Cost (NPC) of the two 'do something' options, suggesting that it offers best value for money in terms of whole life costs.

6.4 It also offers the best benefit cost ratio at 4.48 suggesting that it offers best value for money in terms of the relationship between benefits and costs.

6.5 The Intermediate Option is therefore identified as the Preferred Option for the Project.

6.6 The detailed analysis of the Generic Economic Model (GEM) is provided in Appendix OBC/EC7.

7 SENSITIVITY ANALYSIS OF PREFERRED OPTION

Decision Analysis

7.1 The Economic Appraisal demonstrates that the Preferred Option has the lowest overall cost per benefit point, indicating this option delivers the best value for money of the shortlisted options.

Sensitivity analysis and switching

7.2 The results of the Economic Appraisal above have been subject to a sensitivity analysis to examine the impact of movements in capital and revenue costs.

7.3 Switching value analysis has been applied to areas of material cash flows to identify the extent that costs must change in order for the Net Present Cost to equal that of the preferred option. The results of the analysis are presented in Table 7-1:

Table 7-1: Switching Values

Costs	Do Minimum
Revenue costs	-290.3%
Net Present Cost	-280.1%

7.4 The results above demonstrate that for the Do Minimum Option to rank as the Preferred Option its NPC would need to reduce by 280%. The only way this could feasibly happen would be a for revenue costs to reduce by a similar amount.

7.5 The Do Nothing option has been excluded since it delivers no benefits and is not a feasible option.

7.6 In addition to the switching analysis, alternative scenarios have been used to consider how options may be impacted by future uncertainty and provide an assessment of risk in the ranking of options including:

1. Increase optimism bias to from 5.35% to 15.0%.
2. Exclude optimism bias
3. Revenue costs of RSC increase by 25%
4. Benefits excluded

7.7 The results of the sensitivity analysis are shown in the table below:

Table 7-2: Results of sensitivity scenario analysis

Scenario	Revised NPC		
	Status Quo	Do Minimum	Intermediate
NPC	-242,925	-96,158	290,601

Optimism bias increases to 15%	**-242,925**	**-96,158**	**293,535**
Exclude optimism bias	**-242,925**	**-96,158**	**289,359**
Revenue costs increased by RSC	**-242,925**	**-96,158**	**276,368**
Exclude benefits	**-242,925**	**-96,158**	**-83,589**

7.8 This analysis demonstrates that while each of these scenarios change the NPC, none of them have any impact on the ranking of options and therefore this analysis supports the identification of the Preferred Option.

7.9 The results of the Economic Appraisal are analysed below:

- **Do Nothing Option:** This option has the highest Net Present Cost (NPC) over a 60-year appraisal period of £242.9m. It does not deliver any financial or qualitative benefits and furthermore is not a feasible option as it does not provide sufficient capacity to meet demand without outsourcing activity to external providers and will not achieve the project spending objectives.
- **Do Minimum (nVCC Extension) Option:** This option has a Net Present Cost of £96.2m over the 60-year appraisal period which although significantly lower than the Do Nothing option, does not any quantifiable benefits. This option does not therefore offer the best value for money.
- **RSC Option (Preferred):** This option delivers the lowest discounted Net Present Cost at £83.6m over the 60-year appraisal period. In addition, it delivers £374.2m of monetised benefits over the appraisal period resulting in an overall Net Present Value of £290.6m and a benefit cost ratio of 4.48.

7.10 This analysis confirms the selection of the RSC Option as the Preferred Option.

8 CONCLUSION

8.1 Following a robust Option Appraisal process involving a wide range of stakeholders, the Trust has identified its Preferred Option for developing a Radiotherapy Satellite Centre.

8.2 The Preferred Option delivers a wide range of benefits which are complementary with local and national priorities as well as the delivery of a range of short and long term objectives to support the improvement of specialist non-surgical cancer service delivery across South East Wales.

8.3 In terms of infrastructure the Preferred Option provides a new purpose-built Radiotherapy Satellite Centre at Nevill Hall Hospital, Abergavenny; and

9 APPENDICES

For Information

The following appendices are available in support of this chapter**.**

Appendix Reference	Title

Outline Business Case: 2020

Radiotherapy Satellite Centre

Commercial Case

COMMERCIAL CASE

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Page N°

1 INTRODUCTION

1.1 This section of the OBC sets out the Commercial Case for the Radiotherapy Satellite Centre (RSC) Project which is being delivered through NHS Wales Capital Resources.

1.2 It sets out the basis on which the Project will manage commercial matters and deal with:

- The key Project specific contractual arrangements and risk apportionment between the public and private sector;
- The construction procurement strategy, implementation, timescales and intended procurement route;
- The equipment, major medical equipment and ICT equipment, procurement strategy;
- The management of services over the duration of the Project;
- Any anticipated workforce implications, e.g. TUPE; and
- The accountancy treatment of the Project.

2 POTENTIAL FOR RISK TRANSFER

2.1 The general principle is that risks should be passed to "the party best able to manage them", subject to value for money (VFM). ABUHB has carefully considered those risks best placed with the SCP and those it will bear itself. This has been achieved at OBC stage through a series of structured risk workshops involving the Health Board, SCP, Project Manager and Cost Advisor. Further information on the proposed Risk Management Strategy for the project, together with the quantified risk register has been included in the Estates Annex.

2.2 Under the Designed for life: Building for Wales Framework, which is described in the following section of the Procurement Strategy, the NEC 3 Engineering & Construction (ECC) form of contract is used. The Engineering & Construction contract is a "collaborative" contract that requires each project to include a Risk Register with risk allocated to the party best able to deal with it. The early involvement of a Supply Chain Partner means that they are fully briefed about risks in the project and are better placed to accept ownership and suitably mitigate and manage risks than what would normally be the case under a more traditional form of contract.

2.3 The table below shows how the project risks might be apportioned under a predominantly Public Capital Funded Procurement.

Table - Risk and Potential Allocation

Risk	Potential Allocation		
	ABUHB / VUNHST	SCP	Shared
Design			Y
Site Availability	Y		
Planning	Y		
Approval and Funding	Y		
Construction		Y	
Technical Commissioning		Y	
Operational Commissioning	Y		
Availability of Building		Y	
Operating Risk	Y		
Revenue Risk	Y		
Technological and Obsolescence	Y		
Legislative Change	Y		

2.4 The final risk allocation to be agreed for Stage 4 and will be developed between all parties during the Stage 3 FBC period.

3 REQUIRED SERVICES

3.1 The OBC states a requirement for the delivery of a Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital, Abergavenny under the NEC3 Engineering & Construction (ECC) Form of Contract (Option C) and Designed for Life: Building for Wales Framework.

3.2 A Schedule of Accommodation is available to support the functional content, based on Health building notes and latest available guidance. A full copy of the latest version of the Schedule of Accommodation is included as an appendix to the Estates Annex.

Design Considerations

3.3 A comprehensive Schedule of Accommodation has been prepared to inform the concept design for the RSC.

3.4 To this end 1:200 layout plans have been prepared in full consultation with the Velindre University NHS Trust (VUNHST)/Aneurin Bevan University Health Board (ABUHB) users and relevant stakeholder groups. The 1:200 plans illustrate the critical operational adjacencies in order to set the building footprint requirements and size and massing of the building for planning purposes.

3.5 In addition a site plan and elevations have been developed to inform the planning process. Further details relating to the specific design proposals are included in more detail within the Estates Annex.

ICT Infrastructure

3.6 ICT infrastructure requirements have been considered within the building with provision allowed for 2Nr IT hub rooms. This has been informed via an ICT Infrastructure Brief which has been prepared by ABUHB/VUNHST and shared with the design team. This is included within the Estates Annex. ICT design proposals will be further developed into a detailed design solution at Full Business Case Stage.

Equipment

3.7 The procurement of all Groups 2, 3 and 4 equipment, major medical equipment and ICT equipment for the RSC Project will be funded through Welsh Government capital funding and procured via the assistance of Shared Services Procurement Services.

3.8 Equipment costs have been calculated based on equipment lists provided by VUNHST. These will be developed in more detail at FBC stage as will the split between equipment which will be owned and maintained by VUNHST and that which will be owned and maintained by ABUHB.

3.9 VUNHST/ABUHB, supported by NWSSP Procurement Services, will procure all Group 2,3,4 equipment, medical and non-medical, through the IRS Contract or existing NHS frameworks. Where appropriate frameworks are not available, VUNHST/ABUHB will follow standard NHS and Trust procurement procedures and guidelines in line with the organisations respective SFI's.

3.10 VUNHST will be responsible for the specification, procurement, installation, commissioning, maintenance, replacement and disposal of all major medical equipment for the RSC. Table 3-1 provides a summary of the major medical equipment required for the RSC:

Table 3-1: Summary of the Major Medical Equipment Requirements

Department	Equipment	Number Required
Radiotherapy	Linear Accelerator	2
Radiotherapy	CT Simulator	1

3.11 VUNHST has previously developed a Programme Business Case to enable the effective procurement of an Integrated Radiotherapy Solution (IRS) for both nVCC and RSC which was presented to the Infrastructure Investment Board on the 24th of April 2019. This was approved and Welsh Government allocated resources to the Trust to take forward the procurement and OJEU was issued on 30th October 2019. The procurement is proceeding to plan with the issue of the ITPD on 30th March 2020 and Competitive Dialogue commencing on 15th June 2020.

3.12 The Integrated Radiotherapy Solution (IRS) procurement has commenced ahead of the approval of the nVCC and RSC OBC's to support vendor identification and specification information being fed into the Competitive Dialogue process of the nVCC and to inform the FBC of the RSC.

3.13 VUNHST will seek to procure an Integrated Radiotherapy Solution (IRS) utilising a competitive dialogue process. The solution will be delivered by a Prime Contractor arrangement and a robust goods and services contract of a minimum of 14 years is being developed. The procurement programme for major medical equipment has been set out to ensure the design interface risk is mitigated.

4 PROPOSED CONTRACT MECHANISMS

4.1 For the RSC development there will be no ongoing service and, therefore, no recurring charges by the SCP following completion of the hospital building.

Proposed Contract Length

4.2 The overall programme is designed to allow the building to be completed by the Summer of 2023.

4.3 In terms of programme management for Stage 3, the SCP will submit a draft programme to the Employer and Project Manager for consideration in relation to the programming of the works for stage 3 / FBC. The SCP will also submit an overall programme for the provision of the works at Stage 4, 5 and 6. It is noted, however, that this will still be indicative at this stage and subject to further development during the FBC period.

4.4 The programme will fully comply with the requirements of the NEC3 ECC contract and contain a reasonable programme of activities with a Completion Date for Stage 3/FBC identified. The accepted programme will be required to be issued by the SCP to the Project Manager on a monthly basis for acceptance. It will need to include a mark-up of actual progress achieved in the month, in order to monitor progress as work proceeds.

4.5 The above process will be replicated at the Stage 4 Contract Stage In order to robustly manage the programme to ensure timely delivery of the Project.

Proposed Key Contractual Clauses

4.6 The contract will be in accordance with the All Wales Designed for Life 4 Building for Wales Framework. The contract will be the NEC 3 Form of Contract. The conditions of contract are the core clauses and the clauses for main Option C: Target Contract and Secondary Options – X1, X2, X4, X5, X7, X15, X16, X18, Y(UK2), Y(UK3) and Z of the NEC Engineering and Construction Contract (April 2013), The additional Z clauses comprise the standard Designed for life: Building for Wales Framework amendments.

4.7 This contract is based on the following key principles:

- Clarity – The Contract is written in plain language
- The Risk Register is a key project and contract management tool
- Foresight and Early Warning Notifications
- A Target Cost and Cost not to be exceeded
- Timely two-way communication
- Compensation Events
- Monthly Accepted Programme is sued as a key project and contract management tool

4.8 Key external professional roles appointed on behalf of the Employer include, direct client appointments for the Project Manager and Supervisor. A Cost Advisor will also be appointed to support the Project Manager and Health Board.

Personnel Implications (including TUPE)

4.9 It is anticipated that TUPE (Transfer of Undertaking and Protection of Employee) will not apply to this investment as there is no change to the employing organisation. However there may be an implication for some staff in terms of change in location of employment. This will be managed using the VUNHST management of Change Policy.

5 PROCUREMENT STRATEGY

5.1 The [SJR5] RSC development, post OBC approval, will fall within the terms of the new All Wales Designed for Life 4 Building for Wales Framework.

5.2 Shared Services – Facilities – Estates Development Framework managers have participated in the development of the Outline Business case and have also facilitated an AEDET review of the design.

5.3 ABUHB has appointed External Project Managers and External Cost Advisers.

5.4 In terms of procurement, getting to the Target Price agreement is the most difficult stage of the whole Designed for Life: Building for Wales Framework process. There are conflicting objectives and the process requires firm management and significant negotiation.

5.5 The Target Price will be established towards the end of the FBC stage. Prior to this "a price not to be exceeded" will have been agreed between ABUHB and the SCP and will be included in the FBC submission to Welsh Government. While approval to the FBC is awaited, the total of the prices for the Stage 4 Contract will be finalised and agreed and all necessary contractual documentation drawn up in readiness (once approval is received) for a speedy exchange of contracts and start on site.

Design Completion

5.6 It is a requirement of the Designed for Life Framework that 70-80% of the design (for each element including engineering services) should be progressed and completed at FBC. This has been clarified to mean the achievement of RIBA Stage 4. It does not mean 70-80% cost certainty as this should have been achieved earlier in the process. It is expected that good co-ordination of the building enclosure, structure and engineering services are part of this requirement.

5.7 The purpose of the requirement for 70-80% design completion is to ensure that robust market testing of works packages can take place to ensure that the "price not to be exceeded" in the FBC is sound and that everyone can have confidence in it. This level of design should also ensure there are no delays to construction activity because of incomplete or uncoordinated design proposals.

5.8 It is difficult to measure design completion. However, to assist this, the SCP will be required to provide detailed design sub-programmes linked back to the Accepted programme and the RBA plan of Work Stages showing design activities carried out by the design team within the supply chain. The supply chain comprises: architects, Civil and Structural Engineers and Building Service Engineers. The provision of such programmes will assist in identifying the key deliverables in achieving 70-80% design completion. In addition, an assessment of the design fee expended at completion of FBC as a proportion of the total fee will provide a supplementary "rule of thumb" guide as to whether the targeted level of required design completion has been achieved.

Target Price

5.9 The key to compiling the Target Price / total of the Prices is clearly stated in Clause 52.1 of the NEC3 Engineering & Construction Contract, which states that Defined Cost includes only amounts calculated using:

- Rates and percentages stated in the Contract Data
- Competitively targeted prices
- Other amounts at open market rate

5.10 With deductions for all:

- Discounts
- Rebates
- Taxes which can be recovered

5.11 The percentages stated in the contract Data would be:

- Direct Fee
- Subcontracted fee
- Working Area overheads
- Manufacture and fabrication overheads
- Design overheads

NEC Contract Data Rates and Percentages

5.12 At framework level, rates for the following cost centres have already been agreed:

- All pre-construction staff involved in taking forward the design to approval of Full Business Case. These rates will be adjusted annually in accordance with the Average Earnings Index, as confirmed by NWSSP-FS.
- All working Areas based staff – These rates will be used to cost Preliminaries. These rates will be adjusted annually in accordance with the Average Earnings Index, as confirmed by NWSSP-FS.

Competitively Tendered Prices

5.13 The elements essential to the successful conclusion of this process are dependent upon sufficient time being allowed for:

- Design to advance to a minimum of 70-80% completion;
- Comprehensive and complete tender documentation to be prepared;
- Tenderers to prepare their bids;
- Proper evaluation and negotiation with tenderers.

Open Market Rates

5.14 It is widely accepted that there will be elements of the work that are not competitively tendered. However, the extent of elements not competitively tendered will be limited to no more than 30% of the total target price. The SCP will be required to demonstrate to the Cost Advisor that "open market rates" are comparable to those that could be obtained in competitively tendered circumstances. This can be clearly demonstrated by benchmarking against other SCP's or projects or by demonstrating how best value for money will accrue to the project.

Procurement Procedure

5.15 At commencement of FBC stage, a procurement strategy will be produced by the SCP and agreed with the Project manager. This will identify how the project is to be broken down into work packages and how each is to be procured. The Procurement Procedure or Strategy will be required at commencement of FBC. This is especially important where in-house organisations are to be utilised that may not be subject to market testing. Failure to follow this procedure may result in Disallowed Cost being levied upon the SCP.

5.16 The Project Cost Plan will also be re-cast at this stage, to reflect the cost of the work packages (identified in the procurement procedure) from the previous elemental breakdown. Dependent upon the number of work packages subject to market testing the Project Risk Register may also need to be revised to suit.

5.17 Each of the works package elements in the Cost Plan should reflect the total expected cost of the works package aftermarket testing. They should not include any SCP design costs but may include subcontract design costs.

5.18 Sufficient time will be required to be built into the Accepted Programme for design to be advanced to a stage where clear and meaningful tender documentation can be drawn up to allow robust market testing to take place.

5.19 A minimum of three bids per works package should be obtained as part of the market testing process. The Health Board may insist on increasing the minimum number of bids in order to comply with their own procurement procedures. Bids will be opened jointly by the SCP and the Cost Advisor.

Evaluation

5.20 When the bids have been received they will be comprehensively evaluated, by the SCP and Cost Advisor, to ensure that like for like comparisons between tenders are being made. All bids will be "levelled" to achieve this and any adjustment will be made for any stated omissions or exclusions. The adjustments will be agreed with each works package subcontractor.

5.21 In the tender documentation the SCP will identify those "attendances" that it expects the bidding subcontractors to provide. All other attendances that are expected to be provided by the SCP to the subcontractors will be required to be priced for in the Contractors Preliminaries and not against the works

packages.

5.22 SCP Risk in respect of work packages should be allowed for in the risk register and quantified in the SCP quantified Risk build-ups. There will be no SCP Risk in Work Package Costs. Subcontractor risk assessments will be required to be covered in their bids.

5.23 It is accepted that some work packages may still require further design development to be undertaken after bidding. The design frees for this portion of work will need to be allowed for by the subcontractor in his bid submission or, if the work is to be designed by the SCP, suitable provision will alternatively be made in the SCP fees.

5.24 The cost of the outstanding work will also need to be assessed. Theoretically it should be no more than the difference between the Works package element cost and the bid submission received form the subcontractor. If more funding is required it should be drawn from the Cost Plan Design Reserve or from savings made elsewhere. Unless previously agreed with the Cost Advisor, the cost effect of Design development should not amount to more than 5% of the value of an individual works package or 2.5% of the total of all work packages.

Post Target Price Re-Tendering of Works Packages

5.25 On occasions it may be the case that some work packages are required to be re-tendered after the Target Price has been agreed (i.e. in the event of subcontractor insolvency). If a packages has to be re-tendered then it will be required to be undertaken in full agreement with the Project manager ad under the same process and implications as Pre-Target Price market testing.

Pain/Gain Share

5.26 In term of the framework, Pain Share rest 100% with the SCP at all stages.

5.27 During Stages 2 (OBC) & 3 (FBC), there is no Gain Share.

5.28 In terms of Stage 4 onwards (Construction and Project Closure), the Gain Share will be limited to the first 5% of any savings between the total of the Prices and the Price for Work Done to Date arising during Stages 4, 5 and 6 and will be equally apportioned 50:50% between the Health Board and the SCP. Savings over this amount (i.e. less than 95% of the) will accrue 100% to the Health Board. To summarise:

The *Contractor's* share percentages and the *share ranges* are:

Share Range	*Contractor's* Share Percentage
Less than 95%	Nil
From 95% to 100%	50%
Greater than 100%	100%

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Outline Business Case: 2020

Radiotherapy Satellite Centre

Financial Case

FINANCIAL CASE

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1 INTRODUCTION

1.1 The case for a new Radiotherapy Satellite Centre (RSC) has been clearly articulated within the Strategic Case.

1.2 The Economic Case has identified the Preferred Option. Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) has developed a proposal to develop an RSC on land under the ownership of the Health Board at Nevill Hall Hospital, Abergavenny. The Preferred Option provides a modern, fit for purpose environment that can evolve to meet future demands and developments as they emerge and support a process of continued clinical improvement.

1.3 The Commercial and Management Cases sets out the approach to the procurement processes, the partnership approach and the governance and management processes to deliver the Preferred Option.

1.4 The Financial Case demonstrates the affordability of the Preferred Option. The Case initially sets out the Financial Framework used for the development of the Financial Case. The Financial Case continues by setting out the approach to the establishment of the revenue and capital costs. It presents the methodology for capital cost development, identified by our Technical Advisors, and scrutinised by Shared Services Estates Division. The methodology for revenue cost development agreed with the Collective Commissioning Group (CCG), is also presented.

1.6 The Balance Sheet impact is also presented along with the modelled implications for capital charges.

1.7 The financial appraisal establishes the financial costs and funding requirements of the Preferred Option and demonstrates the affordability of the Project.

1.8 It should be noted that significant additional revenue costs will be required in excess of the revenue cost of the preferred option to provide additional Radiotherapy capacity to meet forecast demand if the proposed satellite unit does not progress. The majority of that activity will need to be provided via other Providers.

2 FINANCIAL FRAMEWORK

2.1 A Financial Framework has been developed for the RSC that focuses on the investment dependent costs in order to facilitate decision making. This Financial Framework has been developed and agreed with the Financial Leadership of Commissioners through the Collective Commissioning Group (CCG). The role and function of the CCG is presented in Sections 6 and 10. The Financial Framework is set out below.

2.2 Specifically, the RSC focuses on the investment decision to expand radiotherapy capacity in South East Wales. The Financial Framework established to support the investment decision has clarified that only the costs that are driven by this investment decision should be considered. Costs that are driven by demand for other services, and other factors, are a constant for all options and are, therefore, not presented.

2.3 The Collective Commissioning Group has agreed the baseline cost methodology for this element of the work. The costs produced from this methodology and proposed contractual arrangements were scrutinised at the CCG meeting on the 28 July 2020.

2.4 The approach the NHS Wales Finance Community has adopted has enabled a transparent and credible Financial Case to be developed and collaboratively endorsed.

2.5 The Financial Case highlights the cost impact over the following areas of expenditure within the Project:

- Capital costs;
- Recurring Revenue costs;
- Transitional (Non-recurring) Revenue costs; and
- Depreciation.

2.6 Fundamentally, the Financial Case outlines the full financial costs of the Project and the sources of funding, from the Trust's Commissioners and the Welsh Government, to meet them.

2.7 The next section of the Financial Case, Section 3, sets down the costing approach deployed in the development of the Project's Costs.

3 COSTING METHODOLOGY

3.1 This section of the Financial Case provides detail on the costing methodology employed to develop the cost estimates for the following areas:

- Construction and Equipment Capital Costs;
- Recurrent Revenue Costs;
- Transitional (Non-Recurring) Revenue Costs; and
- Depreciation.

3.2 The methodology is fundamental to support both the Health Board and the Trust in ensuring robust cost information is determined to underpin the RSC.

3.3 The costing methodology reflects a professionally and technically recognised approach to determining OBC cost information. The costings have been derived using the best available information and, in some instances, reflects current market prices. The costing methodology reflects an approach that is acceptable to Welsh Government and Shared Services.

3.4 The Trust has appointed Technical and Professional advisors to assist in the calculation of aspects of the costs relating to healthcare facilities at the different stages of cost planning. Further, the Revenue costs have been fully scrutinised by the CCG (see Section 6). The cost models described will continue to be reviewed and refined as further detailed work is undertaken to inform the Full Business Case.

Capital Costs

3.5 The preferred option is Option 3 the construction of a Radiotherapy Satellite Centre on the Nevill Hall Hospital site. The estimated outturn costs for the preferred option is £30.285 million excluding inflation, the detail of which is set out below:

	Option 3 - New Build (£)
Works Cost	15,337,624
Fees	2,751,814
Non-Works	2,859,000
Equipment	2,723,009
Contingency	1,707,310
Total Option Costs	**25,378,758**
VAT (net of reclaim)	4,906,774
Total Option Costs (including VAT)	**30,285,532**

**** Equipment costs exclude both Treatment Machines as these are being approved for procurement via a separate business case.***

3.6 A more detailed breakdown of the capital cost calculations is contained within the OB Forms in the Estates Annex. The costs shown exclude optimism bias which was calculated in line with HM Treasury Guidance for the Economic Case only.

3.7 In terms of design status BREEAM workshops have been undertaken and will continue to be reviewed and assessed throughout the project lifecycle. In the case of the preferred option, the project will be required to achieve a BREEAM 'Excellent' rating for industrial as a minimum, which remains within the acceptable benchmark standard for a new build project.

3.8 A risk register has been prepared for all of the options and developed in detail for the preferred option in order to inform the level of planning contingency required. The format of the risk register is consistent with the standard Designed for Life and the latest guidance for preparing Business cases. This will be further developed in due course for the Full Business case Stage by the External Project manager in conjunction with the Supply Chain Partner, Cost Advisor and Client Team.

3.9 Submission of the OBC to Welsh Government is currently programmed for the end of September 2020. Commencement of the Full Business Case (FBC) is currently planned to start in early 2021, concurrent with the Welsh Government OBC scrutiny and approval period.

3.10 The detailed cash flows for the preferred option is contained with the OB forms in the estates annex and is summarised below:

2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
£0.370	£4.798	£5.238	£14.984	£4.709	£0.277

3.11 The OBC assumes all capital costs and inflation will be funded by Welsh Government in each of the years as per the above, in accordance with current Welsh Government policy.

3.12 The following key assumptions have been made in the capital case:

- Capital costs are reported at BCIS Pub Sec Index Level 250
- Costs included for Fees are based on typical rates assuming the scheme is procured through the Designed for Life: Building for Wales procurement programme
- Non-Works Costs are based on estimated capital costs that will be incurred in developing the scheme through to Operational Completion and include Enabling Works, Planning Fees, IT infrastructure, Artworks and Commissioning costs

- Equipment costs are based on a detailed schedule of equipment provided by VUNHST and exclude the two treatment machines, the procurement of which is currently being progressed as part of a much larger procurement for both the existing Velindre site and potentially the proposed new Velindre Cancer Centre. More information on this is provided in 3.13 to 3.16 below.

- A Contingency allowance of £1.707m has been included based on a quantified Risk Register. The Risk Register is included in the Estate Annex.

- VAT has been applied at the rate of 20% to all cost components. A modest reclaim of £169k has been assumed based on 100% recovery of professional fees only at this stage. Further advice on the VAT reclaim on supply chain partner costs will be sought as the FBC progresses.

3.13 Capital costs reflect the capital requirements of the Project that will be funded from a Capital Resource Allocation. In this instance the capital resource will flow to both organisations, VUNHST and ABUHB. The former will own and be responsible for the ongoing maintenance and replacement of almost all of the proposed equipment. ABUHB will own and be responsible for the proposed new building and associated site infrastructure works.

3.14 It is important to note that the VUNHST developed a Programme Business Case (PBC) to commence the procurement (via the use of a competitive dialogue procedure) of an integrated Radiotherapy Solution ahead of the approval of both the nVCC and RSC Outline Business Case. The PBC was approved by Welsh Government in August 2019 and includes:

a. Treatment Machines;
b. Radiotherapy Informatics Solution;
c. Oncology Information System (OIS);
d. Dosimetry; and
e. Ancillary equipment, IT and infrastructure.

3.15 This PBC confirmed the need for VUNHST to deliver a modern Radiotherapy Solution that is more resilient and has greater capability and capacity to enable the Trust to continue to treat increasing numbers of referrals from secondary care. These referrals often require increasingly more complex Radiotherapy Treatments. The procurement is also needed as part of the nVCC's normal equipment replacement cycle.

3.16 This PBC explored a range of options to identify a solution that both supports the urgent need to commence a procurement to mitigate service delivery risks, whilst supporting the key dependencies of the TCS Programme; specifically, the nVCC OBC and the Radiotherapy Satellite Centre (RSC) OBC.

3.17 In addition to the resource identified above, Cognitive by Design will require further investment to fully deliver the digital benefits for Cancer Services

patients. This will be done through the usual NHS Wales Capital Investment process.

Recurring Revenue Costs

3.18 Revenue costs reflect the revenue requirements of the project associated with the infrastructure and relevant clinical costs.

3.19 Costs have been determined using appropriate baseline information 2019-20; financial information from Technical and Professional advisors and the professional knowledge of the in-house hard and soft facilities management (FM) team(s).

3.20 Hard and Soft Facilities Management costs reflect the requirements of the services the Health Board is expected to provide, the various contractual and healthcare related standards requirements and on the additional sqm of the Preferred Option.

3.21 Rates costs have been based on the information in the 2017 Rating List for hospitals provided by the Valuation Office Agency.

3.22 The estimated Rateable Value (RV) is multiplied by the multiplier, which is an estimate currently linked to September's Retail Price Index (RPI) figures, which is due to switch to Consumer Price Index (CPI) figures.

3.23 Equipment maintenance has been costed using baseline financial information projected using professional advice and in the context of Advisor input. This will be further informed by the FBC by the IRS (Integrated Radiotherapy Solution) Procurement.

3.24 Information Management & Technology (IM&T) and maintenance has been assessed on the 'hospital building related' requirements of the Project and mainly covers the hospital digital infrastructure.

3.25 All the costs have been identified and verified using assumptions generated from the input of external advisors as well as Trust personnel and scrutinised by the CCG.

Transitional (Non-Recurring) Revenue Costs

3.26 Costs associated with the delivery of the Project have been established using information from the in-house team and Specialist Advisors.

Depreciation

3.27 Depreciation has been determined using the equipment bill of quantities and the estimated useful life of the asset in accordance with NHS Finance guidance.

3.28 The detailed costs derived from this costing approach are set down in Sections 4 to 10.

4 RECURRING REVENUE COSTS

Methodology & Approach

4.1 The section outlines the recurring revenue costs associated with the operation of the Preferred Option.

4.2 As discussed earlier in the Financial Framework Section (Section 2), recurring revenue costs cover the infrastructure related costs and includes the financial impact of the increases in demand and growth of Radiotherapy services and clinical services that are met by the RSC.

4.3 The following options considered were as follows

- Outsourcing of activity to English Providers
- Activity delivered as part of an expansion of the new Velindre Cancer Centre
- Development of a Radiotherapy Satellite Centre at Nevill Hall Hospital, Abergavenny (Preferred)

4.4 Each option is predicated on the delivery of the following level of activity:

Table 4-1: Activity Case Mix

Treatment Type	No of Fractions
Prostate Fractions	7,434
Breast non-DIBH	3,234
Breast DIBH	3,234
Palliative Treatment	1,699
Total	15,600

4.5 The activity assumptions are consistent with the activity growth projections in the new Velindre Cancer Centre OBC.

4.6 To aid transparency the cost of the options are presented initially with the additional revenue costs of the 'Preferred' option being subsequently presented. The total Recurring Revenue costs of the Preferred Option are then presented.

4.7 The revenue cost assumptions are outlined below:

Table 4-2: Revenue Cost Assumptions

Revenue cost assumptions

- Recurring revenue costs associated with the services within the scope of the project are presented at 2019/20 prices.
- Inflation has been excluded.
- Transitional Revenue Costs are excluded from this section and presented in Section 5.
- Depreciation is excluded from this section and presented in Section 7.

Recurring Revenue Costs

4.8 The recurring revenue costs of each of the options is as follows

Table 4-3: Recurring Revenue Costs

	Option - Outsource	Option - nVCC	Option - NHH RSC (Preferred)
	£	£	£
Workforce			
Radiotherapy Delivery		1,140,166	1,276,039
Medical Physics Delivery		509,208	526,394
Facilities		66,554	72,858
IT		0	16,223
Pharmacy		0	8,738
Pay		**1,715,928**	**1,900,252**
Non Pay			
Utilities		62,209	95,276
Hard FM		49,505	69,207
Rates		62,536	62,536
Soft FM		62,901	9,137
Consumables		75,000	75,000
Patient Transport		10,000	5,000
Equipment Maintenance		264,390	264,390
IM&T Maintenance		27,097	27,097
Pharmacy		0	708
Travel		34,319	38,005
Non Pay		**647,955**	**646,355**
Cost of Outsourcing	10,866,325		
Financing - TCS MIMs		1,200,000	
TOTAL COST	**10,866,325**	**3,563,884**	**2,546,607**
Remove TCS MIMS (see note)		-1,200,000	
TOTAL COST (COMMISSIONERS)	**10,866,325**	**2,363,884**	**2,546,607**

4.9 Note: MIMs costs have been removed from the costs attributed to commissioners as these would be borne directly by Welsh Government.

4.10 A full cost analysis of each option is set out in Appendix 1

4.11 For the nVCC and RSC options, recurring revenue costs reflect expenditure which the Trust and ABUHB will incur on an on-going basis to maintain the infrastructure and deliver the clinical services at point of commissioning. The

Financial Case assesses these costs associated with the implementation of the proposed project. It is important to note that the revised expenditure reflects the requirements to meet the forecast level of activity upon the opening of the RSC in June 2023.

4.12 The following tables analyse the costs over the major cost headings for the preferred option:

Table 4-4: Recurring Revenue Costs

	NHH RSC Preferred Option
	£
Workforce	
Radiotherapy Delivery	1,276,039
Medical Physics Delivery	526,394
Facilities	72,858
IT	16,223
Pharmacy	8,738
Pay	**1,900,252**
Non Pay	
Utilities	95,276
Hard FM	69,207
Rates	62,536
Soft FM	9,137
Consumables	75,000
Patient Transport	5,000
Equipment Maintenance	264,390
IM&T Maintenance	27,097
Pharmacy	708
Travel	38,005
Non Pay	**646,355**
TOTAL COST	**2,546,607**

4.13 The Baseline Recurring Costs have been agreed with the CCG.

Table 4-5: Recurring Pay Costs

	£
Workforce	
Radiotherapy Delivery	1,276,039
Medical Physics Delivery	526,394
Facilities	72,858
IT	16,223
Pharmacy	8,738
Pay	**1,900,252**

4.14 The proposed Radiotherapy and Medical Physics staff are to be employed by VUNHST with the skill mix provided at Appendix 1.

4.15 The proposed facilities staff will be employed by ABUHB and represent the cost of portering, domestics, security and other facilities support staff.

4.16 The proposed IT staff will be employed by ABUHB and will support the operation of the IT systems in the RSC.

4.17 The proposed pharmacy staff will be employed by ABUHB and represent the staff costs to support the RSC onsite Omnicell.

4.18 The pay costs above and the Recurring, Non-Pay Costs below have been agreed with the CCG as fair and reasonable.

Table 4-6: Recurring Non Pay Costs

	£
Non Pay	
Utilities	95,276
Hard FM	69,207
Rates	62,536
Soft FM	9,137
Consumables	75,000
Patient Transport	5,000
Equipment Maintenance	264,390
IM&T Maintenance	27,097
Pharmacy	708
Travel	38,005
Non Pay	**646,355**

Utilities, Hard FM and Soft FM Costs

4.19 The total costs of utilities, Hard FM and Soft FM are presented in the table below:

Table 4-7: Utilities, Hard FM and Soft FM Costs

	£
Non Pay	
Utilities	95,276
Hard FM	69,207
Soft FM	9,137
Total	**173,620**

4.20 The costs have been calculated with reference to the proposed floor m2 and EFPMS benchmarks and have been agreed with the CCG as fair and reasonable.

Equipment Maintenance and IM&T Maintenance

4.21 The total costs of Equipment Maintenance and IM&T Maintenance are presented in the table below:

Table 4-8: Equipment Maintenance and IM&T Maintenance

	£
Equipment Maintenance	264,390
IM&T Maintenance	27,097
Total	**291,487**

4.22 The Medical Equipment Maintenance costs have been calculated based on the schedule of Equipment set down in Economic Case. These costs reflect the requirements associated with the additional Medical Equipment with new infrastructure. The costs will be be refined when the IRS procurement provides actual costs.

4.23 The maintenance costs for IM&T have been calculated based on the schedule of equipment set down in Economic Case.

4.24 IM&T costs relate to the support required for the infrastructure to support the clinical services, major clinical equipment and the RSC.

4.25 This approach been agreed with the CCG as fair and reasonable.

Other Non-Pay Costs

4.26 The total costs of other Non-Pay costs are presented in the table below:

Table 4-9: Other Non-Pay Costs

	£
Rates	62,536
Consumables	75,000
Patient Transport	5,000
Pharmacy	708
Travel	38,005
Total	**181,249**

4.27 Business rates are determined based on the rateable value of the premises. This is independently assessed by the Valuation Office Agency, who maintains a hospital framework in place for 2017 Rating list.

4.28 The forecast rates have been established using the estimated rateable value. It was highlighted that this cost head is beyond the direct control of ABUHB and VUNHST.

4.29 Other non-pay costs have been agreed with the CCG as fair and reasonable.

Other Costs

4.30 Section 7 provides more detailed analysis of the key areas of expenditure for the cost heads of:

- Buildings and equipment depreciation (Section 7)

5 TRANSITIONAL REVENUE COSTS

Overview

5.1 Non-recurring revenue costs reflect expenditure that the Health Board and Trust will incur in order to deliver the Project but will not recur over time. They are largely one off, up-front costs. Non-recurring costs are to be incurred to facilitate Pre Commissioning.

5.2 Velindre has discussed the profile of pre-commissioning costs, specifically on the 3-6 month maximum lead in time for recruitment of posts. The proposed costs remain on a staggered basis based on market availability of staff, associated programmes and procurements that enable the Satellite Centre and lead in training times. This position will continue to be scrutinised as part of the commissioner review and internal Velindre Project management review. The estimates, however, at present remains the OBC proposed costs.

5.3 The table below sets out the pre-commissioning costs (in year charges described), assuming a 23/24 commencement:

Table 5-1: Transitional Revenue Costs

	2022-23
	£
Phasing	712,000

6 SCRUTINY PROCESS

Overview of Scrutiny Process

6.1 In order to enable constructive financial consultation and engagement during the process, the case was considered by the Collective Commissioners Group (CCG).

6.2 The work of the CCG has dovetailed into the Collaborative Cancer Leadership Group (CCLG) that has brought together representations from Chief Executives, Directors of Planning and Directors of Finance to develop seamless cancer services across South East Wales and improve cancer outcomes for our collective catchment population.

6.3 The narrative below presents the scrutiny process undertaken by CCG.

Collective Commissioning Group

6.4 The CCG built on existing collective commissioning arrangements to lead the financial scrutiny of the OBC for the RSC.

6.5 This group consisted of senior finance officers and commissioners from the stakeholder Health Boards.

6.6 As stated previously, the OBC for the RSC will focus on the additional infrastructure and clinical costs directly attributable to the RSC.

6.7 The main objective of the CCG is to confirm the financial affordability settlement in relation to the additional costs in relation to the RSC and its distribution across commissioners.

6.8 The key agreements to date include:

- Agreement of the Financial Framework to enable the construction of the OBC Financial Case
- Gaining a shared understanding of the need for a RSC;
- Discussing the OBC options;
- Sharing the approach to the Financial Case;
- Discussing the Preferred Option
- Approach and methodology for finalising and agreeing a financial affordability settlement in relation to the RSC OBC
- The cost headings (and their presentation) to be included in the OBC, ensuring transparency and agreement of the financial investment set down:
  - Velindre clinical costs
  - Health Board service costs
  - Facilities Management (Soft FM/Hard FM/Utilities);
  - Medical and other equipment;
  - IM&T;
- The cost baseline relating to the agreed cost headings;

- Inflation mechanism;
- Approach to risk;
- Approach to rates; and
- Agreement of a methodology to distribute the additional cost across Local Health Boards.

7 DEPRECIATION

7.1 Depreciation reflects the recurring annual impact of capital expenditure over its assumed useful life. The costs described earlier in the capital section of this chapter will require to be recorded as assets and, therefore, the depreciation impact of each is considered.

7.2 The 'asset lives' for the up-front capital expenditure are outlined in the table below:

Table 7-1: Asset Life Assumptions

Asset type	Estimated useful life for depreciation
Buildings and infrastructure	60 years
Treatment Machines	10 years
Other radiotherapy equipment	7 – 10 years
Diagnostics equipment	7 years
IM&T equipment	5 – 6 years
Other equipment	10 years

7.3 The funding for depreciation costs is planned to be sourced from the Welsh Government.

8 BALANCE SHEET IMPACT

Accounting Treatment

8.1 Under the proposed funding arrangements the RSC will be ‘on balance sheet’ from a Health Board and Trust perspective.

9 DISTRIBUTION OF COMMISSIONER REVENUE COSTS

Distribution of Recurring Revenue Costs

9.1 The Collective Commissioning Group have considered and agreed the approach to the distribution of revenue costs to inform the OBC process.

9.2 The methodology was developed through the following stages

- Identification of recurring revenue costs in the establishment of the RSC
- ABUHB costs to be recharged to Velindre under a Service Level Agreement.
- Velindre to charge HBs under LTA arrangements
- Identification of the proposed activity casemix at the RSC
- Calculation of the income to Velindre of the proposed activity casemix using the new Velindre Contractual LTA Framework.

9.3 The key assumption used is activity undertaken at the RSC will be chargeable as any other Velindre activity.

9.4 On this basis the new Velindre Contractual LTA Framework would generate a full cost tariff of £2,846,378 to Velindre from commissioners using the agreed casemix.

Table 9-1: Activity Casemix

Treatment Type	No of Fractions
Prostate Fractions	7,434
Breast non-DIBH	3,234
Breast DIBH	3,234
Palliative Treatment	1,699
	15,600

9.5 When the full cost tariff is compared to the RSC cost proposal, it shows that the cost proposal is 89% of the full cost tariff.

Table 9-2: Tariff Income compared to RSC costs

	Recurring Revenue Costs £000
RSC Cost proposal	2,546,607
Tariff Income at Full Cost Rates using activity casemix	2,846,378
Comparator as % of Full Cost Tariff	89%

9.6 Actual costs are to be charged under the LTA Framework mechanism on activity residency with the costings underpinning the Velindre Contractual Framework being updated to reflect the 89% stepped cost.

9.7 On a notional basis, the RSC cost proposal split by commissioners using the percentages shares in current LTA arrangements would result in the following

Table 9-3: Indicative Split of Commissioner Costs

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Commissioners	Split %	Recurring Revenue Costs £
Swansea Bay UHB	0.64%	16,298
Aneurin Bevan UHB	39.25%	999,543
Cardiff & Vale UHB	28.69%	730,622
Cwm Taf Morgannwg UHB	27.78%	707,447
Hywel Dda UHB	1.51%	38,454
Powys THB	2.14%	54,497
WHSSC	0.00%	0
Total Recurring Revenue Costs	**100%**	**2,546,607**

9.8 To ensure full cost recovery by VUNHST under the LTA contractual framework, the full and marginal rates in the LTA mechanism would need to be re-costed to include the RSC development.

Transitional Revenue Costs

9.9 The commissioner shares have been utilised to distribute the transitional (non-recurrent) revenue costs of the Project over Commissioners.

Table 9-1: Transitional Costs

	Split %	2022-23 Costs £
Swansea Bay UHB	0.64%	4,557
Aneurin Bevan UHB	39.25%	279,460
Cardiff & Vale UHB	28.69%	204,273
Cwm Taf Morgannwg UHB	27.78%	197,794
Hywel Dda UHB	1.51%	10,751
Powys THB	2.14%	15,237
WHSSC	0.00%	0
Total Transitional Revenue Costs	**100.00%**	**712,000**

Cost Inflation and Risk Sharing

9.10 The CCG has agreed an approach to risk sharing where the cost base will be reviewed prior to commissioning the RSC.

9.11 The CCG has agreed to an appropriate inflation mechanism, whereby the agreed commissioner quantum will be uplifted using CPI.

9.12 It was agreed that further scrutiny of the costs base will be required over the Project life and finally prior to commissioning of the new Centre. At this time, any costs that have increased outside of ABUHB and VUNHST's control would require separate discussion.

9.13 The CCG has agreed that the costs identified and scrutinised are appropriate indicative costs and the assumptions are fair and reasonable. As identified above, it is recommended that the costs be reviewed at FBC stage and prior to commissioning. It is acknowledged that OBC approval will result in the risks being borne by VUNHST and/or ABUHB as appropriate (unless a case is made otherwise as identified below).

9.14 In that regard, Commissioner funding for professionally supported cost increases, outside of Velindre's control, should not be unreasonably withheld. It was agreed that rates should be specifically mentioned as areas for review given they are beyond the ability of the Trust to control. Further, cost drivers such as pay awards, mandated standards and unavoidable external policies would also be accepted as reasonable factors for post approval support. The revenue costs flowing from the IRS Procurement are also identified in this regard.

9.15 It has been agreed that the cost distribution will apply to these, and any future variant of the OBC cost, unless Commissioners collectively agree to the application of another method at some point in the future.

9.16 The preferred option results in an NHS saving of £1.2m costs for MIMs financing payments. Commissioner Health Boards will appreciate Welsh Government consideration of a proportion of this avoided cost be made available to mitigate the recurrent revenue costs of the preferred option.

10 FUTURE COMMISSIONING ARRANGEMENTS

Collective Commissioning Group

10.1 The Financial Framework, presented in Section 2, identified that the RSC OBC has focused on the additional costs of this new building and service at a projected level of activity outlined in Section 9. The actual level of activity and casemix required will be addressed through the commissioning and planning cycle irrespective of the provision of a new building.

10.2 It is necessary to highlight that, although not a decision dependent factor, the additional variable clinical costs of demand, and the associated approach to provide further additional resources through a new Commissioning LTA Framework, are important business factors that require determination and collaborative commissioning agreement. This process will be managed through the Collective Commissioning Group (CCG).

10.3 The OBC is predicated on the implementation of the new VCC contractual framework which is currently being implemented with commissioners.

11 SUMMARY OF FUNDING REQUIREMENTS AND SOURCES

11.1 The Health Board and Trust has had active dialogue with other Health Board commissioners and the Welsh Government regarding the funding arrangements for the Project.

11.2 It is assume the preferred option capital costs of £29.577 million will be funded by Welsh Government from public sector capital.

11.3 The table below provides an overview of total recurring revenue costs for the Project of **c£2.546m** in 2023/24, the first full of operation for the RSC.

Table 11-1: Summary Recurring Revenue Requirements

	£	Funding Source
Workforce	1,900,252	Commissioners
Non Pay		
Utilities	95,276	Commissioners
Hard FM	69,207	Commissioners
Rates	62,536	Commissioners
Soft FM	9,137	Commissioners
Consumables	75,000	Commissioners
Equipment Maintenance	264,390	Commissioners
IM&T Maintenance	27,097	Commissioners
Other	43,713	Commissioners
TOTAL COST	**2,546,607**	

11.4 Recurring revenue costs will be funded by Commissioners on an actual usage basis under the new contractual mechanism. However, it is planned that the Welsh Government will fund the increased buildings and equipment depreciation.

11.5 Pre-commissioning transitional costs (in year charges described), assuming a 23/24 commencement have been identified as follows:

Table 5-1: Transitional Revenue Costs

	2022-23
	£
Transitional Costs	712,000

12 CONCLUSION

12.1 In developing the Financial Case, ABUHB and VUNHST has worked closely with its specialist advisors, Commissioners and the Welsh Government to agree the Financial Framework to be adopted and present a robust assessment of the overall capital and revenue consequences of the proposed Project.

12.2 In assessing affordability, the Health Board and Trust has carefully considered the timing of expenditure up to 2023/24 and how this will impact on commissioners and other stakeholders, including the presentation of the professionally agreed approach to the distribution of the agreed revenue costs.

12.3 It should be noted that significant additional revenue costs will be required in excess of the revenue cost of the preferred option to provide additional Radiotherapy capacity to meet forecast demand if the proposed satellite unit does not progress. The majority of that activity will need to be provided via other Providers.

13 APPENDICES

For Information

The following appendices are available in support of this case**.** Information in support of the capital costs is included in the Estates Annex

Appendix Reference	Title
OBC/FC1	Recurring Revenue: Pay Costs

Appendix 1

OBC/FC1 Recurring Revenue Pay Costs

Costings	Option - nVCC		Option - NHH SRU	
Radiotherapy Delivery	**WTE**	**£**	**WTE**	**£**
Consultant	1	110,359	1	110,359
Medical Sec	1	26,805	1	26,805
Senior Leader	0	0	1	65,883
Advanced Practitioner	2	97,052	2	97,052
Superintendent Radiographer	1	57,119	1	57,119
Senior Therapy Radiographer	6	291,156	7	339,682
Treatment Radiographer	8	324,224	8	324,224
Treatment Radiographer	5	162,230	5	162,230
Radiotherapy Helpers	1	21,464	2	42,928
Review Assistant	1	26,805	1	26,805
Clerical Officers - Booking Clerk	1	22,952	1	22,952
	27	1,140,166	30	1,276,039
Medical Physics				
Senior Leader	1	79,877	1	79,877
Clinical Scientist	1	57,119	3	171,357
Treatment Machine or Computer Engineer	6	291,156	4	194,104
Dosimetrist	2	81,056	2	81,056
	10	509,208	10	526,394
Facilities Staff				
Porters	0	0	1	28,656
Domestics	0	0	2	32,978
Linen	0	0	0.1	3,098
Administrative Support	0	0	0.1	4,253
Security	0	0	0.2	3,872
	0	66,554**	3.4	72,858
IT				
Staff to Provide SLA	0	0	0.5	16,223
Pharmacy				
Pharmacists		0		8,738
TOTAL		**1,715,928**		**1,900,252**

Note : ** nVCC apportioned cost

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Management Case

MANAGEMENT CASE

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1 INTRODUCTION

Approach

1.1 To achieve an effective implementation and full benefits realisation the Project must manage, co-ordinate and oversee the delivery of all Project activities and key deliverables over the lifecycle of the Project. The Radiotherapy Satellite Centre (RSC) is a crucial pillar of the Transforming Cancer Services (TCS) Programme and is essential in order to meet projected demand and deliver care closer to home.

1.2 In response to this need, Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) have developed, in partnership, a Project Management capacity and capability to effectively facilitate the delivery of the RSC Project. This has included appointing and integrating a number of skilled and experienced project officers to meet the current and future demands of the RSC Project.

1.3 The RSC Project has not only developed its Project Management capacity and capabilities, it has also developed governance structures and processes, partnership arrangements and identified key deliverables to facilitate the delivery of the RSC Project.

1.4 This OBC Management Case therefore sets out the management arrangements which will successfully deliver the RSC Project to time, cost and quality. The Management Case will outline the following arrangements:

- Project Management Arrangements;
- External Advisors;
- Use of Specialist Advisors within NHS Wales;
- Project Partnership Arrangements;
- Procurement and Contracts Management;
- Change Control;
- RSC Project Plan;
- Benefits Realisation;
- Communication and Engagement;
- Risk Management Plan; and
- Arrangements for Post Project Evaluation.

1.5 The Management Case will provide assurance on the capacity and capability of the Project Management arrangements to deliver the Projects objectives.

2 PROJECT MANAGEMENT ARRANGEMENTS

Project Roles and Responsibilities (The People)

2.1 The Health Board and Trust have invested in developing an effective Project Leadership Team (that form the core of the RSC Project Management Arrangements). The RSC Project Board, and the associated Project Team Management capacity and capability, will facilitate the effective delivery of the RSC Project operationally.

2.2 The key individual roles and responsibilities required to support the delivery of the RSC Project are set out in table 2-1 below:

Table 2-1: RSC Project Leadership Team

Role	Name/Status	Responsibility
Senior Responsible Owner (SRO) **ABUHB**	Nicola Prygodzicz	The SRO is accountable for the success of the RSC Project. The SRO is responsible for enabling the organisation to exploit the new environment resulting from the RSC Project, meeting the business needs and delivering the required levels of performance, benefit, service delivery and value. The SRO owns the vision for the RSC Project and is required to provide clear leadership and direction and secures the investment required to set up and run the Project throughout its lifecycle and beyond.
Project Director **ABUHB**	Andrew Walker	The Project Director reports to the SRO and is operationally accountable for project delivery of the RSC including the operational delivery of the RSC Procurement through the appropriate processes which he will lead. The Project Director will provide leadership and positive team working to create an environment that facilitates effective project delivery.
Director of Commercial and Strategic Partnerships **VUNHST**	Huw Llewellyn	The Director of Commercial and Strategic Partnerships is the Project Director for the TCS Digital and Equipment Project and along with the RSC Project Director will ensure that the interface between the RSC Project and the TCS Digital and Equipment Project is effective. The Director of Commercial and Strategic Partnerships will advise on the commercial, partnership, management, financial and economic aspects of the Project process and provide strategic advice to the RSC Project and on its interface with the nVCC Project.

TCS Service Director VUNHST	Andrea Hague	The Trust Director of Service Improvement will be responsible for leading a group of operational managers in order to ensure that a service and operational focus is maintained in all aspects of the RSC project. The post holder will be responsible for identifying, developing, agreeing and delivery of all operational and clinical aspects of the Velindre Service at the RSC. This will include workforce, operational procedures and processes, facility requirements for interface management and commissioning.

2.3 Senior Clinical Leadership is provided to the Project through two key posts; one from each of the partner organisations.

Table 2-2: RSC Project - Clinical Leads

ABUHB Clinical Lead	Ian Williamson	The Health Board will appoint a clinical lead who will be responsible for leading a group of clinicians to ensure that a 'local' clinical focus is maintained in all aspects of the RSC project and that patient experience and quality is always a primary consideration.
VCC Clinical Lead	Tom Crosby	The Trust will appoint a clinical lead who will be responsible for leading a group of clinicians to ensure that a 'specialist' clinical focus is maintained in all aspects of the RSC project and that patient experience and quality is always a primary consideration.

2.4 These officers will comprise of the RSC Project Board along with other colleagues from the Health Board and Trust as set down below:

Table 2-3: RSC Project Board

Name	Role
Nicola Prygodzicz	Executive Director of Planning, Digital and IT, ABUHB (Chair)
Andrea Hague	Director of Service Improvement, VUNHST (Deputy Chair)
Andrew Walker	Strategic Capital and Estates Programme Director, ABUHB
Huw Llewellyn	Director of Commercial and Strategic Partnerships, VUNHST
Ian Williamson	Lead Clinician, ABUHB
Prof. Tom Crosby	Lead Clinician, VUNHST

Robert Holcombe	Assistant Director of Finance, ABUHB
Lorraine Morgan	Programme Manager – Strategic Capital and Estates, ABUHB

2.4 The Officers above will be supported by a Project Team including a range of "Technical" ABUHB and Velindre Clinical and Technical Leads, as set out below, as well as a team of External Advisors (see Section 3).

Table 2-4: RSC Project Team

Name	Role
Andrew Walker	Strategic Capital and Estates Programme Director ABUHB (Chair)
Andrea Hague	Director of Service Improvement, VUNHST (Deputy Chair)
Lorraine Morgan	Programme Manager – Strategic Capital and Estates, ABUHB
David Osborne	Finance Lead, VUNHST
Phil Meredith	Finance Lead, ABUHB
Robert Holcombe	Assistant Director of Finance, ABUHB
Jacqui Couch	Clinical Transformation Manager, VUNHST
Bernadette McCarthy	Radiotherapy Services Manager, VUNHST
Kelly Jones	Capital Accountant, ABUHB
Steve Gardiner	Assistant Project Director nVCC (Technical), VUHNST
Glenn Evans	Strategic Estates Manager, ABUHB
Phil Richards	ITC Lead VUNHST
Tony Millin	Head of RT Physics, VUNHST
Mark David	Operations Manager, VUNHST
Jane Williams	Workforce Lead, VUNHST
Chris Lines	Comms Lead, VUNHST
Claire Harding	Comms Lead, ABUHB

Project Management (The Methodology)

2.5 The delivery of the Project will be managed in accordance with the PRinCE2 ('Projects in a Controlled Environment') methodology suitably adapted for local circumstances in order to meet the needs of this Project. The Project management arrangements will therefore be driven by outputs, or in the PRINCE2 terminology, "Products". All products will be formally signed off by the RSC Project Board before being approved (if appropriate) by the TCS Programme Delivery Board or the Health and Trust Boards as appropriate.

2.6 The Infrastructure Project Execution Plan (PEP) includes all the management controls required to ensure the RSC Project, and its contracted firms, meet their fiduciary obligations with respect to the development of the Business Cases, the implementation of the Project, and the management of the Project within a framework of acceptable risk.

2.7 The RSC Project is predicated on the following principles:

- Decisions on the strategic direction and future needs of health care are only made after appropriate consideration;
- The views and interests of patients, staff and all stakeholders are considered;
- Appropriate behaviour with respect to the codes of corporate governance and policy;
- Guidance and good management practice; and
- Open and regular reporting of Project progress and performance.

2.8 To ensure the quality of the outputs are maintained and the objectives are met, the Project Execution Plan will be managed and undertaken on the basis of:

- Proven methodologies and standards;
- Effective monitoring procedures;
- Effective change/issues/problem management;
- Review and acceptance procedures; and
- Appropriate documentation and record keeping.

Project Governance and Management

2.9 Key to the success of the RSC Project is the Project Governance and Management inputs required for the co-ordination of sub projects and their outputs, reporting progress against plan, approvals and escalations of risks and issues. The Governance and Management processes have been designed to allow for key approvals to occur at the most appropriate level.

2.10 Of particular importance is the dovetailing of the TCS Programmes, and its constituent Projects, governance arrangements, with both ABUHB's and VUNHST Corporate Governance arrangements and that of Welsh Government's

sponsorship, scrutiny and approvals process. In particular, this will allow for rapid approvals and the effective escalation of risks and issues to a level where senior sponsors can intervene as necessary to support the delivery of this important project**.**

2.11 This section provides an overview of all aspects relating to the Project Management structure and individual roles and responsibilities.

2.12 The Project Governance Arrangements are organised over three levels, namely:

- ABUHB and VUNHST Boards (Corporate) – **Level 1**
- TCS Programme Delivery Board – **Level 2**
- RSC Project Board – **Level 3**

2.13 The Project structure ensures clear accountability and also deploys mechanisms to facilitate decision making, communication and alignment. The Governance Arrangements are set down within the TCS Programme Board, TCS Programme Scrutiny Committee, RSC Project Board and RSC Project Team Terms of Reference.

Project Management: Roles and Responsbilities

2.14 The shared Project Management and Administration roles and responsibilites for the RSC Project are set out in Table 2-5 below.

Table 2-5: Project Management and Administration Specific Roles and Responsibilities

Role	Responsibility
Project Manager (PM)	The Project Manager has overall responsibility for the delivery of all sub projects within the identified portfolio. To ensure that they are delivered to time, cost and quality. Key to the success of this role is the efficient and effective use of project resources, and the identification and management of, interdependencies, risks and issues, and benefits delivery.

Role	Responsibility
Project Co-ordinators (PC)	The Project Co-ordinator(s) will provide high quality Project support and administration services to the Project. This will include co-ordinating meetings, capturing issues, decisions and actions. To act as a configuration management librarian and to oversee all document control during project delivery.
Project Administration (PA)	The Project Administration duties include all aspects of facilitating a project: scheduling meeting times and locations, taking meeting minutes, capturing action points and arranging training for project staff. In addition, the project administrators participate in budget administration, providing analysis and maintaining project records and facilitating procurement.

2.15 The costs of the Project Management have been included within the RSC Project capital costs.

3 EXTERNAL ADVISORS

3.1 The preparation of the OBC will be supported by an External Project Manager and External Cost Advisor both of which have been appointed from the All Wales Designed for Life: Building for Wales Framework.

3.2 The Project Manager (Gleeds Management Services) will perform the role in accordance with the Outline Schedule of Duties for Project Managers, as defined at Framework level, unless otherwise amended and agreed with the Health Board. This role encompasses a project management role of the technical aspects of the business case process and subsequent design, procurement, construction and project closure stages under the NEC3 Form of Contract.

3.3 The Cost Advisor (Lee Wakemans) will oversee the financial management of the capital expenditure, in conjunction with the Health Board Finance Directorate. They will monitor project costs, implement rigorous verification and checking of all costs presented by the SCP, and deliver a project from a Health Board perspective which is affordable and provides value for money.

3.4 In addition to the above a Health Care Planner (Archus) has been appointed to lead the preparation of the OBC Economic Case. Capita will fulfil this role, they have been appointed via the All-Wales HCP Framework. In May 2020, the Project were informed that Capita were unable to provide Business Case Support from the middle of June 2020. Alternative arrangements with Archus have been made to maintain continuity to this important role.

3.5 The RSC Project Director will provide lead and co-ordinate the Trust Advisors.

4. USE OF SPECIALIST ADVISORS WITHIN NHS WALES

4.1 The RSC Project utilises the advice of a number of specialist advisors provided via the NHS Wales Shared Services Partnership (NWSSP) and other areas of the NHS in Wales.

4.2 These include the following:

- NWSSP – Specialist Estates Services;
- NWSSP – Procurement Services;
- NWSSP – Legal and Risk Services;
- Health Education and Improvement Wales (HEIW); and
- NHS Wales Informatics Service (NWIS).

4.3 Discussions have been held with NWSSP – Procurement Services and the NHS Specialist Estates Services regarding the professional relationship, and management processes, required to support the Project. It is important that these two key National Services are fully aligned with the RSC Project. The quarterly TCS briefings and advisory sessions with Shared Services are intended to continue throughout the process to ensure appropriate engagement with the TCS Programme and their constituent projects.

4.4 Processes have been included within the TCS Programme and RSC Project to enable these important relationships to be managed and co-ordinated.

5 PROCUREMENT AND CONTRACT MANAGEMENT

5.1 The delivery process is a 'team' effort with the RSC Project Team leading the operational processes. The Project Team will co-ordinate the External Advisory Teams.

5.2 The roles and responsibilities of each of the elements of the Project Team are set out below:

- ✓ **The RSC Project Team:** responsible for leading the process on behalf of the Project Board. The Team consists of both Health Boards and Trust decision-makers who will be responsible for shaping the scheme within Project Scope and Brief and have delegated authority to take key operational decisions during the process.

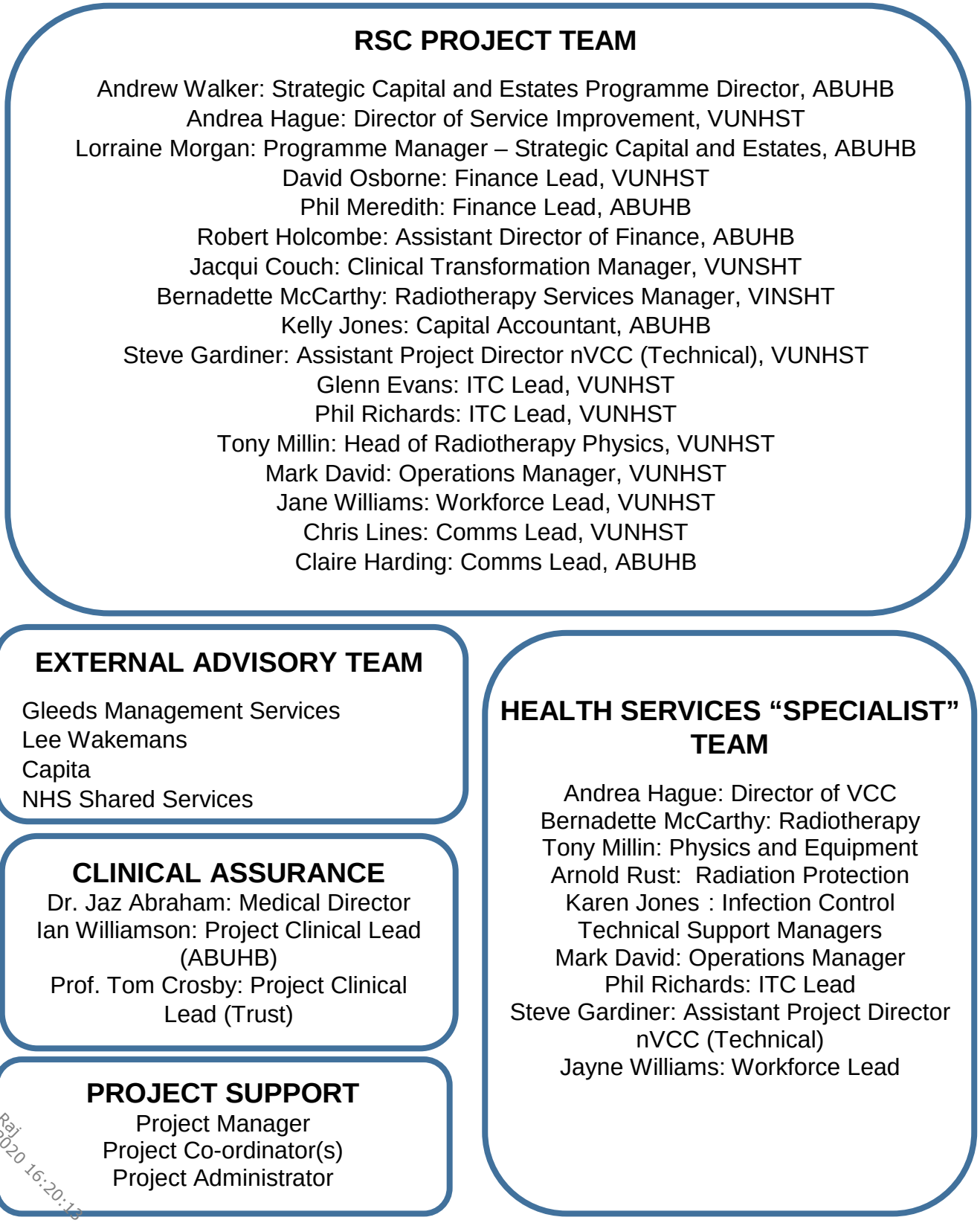
- ✓ **The External Advisory Team:** responsible for providing technical / specialist knowledge and "specialist" expertise to the Trust team to enable them to secure the optimal solution.

- ✓ **Trust and Health Board Service Representatives:** responsible for providing the Team with professional and operational information, advice and guidance. The Health Board Service Advice is pivotal in providing consolidated views on the various solutions put forward by the SCP. For example, different design solutions that may impact patient flows, clinical adjacencies, infection control etc.

- ✓ **Trust Clinical Assurance Representatives:** The Trust Clinical Assurance Representatives will ensure that a clinical focus is maintained in all aspects of the RSC project. Thus, ensuring that patient experience and quality of care is always a primary consideration in the planning of the RSC.

5.3 Details of roles and staff likely to be involved in the dialogue process are set out in Figure 5-1 overleaf:

Figure 5-1: Project Governance Arrangements



6 CHANGE CONTROL

Introduction

6.1 This section of the Management Case sets out the approach to Project change control.

Change Control

6.2 The Change Control process is managed by the Project Management Team. The Change Control comprises of:

- Change Control Management Document - which gives guidance of version control in regards to documents and the change control procedure;
- Change Management Log - captures all version controlled Project documents/products;
- Change Form - formal process staff are required to follow to request change to a version controlled document/products; and
- Change Log - this captures all change requests.

6.3 The Project Team, and external contractors, are expected to comply fully with the Change Control Procedure.

Change Control Principles

6.4 The Change Control and Management principles of the framework agreed to date are, to:

- Recognise the need to maximise the benefits of the change for patients, who should be at the heart of the changes made;
- Take advantage of the time required to complete the development to start the change process immediately and avoid risks related to a 'big bang' approach;
- Test and prove the changes through careful piloting of any aspects of the new models and processes that can be implemented before the new facility is finally commissioned;
- Work in partnership with staff and other stakeholders both within and outside RSC to engage all those involved in the delivery of care in the change process; and
- Focus on staff skills and development required so staff are both capable and empowered to deliver healthcare effectively and to a high-quality standard in the new facility through new models of care.

6.5 Once the RSC OBC has been approved, these principles will be revisited and confirmed. The Change Control Principles will be communicated to all staff as part of the launch of the change control management process.

The Project Change Management Approach

6.6 The Project Management Team has designed a change management approach that encompasses the framework and principles outlined above.

6.7 The implementation of a change management process will progress well in advance of FBC approval.

6.8 Where proposed changes to service impact on the workforce the NHS Wales, Organisational Change Policy will apply. This national document makes clear the onus upon the service to consult with staff affected and their individual employment rights.

The Change Control Plan

6.9 A Change Management Plan will be developed. Once the OBC has been approved three actions will occur:

- The Core Plan will be reviewed to identify other relevant areas that need to be included;
- Detailed plans will be set up for each of the tasks in the Core Plan; and
- An overall timetable will be developed and the high level milestones communicated as part of the launch of the Change Management Plan.

6.10 The table overleaf sets out the core plan and the main tasks identified to date.

Table 6-1: Change Management Plan

Area	Planned tasks
Planning phase	✓ Appoint key Project roles and Change Managers, confirming responsibilities and leadership ✓ Confirm stakeholders and interested parties both within and outside ABUHB and VCC ✓ Develop core plan in more detail, identifying high level milestones for the Change Management Plan, mapped to the overall Project Plan ✓ Confirm involvement of HR, managers and other individuals/groups in the process
Communications and stakeholder engagement	✓ Confirm communications lead and protocols (route and timing of approval of communications) ✓ Develop communications routes, including face to face briefings bulletins, intranet pages ✓ Formulate and agree key communications messages against high level milestones ✓ Set up stakeholder map and engagement plan ✓ Launch change Programme ✓ Ongoing communications work
Training and development	✓ Complete detailed workforce planning to identify 'shadow' structures, roles and competencies for those roles ✓ Work with staff through workshops and other training to clarify the workings of the new Service Models and how these will impact in practice ✓ Identify training and development required to fulfil roles and competencies ✓ Develop training plan, aligned to pilot work and overall milestones in implementation plan ✓ Link training and development into communications plan
Piloting	✓ Identify and confirm areas where piloting of new models and practice will be implemented ✓ Confirm schedule of pilot work, mapped against high level project and change management milestones ✓ Agree feedback arrangements from pilots and how this links into training/development, communications and overall change management plan ✓ Execute pilots, feedback and report progress
Full Implementation	✓ Identify scheduling/phasing of full implementation at VCC ✓ Using results of piloting and training work, develop detailed implementation and transition plan, mapped to project phasing ✓ Discussion and agreement with key staff ✓ Execute implementation and transition plans

7 RSC PROJECT PLAN

7.1 The project plan key milestones are set out in the following table, the Estates Annex includes the detailed programme:

Table 7-1: Project Plan Key Milestones

Milestone	Dates
Submission of OBC to Commissioners and Welsh Government	September 2020
Welsh Government Approval / FBC Commencement	January 2021
Enabling Works Commencement	January 2021
Submission of FBC to Welsh Government	September 2021
Welsh Government Approval / Start-on-site	November 2021
Completion	August 2023 (subject to confirmation of IRS Preferred Partner and commissioning period)

7.2 Discussions are ongoing with Welsh Government regarding this Project Plan and the key tasks required to be achieved in order to deliver it.

8 BENEFITS REALISATION

Introduction

8.1 This section of the Management Case will describes how the Trust will manage the delivery benefits associated with the RSC Project. It will cover the following areas:

- Benefits Realisation Strategy;
- Benefits Mapping and Assurance;
- Benefits Management Process;
- Benefits Realisation Plan; and
- Process for Managing and Monitoring Work.

Benefits Realisation Strategy

8.2 The TCS Programme team has been working closely with the Welsh Government and other partners to ensure that the management of the RSC Project benefits are robust. Much of this detail is contained within the Strategic Case of this OBC. This work has included the identification and quantification of Project Benefits where possible. This has then allowed for the quantified benefits to influence the Economic Case where the choice of the preferred option is made. The quantification of benefits relating to the RSC reflect the wider societal benefits within the wider TCS Programme. These are included only where they can be directly attributable to the provisioning of the RSC.

8.3 This Project is about the provisioning of the RSC to improve clinical outcomes. It delivers a key aspect of the clinical model and increases integration with local services and support for further research and education.

8.4 The use of a quantified benefits assessment methodology brings significant rigour to how the benefits have been assessed and informed the preferred option.

8.5 This brings into sharp focus the need to ensure that the Project maximises the delivery of the benefits associated with the RSC Project.

Benefits Mapping and Assurance

8.6 One of the most important features in benefits realisation is to ensure that the perceived benefits identified as part of the preferred option will deliver the Project Spends Objectives (PSOs).

8.7 As previously described in the Strategic Case, the benefits associated with the Project have been captured and presented.

8.8 All Benefit Groups have been matched to a beneficiary, whether this be a patient, carer, ABUHB and Velindre University NHS Trust, other Local Health Boards, or

at a Governmental level or societal level.

Benefits Management Process

8.9 The Benefits Management Process takes due account of changes in the Project during the delivery phase which may impact on, or alter the anticipated benefits.

8.10 Benefit Reviews will be led by the SRO, and involve stakeholders, to establish the extent to which benefits have been realised to date, and are likely to be in the future.

8.11 The Benefits Management approach is a cycle of identification, planning, execution and review. Further details of each stage are provided overleaf:

Stage 1 Benefits Identification and Assessment: Selection of appropriate and significant benefits that makes the best use of scarce resources;

Stage 2 Benefits Realisation Planning: Rational decisions about how, when, and by whom benefits will be delivered, with clear ownership, accountability and timetable;

Stage 3 Execute and Deliver the Benefits Realisation Plan: Successful delivery of the Benefits Realisation Plan; and

Stage 4 Review: Input to a culture of continuous improvement either through incremental change to the existing system or by triggering the inception of new projects.

8.12 A Benefits Review for the RSC Project will also take place which will focus on Benefits Realisation.

Benefits Realisation Plan

8.13 A formal Benefits Realisation Plan has been prepared for the RSC Project. The plan is designed to enable benefits, and dis- benefits, that are expected to be derived from the RSC Project, to be planned for, managed, tracked and realised.

8.14 The Benefits Realisation plan will help demonstrate whether the scheme's investment objectives are able to generate the desired 'measures for success. This can be assessed by tracking the desired outcomes and subsequent benefits of the RSC Project.

8.15 As part of the information required for the OBC, benefits have been incorporated into a Benefits Realisation Plan which will detail the:

- Beneficiaries;
- Category of benefit;
- Baseline measure;
- Trajectory to target; and
- Benefit owners.

Process for Measurement and Monitoring

8.16 Measuring and monitoring the delivery of benefits is key in assessing the extent to which they are being delivered against the plan.

8.17 In some cases, measurement can be achieved through existing systems and information source. In some cases, however, this requires the establishment of new arrangements. It is, therefore, important that where new mechanisms are required, these are identified at an early stage.

8.18 Additionally, it should be recognised that only a proportion of the benefits will be 'hard' or quantifiable (e.g. additional activity delivered) with many requiring 'soft' or qualitative measures to assess their delivery. These qualitative measures are often the areas requiring the greatest level of bespoke development. Finally, the frequency of benefit monitoring will be established as part of this process.

8.19 For each benefit criterion considered, the Project Team were tasked with identifying and documenting:

- How would you know that the benefit has been achieved?
- Could both qualitative and quantitative measures be used?
- How will the partnership monitor the achievement of the benefit?

Identification of Potential Dis-benefits

8.20 In realising a benefit, it is recognised that as a consequence there is often a resulting negative impact or dis-benefit. Whilst these rarely outweigh the positive benefit it is important that dis-benefits are identified and any potential impact managed as part of the overall BRP.

8.21 For each benefit criteria considered, the group was tasked with identifying and documenting:

- What dis-benefits or problems could achieving the benefit cause?
- What negative impacts could there be on staff, patients or public?
- What impact could there be on organisational culture, strategy or structure?

8.22 All the benefits identified in the RSC Strategic Case and Economic Case must be accounted for within the benefits register. Certain quantified benefits are included within the Economic Appraisal for the preferred option.

9 COMMUNICATION AND ENGAGEMENT

Overview

9.1 Effective communication and engagement with all internal and external stakeholders is vital in the delivery of a successful Project.

9.2 Following the development of the Programme Business Case the TCS Programme has embarked upon a programme of engagement with numerous key stakeholders including:

- Patients, families and carers;
- People who may use service in the future;
- HBs, VCC, 3rd sector, HEIs etc.; and
- Potential strategic/commercial partners.

9.3 The TCS Programme, and the RSC Project, have delivered a Programme of Engagement during the development of this OBC and also engaged with the South East Wales Collaborative Cancer Leadership Group. This Collaborative Cancer Leadership Group chaired by Len Richards, Chief Executive of Cardiff and Vale UHB, also included Board Directors from Planning, Medical and Finance from all of the commissioning Health Boards in South East Wales.

9.4 A Communication and Engagement Plan has been developed and is being implemented and will be led by the TCS Programme Communications and Engagement Manager.

10 RISK MANAGEMENT PLAN

Introduction

10.1 This section of the RSC OBC sets out the Projects approach to risk management and presents:

- Risk Management Overview;
- Issue Management and Risk Management Philosophy;
- Recording and Assessment of Risk;
- Risk Management Framework;
- Responsibility for Managing the RSC Project Risk Register;
- Quantification of Project Risks;
- Risk Mitigation;
- Review and Escalation of Risk; and
- Issues Management.

Risk Management Overview

10.2 The RSC Project utilises its governance structure and arrangements to ensure the effective management of risk. The governance structures allow for risks to be escalated from the Project Teams and its sub groups, through to the RSC Project Board, and onto the TCS Programme Delivery Board and/or the ABUHB and/or Trust Board as appropriate.

10.3 All risk registers are updated dynamically, but are also formally reviewed on a monthly basis. A monthly risk report for the RSC Project will be submitted by the RSC Project Director to the SRO. This risk paper will highlight new risks, the movement in existing risks and issues and where appropriate it will recommend the closure of resolved risks or issues.

10.4 The TCS Programme Delivery Board, upon receiving the RSC risk register (via the RSC Project Director), will consider if the mitigating actions are sufficient and if the identified risks are receiving the right level of treatment. The TCS Programme Delivery Board will consider the escalation of RSC Project Risks onto the Trust Risk Register as appropriate. The remainder of this section sets out the detailed management of risks and issues.

Issue Management and Risk Management Philosophy

10.5 The RSC Project Board sees effective risk management as a positive way of achieving the Project's wider aims. The RSC Project Board regards risks as the mirror opposite of benefits. Inadequate risk management would therefore reduce the potential benefits to be gained from the delivery of the RSC Project.

10.6 Effective Risk Management supports the achievement of wider aims, such as:

- Effective Change Management;
- Enhanced use of resources;
- Better Project Management;
- Minimising Waste and Fraud; and
- Innovation.

10.7 The Project utilises the TCS Programmes Risk Management Framework to systemically identify, actively manage and minimise the impact of risk. This is achieved by:

- Identifying possible risks before they manifest themselves and put stringent mechanisms in place to minimise the likelihood of them materialising with adverse effects on the project;
- Putting in place robust processes to monitor risks and report on the impact of planned mitigating actions;
- Implement the right level of control to address the adverse consequences of the risks if they materialise into issues; and
- Having strong decision-making processes supported by a clear and effective framework of risk analysis and evaluation.

10.8 Once risks are identified, the response for each risk will be one or more of the following types of action:

- **Prevention**, where countermeasures are put in place that either stop the threat or problem from occurring, or prevent it from having an impact on the project;
- **Reduction**, where the actions either reduce the likelihood of the risk developing or limit the impact on the project to acceptable levels;
- **Transfer**, where the impact of the risk is transferred to the organisation best able to manage the risk, typically a third party (e.g. via a penalty clause or insurance policy, or contractual responsibility);
- **Contingency**, where actions are planned and organised to come into force as and when the risk occurs; and
- **Acceptance**, where the RSC Project Board decides to go ahead and accept the possibility that the risk might occur, believing that either the risk will not occur or the potential countermeasures are too expensive. A risk may also be accepted on the basis that the risk and any impacts are acceptable.

10.9 RSC Project Board will adopt a proactive approach to the identification, assessment and management of risks throughout the whole project lifecycle. The effective management of risk and the prevention of issues arising will support the

timely delivery of the RSC Project, by preventing delays, avoiding costs and ensuring quality is upheld.

10.10 The management of RSC Project risk will be in accord with the principles of the TCS Programmes Risk Management Policy.

Recording and Assessment of Risk

10.11 The RSC Project has a Risk Register that is a dynamic document which will be updated with all new identified risks being assessed. All risks will have an individual identifier, an assigned owner and be scored using the standard matrices to ascertain the risk rating colour.

10.12 It is worth reiterating that, as set out in the Commercial Case, a number of the risks associated with the procurement will be either wholly transferred or shared with the successful Contractor.

10.13 In developing the preferred solution, the Project examined three categories of risks for each option. These are set out in Table 10-1 below, together with a summary of how these were assessed.

Table 10-1: Risk areas

Area	Description	How assessed
Capital Risks	Capital risks relate to unknown or unidentifiable factors that increase the cost and time of the project construction.	Qualitative and quantitative risks assessed by Quantity Surveyor.
Optimism Bias	Optimism bias is the demonstrated Systemic tendency for appraisers to be over optimistic about key project parameters. This creates a risk that predicted outcomes do not fully reflect likely costs	Standard methodology to identify extent of optimism bias, with mitigating factors confirmed through RSC Project assessment
Revenue Risks	These are risks relating to everyday management encompassing cost and activity as well as external environmental factors	Risks identified, with quantitative and qualitative assessment through workshop

10.14 The risk values for the shortlisted options were identified and evaluated as part of the assessment process in choosing the preferred option in the Economic Section. Although the focus of this section is on the approach to managing the

risks of the preferred solution, the scope of Risk Management will continue to cover all three areas of risk.

Risk Management Framework

10.15 The RSC Project has a Risk Management Framework that focuses on effective identification, reporting and management of risks. There are three roles in the risk management process that are summarised in the table below.

10.16 The RSC Project Team will oversee the operation of the Risk Management Framework and will report to the Project Board.

10.17 Although overseeing the Risk Management Framework the Risk Management Lead will not be responsible for the actually taking forward risk mitigating actions. In most cases this will be the nominated risk owner. The risk management roles are set out in Table 10-2 below.

Table 10-2: Risk management roles

Role	Responsibility	Reporting & accountability
Risk Management Lead	Manages the process for identifying and addressing risk, maintaining the risk register on a day to day basis	SRO and Project Board
Risk Management Co-ordinated Assessment	Brings together key risk owners to co-ordinate the identification and assessment of risks plus the management of key risks	Project Team and Project Board
Risk Owner	Individual or group responsible for developing and implementing risk mitigation measures for individual risks they are responsible for	Risk management lead and Risk Management Sub Group

10.18 The Project Board have recognised and acted upon their responsibility for leading effective risk management throughout each stage of the RSC Project. This is particularly important at OBC stage, to ensure that the risks associated with the preferred solution have been identified and addressed. The paragraphs below set out the work completed to date, demonstrating the proactive approach to risk management.

Responsibility for Managing the RSC Project Risk Register

10.19 The RSC Project Director is accountable for ensuring that there is robust and proportionate risk management across the Project. To do this it is important that the relevant information on risk is available. The responsibility for managing the RSC Project Risk Register lays with the RSC Project Manager who will review the Risk Register and where necessary hold Risk Reduction Meetings as and when required. Otherwise, the Risk Register will be issued monthly with updated changes.

10.20 The Risk Register should be updated and reviewed continuously throughout the course of the RSC Project and capture the following information for each risk:

- Risk Register Risk number (unique within the Register);
- Risk type Author (who raised it);
- Date identified;
- Date last updated;
- Description (of risk);
- Likelihood;
- Interdependencies (between risks);
- Expected impact;
- Bearer of risk;
- Countermeasures; and
- Risk status (action status).

10.21 All the risks identified in the Strategic Case and Economic Case sections of the RSC Project OBC must be accounted for within the RSC Project Risk Register.

Quantification of Project Risks

10.22 Quantified risk has been developed in a number of areas within this OBC. Capital risks have been completed as part of the ongoing project management and regular reviews with the SCP and external advisors. The Capital Risk Register is included in the Estates Annex.

Mitigation of Risk

10.23 The RSC Project Board will have a dynamic risk register that will be formally reviewed monthly at the Project Board meetings. The RSC Risk Register must have mitigating actions associated with them. All risks will then be re-evaluated after considering the effect of the mitigating actions, resulting in a post mitigation risk score.

Review and Escalation of Risk

10.24 The Project Team will consider and mitigate risk and maintain those which can be actively managed by this Group. However, when a risk is deemed so

potentially severe post mitigation that it could impact on the overall delivery of the RSC (to time, cost or Quality) the risk will be escalated to the RSC Project Board for more senior oversight. The RSC Project Board will manage risk that directly affects their prescribed deliverables. The members of the RSC Project Board will review the Risk Register at each meeting adding, reassessing or closing risks as necessary and where consideration will also be given to the escalation of risks to the TCS Programme Delivery Board and/or the Health Board and/or the Trust Board as appropriate.

Issue Management

10.25 Issues are Risks that have materialised. Similar to risk, the RSC Project Board will hold an Issues Register and follow the same escalation path.

10.26 All issues should have an owner and an allied action plan and will be reviewed during all RSC Project Board meetings and are categorised as high, medium and low priorities.

10.27 Issues will be regularly reported to the RSC Project Board and escalated to the TCS Programme Delivery Board and/or Health Board and/or Trust Board as appropriate.

10.28 Issues that are outside the scope or authority of the RSC Project Board will be referred to the TCS Programme Delivery Board and/or the Health Board and/or the Trust Board as appropriate.

11 ARRANGEMENTS FOR POST PROJECT EVALUATION

Introduction

11.1 This section of the OBC sets out the plans to undertake a thorough Post-Project Evaluation (PPE). The areas covered are:

- The requirement for Post-Project Evaluation;
- Framework for Post-Project Evaluation;
- The Four Stages of PPE; and
- Management of the Evaluation Process.

The Requirement for Post-Project Evaluation

11.2 The requirement to carry out a post Project evaluation is essential in establishing if the RSC Project has been successful, has it met the, spending objectives and realised its expected benefits. Additionally, it is important that any lessons that have been learned can be factored into future projects.

11.3 A critical element of the Project closure activities will be the need to carry out a review of the RSC Project (Benefits Realisation).

Framework for Post-Project Evaluation

11.4 The RSC Project Board is committed to ensuring that a thorough and robust Post-Project Evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the RSC Project.

11.5 The purpose of Post Project Evaluation is to:

- Improve Project appraisal at all stages of a Project from preparation of the Business Case through to the design, management and implementation of the scheme. This is often referred to as the 'Post Project Evaluation" (PPE) and is typically carried out six months after completion; and
- Provide a longer-term assessment to appraise whether the RSC Project has delivered its anticipated improvements and benefits. This is often referred to as the 'Post Occupancy Evaluation' (POE) and can be carried out approximately 2-5 years after completion depending on the nature of the Project.

11.6 If properly planned and resourced, evaluation can produce significant benefits, which are summarised in the table 11-1 below.

Table 11-1: PPE Benefits

The benefits obtained	Who benefits
✓ Improve the design, organisation, implementation and strategic management of projects ✓ Ascertain whether the project is running smoothly so that corrective action can be taken if necessary ✓ Promote organisational learning to improve current and future performance ✓ Avoid repeating costly mistakes ✓ Improve decision-making and resource allocation (e.g., by adopting more effective project management arrangements) ✓ Improve accountability by demonstrating to internal and external parties that resources have been used efficiently and effectively ✓ Demonstrate acceptable outcomes and/or management action thus making it easier to obtain extra resources to develop healthcare services	✓ Health/Trust Board – in using this knowledge for future projects including capital schemes ✓ Programme Board – in using this knowledge for future projects including capital schemes ✓ Partners and local stakeholders – to inform their approaches to future major projects ✓ Lead organisations to test whether the policies and procedures which have been used in this procurement are effective

11.7 PPE also sets in place a framework within which the Benefits Realisation Plan can be tested to identify which benefits have been achieved and which have not. The key PPE stages applicable for the RSC Project are set out in the Table 11-2 below along with likely timing.

Table 11-2: Four Stages of PPE

Stage	Evaluation undertaken	When undertaken	Timing
1	Plan and cost the scope of the PPE work at the Project appraisal stage. This should be summarised in an Evaluation Plan.	Plan at PBC, fully costed at FBC stage	Completed before submission of FBC and included within FBC costs and FBC submission
2	Monitor progress and evaluate the Project outputs	On completion of the RSC	Within six to eight weeks of the completion RSC

Stage	Evaluation undertaken	When undertaken	Timing
3	Initial post-project evaluation of the service outcomes	After the RSC has been commissioned	Six months after commissioning of the RSC
4	Follow-up post-project evaluation (*or post occupancy evaluation - POE*) to assess longer-term service outcomes two years after the facility has been commissioned. Beyond this period, outcomes should continue to be monitored.	Typically at intervals of 2-5 years.	Two years after the commissioning of RSC

11.8 The detailed plans for evaluation at each of these four stages will be drawn up by the Health Board and Trust in consultation with its key stakeholders. The paragraphs below set out the types of issues considered at each stage of the review and the timescales for each stage.

The Four Stages of PPE

11.9 The guidance on PPE identifies four stages in the PPE process, which are discussed in the paragraphs below.

Stage 1: The Evaluation Plan

11.10 The Evaluation Plan is a requirement for the FBC and will be completed before the FBC is submitted and form part of the FBC document. The Evaluation Plan will:

- Set out the objectives of the evaluation, confirming what type of information it is designed to generate and for what purpose;
- Set out the scope of the evaluation to show the type of evaluation to be undertaken at the various stages of the project and the key issues to be addressed;
- Define the success criteria for assessing the success or otherwise of the Project;
- Define performance indicators/measures for these criteria;
- State the method(s) that will be used to obtain the information;
- Set out the team and its membership - who will be responsible for undertaking the evaluation and their respective roles;
- State the proposed membership of the Evaluation Steering Group;
- Identify the resources and budget for the evaluation, including the need for written reports and dissemination activities;
- Develop a dissemination plan for ensuring the results from the evaluation are used to re-appraise the Project; and

- Clarify the timing of the evaluation, with expected start and finish dates.

11.11 The Evaluation Plan will be developed in conjunction with the Benefit Realisation Plan and Risk Management Strategy, as all three strategies are closely related. This will help ensure that:

- The assessment of whether the Benefits expected from the Evaluation, including the risks of non-delivery of the Benefits, have materialised; and
- Changes in the Project objectives and other important parameters can be tracked and explicitly noted in the Evaluation Plan.

11.12 The Evaluation Plan will be a live document and kept under constant review.

Stage 2: Evaluation Requirements at the Implementation Stage

11.13 The Project will be monitored for time, cost and service performance. Other aspects of the Project which will be subject to monitoring include:

- The management procedures;
- The procurement process;
- The design solution; and
- The contractor's performance during the implementation and operational stages of the Project.

11.14 Monitoring reports will be produced at regular intervals to help the RSC Project Director determine whether Project Objectives are being met. These reports will be produced on a monthly basis.

11.15 The key issues to address at this stage will include:

- Was the project completed on time?
- Was it completed within the agreed budget?
- What were the reasons for any delay?
- What action would management recommend to prevent future problems?
- Has the estate maintenance backlog been eliminated as planned?
- Functional suitability of the building?

11.16 When the building has been completed, its construction record and functional suitability will be reviewed.

11.17 The issues identified in the review process up to this point, will form the basis of the Post-Project Evaluation Report for this stage.

Stage 3: Evaluation Requirement during the Operational Stage

11.18 Once services are being delivered in the RSC and a reasonable bedding-in period of some six to twelve months after commissioning of the RSC has been allowed,

a more wide-ranging Evaluation of the Costs and Benefits of the Project will be undertaken.

11.19 This Evaluation will build on the work carried out in Stage 2. It will involve reviewing the performance of the Project in terms of the Project Spending Objectives. These will have been defined clearly at Stage 1 of the evaluation process.

Stage 4: Evaluating Longer-term Outcomes

11.20 Further Post-Project Evaluation will be undertaken at a later stage to assess longer-term outcomes and/or the extent to which short-term outcomes are sustained over the longer term. By this stage, the full effects of the RSC including any clinical effects will have materialised.

11.21 As well as re-assessing the preliminary outcomes identified in the previous phase, the evaluation at this stage will address issues such as:

- Changes in operating costs;
- Changes in maintenance costs;
- Changes in risk allocation and transfer; and
- Changes in activity as expected.

Management of the Evaluation Process

11.22 The RSC Project Director will be responsible for ensuring that the arrangements have all been put in place and that the requirements for PPE are fully delivered. The Programme Manager (Strategic Capital and Estates) will be responsible for day to day oversight of the PPE process, reporting to the RSC Project Director, and the RSC Project Board.

11.23 The RSC Project Director will set up an Evaluation Steering Group (ESG), which will:

- Represent interests of all relevant stakeholders; and
- Have access to professional advisors who have appropriate expertise for advising on all aspects of the RSC Project.

11.24 A Project Manager will be appointed to co-ordinate and oversee the evaluation. It has not yet been confirmed whether the evaluation will be carried out by in-house staff, external advisors or a team comprising of both. Whichever configuration is chosen, the key principle will be that the evaluation is “arm’s

length" and objective. Therefore, the Evaluation Team will be unrelated to the RSC Project to promote a detached assessment.

11.25 The Evaluation Team will be multi-disciplinary and include the following professional groups, although the list is not exhaustive:

- Clinicians, including Consultants, Nursing Staff, Clinical Support Staff and Allied Health Professionals;
- Social care representatives;
- Healthcare Planners, Estates professionals and other specialists that have an expertise in facilities;
- Accountants and Finance specialists, IM&T professionals, plus representatives from any other relevant technical or professional grouping; and
- Patients and/or representatives from Patient and Public Groups.

11.26 The costs of the final Post-Project Evaluation will be identified at FBC State. These costs are therefore not currently included in the costs set out in this OBC.

Conclusion

11.27 The RSC Project has identified a robust plan for undertaking PPE in line with current guidance, which is fully embedded in the project management arrangements of the project. These plans have not yet been costed, but will be fully developed and the costs identified for inclusion in the FBC.

12. APPENDICES

For Information

The following Appendices are available in support of this Case:

Appendix Reference	Title
OBC/MC1	Estates Annex

Report Title:	**Development of Radiopharmacy Services at University Hospital of Wales – Outline Business Case**							
Meeting:	**Cardiff and Vale UHB Board**					**Meeting Date:**	**09/11/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	√	**For Information**	
Lead Executive:	**Executive Director of Strategic Planning**							
Report Author (Title):	**Service Planning Project Lead – 029 2183 3060**							

Background and current situation:

This paper sets out a summary of proposals and associated capital and revenue implications for the Development of Radiopharmacy Services at University Hospital of Wales. It is provided to the Board to agree the submission of the Outline Business Case (OBC) to Welsh Government (WG) for £12.756m capital funding to proceed to FBC development. The Executive Summary is attached (and the full OBC is available on request).

The Board is asked to authorise the submission of Development of Radiopharmacy Services at University Hospital of Wales – Outline Business Case to Welsh Government as part of the process to access capital funding to proceed to develop the FBC.

This business case seeks approval to enable the further development of Radiopharmacy Services within the Health Board and permit the continued provision of radiopharmaceutical products from facilities that are both safe and of sufficient size to provide the required capacity for the future.

This development of services is critical as there is currently a significant risk of failure to the existing Radiopharmacy Unit that would have substantial impact. The Radiopharmacy Service was inspected by the Medicines and Healthcare Products Agency (MHRA) on 25 July 2019 and in response to the concerns raised some refurbishments have been carried out to maintain continuation of the service on an interim basis until a new suitable facility is built. The Health Board has therefore agreed with the MHRA and given a commitment to complete the new Radiopharmacy facilities at the earliest possible opportunity. The Health Board had previously indicated their intention to have provided a repalcement facility by the summer of 2021. However, the current pandemic has delayed significantly the development of the OBC to facilitate such a challenging programme.

The Project Board has received regular progress reports on the project throughout the development of this scheme.

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

- The UHB have recognised the inadequacy of the existing Radiopharmacy facility and are committed to providing a new fit for purpose unit.
- The UHB had indicated to the MHRA that it would have commissioned a new facility by July 2021, this is clearly not going to be achieved and the Health Board should advise the

MHRA accordingly.

- The current facility has benefitted from some upgrade work, however there remains a risk with regards to the existing infrastructure.

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

The service operates under a MHRA Special Licence and is expected to adhere to the principles of GMP (good manufacturing practices) as laid out by the MHRA. The required standards cannot be met within the existing footprint and building including the introduction of isolator technology designed for radiopharmaceutical production which cannot be accommodated within the current facility due to the size of such equipment.

During the MHRA inspection on 25 July 2019, the condition of the Radiopharmacy facility was identified as a “Major” non-conformance. The facility had previously been inspected in 2015 with issues raised by the MHRA then. In the 2019 inspection the inspector commented that the design of the facility did not meet current standards and that the Health Board should consider strategic options to upgrade the unit. Furthermore, annual service and revalidation reports from an external contractor (Envair Ltd.) indicate a trend for deterioration in clean room technical performance, with additional air change rate failures in 2016 and 2017.

In response to the concerns raised during the inspections, some refurbishments have been carried out to maintain continuation of the service on an interim basis until a new suitable facility is built.

Previous unit closures and cessation of service to hospitals have occurred resulting in emergency supply arrangements via other Radiopharmacy services (including Swansea, City Hospital Birmingham and University Hospitals Bristol). The local and national contingency capacity for Radiopharmacy is very limited with no guaranteed capacity and at best only emergency supplies being available. These closures were due to:

- Leakage of sewage onto radiopharmaceutical materials stored in the Medical Physics In Vitro Laboratory resulting in a closure of the unit for one week in January 2019;
- Environmental microbiological failure of the unit linked to the poor condition of the facility resulting in closure between 28 August and 21 October 2019;
- Leakage of water into the main production clean room via pipework behind the clean room wall void. This resulted in closure for 2 weeks whilst repair work and revalidation of the unit was carried out. The closure was between 7 May 2020 and 21 May 2020;
- Failure of the air handling unit 2 September 2020 resulting in two days of closure at short notice resulting in no emergency supply arrangements for 3rd September and a limited supply emergency supply from Swansea Radiopharmacy on 4 September.

The most significant failure was a significant routine environmental microbiological failure that occurred in August of 2019. This resulted in the Radiopharmacy Unit closing for 6 weeks whilst refurbishment work was carried out. The changes to the facility were largely cosmetic and due to the age and condition of the facility were not able to improve the issues highlighted via external inspectorate including the filtered air supply to the clean rooms and adjacent support areas. The closure had a significant impact on the supply of Radiopharmaceuticals to the South East of Wales. Support was provided initially via the Health Boards business continuity arrangement with Swansea Bay Radiopharmacy. The increase in required capacity had a significant impact on Swansea’s own capacity resulting in cessation of supply after 3 weeks. Further supply was sought via University Hospital Bristol and City Hospital Birmingham. This provided a much

reduced capacity for delivery of radiopharmaceuticals.

The Cardiff and Vale Radiopharmacy Unit is back providing radiopharmaceuticals but significant challenges exist to ensure effective control of the ageing facility whilst plans for a new unit are in progress. The Health Board indicated an 18 to 22 month timeframe until completion of a new build unit and as agreed with the MHRA inspectorate has given a commitment to complete the new Radiopharmacy facilities by the end of summer 2021. This timeframe must be achieved to maximise the likelihood of effective continuity of supply. The above incident has highlighted the limited contingency capacity available in Wales and beyond and demonstrates the need for the new facility to have sufficient capacity to enable support for the whole of South Wales and beyond. This includes effective contingency and business continuity arrangements with University Hospital Bristol, Swansea Bay and once opened Royal United Bath Radiopharmacy units.

Impact of Service Shutdown

During the shutdown of the Radiopharmacy unit, initially supply was procured from Swansea Bay Radiopharmacy. At first Swansea tried to match demand from Cardiff and Vale customers. This created significant issues with Swansea exceeding their capacity. These issues included significantly delayed delivery affecting patient administration and had significant impact on Swansea's environmental results. This impacted on their ability to effectively deliver to their own patients and Cardiff's. Due to these issues Swansea significantly reduced the quantity of doses supplied to Cardiff and Vale customers and resulted in the Health Board obtaining additional support from the City Hospital of Birmingham and University Hospital Bristol, even then the supply to Cardiff and Vale patients was significantly reduced with largely only emergency and surgery related radiopharmaceutical doses supplied.

The significant impacts of the Health Boards' Radiopharmacy closure included:

- Supply to Cardiff and Vale patients reduced by greater than 60%;
- Closure of blood cell labelling service;
- A significant back log of diagnostic radiopharmaceutical treatments for all customers;
- Later delivery of radiopharmaceuticals, reducing scanning time through a Nuclear Medicine clinic day;
- Short notice patient cancellation or rearrangement of clinic times due to changes in available capacity as individual Radiopharmacies prioritised treatments for their local patients and customers.

A number of lessons were learnt from the closure. These learnings were implemented over a shorter two week closure period in May 2020 when a water leak occurred in the clean room facility. These included:

- Significant reduction in supply capacity to ensure management of supply and individual Radiopharmacies control of their facilities environment;
- Changes in timings of patient doses to later in the day to ensure the correct radioactivity in radiopharmaceutical doses;
- Effective communication between customers and Radiopharmacies with Cardiff and Vale team as point of liaison between all.

Service Scope

The development of the Radiopharmacy service will look to provide the following functional

content:

- Delivery of Diagnostic Radiopharmaceuticals to the South East Wales region;
- Delivery of blood cell labelling services to the South East Wales region;
- Delivery of radioactive therapeutic agents to Velindre and University Hospital Wales as well as options for delivery to other hospitals in South East Wales.;
- Delivery of Investigational Medicinal Products to Velindre and University Hospital Wales as well as options for delivery to other hospitals in South East Wales;
- Provide contingency support for other Radiopharmacy services in Wales and South West England.

There will be a requirement for collection and delivery of radiopharmaceuticals to customers and for out of hours delivery of radiopharmaceuticals including technetium generators which will require secure access and drop off.
No Positron Emission Tomography (PET) or clinical work will be carried out at the site.

A summary of the projected capital costs is shown below:

Capital Costs at PUBSEC 250	**Option 1** Do nothing: addressing backlog maintenance only	**Option 2** Do minimum : convert another area (within Medical Physics footprint)	**Option 4 Preferred** Off site development (SMPU at Fieldway)	**Option 5** Off site development (IP5, Newport)	**Option 6** Off site development (Knox and Wells site adjacent to SMPU at Fieldway)
	£000	**£000**	**£000**	**£000**	**£000**
Works Costs	463	9,273	7,395	5,350	7,228
Fees	317	1,783	1,435	1,266	1,431
Non-Works	104	502	382	375	542
Equipment Costs	0	560	560	560	560
Planning Contingency	146	1,350	970	942	966
Subtotal excluding VAT	**1,030**	**13,470**	**10,742**	**8,493**	**10,727**
VAT @ 20% less reclaimable	182	2,509	2,014	1,588	2,012
Total Capital Cost	**1,212**	**15,979**	**12,756**	**10,081**	**12,739**

The **revenue implications** will be finalised as part of the FBC.

- Funding is anticipated from WG for additional recurrent capital charges and non-recurrent impairment based on actuals;
- It is assumed that there will not be any transition or decant costs.
- All of the additional revenue costs of £0.140m relate to estates and facilities costs, of which £0.093m (66%) relates to business rates. This is consistent with other new builds, where rateable values are much higher than for existing estate.
- No assumptions are made about potential estates savings which may accrue from no longer needing to maintain the ageing existing Radiopharmacy
- This business case and associated additional revenue costs will be considered by the UHB Business Case Approval Group (BCAG). This will consider the increased revenue streams available (e.g. increased supply to Velindre Cancer Centre) to fund the additional

revenue costs.

Key Benefits
A summary of the main benefits is provided below:

- High quality and timely service to patients.
- The provision of therapies to the University Hospital Wales (UHW) and Velindre sites for highly radioactive products with a short shelf life.
- Able to meet growing patient demand for diagnostic radiopharmaceuticals and blood cell labelled products.
- Maintain continuity of services.
- Improvements in health and safety.
- Staff recruitment and retention will improve as investment in new facilities will help attract and retain high quality professional staff.
- High quality products provided to all patients in a timely manner.
- Health Board to put Investigational Medicinal Products (IMPs) back on its license and will be able to prepare research radiopharmaceuticals for use throughout South East Wales.
- Lead new research for therapies and radiopharmaceutical diagnostics.
- Ability to deliver emergency radiopharmaceutical diagnostics.
- Improved clinical morale gained from improved access to modern equipment, technologies and facilities.
- Provide services that the population is entitled to expect and meet a growing demand
- Enable access to research diagnostics
- Improved delivery times.
- Reduced pressures on other facilities and provides appropriate capacity for the population
- Opportunity to meet growing demand for therapies and radiopharmaceuticals by future proofing the new facility.
- Services provided within the revenue affordability envelope

Assurance is provided by:
The UHW Infrastructure and Sustainability Programme Board's governance structure established for the development and reconfiguration of UHW infrastructure.

Recommendation:

The Board is asked to **approve** the submission of Development of Radiopharmacy Services at University Hospital of Wales – Outline Business Case to Welsh Government for capital funding to proceed to develop the FBC.

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. EHIA included as appendix 12 to the OBC

Development of Radiopharmacy Services at University Hospital of Wales

Outline Business Case: Executive Summary

October 2020 –V3

1.0 PREFACE

This business case is being presented in accordance with the outline business case (OBC) / full business case (FBC) requirements stipulated by welsh government (WG). Following WG approval of the OBC, the project will be further developed to a FBC submission.

2.0 EXECUTIVE SUMMARY

This business case seeks the approval for a capital investment of £12.756m to enable the further development of Radiopharmacy Services within the Health Board and permit the continued provision of radiopharmaceutical products from facilities that are both safe and of sufficient size to provide the required capacity for the future.

This development of services is critical as there is currently a significant risk of failure to the existing Radiopharmacy Unit that would have substantial impact. The Radiopharmacy Service was inspected by the Medicines and Healthcare Products Agency (MHRA) on 25th July 2019 and in response to the concerns raised some refurbishments have been carried out to maintain continuation of the service on an interim basis until a new suitable facility is built. The Health Board has therefore agreed with the MHRA and given a commitment to complete the new Radiopharmacy facilities by the end of summer 2021.

2.1 Strategic Context

Cardiff and Vale University Health Board (UHB) is responsible for planning and delivering health services for its local population of around 485,000, which represents 15.5% of the country's residents. This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres, community health teams and mental health services. The Health Board employs approximately 14,500 staff and has an annual budget of £1.4 billion.

Along with serving the Cardiff and Vale population, the Health Board supplies diagnostic radiopharmaceuticals and a radioactive blood cell labelling service to Velindre Cancer Centre, Aneurin Bevan University Health Board and Cwm Taf Morgannwg University Health Board and is the single supplier of radioactive diagnostic products for SIMBEC Medical Research. The diagnostic radiopharmaceutical can be used by any age of patients. The Radiopharmacy Unit also supplies therapeutic radiopharmaceuticals for Cardiff and Vale.

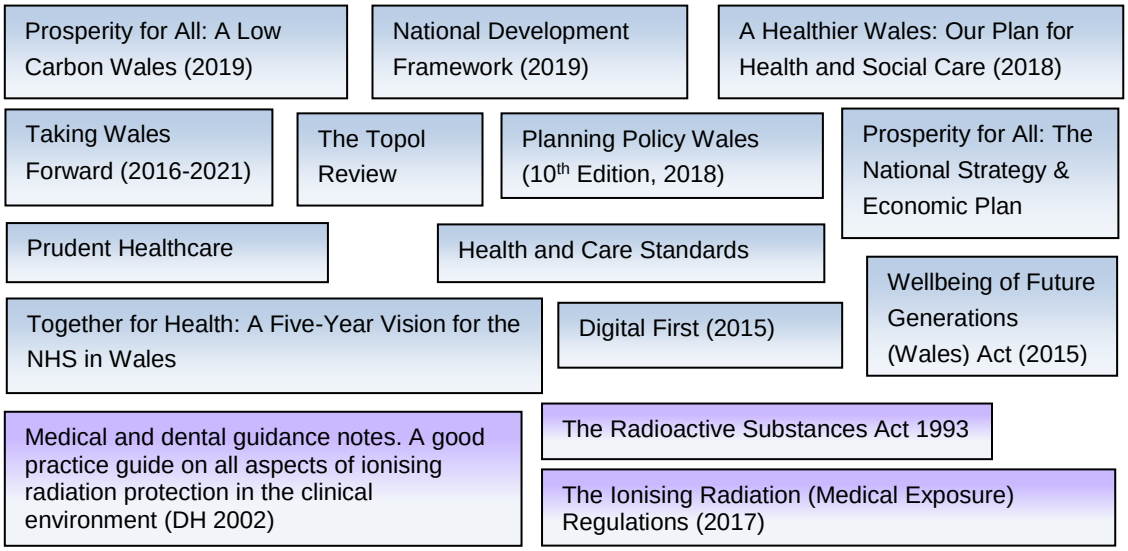
As a teaching Health Board, there are very close links to Cardiff University, which boasts a high-profile teaching, research and development role within the UK and abroad. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Training the next generation of clinical and non-clinical professionals, in order to develop expertise and improve clinical outcomes is a key priority for the Health Board.

The population served by the Health Board is growing rapidly in size, projected to increase by 10% between 2017-27, higher than the average growth across Wales and the rest of the

UK. An extra 36,000 people will live in Cardiff over the next five years who require access to health and wellbeing services.

The Health Board is confident that the strategic drivers for this investment and associated strategies, programmes and plans are consistent with national, regional and local strategy and policy documents. Some of the key Welsh Government policies that have shaped this Outline Business Case (OBC) are:

Executive Summary Figure 1: Key Strategies and Policies



This OBC also takes cognisance of all relevant regional and local strategies, these are:

- Shaping Our Future Wellbeing: In Our Community Strategy 2015 – 2025
- Integrated Medium Term Plan 2019 – 2022
- Partnership Strategies and Priorities
- Cardiff and Vale UHB Estates Strategy
- Cardiff and Vale UHB Delivering Digital
- Cardiff and Vale UHB Informatics Strategy (2017/18 – 2019/20)

2.2 Case for Change

The specific investment objectives for this business case which relate directly to the Radiopharmacy service are:

1. Quality and Safety of Services - Services that deliver quality care and meet agreed clinical, quality and safety standards;
2. Provide a High Quality Environment - To provide facilities that comply with statutory standards and best practice;
3. Access / Capacity - To ensure that the changing needs and expectations of a growing population are met in line with Health Board clinical strategies and national guidance standards;

4. Effective Use of Resources - To maximise the use of available resource and provide an environment that promotes improved service efficiency;
5. Sustainability - To provide a solution that will ensure the reputation of the Health Board and will support the delivery of safe, sustainable and accessible services both in the short and medium term.

2.2.1 Business Need

The service operates under a MHRA Special Licence and is expected to adhere to the principles of GMP (good manufacturing practices) as laid out by the MHRA. In order to comply, the existing facility requires a major update to replace ageing plant. New guidelines also recommend the use of isolators designed for radiopharmaceutical production which cannot be accommodated within the current facility due to the size of such equipment.

During the MHRA inspection on 25th July 2019, the condition of the Radiopharmacy facility was identified as a "Major" non-conformance. The facility had previously been inspected in 2015. The inspector commented that the design of the facility did not meet current standards and that the Health Board should consider strategic options to upgrade the unit. Furthermore, annual service and revalidation reports from an external contractor (Envair Ltd.) indicate a trend for deterioration in clean room technical performance, with additional air change rate failures in 2016 and 2017.

In response to the concerns raised during the inspections, some refurbishments have been carried out to maintain continuation of the service on an interim basis until a new suitable facility is built.

Previous unit closures and cessation of service to hospitals have occurred resulting in emergency supply arrangements via other Radiopharmacy services (including Swansea, City Hospital Birmingham and University Hospitals Bristol). The local and national contingency capacity for Radiopharmacy is very limited with no guaranteed capacity and at best only emergency supplies being available. These closures were due to:

- Leakage of sewage onto radiopharmaceutical materials stored in the Medical Physics In Vitro Laboratory resulting in a closure of the unit for one week in January 2019;
- Environmental microbiological failure of the unit linked to the poor condition of the facility resulting in closure between 28th August and 21st October 2019;
- Leakage of water into the main production clean room via pipework behind the clean room wall void. This resulted in closure for 2 weeks whilst repair work and revalidation of the unit was carried out. The closure was between 7th May 2020 and 21st May 2020;
- Failure of the air handling unit 2nd September 2020 resulting in two days of closure at short notice resulting in no emergency supply arrangements for 3rd September and a limited supply emergency supply from Swansea Radiopharmacy on 4th September.

The most significant failure was a significant routine environmental microbiological failure that occurred in August of 2019. This resulted in the Radiopharmacy Unit closing for 6 weeks

whilst refurbishment work was carried out. The changes to the facility were largely cosmetic and due to the age and condition of the facility were not able to improve the issues highlighted via external inspectorate including the filtered air supply to the clean rooms and adjacent support areas. The closure had a significant impact on the supply of Radiopharmaceuticals to the South East of Wales. Support was provided initially via the Health Boards business continuity arrangement with Swansea Bay Radiopharmacy. The increase in required capacity had a significant impact on Swansea's own capacity resulting in cessation of supply after 3 weeks. Further supply was sought via University Hospital Bristol and City Hospital Birmingham. This provided a much reduced capacity for delivery of radiopharmaceuticals.

The Cardiff and Vale Radiopharmacy Unit is back providing radiopharmaceuticals but significant challenges exist to ensure effective control of the ageing facility whilst plans for a new unit are in progress. The Health Board indicated an 18 to 22 month timeframe until completion of a new build unit and as agreed with the MHRA inspectorate has given a commitment to complete the new Radiopharmacy facilities by the end of summer 2021. This timeframe must be achieved to maximise the likelihood of effective continuity of supply. The above incident has highlighted the limited contingency capacity available in Wales and beyond and demonstrates the need for the new facility to have sufficient capacity to enable support for the whole of South Wales and beyond. This includes effective contingency and business continuity arrangements with University Hospital Bristol, Swansea Bay and once opened Royal United Bath radiopharmacy units.

2.2.1.1 Impact of Service Shutdown

During the shutdown of the Radiopharmacy unit, initially supply was procured from Swansea Bay Radiopharmacy. At first Swansea tried to match demand from Cardiff and Vale customers. This created significant issues with Swansea exceeding their capacity. These issues included significantly delayed delivery affecting patient administration and had significant impact on Swansea's environmental results. This impacted on their ability to effectively deliver to their own patients and Cardiff's. Due to these issues Swansea significantly reduced the quantity of doses supplied to Cardiff and Vale customers and resulted in the Health Board obtaining additional support from the City Hospital of Birmingham and University Hospital Bristol, even then the supply to Cardiff and Vale patients was significantly reduced with largely only emergency and surgery related radiopharmaceutical doses supplied.

The significant impacts of the Health Boards' radiopharmacy closure included:

- Supply to Cardiff and Vale patients reduced by greater than 60%;
- Closure of blood cell labelling service;
- A significant back log of diagnostic radiopharmaceutical treatments for all customers;
- Later delivery of radiopharmaceuticals, reducing scanning time through a Nuclear Medicine clinic day;

- Short notice patient cancellation or rearrangement of clinic times due to changes in available capacity as individual Radiopharmacies prioritised treatments for their local patients and customers.

A number of lessons were learnt from the closure. These learnings were implemented over a shorter two week closure period in May 2020 when a water leak occurred in the clean room facility. These included:

- Significant reduction in supply capacity to ensure management of supply and individual Radiopharmacies control of their facilities environment;
- Changes in timings of patient doses to later in the day to ensure the correct radioactivity in radiopharmaceutical doses;
- Effective communication between customers and radiopharmacies with Cardiff and Vale team as point of liaison between all.

2.2.2 Proposed Scope

In line with Welsh Government guidance, the scope has been assessed against a continuum of need ranging from:

- A minimum – essential or core requirements/outcomes;
- An intermediate – essential and desirable requirements/outcomes;
- A maximum – essential, desirable and optional requirements/outcomes.

This business case sets out the need for the intermediate scope therefore seeing a proposed facility with the capacity to deliver therapeutic services to Velindre and to deliver research investigational medicinal products (IMPs) to South East Wales.

A summary of the main benefits is provided below:

Benefits are expressed by investment objective, recipient and benefit classification:

- CRB – cash releasing benefits (e.g. avoided costs);
- Non CRB – non cash releasing benefits (e.g. staff time saved);
- QB – quantifiable benefits (e.g. achievement of targets);
- Non QB – non-quantifiable or qualitative benefits (e.g. improvement in staff morale).

Investment Objective	Stakeholder Group	Main Benefits
Investment Objective 1: Quality and Safety of Services	Patients	Non QB - High quality and timely service to patients QB - The provision of therapies to the University Hospital Wales (UHW) and Velindre sites for highly radioactive products with a short shelf life QB – Able to meet growing patient demand for diagnostic radiopharmaceuticals and blood cell labelled products
	Staff	Non QB – Maintain continuity of services QB – Improvements in health and safety QB – Staff recruitment and retention will improve as investment in new facilities will help attract and retain high quality professional staff

Investment Objective	Stakeholder Group	Main Benefits
	Health Community	Non QB – High quality products provided to all patients in a timely manner QB – Health Board to put Investigational Medicinal Products (IMPs) back on its license and will be able to prepare research radiopharmaceuticals for use throughout South East Wales QB - Lead new research for therapies and radiopharmaceutical diagnostics Non QB - Ability to deliver emergency radiopharmaceutical diagnostics
Investment Objective 2: Provide a high quality environment	Patients	Non QB – Provide safe and appropriate environments in order to deliver appropriate products
	Staff	Non QB – Provide a safe and appropriate environment for staff and be a better place to work Non QB – Improved clinical morale gained from improved access to modern equipment, technologies and facilities Non QB - Better technology to deliver a more quality assured product as well as safer for operators
	Health Community	QB - Compliance with radiation regulatory requirements i.e. NRW, Ionising Radiation Regulations 2017, (IR(ME)R) 2017, Environmental Permitting (England and Wales) Regulations 2016 and amendments QB – Compliance with statutory standards especially MHRA QB – Compliance with NHS guidance/best practice QB – Improved environments to enable productivity gains
Investment Objective 3: Access/Capacity	Patients	Non QB – Provide services that the population is entitled to expect and meet a growing demand QB – Enable access to research diagnostics QB – Enable local access to radiotherapies QB – Improved delivery times
	Staff	QB – Reduction in staffing working late to meet demand Non QB – Staff able to work in a pleasant fit for purpose building and clean room facility
	Health Community	QB – Reduced pressures on other facilities and provides appropriate capacity for the population QB - Sufficient capacity and facility to support contingency for SE Wales and all of S Wales QB - Sufficient capacity and facility to support contingency beyond S Wales QB - Opportunity to meet growing demand for therapies and radiopharmaceuticals by future proofing the new facility
Investment Objective 4: Effective use of Resources	Patients	QB – Improved delivery times
	Staff	Non CRB – Maximises use of staff Non CRB - Close proximity to Quality and Technical Pharmacy staff essential to maintain regulatory support and release of IMPs

Investment Objective	Stakeholder Group	Main Benefits
	Health Community	Non QB - Maximise use of existing Health Board accommodation to improve utilisation
Investment Objective 5: Sustainability	Patients	Non QB – Services continue to be provided to meet demand
	Staff	QB - Reduction in vacancy and turnover rates QB - Reduction in staff sickness rates QB - Improved job satisfaction
	Health Community	Non QB - Maximise flexibility of facilities QB – Services provided within the revenue affordability envelope

Executive Summary Table 1: Main Benefits

2.3 Available Options

In consultation with the Clinical Board including clinical and managerial staff, along with staff from capital and estates, and strategic and service planning the following list of options were identified and assessed:

- Option 1: Do nothing - This option would maintain existing services but would address current backlog maintenance.
- Option 2: Do minimum - Convert another area (within Medical Physics footprint). This option includes the refurbishment and remodelling of an existing area within the current Medical Physics area. There would also be a requirement to relocate Medical Physics on the site via part refurbishment and part new modular build.
- Option 3: New build on site - This option would be a new build radiopharmacy unit located on the UHW site.
- Option 4: Off site development - This option includes a new build adjacent to the existing St Mary's Pharmaceutical Unit (SMPU) building.
- Option 5: Refurbishment off site - This option would be a refurbished/remodelled unit located on the Imperial Park (IP5) site in Newport.
- Option 6: Off site development - This option includes a new build development on immediately adjacent land to the SMPU in Fieldway owned by Knox and Wells Ltd.

The options to be further appraised were:

- Option 1: Do nothing
  - This option includes maintaining the current department and addressing current backlog maintenance.
- Option 2: Do minimum - convert another area (within Medical Physics footprint)
  - This option includes the refurbishment and remodelling of an existing area within the current Medical Physics area. There would also be a requirement to relocate Medical Physics on the site via part refurbishment and part new modular build.
- Option 4: Off site development
  - This option includes a new build adjacent to the existing SMPU building.
- Option 5: Refurbishment off site

- This option would be a refurbished/remodelled unit located on IP5 site in Newport.

- Option 6: New build off site adjacent to SMPU site
  - This option would be a new build radiopharmacy unit located on land owned by Knox and Wells immediately adjacent to the SMPU facility in Fieldway.

Option 3 has not been carried forward for further appraisal due to there being no suitable location on the UHW site for such a development.

During an option appraisal workshop each option was scored against the benefit criteria. The results of this exercise were as follows:

Benefit Criteria	Weighted Scores				
	Option 1	Option 2	Option 4	Option 5	Option 6
1. Enables the Health Board to deliver high quality services that meet MHRA requirements and best practice.	20	100	200	200	200
2. Provides appropriate departmental adjacencies and minimises journey times both within the department and to end users.	72	72	72	36	72
3. Provide safe and appropriate environment for radiopharmacy services	54	90	162	162	162
4. The facilities meet the relevant MHRA standards and guidelines within the required timescales.	0	126	162	162	126
5. Provides sufficient capacity to meet the demands of the current patient population over the next 10 years including those other health organisations currently supplied by the Health Board and the additional demands from Velindre Cancer Centre.	0	84	120	120	120
6. Enables the Health Board to improve productivity and provide a service that supports patients.	0	49	63	49	63
7. Maximise use of existing accommodation to enable estate rationalisation and improved utilisation.	60	54	54	36	36
8. Maximise flexibility of facilities to enable the delivery of safe, sustainable and accessible services in the short to medium term.	0	50	80	60	70
TOTALS	**206**	**625**	**913**	**825**	**849**
RANK (weighted)	**5**	**4**	**1**	**3**	**2**

Executive Summary Table 2: Analysis of Key Results

Sensitivity analysis was undertaken by changing the ranking of the benefit criteria to evaluate the impact on the overall score for each option. The analysis included applying reverse, high, low and no weightings to the criteria.

The results indicated that even if the weighting of the benefit criteria were to be changed there is still no overall resultant impact on the outcome of the preferred option and therefore option 4 would remain the non-financial preferred option.

2.3.1 Economic Appraisal Key Findings

A summary of the economic appraisal are summarised in the table below:

Economic Cost	Option 1 £000	Option 2 £000	Option 4 £000	Option 5 £000	Option 6 £000
Net Present Value (NPV)	43,917	59,088	56,665	55,750	56,659
Equivalent Annual Cost (EAC)	1,656.1	2,228.3	2,136.9	2,102.4	2,136.6
Ranking of Options	**1**	**5**	**4**	**2**	**3**
Ranking of Development Options		**4**	**3**	**1**	**2**
EAC Margin Development Options		125.9	34.5	0.0	34.3
EAC Margin %		5.6%	1.6%	0.0%	1.6%

Executive Summary Table 3: Summary of Economic Appraisal Outputs

On the basis of the economic appraisal undertaken, in terms of the development options:

- Over the 60-year appraisal period, the economic cost of each of the development options is broadly similar, with Option 2 being the least preferred by a margin of 5.6%;
- Option 5 is preferred over Options 4 and 6, by a margin of 1.6%, reflecting the net benefit of:
- A lower level of capital cost;
- Allowance of £73,000 annual rental costs in respect of the IP5 building in Newport, owned by Welsh Government.

Sensitivity Testing indicates that in order to trigger economic switch values in favour of Options 4 or 6, differential changes in the key cost drivers would need to be:

- Capital cost reductions of circa £950k (9%) under Options 4 or 6, or an increase under Option 5 of £940k (11%); or
- Revenue cost changes of £35k (2% of total revenue or 20% of estates and facilities costs) – reductions under Options 4 and 6 or an increase under Option 5;
- Differential changes of this magnitude are considered to be unlikely.

Option 5 is therefore confirmed as the preferred option from a quantitative appraisal perspective.

2.3.2 Combined Appraisal

The outputs of the Non-Financial and Economic Appraisals have been combined to assess which option offers the best benefit/cost outcome based on the number of benefit points delivered per EAC £000.

Combined Appraisal	Option 1	Option 2	Option 4	Option 5	Option 6
Weighted Non-Financial Scores	206	625	913	825	849
EAC Impact of options (£000s)	1,576.0	2,228.3	2,136.9	2,102.4	2,136.6
Benefit Points per EAC £000	**0.131**	**0.280**	**0.427**	**0.392**	**0.397**
Ranking of Development Options	**5**	**4**	**1**	**3**	**2**
Margin %	-69.4%	-34.4%	0.0%	-8.2%	-7.0%

Executive Summary Table 4: Summary of Combined Appraisal Outputs

The output of this option appraisal therefore shows that:

- Option 4 delivers 0.427 benefit points per EAC £000 and is comfortably preferred over Options 6 and 5, by margins of 7% and 8.2% respectively, with Options 1 and 2 being least preferred by a significant margin;
- Sensitivity testing indicates that the Non-Financial scores of Options 6 and 5 would have to increase by 7.8% and 9.2% (or the Option 4 score to reduce by 7.2% or 8.4%) respectively, in order for Option 4 not be preferred.

Option 4 is therefore confirmed as the preferred option.

2.4 Preferred Option

The preferred way forward has been identified as option 4: A new Radiopharmacy cleanroom facility to be located within a new building adjacent to the St Mary's Pharmaceutical Unit, 20 Field Way, off Maes y Coed Road, Cardiff.

The preferred option will provide the following functionality:

- Delivery of Diagnostic Radiopharmaceuticals to the South East Wales region and beyond;
- Delivery of blood cell labelling services to the South East Wales region and beyond;
- Delivery of radioactive therapeutic agents to Velindre Cancer Centre and University Hospital Wales as well as options for delivery to other hospitals in South East Wales;
- Delivery of Investigational Medicinal Products to Velindre and University Hospital Wales as well as options for delivery to other hospitals in South East Wales and beyond;
- Provide contingency support for other Radiopharmacy services in Wales and South West England.

2.5 Procurement Route

The preferred procurement route therefore for this scheme is to use the NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) established NHS 'Building for Wales' Framework.

This procurement route offered the Health Board the benefit of suitably experienced Supply Chain Partner teams who are skilled in the delivery of complex health care buildings in accordance with relevant WHBN / WHTM guidelines and statutory legislation whilst taking account of cost, time and quality.

Other than the main works construction contract and associated works and related design team contracts, no other external contracts are being considered within the OBC submission.

It is anticipated that the main building contract will run for approximately 66 weeks although the start date for this is dependent on the approvals process and securing support for the investments.

2.6 Funding and Affordability

This section of the business case considers the financial implications of the preferred option on the financial position of the Health Board.

2.6.1 Capital Costs

A summary of the capital costs and impairment for the preferred option is as follows:

	£000
Works costs	7,395
Fees	1,435
Non-works costs	382
Equipment	560
Contractor Quantified Risk provision	645
UHB Quantified Risk provision	325
Total Net	**10,742**
Gross VAT	2,014
Total Gross	**12,756**

Executive Summary Table 5: Capital Costs for the Preferred Option

Year	DEL Impairment £m	AME Impairment £m	TOTAL £m
2020/21	0	0	0
2021/22	0	0	0
2022/23	1.37	7.184	8.554
2023/24	0	0	0

Executive Summary Table 6: Impairment for the Preferred Option

The OBC assumes all capital charges and depreciation will be funded by Welsh Government.

2.6.2 Revenue Costs

The table below shows the total revenue costs including showing the difference from the current revenue costs (excluding capital charges, depreciation and impairment):

		Cost £'000
Radiopharmacy	Direct Pay Costs	479
	Generators and other consumables	802
	Other non-pay	143
	Transportation costs above baseline	
	Income	(1,181)
Capital, Estates and Facilities	Rental	0
	Business rates	98
	Energy	31
	Estates maintenance	29
	Domestic services	10
	Security	3
	Waste	4
Total		**418**
Variance to current costs		**140**

Executive Summary Table 7: Revenue Costs

2.6.3 Assumptions That Underpin Affordability

- Funding is anticipated from WG for additional recurrent capital charges and non-recurrent impairment based on actuals;
- It is assumed that there will not be any transition or decant costs;
- All of the additional revenue costs of £0.140m relate to estates and facilities costs, of which £0.093m (66%) relates to business rates. This is consistent with other new builds, where rateable values are much higher than for existing estate;
- No assumptions are made about potential estates savings which may accrue from no longer needing to maintain the ageing existing radiopharmacy;
- This business case and associated additional revenue costs will be considered by the UHB Business Case Approval Group (BCAG). This will determine how the additional revenue costs will be funded.

2.6.4 Overall Affordability

As highlighted above, it is assumed the impairment and recurrent charges for depreciation will be funded by WG. The net additional revenue costs and funding are summarised in the table below:

	£m
Impairment WG impairment funding	 8.554
Depreciation WG Strategic Capital charge funding	 0.074
Other Additional Revenue Costs	0.14

Executive Summary Table 8: Overall Affordability

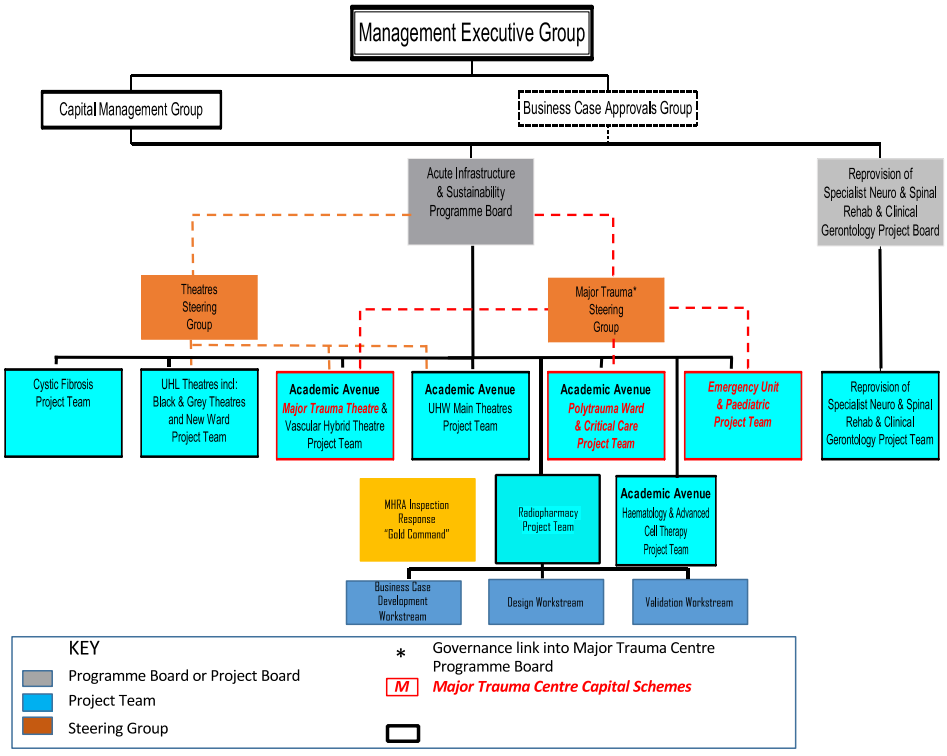
2.6.5 Project Bank Account

The Health Board can confirm that a Project Bank Account will be prepared at the appropriate stage as the project exceeds the Welsh Government value threshold for the mandatory use of Project Bank Accounts.

2.7 Management Arrangements

Robust project management arrangements are vital to ensure the implementation of the overall project and that effective control is maintained over the capital scheme.

The reporting organisation and the reporting structure for the whole of the project is shown as follows:



Executive Summary Figure 2: Project Reporting Structure

The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
OBC submission to WG	February 2021
Design completion and commence construction (mobilisation)	April 2021
Access date (proposed)	May 2021
Construction completion	August 2022
Facility operational	November 2022

Executive Summary Table 9: Project Plan

Report Title:	**Proposed Changes to Governance Arrangements**								
Meeting:	Board						**Meeting Date:**	26.11.20	
Status:	**For Discussion**	**x**	**For Assurance**	**X**	**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

There has been a need to review our Governance arrangements in light of the learning from the first wave of Covid 19 and also as numbers are now increasing and progressing to a second wave. We have also now received the final reports and recommendations of all three audits on Governance which were undertaken as follows:

- Due Dilligence Review of the Principality Stadium – KPMG
- Structured Assessment – Audit Wales
- Governance Review – Internal Audit

A further Governance Review has also been undertaken, by Welsh Government on the Lakeside Wing and this review commenced on the 2nd November. Recommendations made from this review will also be considered when the report is finalized.

The KPMG Review was presented to the Private session of the Audit Committee on 17th November (along with responses to recommendations and observations) and the Wales Audit Structured Assessment and the Internal Audit Review of Governance was presented in Public Session on 17th November.

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

The Proposed Amendments to Governance Arrangements (Appendix 1) include the development of a New Covid 19 Report (Appendix 2), changes to the Terms of Reference (Appendix 3) of the Covid 19 Board Governance Group and a further updated Governance Structure (Appendix 4). These arrangements not only reflect the recommendations made by Audit Wales but will also ensure robust and improved governance arrangements are in place during the second wave of the pandemic.

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

Implementation of these revised governance arrangements will further stregthen what was previously in place and will ensure a more transparent approach with the involvement of the whole cadre of Independent Members.

In addition to the above and in order to apply additional Board member scrutiny and to assist with their individual development, all Independent Members should attend the Board Governance Group as often as possible. This will provide additional assurance to the full Board

and minimise any possible criticism when the minutes are presented in public.

It will however be important to ensure that there is no duplication in these reporting arrangements at the various Committtees and the Board Governance Group.

Recommendation:

It is recommended that the Board:

(a) Approve the proposed amendments to governance arrangements (Appendix 1);
(b) Approve the changes to the Board Governance Group Terms of Reference (Appendix 2) which extends the Membership to include all Independent Members;
(c) Approve the Covid 19 Report Template (Appendix 3) covering the key areas of Quality and Safety, Workforce, Governance, Operational Framework, Governance and Public Health;
(d) Approve that the first 90 minutes of future Board Development sessions are in public demonstrating that the Board is meeting in public every month;
(e) Approve the revised Governance Structure ensuring appropriate reporting to the Committees of the Board during the second wave (Appendix 4).

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	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		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.*

Proposed Amendments to Governance Arrangements October 2020

In light of the surge of Covid infection rates across Cardiff & Vale region, we will need to further consider, once again, reviewing and strengthening our governance arrangements to ensure that appropriate assurance is being provided on the work of the Board in the Covid and non-Covid arenas.

I am mindful of the contents of the recent draft Structured Assessment report provided by Audit Wales where several helpful suggestions have been put forward that will allow us to provide additional scrutiny opportunities to take place in the public domain. The following will apply with effect from 1st December 2020.

Board/Committee	**Additional Pandemic Requirements**
Board meetings held in public	New Covid report (Appendix 2) covering the impact of Covid on key areas including: • Quality of service and Patient safety (Lead Exec of QPS Committee) • Workforce including staff wellbeing and safety (Lead Exec of S&D Committee) • Governance arrangements (Director of Corporate Governance) • Operational framework and update (CEO and COO) • Public health update (Exec Director of Public Health) Where any of these key areas form part of a separate report on the same agenda and they pick up Covid specific impact, there will be no need to duplicate in this report. A simple cross reference will be sufficient. No other amendments proposed at this time
Board Development meetings	The first 90 minutes of this meeting will be held in public. Agenda items for the public part of the meeting will be primarily directed towards Covid related updates, issues, concerns and probably incorporate the new style report as outlined above to make it effectively a monthly update.
Covid Board Governance Group	Core membership to be expanded to include CEO, Vice Chair, Chair of Audit Committee, IM Finance (if not Audit Committee Chair), IM Legal, IM Capital and Estates, Director of Corporate Governance and UHB Chair. Additional executives will be invited by the CEO when appropriate. The core membership is geared towards delivery against the main focus of the Covid Board Governance Group which is to provide speedy turnaround of Chairs Actions when required. An open and standing invitation to be extended to all Independent Board members to attend this meeting if they are available and wish to do so. Terms of Reference to be amended and scrutinised by the Audit Committee prior to Board approval.
Audit Committee	Additional paper to be considered at each committee to outline the impact of Covid on governance arrangements, assurance framework, and committee frameworks and assure the Board on public scrutiny levels across the UHB. Also review of WG Guidelines and compliance against them.

Quality, Safety and Experience Committee	Additional paper to be considered at each committee to outline the impact of Covid on patient safety identifying any key areas of concern e.g. IP&C, PPE, clinical staffing levels etc.
Strategy & Delivery	Workforce paper to specifically cover impact of Covid on capacity, staff numbers, well-being and safety
IMs	Series of 121s planned for this month followed by team meeting afterwards to discuss how IMs are “maximised”

COVID 19 – Update Report covering key activities in relation to • Quality and Safety • Workforce • Governance • Operations • Public Health	Month: November 2020
Quality and Safety	Executive Nurse Director/Executive Medical Director
Workforce	Deputy CEO and Executive Director of Workforce and OD

Governance	Director of Corporate Governance
Operations including Operational Framework	Chief Operating Officer
Public Health	Executive Director of Public

	Health

COVID 19 Board Governance Group – Terms of Reference

1. Introduction

This Group has been set up to enable the Board to approve decisions between Board Meetings specifically decisions arising as a result of and relating to COVID 19.

2. Constitution and Purpose

Within current Standing Orders the Chair may take decisions or action on urgent matters which would normally be made at a Board Meeting. This meeting has been developed as a Chair's action group which has the same authority as the Chair has when signing off Chairs actions. The only difference is the way the Chairs actions are being executed in that those involved are meeting virtually.

The Chair and the Chief Executive supported by the Director of Corporate Governance as appropriate may deal with an action or decision on behalf of the Board after consulting with two Independent Members. Such decision should be formally recorded and reported to the next meeting of the Board for consideration and ratification. To ensure that all Independent Member are aware of all decisions being made which require Chair's action the membership of the group includes all Independent Members.

3. Delegated Powers

The Board Governance Group can make decisions on behalf of the Board in line with normal process set out for Chair's action within Standing Orders.

Attached at the appendix are decisions which will be presented to the Group from the COVID 19 Strategic Group.

The Group also has authority to make decisions on other urgent matters which would normally go to the Board if that matter cannot wait until the next Board Meeting.

4. Membership

Members

Chair of the Board
Vice Chair (Chair of Strategy and Delivery Committee)
~~Chair of Audit Committee~~
Independent Member – Finance (Chair of Audit Committee)
Independent Member- Estates (Chair of Finance Committee)
Independent Member – Local Authority (Chair of Quality, Safety and Experience Committee)
Independent Member – ICT (Chair of Digital Health Intelligence Committee)
Independent Member – Trade Union

Independent Member – Third Sector (Interim Chair of Mental Health and Capacity Legislation Committee)
Independent Member – Communities (Chair of Health and Safety and Chair of Charitable Funds Committee)
Independent Member – Universities
Independent Member - Legal

Chief Executive

In attendance

Director of Corporate Governance
Other Executive Directors who the Chief Executive decides should attend to present on specific issues or at the request of Independent Members

Member Appointments

The membership of this Group shall be determined by the Chair of the Board.

Secretariat

The Secretary to the Group will be determined by the Director of Corporate Governance.

Support to Group Members

The Director of Corporate Governance, on behalf of the Group Chair, shall:

- Arrange the provision of advice and support to Group Members on any aspect related to the conduct of their role

5. Group Meetings

Quorum

At least three Independent Members plus the Chief Executive Officer or his Deputy must be present to ensure the quorum of the Committee. The Independent Members should include ~~either~~ the Chair~~, or~~ the Vice ~~Chair~~ Chair, the Chair of Audit Committee, Chair of the Finance Committee or Independent Member Legal of the Board.

Frequency of Meetings

Meetings shall be held on a weekly basis. This will be reviewed on a regular basis.

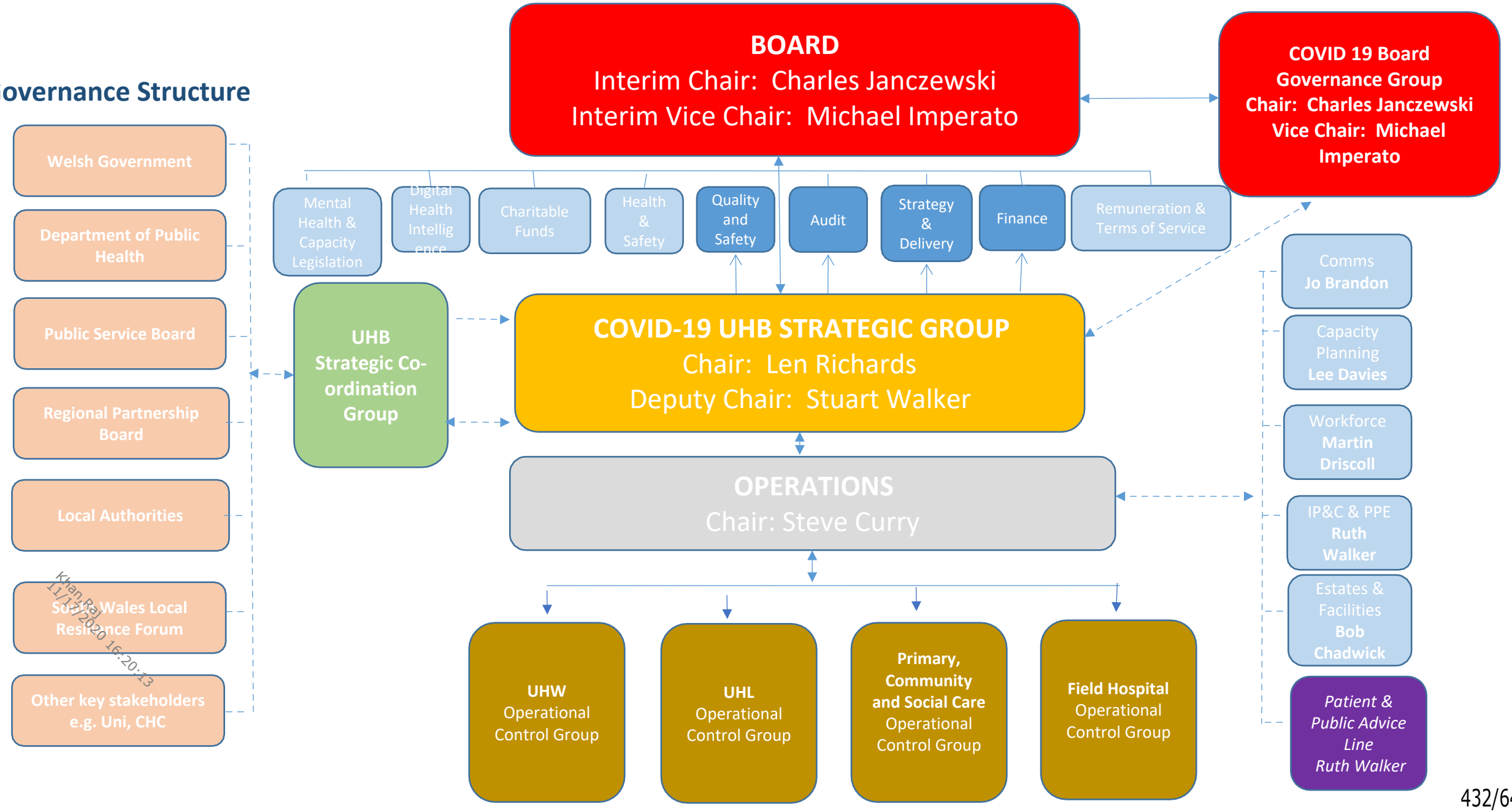
6. Reporting and Assurance Arrangements

The Group Chair shall:

- Report to each Board meeting on the Groups decisions and other activities via the Chair's report
- Ensure the minutes of each meeting of the Group are presented to the Board meeting and circulated to Independent Members as soon as possible after each meeting.
- Ensure appropriate escalation arrangements are in place to alert the Board and Welsh Government of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

UHB GOVERNANCE AND DELIVERY ARRANGEMENTS FOR THE MANAGEMENT OF COVID – 19

Governance Structure



Confirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 8th September 2020 09:00am – 11:00am
Via Skype

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
In Attendance:		
Bob Chadwick	BC	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Craig Greenstock	CG	Counter Fraud Manager
Darren Griffith	DG	Audit Wales
Mark Jones	MJ	Audit Wales
Chris Lewis	CL	Deputy Finance Director
Mike Usher	MU	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Dawn Ward	DW	Independent Member – Trade Union
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Len Richards	LR	Chief Executive Officer
Martin Driscoll	MD	Executive Director of Workforce & OD / Deputy Chief Executive Officer

AAC 20/09/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting. CC also welcomed Darren Griffiths, Audit Wales who had taken over from Anne Beegan.	**ACTION**
AAC 20/09/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/09/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/09/004 Khan,Raj 11/17/2020 16:20:13	**Minutes of the Committee meeting held on 7th July 2020** **Resolved that:** (a) The Committee approved the minutes of the meeting held on 7th July 2020 as a true and accurate record.	
AAC 20/09/005	**Action Log following the Meeting held on 7th July 2020**	

	The Committee reviewed the action log and the following updates were provided: **AAC 19/12/015** – It was agreed that the Internal Audit tracking report would be brought back to the Committee in November; the Director of Corporate Governance (DCG) commented that Internal Audit were validating to check if work had been completed. **AAC 20/04/010** – The Head of Risk and Regulation had met with the Director of Digital Health Intelligence and responses would be provided for a future meeting. **AAC 20/04/015** – set up a dedicated landing page for Covid learning and link to be provided for members to have view of this. **AAC 20/05/007** – Query raised by Independent Member – ICT in previous meeting, happy with comment provided by the Deputy Director of Finance. **Resolved that:** (a) The Committee reviewed and noted the action log and the updates provided.	
AAC 20/09/006	**Any Other Urgent Business** There were no items raised.	
AAC 20/09/007	**Internal Audit Progress and Tracking Reports** The Head of Internal Audit (HIA) introduced the report and stated that its main focus was to update Committee in relation to delivery of the Internal Audit Plan for 2020-2021. The HIA highlighted that 5 reports due for the September Committee had been delayed. The first two of these reports were in draft and the final three work in progress due to due to availability of UHB staff and supply of information in addition to Covid-19 related delays. The HIA then highlighted reports relating to the 2019-20 plan that had been finalised and would be presented in today's meeting as a final report in relation to strategic planning and IMTP. The report on pre-employment checks had been delayed due to staff changes so was still in the process of being finalised therefore this final report would be brought to the next meeting. HIA then reported delays in relation to the Internal Audit Plan 2020-21 and advised that these reports would be brought to the November/February meetings with the caveat that another Covid spike could potentially cause further delays. The HIA confirmed that they were working with the Director of Audit Assurance (DAA) to explore what items could potentially be removed from the audit plan whilst still allow an overall audit opinion to be provided for the UHB for the year. It was	**IV**

	confirmed that the DAA had held conversations with the Board Secretaries Group to remove from their opinions some of the normal domains they would include, to instead provide one formal opinion across the 8 domains (All Wales approach). CC queried whether we were in the same place as other UHBs in terms of delays. HIA confirmed that other Heads of Internal Audit had voiced similar positions. HIA revealed that the Covid governance audit had taken up time and impacted on delivery of other work however it had given a better view of governance arrangements and controls over the past few months which could provide an overarching piece of work to form an opinion on. DCG welcomed what HIA mentioned in terms of looking at a plan but commented that it needed to be recognised that 6 months had been lost due to Covid and an increased amount of staff leave had hindered matters, also in respect of work that should have been completed, a plan would need to be formulated to ensure appropriate audits were completed to give that overall HIA opinion. **Resolved that:** (a) The Committee considered the Internal Audit Progress Report; (b) The Committee approved the amendments to the timing of specific audits within the Internal Audit Plan for 2020-21.	
AAC 20/09/008	**Audit Wales Update** Darren Griffith (AW) firstly updated the Committee with regards to the work undertaken for the structured assessment for 2020. He explained how their approach had been adapted this year to consider governance arrangements, managing financial resources, and operational planning in the context of Covid-19. As mentioned in previous meetings, AW had been working closely with Internal Audit to coordinate work as much as possible to minimise the burden placed on the UHB and provide added value from sharing work. This had resulted in a draft report being prepared and issued for consideration and a feedback meeting would be held at the end of the month. AW then referred to TTP, which was a national high level piece of work which would look at the whole systems governance arrangements as well as the local Covid-19 response plans. Field work was currently underway and the Executive Director Public Health would also be interviewed as part of the process, being the regional lead for C&V. AW aimed to publish the report and its findings by October. AW would also be publishing an All Wales summary around clinical coding which would be brought to the next meeting. They were also aiming to publish their national follow up study on elective waiting times as well as a draft report on orthopaedic services.	**AW**

	AW then discussed their work in relation to Covid-19 learning and good practice exchange. A learning project had been established to share learning during the pandemic and public bodies were encouraged to share information and new ways of working via a dedicated landing page on their website in various output forms such as blogs, articles, etc. **Resolved that:** (a) The Committee noted the Audit Wales Update.	**AW**
AAC 20/09/009	**The 2019-20 Audit of Accounts Addendum Report** AW explained how this report is the final output that comes to Committee each year at the end of September in regards to the audit of the annual accounts. The report was shorter this year which reflected well on overall quality plans and underlying processes. This year only 3 areas were reported compared to 10 last year, indicating a positive outcome where recommendations were taken on board and implemented. The following areas were reported: Area 1 – Level of manual adjustment that sits outside financial ledger This was reported on 2 years ago where the recommendations were partially accepted at the time. The report was similar to how it was two years ago with minor changes. Area 2 – Information which sits outside of the Ledger AW described how some information rightly sat outside the ledger however a lot of the information was complex and inefficient to prepare and audit. The recommendation was just for the Health Board to simplify this information. Area 3 – Premature Party Returns AW advised that last year's recommendations had all been implemented by management as intended which showed a positive outcome and reflected well on the UHB. CC was pleased to see all of last year's recommendations agreed and implemented and with reduced recommendations this year and thanked all for the work done. **Resolved that:** (a) The Committee noted the Audit Wales 2019-20 Audit of Accounts Addendum Report.	
AAC 20/09/010	**Effectiveness of Counter-Fraud Arrangements Report** AW provided their review together with management response. The national report made 15 recommendations and built on the report from last year which provided a landscape description of arrangements in	

	place to tackle fraud across the Welsh public sector, and highlighted variability in arrangements and found NHS Wales ranked the highest above other public bodies with local and national counter fraud arrangements. This year's National report was a more in depth review of how effective these arrangements were in practice (across all Welsh Public Bodies). AW advised that Public Bodies in general could do more in the following areas: 1. Strengthening strategic leadership, coordination and oversight for counter-fraud across the Welsh public sector; 2. Increasing counter-fraud capacity and capabilities, especially across local government, and exploring the potential for sharing resources and expertise across public bodies; 3. Getting the right balance between proactive and reactive counter-fraud activities; 4. Improving awareness-raising and staff training in counter-fraud; and 5. Better evaluation of fraud risks and sharing of fraud information, both within and across sectors. AW referred specifically to the last recommendation, aimed at all committees recognising this very wide variation of existing practice across the public sector, albeit NHS Wales is in a better place than others. AW then discussed the local report which identified that the UHB had suitable arrangements to support the prevention and detection of fraud and was able to respond appropriately where fraud occurs. Some areas for improvement were identified which should be considered alongside the themes identified in the national report. The Committee were happy with the current findings, CC noted that this was to be kept under review and should any items of concern arise in regards to mandatory training or resources then it could be escalated. **Resolved that:** (a) The Committee noted the Audit Wales 2019-20 Effectiveness of Counter-Fraud Arrangements Report.	
AAC 20/09/011 Khan Raj 11/17/2020 16:20:13	**Declarations of Interest and Gifts and Hospitality Tracking Report including Declarations of Interest and sign off in relation to Ysbyty Calon Y Ddraig** The DCG introduced the report and advised Committee that the current number of declarations were very low compared to the last report where good numbers of DOI had been sent in throughout the year and progress made on previous years. The reason for the lower numbers were due to the fact that the end of year chasers had not been sent due to Covid-19, this was usually done at the end of April but had been deferred to October so by then the numbers should start to increase again through the reporting cycle.	

	Going forward, a communications plan would be put in place around DOIs. Communications would be issued around Christmas and key events to remind people to declare The DCG assured the Committee in terms of all the gifts and hospitality received through Covid-19, these had been reported to the Charitable Funds Committee. CC was pleased with the update. **Resolved that:** a) The Committee noted the ongoing work being undertaken within Standards of Behaviour. b) The Committee noted the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.	
AAC 20/09/012	**Regulatory Compliance Tracking Report including Ysbyty Calon Y Ddraig** DCG advised that regulatory compliance tracking was paused during Covid and that this current report was now an up to date position of inspections that had taken place since the beginning of the year. The DCG added that this report was new to the Committee and was continually developing, there was now a dedicated Risk and Regulation team to focus on all trackers and standards of behaviour and therefore better progress was expected from October. CC queried regulatory inspection number8, where there was a recommendation around fire doors. He queried whether the role of the Audit Committee was to check that works had been carried out satisfactorily. The DCG clarified that the role of audit was to reassess works carried out, if works were not carried out then the DCG would flag these occurrences. Independent Member - TU flagged that the Teddy Bear nursery did not have a rating and number 10 in the report did not specify a location, the DCG will amend accordingly. **Resolved that:** a) The Committee noted the inspections which had taken place since the last meeting of the Audit Committee in September 2020 and their respective outcomes. b) The Committee noted the continuing development of the Legislative and Regulatory Compliance Tracker.	**NF**
AAC 20/09/013	**Internal Audit Tracking Report**	

	The DCG introduced the Internal Audit Tracker and stated how her team had started to again chase and progress these. The summary tables provided with the report showed progress being made, the recommendations from 2017/18 had reduced significantly, 2018/19 were also reducing and 2019/20 had remained stable. Due to the fact that all the internal audits for the end of the year had been added on, it might seem like nothing had progressed but the DCG assured the Committee that progress was still being made. DCG mentioned that the figures for 2020/21 would soon be received and reported on, Internal Audit would also check on completed items to confirm that they had been completed in full providing further assurance to the Committee. The CC highlighted that the trackers showed we were keeping a note of the recommendations, that they were also being internally audited and that excellent progress was being made. **Resolved that:** (a) The Committee noted the tracking report now in place for tracking audit recommendations made by Internal Audit. (b) The Committee noted that progress would be seen over coming months in the number of recommendations completed/closed.	
AAC 20/09/014	**Audit Wales Tracking Report** The DCG confirmed that the report showed where we were with Audit Wales recommendations and that the ones from today would also be added to the tracker. The overall percentages provided showed progress made since previous meetings, this would continue to be monitored to ensure that areas were doing what they had committed to when signing up to the recommendations. The Independent Member - TU commented that the internal audit tracker used actual numbers but percentages in the external audits tracker and queried the reason why. The DCG responded that there was no specific reason other than there being more recommendations internally and therefore easier to use numbers but would provide numbers in both for consistency going forward. **Resolved that:** (a) The Committee noted the progress made in relation to the completion of AW recommendations. (b) The Committee noted the continuing development of the AW Recommendation Tracker.	**NF**
AAC 20/09/015 Khan,Raj 11/17/2020 16:20:13	**Items for Information and Noting - Internal Audit reports for information** The Committee received the following 2 reports: • Strategic Planning / IMTP – Reasonable assurance • Annual Quality Statement – Substantial assurance	

	Resolved that: (a) The Committee noted the Internal Audit reports.	
AAC 20/09/016	**Items to bring to the attention of the Board / Committees** There were no items to be brought to the attention of the Board / Committees.	
AAC 20/09/017	**Review of the Meeting** The CC thanked everyone for their attendance and contribution to the meeting.	
AAC 20/09/018	**Date and Time of Next Meeting** To note the date, time and venue of the next Committee meeting: **Tuesday 17th November 2020 at 9.00am, Via Skype**	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE
HELD ON 26th AUGUST 2020
CEFN MABLY MEETING ROOM/SKYPE , WOODLAND HOUSE

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
Charles Janczewski	CJ	Board Chair
John Union	JU	Independent Member - Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Andrew Gough	AG	Assistant Director of Finance
Len Richards	LR	Chief Executive
Robert Chadwick	RC	Executive Director of Finance
Ruth Walker	RW	Executive Nurse Director
Steve Curry	SC	Chief Operating Officer

In Attendance:

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Chris Lewis	CL	Deputy Director of Finance
Martin Driscoll	MD	Executive Director of Workforce and Organisational Development
Nicola Foreman	NF	Director of Corporate Governance

FC 20/071	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 20/072	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 20/073	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 20/074	**MINUTES OF THE COMMITTEE MEETING HELD ON 29th JULY 2020**	

	The minutes of the meeting held on 29th July 2020 were reviewed for accuracy and were agreed as a true and accurate record. **Resolved – that:** The minutes of the meeting held on 29th July 2020 were approved by the Committee as an accurate record.	
FC 20/075	**ACTION LOG FOLLOWING THE LAST MEETING** **The Finance Committee was advised that there were no outstanding Actions.** **Resolved – that**: The Finance Committee **noted** that there were no outstanding Actions.	
FC 20/076	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 20/077	**FINANCIAL PERFORMANCE MONTH 4** The Assistant Director of Finance informed the Committee that at month 4, the UHB had reported an overspend of £52.656m against the 2020/21 plan. The reported position was primarily a result of net expenditure of £63.794m arising from the management of COVID 19 which was offset by Welsh Government COVID 19 funding of £11.322m and an operating deficit of £0.184m. The Executive opinion noted that managing the impact of COVID 19, would come with a significant cost and that the financial focus would be on financial governance, justifying additional expenditure incurred in dealing with COVID 19 and assessing its impact on the reported financial position. The UHB also needed to keep in check its non COVID operational position to ensure that financial control is maintained particularly as planned care workflows come back on line. In addition the UHB needed to avoid adding recurrent expenditure to the UHB's underlying position to support the recovery from this period. The UHB Chair (CJ) noted the additional Welsh Government COVID 19 funding which covered part of the additional costs arising from the management of COVID 19 and asked whether the UHB had any assurance as to whether the full costs of managing CoVID 19 would be met by Welsh Government. In reply and referring to the recent Welsh Government announcement of a £800m stabilisation package to help the Welsh NHS the Assistant Director of Finance indicated that at this stage it was not clear what proportion would be allocated to the UHB. The Committee was reminded that a detailed schedule of actual and forecast additional costs arising from the management of COVID 19 was submitted to Welsh Government on a monthly basis	

	and discussions with the Welsh Government's Finance Delivery Unit had relayed that the UHBs split of COVID and non COVID expenditure was broadly consistent with other Welsh NHS organisations. The Chief Executive indicated Welsh Government had signalled in discussion with UHB Chief Executives that it wished to expedite the allocatation of the stabilisation package to Health Boards to provide the stability required to respond to the pressures faced in 2020/21. The UHB Chair (CJ) asked how the UHB would address the £0.184m operational deficit that had emerged at month 4 and in response the Chief Operating Officer confirmed that the operational overspend was primarily a result of specific issues around nursing in the Medicine |Clinical Board and continuing healthcare and prescribing in the PCIC Clinical Board. In this context the UHB was challenging and supporting the respective Clinical Boards to control the specific pressures presenting a financial concern. Performance against the Finance Dashboard continued to be skewed by the impact of COVID 19 and six out of the eight measures remaining RAG rated red namely: staying within revenue resource limits; the reduction in the underlying deficit to £4m; the delivery of the recurrent £25m 3% devolved savings target; the delivery of the £4m non recurrent savings target; performance against the Non NHS creditor payments target and the forecast year end cash position. The creditor compliance payments score had improved again in month and that this was expected to meet the performance target if the current rate of improvement continued. The UHB Chair (CJ) observed that the UHB was forecasting a cash deficit in line with the forecast deficit of circa £131m and asked what plans there were to cover this. In response the Assistant Director of Finance indicated that the forecast cash defict was expected to fall as Welsh Government released further funding to cover the costs of COVID 19 and that historically Welsh Government had provided additional cash support to cover shortfalls in cash arising from annual operational deficits. It was highlighted that within the additional COVID 19 expenditure of £67.623m at month 4, the sum of £40.669m related to the Dragons Heart Hospital with further net expenditure of £26.954m being incurred in Clinical Boards. The expenditure reported against the DHH include a re-evaluation of a number of key contractual liabilities and their phasing. COVID 19 was also adversley impacting on the UHB savings programme where there was an underachievment of £8.418m against the month 4 target of £9.624m and the shortfall in savings was expected to continue until the COVID 19 pandemic passed. Elective work had been significantly curtailed during the first 4 months of the year as part of the UHB response to COVID 19 and this was the main reason behind a £11.310m reduction in planned expenditure.	

Moving onto expenditure headings the Assistant Director of Finance indicated that a surplus of £7.158m was reported against income targets at month 3 as a result of net COVID 19 expenditure of £4.050m, an operational overspend of £0.115m which were offset by additional Welsh Government funding of £11.322m for COVID 19 costs. The key COVID 19 costs were largely unchanged from the previous month and related to income reductions arising from reduced footfall and activity in retail and restaurant services; the Injury Cost Recovery Scheme; patient related English NHS non contracted income; dental patient charges income; laboratories and Radiopharmacy and private patients. It was noted that the Injury Cost Recovery Scheme had improved in month. The overall operational shortfall in income was £0.020m higher than the previous month.

The pay position at month 4 was a deficit of £10.153m made up of a net COVID 19 expenditure of £13.885m and an operational underspend of £3.732m. The main additional COVID 19 pay costs were for medical, nursing and ancillary staff in the Women & Children, Medicine Clinical Boards and in Facilities.

Non pay budgets reported a deficit of £49.661m at month 4 comprising of net COVID 19 expenditure of £45.859m and an operational overspend of £3.802m.

£39.604m of the additional COVID 19 expenditure related to plant and premises costs at the Dragon's Heart Hospital, £9.048m was attributed to other non pay primarily due to slippage against savings schemes and a further £1.669m overspend on general supplies and services primarily relating to PPE. There was also additional spend in other service areas on cleaning, waste management, IT, overnight accommodation and drugs.

Referring to the Financial Forecast for 2020/21 outlined in table 8 the Assistant Director of Finance noted that the additional costs of managing Covid 19 were expected to continue and the financial deficit was forecast to move from £52.656 at month 4 to a deficit of £131.381m at year end. The committee was reminded that some of the the additional costs arising from plans to manage COVID 19, in particular costs relating to the Dragons Heart Hospital were front loaded into the first part of the year, however expenditure reductions arising from the reduction in elective work were also expected to reduce as planned care was re-introduced.

The month 4 operational overspend of £0.184m was expected to move towards a balanced position as the year progressed.

A year-end deficit of £131.381m was forecast and this was a fall of £8.057m when compared to month 4 as a result of the following reductions in forecast expenditure:Dragons Heart Hospital - £1.900m; Green zone COVID plan - £1.800m; Spire (WG funding to 6th September) - £1.800m; TTP net costs - £0.900m; Workforce review

	improvements - £0.900m and Other reductions including PPE - £0.700m The Finance Committee was referred to the key assumptions underpinning the forecast and the following key issues were highlighted: • Dragons Hearth Hospital (DHH) revenue costs were estimated at circa £65.9m and this included decommissioning and an estimate of consequential losses costs. • The UHB had developed alternative plans which have been shared with Welsh Government to establish a facility for surge capacity on the UHW site. However, no costs for additional potential surge capacity requirements were included in the forecast at this stage • Costs for additional capacity commissioned from SPIRE were included up until the end of the year. • Slippage of circa £24.8m against savings plans that the UHB was unable to progress during the pandemic was iincuded in the forecast. Welsh Government had indicated that it expected the UHB to progress savings plans where it could and the UHB continued to identify and maximise all potential savings opportunities available. • The forecast cost of COVID 19 regional Test, Trace and Protect (TTP) was included in the forecast at c £11.0m. In response to a query from the Independent Member (Estates) the Assistant Director of Finance confirmed that the UHB had received confirmation of the following additional Welsh Government funding to in part cover the additional costs of manging the impact of COVID 19: • Funding reflecting COVID workforce costs month 1 to 3 - £11.016m • Test, Trace and Protect (TTP) - £8.239m • Transformation Optimise flow and outcomes - £1.251m • Mental Health Services - £0.503m • GMS DES - £0.210m Following a query from the UHB Chair (CJ) the Assistant Director of Finance also confirmed that the full year cost of CAV 24/7 were included in the forecast. The Finance Committee Chair (RT) raised a query in respect of the forecast slippage against the savings programme and the Assistant Director of Finance confirmed that the UHB maintained a detailed list of actual and forecast peformance against all schemes to facilitate performance management. The detail was also submitted to Welsh Government for scrutiny on a monthly basis. The Committee was informed that it remained important for the UHB to maximise savings in year particularly in respect of medicines management and procurement schemes.	

	In the context of surge capacity following the egress from the Dragoms Heart Hospital the Finance Committee Chair asked whether the UHB had received approval of additional capital to proceed with plans to increase capacity on the UHW site. The Chief Executive indicated that a decision was expected from Welsh Government shortly and the UHB Chair confirmed that the UHB was not in a position to run at risk with the capital build in lieu of Welsh Government approval. In response to further queries from the Finance Committee Chair the Assistant Director of Finance confirmed that considerable progress had been made in agreement of consequential losses arising from the Dragons Heart Hospital and that all significant contentious issues had now been resolved. It was confirmed that estimates of both consequential losses and reparations for stadium damages were included in the UHB's forecast year end defict. The largest operational pressures within Clinical Boards were reported in PCIC where there were pressures against GP prescribing and CHC and Medicine where there were pressures spread against nursing, clinical services and supplies and other areas of non pay. It was noted that the overall operational position had deteriorated in month and as discussed earlier in the meeting this would continue to be monitored. Moving on to the UHBs underlying deficit the Deputy Director Of Finance reported that £21.5m of the £24.8m forecast slippage against 2020/21 savings targets was recurrent. As a result of the savings slippage the forecast year end underlying deficit was £25.5m which was £21.5m more than the planned £4m identified in the submitted IMTP. Picking up on the underlying deficit the UHB Chair (CJ) suggested that it would be helpful for the UHB to consider and reflect on progress made to reduce the underlying deficit over recent years and it was agreed that an outline of progress would be provided with the month 5 Finance report. **ACTION POINT** The UHB cash balance at the end of August was c £4.1m and the UHB was forecasting a year end cash deficit in line with the financial forecast. PSPP performance had improved from 94.1% to 94.8% in July but was still below the 95% target. Performance in future months was expected to continue to improve. Capital expenditure was satisfactory with net expenditure to the end of July being 40% of the UHB's approved Capital Resource Limit (CRL). The Committee was informed that the UHB has requested a further 2.5m COVID 19 capital funding to support the provision of elective and routine services through the creation of green zones and	ADOF

	that without this support the containment of capital costs within the CRL was at risk. The UHB had reprioritized its capital plan to mitigate the risk. In conclusion, the Deputy Director of Finance highlighted that at month 4, the key financial risk facing the UHB continued to be managing the impact of COVID 19 without confirmation of further funding available to cover the additional costs. The UHB also had a capital risk to manage if further COVID 19 funding was not secured from Welsh Government **Resolved – that:** The Finance Committee **noted** the month 4 financial impact of COVID 19 which is assessed at £63.794m; The Finance Committee **noted** the additional Welsh Government funding of £11.322m received in respect of COVID 19 additional costs; The Finance Committee **noted** the month 4 reported financial position being a deficit of £52.656m; The Finance Committee **noted** the forecast deficit of £131.381m arising from managing the impact of COVID 19; The Finance Committee **noted** that the UHB does not yet know what funding may be available from Welsh Government to help support the financial costs of managing COVID 19. The Finance Committee **noted** the revised forecast 2020/21 carry forward Underlying Deficit is £25.5m due to the impact of COVID 19;	
FC 20/078	**FINANCE RISK REGISTER** The Assistant Director of Finance (AG) presented the Finance Risk register. The extreme risks were noted as being: **Fin01/20** – Reducing underlying deficit from £11.5m to £4.0m in line with IMTP submission. **Fin02/20** – Management of budget pressures. **Fin03/20** – Delivery of £29.0m (3.5%) CIP **Fin10/20** – COVID-19 impact on financial plan It was also noted that risks around the Dragons Heart Hospital (DHH) COVID-19 were reported as a sub-set to the main risk register. The Finance Committee Chair observed that there had been little progress in the risk categorisation since the start of the year and the Assistant Director of Finance agreed and indicated that progress in the reduction of risk had been obstructed by the management of COVID	

	19. This was unlikely to change until there was confirmation of the level additional to meet the current cost of COVID 19 and the impact on recurrent saving plans. **Resolved - that:** The Finance Committee **noted** the risks highlighted in the 2020/21 risk register. The Finance Committee **noted** the risks highlighted in the Dragon's Heart Hospital sub set risk register.	
FC 20/079	**MONTH 4 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 20/080	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 20/081	**DATE OF THE NEXT MEETING OF THE COMMITTEE** The Finance Committee Chair (RT) relayed apologies for absence at the next planned meeting and it was agreed that the Independent Member (Estates) (JU) would chair the next meeting**.** **Wednesday** 23rd September **2.00pm; Skype /** Cefn Mably Meeting Room, Ground Floor, HQ, Woodland House	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE HELD ON 23rd SEPTEMBER 2020 VIRTUAL MEETING VIA SKYPE

Present:

John Union	JU	Chair, Independent Member - Finance
Charles Janczewski	CJ	Board Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Andrew Gough	AG	Assistant Director of Finance
Caroline Bird	CB	Deputy Chief Operating Officer
Chris Lewis	CL	Interim Director of Finance
Len Richards	LR	Chief Executive
Martin Driscoll	MD	Executive Director of Workforce and Organisational Development
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director

In Attendance:

Catherine Floyd	CF	Consultant In Public Health

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
Steve Curry	SC	Chief Operating Officer

FC 20/082	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 20/083	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 20/084	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 20/085	**MINUTES OF THE COMMITTEE MEETING HELD ON 26th AUGUST 2020**	

	The minutes of the meeting held on 26th August 2020 were reviewed for accuracy and were agreed as a true and accurate record. **Resolved – that:** The minutes of the meeting held on 26th August 2020 were approved by the Committee as an accurate record.	
FC 20/086	**ACTION LOG FOLLOWING THE LAST MEETING** **FC 20/07– FINANCIAL PERFORMANCE MONTH 4 -** UHB Underlying Deficit. An outline of progress made to reduce the UHB underlying deficit over recent years would be provided with the month 5 Finance report. It was confirmed that an update was included in the Month 5 Finance Report on the agenda of the September 2020 Finance Committee meeting **Action complete**. **Resolved – that**: The Finance Committee **received** the Action Log.	
FC 20/087	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 20/088	**FINANCIAL PERFORMANCE MONTH 5** The Assistant Director of Finance informed the Committee that at month 5, the UHB had reported an overspend of £27.565m against the 2020/21 plan. The reported position was primarily a result of net expenditure of £74.014m arising from the management of COVID 19 which was offset by Welsh Government COVID 19 funding of £46.272m and an operating surplus of £0.177m. The Executive opinion noted that managing the impact of COVID 19, would come with a significant cost and that the financial focus would be on financial governance, justifying additional expenditure incurred in dealing with COVID 19 and assessing its impact on the reported financial position. The UHB also needed to keep in check its non COVID operational position to ensure that financial control is maintained particularly as planned care workflows come back on line. In addition the UHB needed to avoid adding recurrent expenditure to the UHB's underlying position to support the recovery from this period. Five out of the eight measures on the Finance Dashboard remained RAG rated red namely: staying within revenue resource limits; the	

	reduction in the underlying deficit to £4m; the delivery of the recurrent £25m 3% devolved savings target; the delivery of the £4m non recurrent savings target; and the forecast year end cash position. Performance against the targets for creditor compliance payments; the maintenance of a positive cash balance; and remaining within the capital resource limit was RAG rated green. It was highlighted that within the additional COVID 19 expenditure of £78.220m at month 5, the sum of £45.216m related to the Dragons Heart Hospital (DHH) with further expenditure of £33.004m being incurred in Clinical Boards. The expenditure reported against the DHH had moved in month following a re-evaluation of a number of key contractual liabilities and their phasing. COVID 19 was also adversley impacting on the UHB savings programme where there was an underachievment of £10.170m against the month 5 target of £12.283m and the shortfall in savings was expected to continue until the COVID 19 pandemic passed. Elective work had been significantly curtailed during the first 5 months of the year as part of the UHB response to COVID 19 and this was the main reason behind a £13.195m reduction in planned expenditure. The net expenditure due to COVID 19 was £74.014m and £46.272m of additional Welsh Government funding was allocated against the additional COVID 19 costs at month 5. In addition the UHB had a small operational surplus of £0.177m at month 5 leaving a deficit of £27.565m at the end of August. The UHB Chair (CJ) noted that there was still some uncertainty over the additional resource coverage which would be provided by Welsh Government and that changes in the level of funding provided would need to be factored into the Risk Register as the year progressed. Moving onto expenditure headings the Assistant Director of Finance indicated that a surplus of £41.101m was reported against income targets at month 5 as a result of additional Welsh Government funding of £46.272m for COVID 19 offset by net COVID 19 expenditure of £4.990m and an operational overspend of £0.180m. The key COVID 19 costs were largely unchanged from the previous month and related to income reductions arising from reduced footfall and activity in retail and restaurant services; the Injury Cost Recovery Scheme; patient related English NHS non contracted income; dental patient charges income; laboratories and Radiopharmacy and private patients. It was noted that the Injury Cost Recovery Scheme had improved in month. The pay position at month 5 was a deficit of £12.132m made up of a net COVID 19 expenditure of £16.798m and an operational underspend of £4.666. Additional COVID 19 pay costs had been incurred across all Clinical Boards and the main costs were for medical, nursing and ancillary staff in the Women & Children, Medicine Clinical Boards and in Facilities. The additional COVID pay	

costs were in part netted down by nursing staff savings in the specialist and surgical clinical boards.

Non pay budgets reported a deficit of £56.535m at month 5 comprising of net COVID 19 expenditure of £52.226m and an operational overspend of £4.309m. The majority of additional non pay COVID 19 expenditure related to plant and premises costs at the Dragon's Heart Hospital with slippage against savings schemes and additional expenditure relating to PPE also adding to the total.

Turning to the financial forecast for 2020/21 outlined in table 8 the Assistant Director of Finance noted that the additional costs of managing Covid 19 were expected to continue and the financial deficit was forecast to move from £27.565 at month 5 to a deficit of £93.617m at year end.

The non COVID operational overspend was expected to remain broadly balanced as the year progressed.

The revised forecast year-end deficit of £93.617m was an improvement of £37.764m when compared to month 4 primarily as a result of the confirmation of £34.950m additional COVID 19 Welsh Government funding as well as some reductions in forecast COVID related expenditure.

The month 5 forecast assumed the following additional Welsh Government COVID 19 funding:

- Dragons Heart Hospital certificated expenditure £34.905m (received month 5)
- Funding reflecting COVID workforce costs month 1 to 3 - £11.016m
- Test, Trace and Protect (TTP) - £7.300m (HB and LA TTP costs shown in forecast)
- Transformation Optimise flow and outcomes - £1.251m
- Mental Health Services - £0.503m
- GMS DES - £0.210m

The Finance Committee was informed that the key assumptions underpinning the forecast were still subject to variation in the remainder of the year and the following key issues were highlighted:

- Dragons Hearth Hospital (DHH) revenue costs were now estimated at circa £65.9m including capital costs.
- The UHB had developed alternative plans which have been shared with Welsh Government to establish a facility for surge capacity on the UHW site.
- Costs for additional capacity commissioned from SPIRE were included up until the end of the year.
- A further pressure had arisen in month 5 around the cost of an enhanced flu vaccination programme. This was costed at

	£2.330m for 2020/21 and was included in the forecast. The forecast cost of a mass COVID vaccination programme was being assessed and was excluded from the current forecast. • Slippage against savings plans had improved by £0.4m in month to £24.3m. The UHB would continue to progress savings plans where it could to maximise all potential savings opportunities available. • The forecast cost of COVID 19 regional Test, Trace and Protect (TTP) was included in the forecast at c £11.0m. In response to a query from the UHB Chair (CJ) the Interim Director of Finance indicated that the UHB had received confirmation of funding to meet the capital cost of the surge hospital on the UHW site, however no additional revenue costs were included in the month 5 year end forecast. The largest operational pressures within Clinical Boards were reported in Medicine where there were pressures spread against nursing, clinical services and supplies and other areas of non pay and in PCIC where there were pressures against GP prescribing. It was noted that the overall operational position had improved in month, however, this would still need to be monitored as there was variation across Clinical Boards. The UHB Chair (CJ) queried the level of additional COVID expenditure levied against Central budgets and the Assistant Director of Finance indicated that this principally related to PPE which had been purchased centrally and subsequently distributed to clinical teams. It was noted that the narrative under table 9 contained a numerical transcription error and should have stated that “Delegated budgets are £73.837m overspent for the 5 months to the end of August 2020”. Moving on to the UHBs underlying deficit the Assistant Director Of Finance reported that as a result of the savings slippage the forecast year end underlying deficit was £25.4m which was £21.4m more than the planned £4m identified in the submitted IMTP. In addition, the UHB had identified a number of further areas where expenditure could impact upon the underlying position. The risks totalling £4.2m were not exhaustive and were set out in a table at Appendix 5. The UHB Chair (CJ) asked what the UHB was doing to mitigate the risks and in response the Interim Director of Finance indicated that the IMTP had identified a £5m investment reserve for 2021/22 which would be used if the risks could not be mitigated or covered off through the release of other costs. The Chief Executive noted that whilst initiatives such as CAV 24/7 incurred a revenue cost, there were potential efficiencies arising from the consequent change in patient flows which could release costs.	

	In relation to the underlying deficit the UHB Chair (CJ) indicated that the year on year reduction in the underlying deficit shown at appendix 6 was helpful in understanding the progress made by the UHB in improving its financial position since the beginning of 2017/18. The UHB cash balance at the end of August was c £4.1m and the UHB was forecasting a year end cash deficit in line with the financial forecast. PSPP performance had improved from 94.8% to 95.3% in July and was now exceeding the 95% target. Capital expenditure was satisfactory with net expenditure to the end of August being 45% of the UHB's approved Capital Resource Limit (CRL). The Committee was informed that the UHB has requested a further 2.5m COVID 19 capital funding to support the provision of elective and routine services through the creation of green zones and that without this support the containment of capital costs within the CRL was at risk. The UHB had reprioritized its capital plan to mitigate the risk. In conclusion, the Assistant Director of Finance highlighted that at month 5, the key financial risk facing the UHB continued to be managing the impact of COVID 19 without confirmation of the total amount of further funding available to cover the additional costs. The UHB also had a capital risk to manage if further COVID 19 funding was not secured from Welsh Government **Resolved – that:** The Finance Committee **noted** the month 5 financial impact of COVID 19 which is assessed at £74.014m; The Finance Committee **noted** the additional Welsh Government funding of £46.272m assumed within the month 5 position; The Finance Committee **noted** the month 5 reported financial position being a deficit of £27.565m; The Finance Committee **noted** the forecast deficit of £93.617m arising from managing the impact of COVID 19; The Finance Committee **noted** that the UHB does not yet know what funding may be available from Welsh Government to help support the financial costs of managing COVID 19. The Finance Committee **noted** the risks that are being managed on the capital programme The Finance Committee **noted** the revised forecast 2020/21 carry forward Underlying Deficit is £25.4m due to the impact of COVID 19;	

FC 20/089	**FINANCE RISK REGISTER** The Assistant Director of Finance (AG) presented the Finance Risk register. It was noted that risks identified and the scoring of the Risk Register was a reflection of the issues contained within the Month 5 Finance report The number of extreme risks had been reduced by one in month and were noted as being: **Fin01/20** – Reducing underlying deficit from £11.5m to £4.0m in line with IMTP submission. **Fin03/20** – Delivery of £29.0m (3.5%) CIP **Fin10/20** – COVID-19 impact on financial plan The risk around the management of budget pressures had been reviewed and re-assigned from an extreme to high risk in August. An additional risk in respect of the costs of COVID-19 Test, Trace, and Protect (TTP) had been added to the Register in month and this was assigned a moderate risk. Referring to the remaining red (extreme) risks the Interim Director of Finance indicated that the UHB would expect the number of these to fall further if Welsh Government was in a position to provide further funding to provide full coverage of the costs arising from COVID 19. It was also noted that risks around the Dragons Heart Hospital (DHH) COVID-19 were reported as a sub-set to the main risk register and that two additional risks had been added in respect of the exit from the Principality stadium and the development of surge capacity on the Heath site. The Chair of the meeting (JU) observed that the sub set of risks around the Dragons Heart Hospital was now effectively a register of the financial risks around the additional surge capacity at both the DHH and the UHW site. In respect of the risk around the delivery of the £29m savings plan the UHB Chair (CJ) asked how this impacted on the UHB's year end forecast. In response the Interim Director of Finance indicated that Welsh Government had accepted that the estimated shortfall in delivery was a consequence of COVID 19 and that this would be considered if additional funding was provided to cover all additional COVID costs in the current year. It was noted however that any recurrent shortfall in savings delivery would impact on the UHB's underlying deficit carried forward to 2021/22 and that the availability of additional Welsh Government funding to cover the shortfall beyond the present year was uncertain. **Resolved - that:** The Finance Committee **noted** the risks highlighted in the 2020/21 risk register. The Finance Committee **noted** the risks highlighted in the Dragon's Heart Hospital/Surge Capacity sub set risk register.	

FC 20/090	**VALUE BASED HEALTHCARE AND ITS USE IN DECISION MAKING AT CARDIFF & VALE UHB** The Assistant Director Of Finance introduced Catherine Floyd (Consultant in Public Health) to the Committee. Both Catherine and the Assistant Director of Finance presented a number of slides to the Committee and outlined the following: • Value based healthcare related health outcomes & experiences achieved to the resources used & the population served. • Value based decisions rely on timely data. The use of resources and provision of healthcare service is determined by reference to the equity, fairness and sustainability of healthcare provision through a transparent framework which considers the health outcomes that matter most to the people in Wales • The local Cardiff and Vale approach embedded the principles of value based decision making into systems (e.g. procurement), clinical practice and enablers. • A 2017 OECD report on "Wasteful Spending in Health" had challenged the current status quo in healthcare practice and identified that up to 34% of healthcare expenditure could be deemed inappropriate. • The reinvestment from low to high value care is essential for a sustainable and resilient healthcare system • The best financial informatics and health economics were required to determine the best possible value. • The relationship between healthcare provision, health benefits and costs of provision was key to determining the optimality point of highest value (i.e. health benefits minus provision costs) • The Value Based Healthcare equation i.e. Value = Outcomes/Resources (Value is maximised by maximizing the outcomes produced from any given resource) • Costing and costing care pathways is a key element of the value equation • The UHB's financial plan aimed to support the delivery of service priorities and maximise patient outcomes whilst maintaining the sustainability of services • The following examples of values based commissioning in practice within the UHB were outlined:	

	• Ward East 2 bed capacity reduction – Leading to improved patient experience / outcomes due to reduced patient length of stay and cash releasing savings • General Surgery Service Redesign – leading to reduced waiting times; reduction in emergency surgical admissions; reduced length of stay & cash releasing savings. A discussion on the presentation followed and the following points were raised: • A number of specific value based healthcare work streams were being progressed at a national level and the UHB would need to consider any recommendations which might follow. • The value based healthcare approach identified finance as an enabler for improving patient safety and outcomes. • All UHB service provision should be either evidence based or contributing to an evidence base (i.e. an approved R & D Study). • There was evidence that business cases presented to the Business Case Approval Group (BCAG) were increasingly considering the value derived from existing resource investment and strengthening the link between investments and outcomes. • The principles of value based healthcare needed to be applied across the whole health and social care system. **Resolved – that**: The Finance Committee **noted** the presentation.	
FC 20/091	**MONTH 5 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 20/092	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 20/093	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday** 28th October **2.00pm; Virtual Meeting via Teams**	

Confirmed Minutes of the Strategy & Delivery Committee
Tuesday 15th September – 9:00am – 12:00pm
Nant Fawr 2 & 3, Woodland House / Via Skype

Chair:		
Michael Imperato	MI	Committee Chair
Members:		
Rhian Thomas	RT	Independent Member – Estates
Charles Janczewski	CJ	UHB Chair
Gary Baxter	GB	Independent Member – University
In attendance:		
Martin Driscoll	MD	Executive Director of Workforce & Organisational Development
Nicola Foreman	NF	Director of Corporate Governance
Fiona Kinghorn	FK	Executive Director of Public Health *(for part of the meeting)*
Steve Curry	SC	Chief Operating Officer
Caroline Bird	CB	Deputy Chief Operating Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Kiethley Wilkinson	KW	Equalities Manager
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
David Thomas	DT	Director of Digital Health Intelligence
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Scott Mclean	SM	Director of Operations – Children & Women
Apologies:		
Sara Mosely	SM	Committee Vice Chair & Independent Member – Third Sector

S&D 15/09/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting, which was now being chaired by Michael Imperato having taken over the role as Committee Chair from Charles Janczewski UHB Chair.	**Action**
S&D 15/09/002	**Apologies for Absence** Apologies for absence were noted.	
S&D 15/09/003	**Declarations of Interest** There were no interests declared.	
S&D 15/09/004	**Minutes of the Committee Meeting held on 14th July 2020** The Committee reviewed the minutes of the meeting held on 14th July 2020.	

	Resolved – that: (a) the Committee approved the minutes of the meeting held on 14th July 2020 as a true and accurate record.	
S&D 15/09/005	**Action Log following the Meeting held on 14th July 2020** The Committee reviewed the action log and the following comment and update was made: UHB Chair pointed out for accuracy that the Tertiary Service update would be for 2021 not 2020. **Resolved – that:** Subject to the above amendment; (a) The Committee reviewed the action log following meeting held on 14th July 2020 and noted the updates provided.	**RK**
S&D 15/09/006	**Chair's Action taken following the meeting held on 14th July 2020** There had been no Chair's Actions taken following the meeting held on 14th July 2020.	
S&D 15/09/006	**Developing a Performance Framework Update** The Director of Digital & Health Intelligence (DDHI) introduced the report and the CC confirmed that the paper be taken as read. The DDHI discussed the key points around the Performance Management Framework and advised that it should be considered in principle as the relationship with Welsh Government (WG) was changing and therefore it was not yet clear what measures and performance targets we would be measured against as a result of Covid. DDHI stated that the report outlined the purpose of the Performance Management Framework, what it set out to achieve and the scope of the Framework. He referred to section 2 of the report which highlighted the need to support key frameworks which underpin the performance of the Health Board such as Shaping Our Future Well Being, Integrated Medium Term Plan (IMTP), Clinical Board/Corporate Directorate plans, Operational Plans and Strategies. The DDHI also mentioned that the document, which had been published by WG to enable reporting against the Delivery Framework Reporting Guidance 2020/21, was not currently being used in full given the situation we were in. The DDHI then discussed the principles the UHB had adopted in terms of how the Performance Framework should be managed, which had been	

	shared with the Executive team and was based on work carried out in other Health Boards to provide consistency. Section 4 referred to measuring success within the Framework. With regards to internal reviews, the Board and Committees were reviewing performance across the board from individual level up to Clinical Board level performance and with external reviews around service specifications, quality standards, monitoring arrangements and reporting requirements. There was also a role for audit in terms of internal/external audits and any clinical audit plans. DDHI advised that all staff have the responsibility to promote a culture of high performance and that the role of the Board is set out, as well as the roles of the CEO and Executive Directors. He added that there was a clear role for Clinical Boards and that the role of the HSMB could be one of reviewing how performance is managed right across the individual and collective Clinical Boards. Section 6 referred to the arrangements for Clinical Boards and Corporate Departments, recognising that it was not just the Clinical Boards that had to report on performance. Section 7 referred to the performance requirements for the Board and Committees. The DDHI pointed out that information played a key role in ensuring that performance was supported through dashboards and various data pulled through our information systems. The DDHI concluded with the Escalation and Assurance process and described how information should flow from the individual right up to the Board and that accountability comes from Board level down to the individual. The Independent Member - Estates queried how we were ensuring consistency across Clinical Board's whilst implementing this. The COO commented that there were a couple of items within the Framework that would relate to consistency however there were areas that needed refinement particularity around outcomes and measuring the right things, that matter to people. He concluded that the Tier 1 harder line measures such as waiting times, were in a state of flux due to them not being currently reported upon and also due to the fact that this would all change bearing in mind the current discussions with WG. The final point was a cultural one with regards to Covid in the context of this Framework, and how we were currently on a journey of supporting and empowering teams to take ownerships of issues and deliver rather than performance managing them, although both had a part to play. He concluded that as a Board and as Executive teams there was a need to find the high trust low bureaucracy balance to allow us to have empowered enabled teams to deliver and yet operate within the Framework. The DDHI advised that the Delivery Framework had a number of measures that would be reported on specifically such as the percentage of staff having a performance appraisal.	

	The UHB Chair thanked the DDHI for his report and wanted to know how the Committees of the Board in particular could give assurance to the Board in the delivery of performance. The Committees now had a clearer remit to manage and oversee performance on behalf of the Board, but there were only two instances of Committees engaging with the performance of Clinical Boards at present, the Finance Committee and QSE Committee and therefore we would need to look at how this information could be fed through. The UHB Chair expressed that his main concern was that if we were allocating different areas of responsibilities to different Committee's then it would have to be co-ordinated to ensure that the correct information was supporting the data coming through and that the Board gets the necessary assurance. The CC echoed the comments made by the UHB Chair and added that he would like to see a streamline dashboard, providing a quick output on progress and preview of key warning signs and issues, enabling Committees to investigate further areas of interest/concern. The CC also commented that a traffic light system could allow tracking against the IMTP. The DDHI responded that there were ongoing discussions with Committees to understand what they would find useful in terms of performance metrics. Previous work done with QSE would be expanded upon for others. The DDHI agreed to work up what mini dashboards would look like and bring an update to the next Committee meeting. The Executive Medical Director (EMD) commented that a similar piece of work was underway with the DCG, looking at how performance dashboards may look in regards to QSE, Finance, Workforce and so on but felt that a strategy one could be harder to define. It was agreed that the EMD, DDHI and DCG meet to discuss and avoid replication of work. The Executive Director of Strategic Planning (EDSP) added that a link across to the Outcomes Framework would be helpful to drive things forward via the partnership lens when thinking about progress in terms of outcomes for our population. **Resolved that:** (a) The Committee noted the report.	**DT** **NF / DT / SW**
S&D 15/09/007 Khan Raj 11/17/2020 16:20:13	**Strategic Equality Plan** The Executive Director of Workforce & Organisational Development (EDWOD) updated the Committee that since the first draft of the Plan, significant challenges around Covid-19 and the disproportionate impact on our disadvantaged communities had highlighted the work needed with risk assessments for BAME colleagues and patients. Each characteristic had an Executive lead sponsor, action plan and specific objectives to achieve. The Plan needed to be endorsed by the Equality Rights Commission by 1st October 2020.	

	At the previous Committee meeting there were comments about adding in items regarding agenda pay report which was now included, strengthening the area around equality health impact assessment, and Welsh language issues. The Executive Director of Therapies and Health Sciences (EDTHS) highlighted that there was more work to be done with health improvement for people from minority ethnic communities. The Independent Member - University queried whether the action plan table required more thought in terms of specific measures or targets and that the timeline for the action plan could apply a time point for some of the objectives which could be brought back to a future meeting. The Equalities Manager (EM) agreed to produce the next iteration of the plan for a future meeting would develop a framework around the comments made in regards to monitoring and timelines. The IM-University further queried the gender pay gap increase and whether there was any obvious cause to that. The EM confirmed that this would be investigated in the coming months. The EDWOD further commented that the main disparity was due to female staff working reduced hours but would still investigate further. It was clarified that the UHB had gone beyond the statutory requirements in producing the report. The Independent Member - Estates queried whether there were any issues that could be tackled now i.e. more women being in lesser paid roles. She also queried the intentions and actions of the new Equality Strategy Welsh Language Steering Group. The EM confirmed that in terms of gender pay, it was hoped that a third party contractor would be secured to look into this issue. The Equality Strategy Welsh Language Steering Group was holding its first meeting in October to be chaired by the EDWOD, and the Group would ensure a culture change in regards to equality and Welsh language issues. **Resolved that:** (a) The Committee noted and considered the content of this report; (b) The Committee endorsed the revised Strategic Equality Plan – Caring about Inclusion 2020-2024.	**KW**
S&D 15/09/008	**Update on CAMHS Strategy** The Director of Operations – Children & Women (DOCW) advised the Committee that the specialist CAMHS service, that was with Cwm Taf 18 months ago, was now firmly patriated. Significant work was undertaken prior to lockdown to deal with a backlog of cases and deliver performance against the Part 1 WG target, the service had met the 80% Part 1 target consistently since May 2020,	

against a backdrop of 0% compliance 12 months previously, it now sits at 80-95%.

The pandemic had impacted the services and a member of staff was lost to Covid.

The services adapted and made use of tele/video communications although there was a reduction in referrals in April and May at 80% of the pre-Covid rates. Although it was more straightforward to do an assessment via tele/video communications, providing treatment was more difficult so whilst assessment performance had increased, treatment performance had decreased.

The DOCW summarised delivery against performance targets:

1. Primary Mental Health
    - there were no longer young people waiting for long periods for assessment or intervention
2. Specialist CAMHS
    - service remained non-compliant against the referral to assessment target of 28 days
    - on transfer from Cwm Taf the waiting list was approximately 180 patients with a >12 week wait. This was reduced to 85 with an >8 week a year later, however Covid impacted on this meaning the waiting list for assessment currently stands at 130 with a >12 week wait
    - the service was currently running with a waiting list for treatment: this stands at 74 patients waiting for >24 weeks – this is significant during this time patients and families were not at school.

With regards recruitment, at the point of transfer, the service had 10.5 vacancies, there was only now a Speciality Doctor Post remaining.

There had been an increase of referrals for eating disorders, this was a specialist area that they were currently not equipped for so there would be a mixed phase of recruitment focusing on that skill set.

Next Period Actions:

- Improve performance and waiting times for Specialist CAMHS services
- Fully operational SPOA wih clinical posts in place
- Finalise School/Locality Offer and agree with partners

The Independent Member – Estates queried whether due to Covid we were likely to see an increase of referrals and what would be the plans to manage the potential bottleneck.

The DOCW replied that we were not ready to see, neither expected to see a significant spike in children's mental health, unlike adult mental health.

Similar to many services, in terms of capacity, they were confident that they could continue to assess via VC however this may not be

	sustainable as more families were waiting for face to face consultations. Finally to assure that there was no growing harm, they had implemented some hard stops, so in the case of a patient waiting 28 weeks a clinician should review the case at various time points to consider if a patient on a waiting list was at risk of harm, providing governance around the waiting list. The UHB Chair queried when the triage and consultation elements would be progressed and when progress would be seen with the digital options and website. The DOCW stated that with regards triage/consultation, posts are currently out to advert. The timescale for the website was not clear and therefore he would bring back an update to a future Committee meeting with the COO. The UHB Chair advised that the Committee should keep an eye on the neuro developmental situation which would relate to young children, it was agreed that this be included in the CAMHS update for the next Committee meeting together with concerns around waiting lists and capacity management. The CC commented that he would like to be kept up to date with regards all such key developments. **Resolved that:** • The Committee noted the status of the CAMHS service inherited by the UHB and the impact of Covid-19; • The Committee noted the improved performance for Part 1 services and continued challenges to delivery of Specialist CAMHS services; • The Committee noted the progress made to develop new service models and recruit to vacancies.	**SM/SC** **SM/SC** **SM/SC**
S&D 15/09/009 Khan,Raj 11/17/2020 16:20:13	**Integrated Medium Term Plan (IMTP)** **- Avoiding waste, harm and variation** The Executive Nurse Director (END) reminded the Committee that the aim of this item was to bring together performance, money and quality and demonstrate how we were impacting all those agendas at the same time. The report was based on the Quality Patient Experience Framework, Health and Care Standards and the key deliverables in the IMTP that focused on the Quality and Safety agenda. The END confirmed with regards to Infection Prevention & Control, improvement had been made in all key areas, although not hitting targets, a reduction had been seen. The END informed the Committee that we came from a position in Wales where we were ranked: • C. difficile – Ranked First • Klebsiella spp bacteraemia – Ranked First • S. aureus bacteraemia - Ranked Second • E.coli bacteraemia - Ranked Second	

	More work was required to ensure progress in all IP&C agendas however this had been impacted considerably by Covid. In addition the END was pleased to report how there were no hospital acquired Covid cases for the following number of days in: • UHW – 72 days • Llandough – 65 days • Barry – 93 days • St David's – 125 days • Rookwood – 148 days Since completion of the report, 10 serious incidents were closed in August, closure and learning remained a priority area for the QSE teams. There was particular focus on and support of Mental Health which had the highest number of open and serious incidents. Performance against response in 30 working days in concerns was now at an all-time high of 90% whilst the quality still remained. The work done by Patient Experience around bereavement during Covid was highlighted, this included chatter lines, virtual visiting and feedback from patients around PPE. The message to loved ones had been extremely powerful along with the bereavement hotline. The EMD added that the mortality review process was changing nationally with the introduction of a medical examiner but this had been delayed by Covid, the first medical examiner service was due to open 05/10/2020. The Independent Member - Estates queried about the type of feedback received and whether it had changed being more virtual. The END replied that the systematic feedback that would normally be received had not been brought back at the moment due to difficulties and the main feedback had been direct compliments to staff and the wards, the chat line and bereavement helpline had been most impactful. **Resolved that:** (a) The Committee noted the contents of the report and progress made against the actions outlined in the UHB IMTP.	
S&D 15/09/010 Khan,Raj 11/17/2020 16:20:13	**Board Assurance Framework Update – Sustainable Primary and Community Care** The DCG highlighted that she had looked into what this Committee had done in terms of Sustainable Primary and Community Care throughout the year which was supported by the report and which would impact on the mitigation and management of this risk which was also a risk on the BAF being presented to Board. The COO added that these risks were part of longer term challenges. Their approach in terms of primary care strategy was still based around	

	the framework of SOFW, National PC Strategy, Issues of Sustainability, improving access, and aligning ourselves to new ways of working i.e. Canterbury. He added how the key actions would be pursuing of multi-disciplinary teams in terms of sustainability, improving GMS access for patients, and moving services closer to home. A Primary Care Framework was being developed in terms of the approach to the pillars of the strategy and then the pathways around Mental Health, musculoskeletal, urgent care, chronic conditions and child health and frailty as being the main pillars of moving this forward. He concluded that resolving primary care resilience would require direct approaches as mentioned in the BAF as well as collateral approaches referenced in the strategy. The CC had brought to the attention the role of the pharmacy in this strategy landscape and queried if they were involved in this strategy. The COO confirmed that they were involved and that there were a number of granular level plans included in the actions and how multi-disciplinary would include pharmacies although on the BAF it would not detail every action. The DCG confirmed that not every action would be detailed just the key actions in relation to mitigating risk. **Resolved that:** a) The Committee reviewed the attached risk in relation to Sustainable Primary and Community Care to enable the Committee to provide further assurance to the Board when the BAF was reviewed in its entirety.	
S&D 15/09/011	**Other significant plans**: Infrastructure and Estates The EDSP confirmed that this was a regular update in relation to the capital programme in terms of the overarching schemes, what the risks were, and any changes to the programme. The CC was happy for the report to be taken as read and invited questions from members. The Independent Member – Estates questioned meeting the statutory obligations and mandatory obligations, what the differences were and risks faced. The EDSP responded that some are statutory and laid out in legislation i.e. being regulated by the Human Tissue Authority and statutory requirements around medical gasses. The mandatory ones did not necessarily have the same legal framework around them but were things we should still be doing. The EDSP highlighted that there were many competing priorities with the capital programme. The Executive team had close oversight over this and balanced decisions about a particular risk verses the risk of slowing down and not delivering the work programme associated with statutory compliance.	

	Resolved that: a) The Committee noted the content of the paper and supporting documentation b) The Committee was assured that the capital programme was being closely monitored to ensure the UHB meets its statutory and mandatory obligations referred to within the report.	
S&D 15/09/012	**Performance Reports:** Key Organisation Performance Indicators The COO highlighted that the waiting list position for planned care continued to age. Since the dip in unscheduled care attendances from April, it was now back up by 3000 per month and there was an increase in mental health activity from 300 to 900 referrals. There were positive outcomes in cancer with a V shaped recovery with 1500 referrals back in July, the single cancer pathway is back at 81% and the number of cancer treatments are back to 170 a month. The COO advised that we had been working under an operating model of being in a Covid ready state and that the relaxation of reporting and targets was still in place. The Deputy Chief Operating Officer (DCOO) provided a presentation and spoke about the scale of the challenge faced in terms of RTT and waiting list times. This was only of the components in terms of risk and there were higher categories in outpatient follow ups. Since June the waiting times had started to deteriorate and the waiting lists had started to grow. The DCOO then spoke about the second lens which was “Age”; analysis showed that while the waiting lists were static up to June and starting to increase, waiting times had significantly deteriorated across the board but had been impacted by Covid. The “Stage of Pathway” was then discussed i.e. what patients on a waiting list were actually waiting for: • Outpatients – represented 60% of the waiting list - biggest and growing problem • Inpatients and diagnostics – represented a 1/3 of the waiting list. The DCOO then touched on “Risk”, in terms of what was recorded on systems. The risks found were not based off prioritisation, neither were they systematic showing a crude measurement between urgent and non-urgent risks. The COO summarised that there were 280,000 patients in total, whilst our waiting lists remained largely static to June, they were starting to grow plus waiting times had deteriorated. 50,000 of patients on RTT pathway at outpatient stage plus 174,000 outpatient follow-ups. The COO discussed how strategically they could implement a framework going forward but there was significant work required to manage risk within the system as any model put in place would be a process not an event and would need managing.	

	He advised in treatment terms they were trying to safely regrow activity which faced challenges of logistics and confidence to improve the amount of activity whilst keeping things safe. The aim with outpatients wass not to re-establish what we used to do but instead re-establish something different. The DCOO gave a breakdown of the structure of the outpatient programme and the order of care model it was thought patients should sit in, in terms of Primary & Community Care and Secondary care. The COO concluded with the following considerations: • Do we default to a risk-based approach • How do we manage risk in transition • Do we think we can recover by working harder or commissioning more • How do we support clinical design and leadership but at pace • What is our 'phone first' moment for planned care. The COO then spoke about clinical design and what the first principles should be: • Designed by our Clinicians – so it is owned • Moving from time to clinical urgency • Hospital appointment as last resort. The CC asked about the Committee's role in terms of scrutiny of the process. The COO responded that the developments would be shared with the Committee every month together with progress against plans to return surgery and outpatients to pre Covid levels. The UHB Chair thanked both for the presentation and commented that it was key that the Committee be kept informed of progress. **Resolved that:** (a) The Committee noted the contents of the report (b) The Committee noted the presentation.	
S&D 15/09/013	**Performance Reports:** Key Workforce Indicators The EDWOD advised how the paper summarised the impact of Covid as headcount numbers increased due to extra recruitment and in turn increased employment costs, which also could be attributed to staff doing more overtime. Absence levels were at 10% which was lower than had been budgeted for but this had now decreased to 5% as expected even with the impact of Covid.	

	Formal training pieces had decreased due to no classroom training. Corporate inductions, were able to go ahead and training had now resumed with social distancing measures. The UHB Chair thanked the EDWOD and his team for producing the KPI table which clearly illustrated the Covid trends and was a major step forward from the previous report. **Resolved that:** a) The Committee noted and discussed the contents of the report.	
S&D 15/09/014	**Influenza Vaccination Update 2019/20 and plans for 2020/21** The Executive Director Public Health (EDPH) highlighted that influenza vaccinations was one of the more important healthcare programmes that the UHB had and along with the Flu programme, would run alongside mass Covid vaccination, so was particularly important this year. The report provided a detailed status update on flu vaccinations: • Good progress was being made with patients over 65 and amongst frontline staff • Consistently exceeded national targets in frontline staff with flu uptake 63.5% last season • Primary school aged children numbers are increasing on a yearly basis since 2017 • Uptake in clinical risk groups under 65 has been a continuing challenge on a UK wide basis with other contributing factors i.e. people with asthma downplaying their actual flu symptoms with asthma symptoms. The EDPH added that the flu programme was always important as part of the winter plans as there was a range of key priorities that the programme included: • Increasing uptake amongst all risk groups, particularly those aged 65 or over with cardiovascular, respiratory, kidney or liver disease, diabetes and adults who are morbidly obese • Significantly increasing flu vaccine uptake in 2 and 3 year olds, and older children aged 11 to 17 years in clinical risk groups (delivered through Primary Care) • Maximising uptake in primary school children • Maximising uptake in health care staff with direct patient contact • Significantly increasing uptake in care home staff and staff providing domiciliary care. The EDPH further added that we had a more mobile population and higher levels than other areas of Wales of people from BAME communities which sometimes made it more challenging to increase vaccination uptake. **Resolved that:**	

	• The Committee noted the UHB's uptake of flu vaccination during 2019/20 (last season); the expansion of eligible groups for the 2020/21 flu programme • The Committee supported the implementation of actions to improve uptake in flu vaccination rates, in order to meet the expected increase in demand for flu vaccinations due to COVID-19.	
S&D 15/09/015	**Annual Update on Childhood Immunisation Uptake** The EDPH advised that during the Covid period, vaccination continued as an essential service although there was a decrease in uptake, normal levels were now returning. She highlighted uptake of most childhood vaccinations had increased in recent years with an increase in uptake of MMR for preschool children. Covid-19 had impacted on timeliness of the vaccination update. The EDPH highlighted some challenges in the available data systems, for example the Primary Care data system does not talk to the Child Health data system for vaccinations which still needed work on a national level. The Action plan priorities for 2020/21 in relation to childhood immunisations had been agreed by the Immunisation Steering Group in light of the Covid-19 pandemic and were pending approval by the Children and Women and PCIC Clinical Boards. These were: • An annual data cleansing and performance cycle for childhood immunisations (particularly at age 1, pre-school, and teenage). This will include an annual data cleansing process to ensure accuracy of data held on the Child Health Information System. • Improvements in the IT systems used by Primary Care and Child Health for documenting immunisations to improve efficiency and accuracy of data. • A regular cycle of escalation which identifies and supports Primary Care with low immunisation uptake to put in place evidence-based interventions. • Dissemination of quarterly Primary Care and cluster uptake profiles, which identify trends and compares C&V with national averages, together with follow-up discussions with localities, clusters and Community Directors to focus action. • Implementation of the Measles Elimination Action Plan for Wales to increase uptake of MMR across age groups. • Delivery of a communications package to raise awareness and provide evidence-based information. The UHB Chair commented that these were very important areas of work and voiced his support for the programme. **Resolved that:**	

	a) The Committee noted the UHB's current uptake of childhood immunisations and forthcoming changes to the immunisation programme; b) The Committee supported focused action on implementation of actions to deliver changes to the programme to improve uptake in childhood vaccination rates.	
S&D 15/09/016	**Move More, Eat Well Plan** The EDPH advised that this was launched late with the particular focus on workplaces, communities and healthy travel. They were now also looking to implement in schools where appropriate depending on the Covid-19 situation. It was highlighted that there was a question on how to support older people who did not have digital access and a guide was now available digitally and via a hard copy. It was a stay well whilst staying at home guide. This was accessible via council hubs, independent living housing scheme, Vale 50 plus forum etc. The EDPH added that it was a push to keep people healthy within the context of Covid and that good work was being done to include older people. **Resolved that:** a) The Committee noted the verbal update.	
S&D 15/09/017	**Committee Effectiveness Review** The CC had agreed the paper for noting. The UHB Chair queried that the action called for a more robust agenda setting but feels it could be a more deeper than just the agenda setting. He mentioned how the COO highlighted that we should deal with the work planning rather than the agenda setting to avoid time pressures towards the end of the period and feels that work plans should be included. The DCG agreed that out of the 18 questions asked that this area requires more work around the work plan. **Resolved that**: a) The Committee noted the results of the Committee's self-assessment Effectiveness Review for 2019-20; b) The Committee approved the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.	

S&D 15/09/018	**Regional Partnership Board (RPB)** The CC stated that he would like to be more informed regarding the RPB as it fed into strategic and delivery issues. The EDSP agreed to meet with the CC. The Committee was asked to note that there was now a further year of ICF & Transformation funding and work was in process around the range of initiatives available. **Resolved that**: a) The Committee noted the update on the RPB.	
S&D 15/09/019	**Changes in Nursing and Midwifery Education** The CC asked the Committee to note the contents of the paper. The UHB thanked the END for the work involved. **Resolved that:** a) The Committee noted the contents of the report.	
S&D 15/09/020	**Review of the Meeting** The CC thanked everyone for their contribution during his first meeting. All confirmed it was a good meeting with an appropriate level of Independent Member challenge and scrutiny.	
S&D 15/09/021	**Date & Time of next Meeting** Tuesday 10th November 2020 9:00am – 12:30pm Via Skype	

Confirmed Minutes of the
Mental Health and Capacity Legislation Committee
Held on 21st July 09:00pm – 12:30pm
Via Skype

Present:

Sara Moseley	SM	Interim Chair and Independent Member – Third Sector
Eileen Brandreth	EB	Independent Member – ICT
Michael Imperato	MI	Independent Member - Legal

In Attendance:

Julia Barrell	JB	Mental Capacity Act Manager
Steve Curry	SC	Chief Operating Officer
Nicola Foreman	NF	Director of Corporate Governance
Akmal Hanuk	AH	Independent Member - Community
Charles Janczewski	CJ	UHB Chair
Robert Kidd	RK	Consultant Clinical and Forensic Psychologist
Simon McDonald	SM	Mental Health Act Manager
Scott McLean	SM	Director of Operations, Children & Women
Annie Proctor	AP	Clinical Board Director – Mental Health
Ruth Walker	RW	Executive Nurse Director
Ian Wile	IW	Director of Operations - Mental Health

Secretariat:

Laura Tolley	LT	Corporate Governance Officer

Observers:

Caroline Bird	CB	Deputy Chief Operating Officer

Apologies:

Sunni Webb	SW	Mental Health Act Manager

MHCL 20/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	**ACTION**
MHCL 20/07/002	**Apologies for Absence** Apologies for absence were noted.	
MHCL 20/07/003	**Quorum** The CC confirmed the meeting was quorate.	
MHCL 20/07/004	**Declarations of Interest** The CC declared an interest in the meeting as the Director of Mind Cymru.	

MHCL 20/07/005	**Minutes of the Committee Meeting held on 21st February 2020** The Committee reviewed the Minutes from the meeting held on 21st February 2020. **Resolved that:** (a) the Committee approved the minutes of the meeting held on 21st February 2020 as a true and accurate record.	
MHCL 20/07/006	**Action Log following the meeting held on 21st February 2020.** The Committee reviewed the action log and noted the following updates: **20/02/015 –** The Chief Operating Officer (COO) welcomed Committee opinion on commissioners being subject to their own governance arrangements in relation to MH services delivered on behalf of CVUHB by other LHBs. The UHB Chair commented that it would be very difficult to obtain assurance from a commissioner with their own governance arrangements, however, advised the Committee that Audit Wales were conducting a review of WHSSC governance arrangements so the Committee could gain some assurance from that. The Independent Member – ICT (IM-ICT) expressed concern as the Committee had a known weakness in this area. The Director of Corporate Governance (DCG) advised the inspection reports may be a clear route for assurance. In response, the COO advised he would look at the planned inspection list and timetable and update the Committee accordingly. **20/02/005 –** The Executive Nurse Director (END) advised the Committee that new national guidance was expected, however this may be delayed due to COVID-19, therefore, it would not be appropriate to undertake a review until the new guidance was in place. **20/02/009** – The Vale & Glamorgan DoLS report had been discussed and would be brought to the next Committee for noting. The END added that the Committee would be pleased to note that there were no areas of concern at present. **Resolved that:** (a) the Committee noted the action log and the updates provided.	**SC**
MHCL 20/07/007	**Chair's Action taken since the last meeting**	

	No Chair's action had been taken.	
MHCL 20/07/008	**Patient Story** There was no patient story available for this meeting, however the I informed the Committee as she had taken over DoLS and the Mental Capacity Act, going forward she would ensure that patient stories were presented at meetings. CC asked for assurance that our support of patients sharing their stories and how this would be managed was reviewed along with the way the Committee works.	**RW** **RW**
MHCL 20/07/009	**Impact of COVID-19 on Reporting and Monitoring** The Director of Operations – Mental Health (DO-MH) advised the Committee that all reporting arrangement targets had been stood down by Welsh Government, however the team had been involved in weekly Welsh Government meetings for assurance and assurances had been provided that Mental Health services had not stopped during COVID-19. The DO-MH advised the Committee that now the physical impact of COVID-19 was decreasing, a surge in mental health was anticipated, therefore to address this the UHB had agreed with third sector partners, Mind in the Vale and Cardiff Mind that contracts would increase by 25% for 3 months, in addition to building into the contracts that patients do not need to visit their GP for their first appointment. The DO-MH informed the Committee that strong partnerships had been developed which has enabled the transformation of mental health services. The UHB Chair expressed thanks to the Mental Health Clinical Board throughout COVID-19. **Resolved that:** (a) the Committee noted Impact of COVID-19 on Reporting and Monitoring.	
MHCL 20/07/010	**Mental Capacity Act Monitoring Report** The Mental Capacity Act Manager (MCAM) introduced the report and advised the Committee that nothing significant had changed despite COVID-19. The MCAM added that interesting issues had arisen during the period, mainly where patients did not have capacity to be involved in the RECOVERY clinical trial (treatments for COVID-19). The MCAM advised that the UHB needed to ensure that Clinicians were more aware of the Mental Capacity Act. The END informed the Committee that a meeting with the MCAM would be arranged to progress this further and an action plan would be developed and brought to a future meeting.	**RW**

	Resolved that: (a) the Committee noted the Mental Capacity Act Monitoring Report.	
MHCL 20/07/011	**The Vale and Glamorgan Local Authority Report on DoLS** The END advised this had been discussed and informed the Committee that there were no areas for concern at present. It was agreed that the report would come to the next Committee meeting for noting. **Resolved that:** (a) the Committee noted the Vale and Glamorgan Local Authority verbal update on DoLS	
MHCL 20/07/012	**Mental Health Act Monitoring Exception Report** The DO-MH introduced the report and confirmed the following: • The number of people detained increased slightly during COVID-19, however this was returning to normal. This was due to the clearing of two wards in preparation for COVID-19; • Number of administration errors had been made in regard to the Mental Health Act, now the UHB were out of the intense COVID-19 period, the errors had ceased; • A couple of lapses in Section 5; • Increase in Section 136, it was believed this was due to a wording error on the documentation; • Slight increase in CAMHS which has been recognised across Wales and England. The CC asked if CAMHS was included in recovery planning. In response, the Clinical Board Director – Children & Women (CBD-CW) confirmed the UHB had 40% more capacity than demand at present, therefore they are well prepared if a surge occurred. CC also sought assurance that patients who had been discharged were receiving follow up and care. **Resolved that:** (a) the Committee noted the Mental Health Act Monitoring Exception Report.	
MHCL 20/07/013	**Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report** The DO-MH introduced the report and confirmed the following; • Started to lose staff at the end of March due to COVID-19,	

	however, patient numbers dropped significantly which allowed the team to develop a single point of contact with the Council; • Capacity has started to increase and the UHB had sufficient capacity; • Team were keen to keep the single point of access as it significantly improved the service; • In relation to Part 1b of the measure, the UHB had remained fully compliant since August 2019; • Care & Treatment Planning – Improvement was required as the target was 90% and the UHB were just above 80%, this was declining therefore discussions with the directorate were being held to understand reasons; • Part 1 measure relating to Children & Young People – it was confirmed the UHB were at 92% and were confident the position would be sustained. The CC asked at the next meeting for there to be a focus on compliance for CAMHS. **Resolved that:** (a) the Committee noted the Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report.	**SM**
MHCL 20/07/014	**Items to bring to the attention of the Board / Committee for information and noting:** **1. Hospital Managers Power of Discharge Minutes** The CC asked how virtual hearings were being handled. In response, the Consultant Clinical and Forensic Psychologist (CCFP) confirmed a number of hearings had been held and positive feedback had been received. An area of concern raised with Welsh Government was in relation to nearest relative attendance. The DO-MH thanked the team for the work undertaken to enable virtual tribunals and hearings which resulted in the UHB complying with legislation as much as possible. **Resolved that:** (a) the Committee noted the Hospital Managers Power of Discharge Minutes. **2. Mental Health Legislation and Governance Group Minutes**	

	The CCFP advised the Committee that the issue relating to conveyancing remained, however conversations were being held with the newly appointed Director of Nursing – Mental Health, to progress this further. A further discussion was held on issues relating to the work of the MH Tribunal and capacity issues. The DO-MH agreed that this was an area we should be raising concerns about as a UHB. **Resolved that:** (a) the Committee noted the Mental Health Legislation and Governance Group Minutes.	
MHCL 20/07/015	**Policy and Procedure - Section 117** The Committee reviewed the Policy & Procedure – Section 117. **Resolved that:** (a) the Committee approved the Policy & Procedure – Section 117.	
MHCL 20/07/016	**Any Other Business** The CC confirmed a Committee Development session was to be arranged.	**NF**
MHCL 20/07/017	**Date & Time of next Committee Meeting** Tuesday 20th October 2020 9:30am – 12:30pm Via Skype	

Confirmed Minutes of the Special Digital Health & Intelligence Committee
Thursday 9th July 2020 9:30am – 12:00pm
Via Skype

Chair:		
Eileen Brandreth	EB	Committee Chair / Independent Member - ICT
Members:		
Michael Imperato	MI	Committee Vice Chair / UHB Interim Vice Chair
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Charles Janczewski	CJ	Interim UHB Chair
Christopher Lewis	CL	Deputy Finance Director
Angela Parratt	AP	Director of Digital Transformation – IM&T
Len Richards	LR	Chief Executive Officer
David Thomas	DT	Director of Digital & Health Intelligence
Allan Wardhaugh	AW	Chief Clinical Information Officer
James Webb	JW	Information Governance Manager
Secretariat:		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		
Gary Baxter	GB	Independent Member
Jonathon Gray	JG	Director of Transformation & Implementation
Stuart Walker	SW	Executive Medical Director

DHIC 20/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**Action**
DHIC 20/07/002	**Quorum** The CC confirmed the meeting was quorate.	
DHIC 20/07/003	**Apologies for Absence** Apologies for absence were noted.	
DHIC 20/07/004	**Declarations of Interest** There were no declarations of interest.	
DHIC 20/07/005	**Minutes of the Committee Meeting held on 4th February 2020** The Committee reviewed the minutes of the meeting held on 4th February 2020. **Resolved – that:**	

	(a) The Committee approved the minutes of the meeting held on 4th February 2020 as a true and accurate record.	
DHIC 20/07/006	**COVID-19 Response** The Director of Digital & Health Intelligence (DDHI) introduced Angela Parratt, newly appointed Director of Digital Transformation (DDT) to the Committee. The DDHI explained the following: • 56/62 practices had gone live and were actively using video consulting; • In secondary care, 32 services are live, 15 are in design and a further 37 had expressed interest; • Attend Anywhere had exceeded 1000 consultations virtually; • Staff resource on the internet, patient facing waiting room and patient communication was being implemented across the UHB; • Zoom was used on an adhoq basis, there were concerns using this, therefore it was only used in extra ordinary circumstances; • Cystic Fibrosis team had used zoom to deliver virtual leisure centre exercises with positive feedback received; • Consultant Connect went live on 1st June 2020, and a further roll out was underway to 8 specialities who had expressed interest in the service, this was due to be completed in the coming weeks; • Hospisfy Platform was used on an adhoq basis; • Microsoft Teams had been rolled out across the UHB, first phase was 250 staff, it would be rolled out to everyone going forward, Teams would require complete integration with outlook therefore it would take time, however once Office 365 was installed by the end of September 2020, the UHB would be able to convert fully to Microsoft Teams; • Office 365 Implementation Board would be chaired by Allan Wardaugh – Chief Clinical Information Officer (CCIO); • Clinical data was being captured remotely via a locally built COM II system; • IT department had built 1400 laptops, 900 maraki boxes and set up 800 blackberry work devices to enable over 2000 employees to work remotely; • WiFi was fully funded by the UHB, instead of the Health Charity; • The IT team supported Dragons Heart Hospital to be fully connected within 2 weeks, the team were able to replicate a smaller version of UHW at the site, therefore all staff had the same access regardless which location they were based; • In relation to lessons learned, the team had created a culture of 'can do' and 'can do at pace' and the challenge was to ensure this would be continually supported. The DDT advised all hospital sites were configured at the same time as everything above, and as a new arrival to the UHB she was very impressed by the commitment and dedication of the digital team.	**DT**

	The CC commended the team on the significant achievement and expressed concern that the team felt appreciated and their achievement was recognised enough. The CC also asked the DDHI to ensure that staff wellbeing was monitored over the coming months. The UHB Chair echoed the comments made by the CC and recognised the work that the digital team had undertaken and achieved over the past few months. The UHB Chair expressed thanks to the whole digital team for the first class support provided across the UHB. The Chief Executive Officer (CEO) commented that the UHB would not have responded to COVID-19 as well as it had without the digital department. The CEO added there was significant work to be carried out across the UHB in relation to digital, therefore clarity would be required on what could be achieved at the new pace of delivery. A key element was Microsoft Teams, this initially had a 3 year delivery programme however it had been delivered within 3 months. The CEO added there had been a positive culture change towards digital across the UHB. The CC confirmed a letter of thanks would be sent out on behalf of the Committee, countersigned by the UHB Chair to the digital team. **Resolved – that:** (a) the Committee noted the COVID-19 Response and that the CC would write to convey recognition and thanks to the digital team.	**EB**
DHIC 20/07/007	**Digital Strategy – Final Version** The DDHI and CCIO introduced the strategy and confirmed the following: • Strategy had been shared with HSMB and was well received; • Strategy would continue to change and developed as technology adapted; • The team had identified objectives with the knowledge these would change over time; • UHB recognised it had not delivered elements of Shaping our Future Wellbeing and Digital was a key enabler of this; • Infrastructure review had been undertaken on an All Wales level and outputs identified all Health Board need to invest in this area; • DDHI lead the infrastructure review during COVID-19 and work was commended by Welsh Government, this was a very important Cardiff & Vale representation; • Strategy was based on open architecture around an open platform; • Three channels identified – Patient, Clinician and Analyst Channel; • Digital Management Board had been set up where all key decisions, investment and direction of travel would be agreed; • Information Governance group developed to address and overcome any Information Governance issues; • Crucial element would be to have patient and staff involvement at design phase.	

	The CEO explained the strategy demonstrated how digital could drive Shaping our Future Wellbeing. The CCIO added that in conversations held with other Health Boards, all Health Boards had the same desire to do things in the National interest but in an individual way to suit the organisations, therefore the UHB were pushing and trying to work collaboratively with Welsh Government, however there may be some difficulty experiences as Welsh Government want systems on an All Wales Level. The CEO explained the UHB needed to endorse the approach taken by the digital team and remain faithful to the strategy that is outlined. The UHB needed to be prepared to take risks and support the digital team as they moved forward. The CC agreed with the CEO and asked how the UHB were engaged with local authorities and communities that the UHB needed to share data with? In response, the CCIO confirmed engagement was at the National Resource Project, the DDHI added that the Digital Programme Board would include Local Authority representation. The CC asked if a change was seen within NWIS. In response, the DDHI explained NWIS was moving to become a special health authority, therefore would have a Board of Directors to ensure they are accountable, this was a positive step forward where the UHB would have an opportunity to shape discussions. The CC queried in relation to Governance where the Digital Management Board would report to? In response, the DDHI confirmed the Digital Management Board Terms of Reference explained the Board would report into Management Executive, HSMB and the Digital & Health Intelligence Committee. The CC advised the Committee that she would like to ensure Board had more direct conversations relating digital and recognise the significant level of investment needed in this area. In response, the CEO informed the Committee there had been changes at Executive level and going forward both DDHI and CCIO would report to the CEO, in addition to being invited to Board meetings as participants to ensure digital had more input at Board level. The CC commented this was very positive progress and welcomed the changes. **Resolved – that:** (a) the Committee noted the Digital Strategy – Update on Progress. (b) the Committee recommended the Digital Strategy to the Board for approval.	
DHIC 20/07/008 Khan,Raj 11/17/2020 16:20:13	**Any Other Business** The CEO explained a year ago the UHB carried out work with the Board on the UHB risk appetite which outlined where the Board felt the UHB were as an organisation and what the direction of travel would look like. The CEO added he would like this to be re-circulated to serve as a reminder to ensure	

	the UHB moved up the scale from a cautious organisation to a seeking organisation. The Director of Corporate Governance (DCG) would circulate the risk appetite to Committee members. **Resolved – that:** (a) the Committee noted the Any Other Business raised.	**NF**
DHIC 20/07/009	**Items to bring to the attention of the Board / Committees** It was agreed the following item would be taken to the Board for approval on 30th July 2020: (a) Digital Strategy **Resolved – that:** (a) the Committee noted the items recommended to the Board for approval.	**LT**
DHIC 20/07/010	**Review of the Meeting** The CC conducted a review of the meeting. All present confirmed the meeting had run very smoothly and good, positive discussions had been held.	
DHIC 20/07/011	**Date & Time of Next Meeting** Thursday 8th October 9:30am – 12:30pm Woodland House / Via Skype	

MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON WEDNESDAY 22 JULY 2020 CONDUCTED VIA MICROSOFT TEAMS

Present:	
Geoffrey Simpson	One Voice Wales (Chair)
Sam Austin	Llamau (items 20/12-20/18)
Frank Beamish	Volunteer
Sarah Capstick	Cardiff Third Sector Council
Zoe King	Diverse Cymru
Tim Morgan	South Wales Police
Lani Tucker	Glamorgan Voluntary Services
In Attendance:	
Nikki Foreman	Director of Corporate Governance, UHB
Abigail Harris	Executive Director of Strategic Planning, UHB
Angela Hughes	Assistant Director of Patient Experience, UHB (item 20/19 onwards)
Sherard Lemaitre	Clinical Director for Urgent Primary Care, UHB
Wendy Orrey	South Glamorgan Community Health Council
Anne Wei	Strategic Partnership and Planning Manager, UHB
Keithley Wilkinson	Equality Manager, UHB
Apologies:	
Mark Cadman	WAST
Jason Evans	South Wales Fire and Rescue Service
Iona Gordon	Cardiff Council
Tricia Griffiths	Carer
Shayne Hembrow	Wales and West Housing Association
Paula Martyn	Independent Care Sector
Secretariat:	Gareth Lloyd, UHB

SRG 20/12 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting. Frank Beamish, Tim Morgan and Lani Tucker were introduced as new members. It was noted that Jason Evans would be the new South Wales Fire and Rescue Service member of the SRG but had tendered his apologies for today's meeting.

The Chair took the opportunity to thank the UHB for sending the SRG the regular C-19 Stakeholder Briefs.

SRG 20/13 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

SRG 20/14 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 20/15 MINUTES AND MATTERS ARISING FROM STAKEHOLDER REFERENCE GROUP MEETING HELD ON 29 JANUARY 2020

The SRG **RECEIVED** and **APPROVED** the minutes of the SRG meeting held on 22 January 2020.

Draft Clinical Services Plan
Abigail Harris explained that the Clinical Services Plan engagement process had been delayed due to the UHB's response to the COVID-19 (C-19) pandemic. There was a need to review and refresh the Plan in light of C-19. Many of the elements have been accelerated in response to the pandemic, for example the transfer of more surgery from the UHW to the UHL site, the use of digital technology for remote consultations and the CAV 24/7 service which would be launched on 5 August. The intention was to undertake a comprehensive virtual engagement process during autumn 2020 with subsequent formal public consultations on specific elements of the Plan as necessary. Abigail Harris and Anne Wei would be meeting with the Consultation Institute on 29 July to discuss what good engagement would look like. The engagement process proposals would be shared with the SRG at its September meeting.

Major Trauma Centre
Abigail Harris reported that until the C-19 pandemic, the Health Boards had been on course to commence the Major Trauma Network and Major Trauma Centre at UHW from April. The Network had, however, taken the collective decision to pause the implementation process due to C-19. It was now anticipated that the Major Trauma Network and Major Trauma Centre would go live in September 2020. This would dovetail nicely with the imminent commencement of a 24/7 Emergency Medical Retrieval and Transfer Service which would be supplemented by a helicopter service from the autumn. The Network has acknowledged the need to respond to C-19 pressures and consideration might have to be given to Major Trauma triage and where patients are diverted.

SRG 20/16 FEEDBACK FROM BOARD

Nikki Foreman provided a brief verbal report on the key items discussed at the UHB Board meetings held on 26 March and 28 May 2020.

March

- The country had just entered lockdown and much of the discussion had centred on C-19. A reasonable worst case scenario of requiring an additional 600-2,000 beds for Cardiff and the Vale of Glamorgan had been identified. It had therefore been decided to create a temporary hospital at the Principality stadium which was subsequently named Dragon's Heart Hospital. Personal protective equipment, testing and self-isolation guidance had also been discussed.
- Routine Patient Safety and Performance Reports and the end of year Board Assurance Framework was discussed.
- The Strategic Outline Case for theatres at UHL had been approved.
- The Board Annual Work Plan was approved.
- The Move More Eat Well Plan was approved but its launch had been delayed until week commencing 27 July due to C-19. Anne Wei asked SRG members to help promote the Plan via their networks.

Action: All

May

- Tributes were paid to staff lost to C-19.
- The re-establishment of non C0-19 activity was discussed.
- Test Trace Protect was discussed.
- Lessons learned during the pandemic were discussed.
- Board Assurance Framework was discussed.one with routine risks and a separate one with C-19 risks. These had now been amalgamated into a single document.
- Patient Quality and Safety Report – Serious Incidents had decreased due to a decrease in activity
- The Medical Director presented a report assuring the Board that deaths were being reported correctly.
- Staff resources and wellbeing
- Nurse staffing levels
- The Service Delivery Plan for 2020/21 was signed off and subsequently submitted to Welsh Government.
- Executive Director of Finance had reported a £38m deficit at month one, £33m due to Dragon's Heart Hospital.

It was agreed minutes of the Board meetings would be sent to the SRG.

Action: Gareth Lloyd

SRG 20/17 SERVICE DELIVERY PLAN 2020/21

Abigail Harris explained that the Quarter 2 Plan had been produced and submitted to Welsh Government. It covered the period July-September 2020 and was the UHB's operational plan for the quarter. There was a need to ensure that services are C-19 ready. A suite of local indicators which overlap with national indicators, had been developed. These were monitored weekly and gave an early indication if C-19 cases are beginning to increase. The UHB is therefore better placed to understand the spread of C-19 in the community and make a quick appropriate response to any increase. It should however be remembered that many people with C-19 are asymptomatic which is why there remains a strong focus on hand hygiene and maintaining 2 metres distancing.

Another potential risk associated with the pandemic is delays to access to emergency or urgent care. The UHB has developed a plan to bring back as much of its pre-C-19 activity as possible whilst remaining C-19 ready. To facilitate this it has created green non C-19 zones and red C-19 zones on its sites with very strict segregation of areas. It was inevitable however that there would be a backlog of cases e.g. in cataract surgery.

The SRG was informed that at the beginning of the pandemic there had been a huge decrease in activity in Emergency Departments. There had also been an increase in non C-19 related death rate compared with recent years possibly due to people being reluctant to present at Emergency Departments or seek other medical advice. Physical distancing would make it impossible to maintain pre C-19 activity in the Emergency Department which is why the UHB would be launching the CAV 24/7 service.

Abigail Harris reported that the UHB and local authorities were working with care homes to make sure they have all the PPE, training and support they require. Welsh Government has launched a rapid review of C-19 in care homes and the UHB has met with the person leading the review and submitted evidence.

There has been considerable concern regarding deterioration of mental health during lockdown. The UHB has introduced a digital platform for many of its Mental Health and Child and Adolescent Mental Health services many of which would continue post pandemic. The majority of GP appointments are also now virtual or telephone consultations. The UHB is mindful of the need to ensure that people are not disadvantaged by digital exclusion and non-digital options for accessing services would therefore be maintained.

Abigail Harris highlighted the size of the achievement in commissioning the Dragon's Heart Hospital in such a short period of time. The Hospital had

been designed to be able to operate with reduced staffing levels. The UHB had decided to open a small number of beds at the Hospital to ensure that the operational policies and staffing levels were appropriate. The patients admitted were very carefully selected and the feedback from them regarding their experiences in the Hospital was overwhelmingly positive.

The UHB would need to retain some C-19 surge capacity and it was clear that the Dragon's Heart Hospital cannot remain at the Principality Stadium indefinitely. In discussion with Welsh Government it had been agreed that approximately 400 additional beds would be required in a reasonable worst case scenario. It was proposed that these would be provided on the UHW site in the area that had been earmarked for a sustainable travel hub. The funding was yet to be agreed.

The SRG enquired whether the UHB had a plan for managing the backlog and whether Welsh Government would provide additional resources to support this Abigail Harris explained that it was estimated that it would take 2-3 years to address the backlog. There was no full plan as to how this would be achieved but the UHB was working with other Health Boards and regional solutions might be the answer in many cases e.g. a regional cataract surgery service capable of providing high volume activity. Additional resources would be required including staffing. Fortunately the UHB was quite successful with its recruitment and had managed to recruit an additional 200 staff for the Major Trauma Centre. Recruitment of some staff groups such as Radiologists would undoubtedly be difficult as there were national recruitment difficulties. The UHB had signalled to Welsh Government the importance of continuing to use the Spire Hospital for NHS work until the end of the year. This would have to be funded but to date Welsh Government had made quick funding decisions during the C-19 pandemic.

The SRG enquired whether Equality Health Impact Assessments (EHIAs) would be undertaken for new methods of service delivery e.g. digital appointments. Abigail Harris confirmed that EHIAs would be undertaken. The UHB acknowledged that not everyone had access to digital technology or was comfortable using it and Abigail Harris re-iterated that face to face contacts would continue to be an option. The UHB had also engaged in discussions with the digital inclusion programme.

It was agreed that the Quarter 2 Plan be circulated to the SRG

Action: Gareth Lloyd

SRG 20/18 TRANSFORMING URGENT CARE CAV 24/7

The SRG received a presentation from Sherard Lemaitre on the CAV 24/7 service that would commence on 5 August.

The SRG was informed that although the number of attendances at Emergency Departments had fallen since the start of the C-19 pandemic, the majority of this reduction was in the category of cases that could be more appropriately dealt with in another setting. The new service would be a phone first service for all but true emergencies such as cardiac arrests or strokes. The intention is for 95% of calls to be answered within one minute. Callers would receive a return triage/assessment call from a Band 6 who would have medical support on shift usually a GP but there would also be two consultants in the service. Once patients have been assessed they will be directed to the right place first time which could be a booked appointment at the Emergency Department or signposting to a community service. This would result in a much better patient experience.

Abigail Harris reported that the Health and Social Services Minister had indicated that he expected all Welsh Emergency Departments to consider introducing a similar model. The UHB had been liaising with the Community Health Council (CHC) regarding the service and had agreed that it needed to be introduced as soon as possible. The service would be very much a pathfinder and it was likely to be adapted as lessons were learned. Rapid feedback from patients and staff would be an integral part of this process and there would continue to be regular discussion with the CHC.

Abigail Harris informed the SRG that there was usually a spike in non-emergency Emergency Department attendances during September and October. This was due to students returning to the area but not registering with local GPs. The UHB was working with local Universities to encourage students to register with GPs as soon as possible.

The SRG generally supported the introduction of CAV 24/7 but made some observations.

- It may be difficult for some groups such as the homeless, vulnerable or victims of domestic abuse or violence to access the service. Sherard Lemaitre assured the SRG that this had been taken into consideration. The UHB was liaising with the IRIS service and call handlers would be undergoing training the following week. A meeting had been arranged with third sector organisations working in the mental health field to discuss how patients would be streamed. There would always be someone at the front door of the Emergency Department and no-one would be turned away although they might be advised that there was a better way to access help.
- Successful communications with the public would be critical to the success of the service. Sherard Lemaitre reported that there was a comprehensive communications plan. Resource packs were being

produced for partner organisations, posters would be put up in high footfall areas and the UHB was liaising with local community groups, schools, religious organisations, sensory loss charities etc. and a meeting was being arranged with South Wales Police. A Facebook live session has been arranged and it was hoped that there would be further publicity on the BBC.

- How will the service interface with NHS Direct? The SRG was informed that there had been discussion with the 111 Programme Director and senior managers within NHS Direct. There were two separate IT systems but a solution has now been identified and would be implemented as soon as practically possible.
- An EHIA would be required to ensure mitigating actions were identified to address any negative impact on any groups.
- Currently if patients in the western Vale of Glamorgan contact the Out of Hours service and a need to attend an Emergency Department is identified, they are currently referred to the Emergency Department in Princess of Wales Hospital. Sherard Lemaitre explained that the existing Service Level Agreement with Cwm Taf Morgannwg UHB would continue but patients would be have the choice of where to receive their treatment.

It was agreed that the SRG would receive an update on the CAV24/7 service at its meeting in September. In the meantime, the UHB would be grateful if SRG members could help to promote the service through their own networks.

SRG 20/19 PHOENIX PROGRAMME

The SRG received a presentation from Abigail Harris on how the UHB was moving beyond the C-19 emergency response

Abigail Harris began by explaining that there were ongoing discussions within the UHB regarding a more appropriate name for the programme. The programme had three phases: emergency response, restart and recovery and rebuilding and renewal although it was important to understand that this was not a linear process.

A number of the changes introduced in response to C-19 had been extremely positive. A comprehensive learning programme has been established which would help identify those which should be maintained. One of the key national findings has been that the 'just in time' supply principle is not always appropriate and some stockpiling of items will be required.

Abigail Harris informed the SRG that winter planning presented a real challenge. It was anticipated that more people than usual would want to receive the flu vaccine and the UHB was also gearing up for a C-19

vaccination programme from September-April should a vaccine become available.

A reset roadmap would be considered by the UHB Board. The Executives would have oversight with sponsorship of key workstreams using the 'alliancing' approach whereby a wide range of different staff not just senior managers will be part of the decision making process.

The SRG suggested that in developing services it would be important to engage with the third sector to ensure seamless services. Abigail Harris acknowledged the importance of this relationship and confirmed that an internal meeting had been arranged to discuss the interface with the third sector.

Angela Hughes suggested that the virtual editorial panel could advise on how best to describe the programme.

SRG 20/20 ANY OTHER BUSINESS

SRG Chair
Anne Wei reminded the SRG that the cancelled March meeting would have been Richard Thomas' last as Chair and member of the SRG. Geoff Simpson had kindly agreed to assume the Chair on an interim basis pending the appointment of a substantive Chair. Anne Wei would be writing to SRG members seeking expressions of interest in the role of Chair

Action: Anne Wei

SRG Eligibility
Gareth Lloyd reported that he had written to all SRG members asking them to complete and return a form confirming their continued eligibility for the Group. He requested that those yet to return their forms could please do so as soon as possible.

Action: All

SRG 20/21 NEXT MEETING OF SRG

Microsoft Teams meeting, 9.30am-12.00pm on Wednesday 23 September.

On behalf of the SRG the Chair concluded the meeting by thanking all NHS, Social Care and Third Sector staff for their efforts during the C-19 pandemic.

Minutes of a Local Partnership Forum meeting held on 3 August 2020 at 10am, remotely and in Nant Fawr 1, Woodland House

Present	
Martin Driscoll	Exec Director of Workforce and OD (co-Chair)
Mike Jones	Chair of Staff Representatives/UNISON (co-Chair)
Len Richards	CEO
Joe Monks	UNISON
Julie Cassley	Deputy Director of WOD (co-Chair)
Steve Gaucci	UNISON
Peter Hewin	BAOT/UNISON
Jo Brandon	Director of Communication and Engagement
Ruth Walker	Exec Director of Nursing
Ceri Dolan	RCN
Rhian Wright	RCN
Abigail Harris	Exec Director of Strategy and Planning (part of meeting)
Dorothy Debrah	BDA
Andrew Crook	Head of Workforce Governance
Rachel Gidman	Assistant Director of OD
Nicola Foreman	Director of Corporate Governance
Lianne Morse	Head of HR Operations
Caroline Bird	Deputy COO
Pauline Williams	RCN
Chris Lewis	Deputy Director of Finance
Rebecca Christy	BDA
In Attendance:	
Cheryl Williams	Public Health Wales
Nicola Bevan	Head of Employee Health and Wellbeing
Apologies	
Fiona Salter	RCN
Peter Welsh	General Manager UHL and Barry
Dawn Ward	Independent Member – Trade Union
Bill Salter	UNISON
Fiona Jenkins	Exec Director of Therapies and Health Science
Stuart Walker	Medical Director
Bob Chadwick	DOF
Mat Thomas	UNISON
Janice Aspinall	RCN
Secretariat	
Rachel Pressley	Workforce Governance Manager

LPF 20/040 WELCOME AND INTRODUCTIONS

Mr Driscoll welcomed everyone to the meeting

LPF 20/041 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

LPF 20/042 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF 20/043 MINUTES OF PREVIOUS MEETING

The minutes from 18 June 2020 were confirmed as an accurate record of the meeting.

LPF 20/044 ACTION LOG

The action log was noted

LPF 20/045 PHYSICAL DISTANCING

Cheryl Williams, Principal Health Promotion Specialist from Public Health Wales gave a presentation on physical distancing in the workplace. She reminded the Forum of the reasons why practising two metres physical distancing is so important, talked about what had been done so far, and what was planned future to promote this. She noted that there was a lot of concern that physical distancing was not happening in all staff groups and asked the Forum for any ideas on how this could be improved.

Mr Jones advised that he was aware that there had been improvements in among certain staff groups though there were other areas which still caused concern.

A small number of local issues were raised including the use of 'sneeze screens' in reception areas and breaks in ITU and it was agreed that these needed to be picked up locally. Ms Bird advised that screens would be picked up as part of the outpatients programme.

Mrs Walker indicated that at a recent UHB wide zoom meeting, views had have been sought on physical distancing and a number of points had been raised including:

- confusion around the appropriate distance (was it 1 or 2 metres?)
- the posters needed refreshing
- markers on the floor would be useful
- not all staff understood the science behind physical distancing very well
- there needed to be clearer messages re washing of mugs, phones etc
- Clinical Boards had been asked to ensure that breaks and handovers were planned in a way that enabled physical distancing
- face coverings should be used if it was not possible to physically distance
- staff areas which the public were not allowed to enter eg in Aroma would be helpful

Ms Williams thanked Mrs Walker for this information. She advised that there were plans for the posters to be refreshed and for more stickers to go onto the floor, and a film was being developed with the Communications team around the science behind physical distancing. Ms Brandon added that when the hospitals were open to visitors and the footfall increased a one way system would be very important and Estates were working through some practical issues relating to this. She asked if anyone had any examples of best practise that could be shared and Mrs Bevan volunteered the Occupational Health Department for this.

Mr Richards stated that it was really very important to get better at physical distancing. He noted that if there was an increased prevalence TTP would have a greater impact, and we could lose large groups of staff if physical distancing was not practiced. This would have an impact on the service so the stakes were very high and could become higher if the prevalence of COVID increased in the community.

Mr Hewin noted that shielding is due to pause from 16th of August. He understood that a risk assessment needed to be completed, but pointed out that working from home is distancing in itself though there was still resistance to this in some areas. He reminded the Forum that a joint statement on agile working had been developed and now needed to be publicised. Mrs Cassley advised that the shielding task and finish group were meeting later on that day and guidance was due to be issued on the pausing of shielding. She agreed that whether working at home or in the workplace the key message was that staff should be working in a safe environment. The individual role and individual needs needed to be explored and therefore the risk assessment conversation was critical. Mr Driscoll stated that they would not be a wholescale move to a different position from the 16th August, rather each case needed to be managed individually.

LPF 20/046 HEALTH AND WELLBEING UPDATE

Mrs Bevan provided the Local Partnership Forum with a wellbeing update focusing on three phases:

- active (ie what had been done) e.g. EWS rapid access, resources, accommodation, staff havens
- co-existing (what we are doing) e.g. bespoke support for managers so they can support their teams, UHB TTP
- recovery (what we are planning)

She emphasised that the recovery phase needs to be evidence based and sustainable, and would take a three stage approach itself (prevent, detect and treat) using the PIES model (proximity, immediacy, expectancy, simplicity). It was important to embed wellbeing throughout the employment life scale and to make sure that staff felt confident to discuss their own wellbeing.

Mrs Kinghorn noted that some fantastic work had been done and it was clear that public health thinking and prevention was embedded throughout. She said it would also be good to also see links with the Move More Eat Well programme.

Mr Hewin noted that mental health was peaking and was likely to still be at its peak at the time of an expected second wave, which would have staffing implications. Mr Richards stated that the organisation had mobilised really well when we had a significant number of patients and we needed to continue to mobilise but staff were tired, frustrated and anxious. He agreed the best response to this was in close proximity and wondered how we could support local areas and wards as they required it. Mrs Bevan advised that there is evidence that counselling and the medical model is not the best way to tackle this rather we should have people such as managers, deputies and chaplains who are in that area and who can talk and ask how individuals are and listen to them.

LPF 20/047 PERFORMANCE UPDATE

Ms Bird advised the Forum that Welsh Government had relaxed its targets and monitoring arrangements in March 2020. Some of these had been reintroduced from June, but the focus was on minimising harm rather than time. The UHB had also started to increase activity and to reintroduce some routine services at that time. The delivery of services now had a new level of complexity and there were attempts to minimise the number of hospital services by providing virtual appointments instead. Flow was being managed very differently but activity had now increased within both unscheduled and planned care and was now at between 75% and 80% of previous levels.

Ms Bird noted the workforce had done a fantastic job but they were tired and now had to prepare for winter pressures. She thanked Mrs Bevan for an excellent presentation and noted that there were more lessons to learn. She said that the Clinical Boards were working on this and were listening to their staff.

A Quarter 2 plan had been prepared which included an operating framework of short four to six weeks cycles with the focus of harm and being COVID ready. Capacity plans were being constantly reviewed and work was taking place around green zones and additional capacity (eg at the Spire hospital) and extended footprints (eg in the emergency unit) to make the environment safe.

It was noted that CAV 24/7 was going live that week and that a clinically led outpatients programme was working across primary and secondary care. An update on this work would be provided at a future meeting.
ACTION: Ms Bird

A copy of the presentation prepared for this meeting would be shared with Forum members.
ACTION: Dr Pressley

LPF 20/048 CEO UPDATE

Mr Richards wished to reinforce that the organisational response to COVID-19 had been nothing short of remarkable. He said that the flexibility, commitment and the way the people had come together and volunteered outside of their normal areas was both humbling and boded well for the future.

He noted that it had been very challenging and would continue to be so going forward. He stated that it was important to get behind the health and wellbeing work that was taking place and to support staff during this down time, before they may have to do it again. Mr Richards reminded the Forum that we need to try and keep on top of COVID and be ready for future spikes, but how we dealt with non-COVID work was also quite a complicated prospect. He stated that there were complex times ahead but the key challenge was how we support our staff.

Mr Driscoll advised the Forum that he and Mrs Gidman had been having conversations with senior leaders about the lessons learned over the last few months and would share their findings at the next LPF meeting.
Action: Mr Driscoll/Mrs Gidman

LPF 20/049 FINANCE REPORT

Mr Lewis referenced the detailed finance report that was presented to the Finance Committee and gave a more strategic update to the LPF.

In March, the UHB were informed by Welsh Government that whilst it had an approvable plan, the IMTP process had been paused for an indefinite period to concentrate on the response to the pandemic. Whilst the UHB is still being monitored against our break even position plan, the main focus was on justifying additional expenditure incurred in dealing with COVID-19. What is key to the Health Board is how it recovers from this period where it needs to avoid adding recurrent expenditure to its cost base, manage the operational position and embed the many positive transformational changes that had been delivered at pace due to necessity,

Reference was then made to Table 8 in the finance report on the forecast financial position where the UHB is reporting a year to date deficit of £45.8m at month 3 and a full year forecast deficit of £139.4m.

In response to a query from Mr Jones, Mr Lewis confirmed that there was an expectation that WG would fund all COVID-19 related costs in 2020/21. In addition, that it would make good its underlying position so that it entered 2021/22 where it finished in 2019/20

LPF 20/050 QUALITY, SAFETY AND EXPERIENCE REPORT

Mrs Walker thanked all staff who had participated in the PPE follow up audit and advised that the results of this would be shared. She wanted to reiterate the importance of physical distancing following the lessons learned from an outbreak on Ward E2. She also emphasised the importance of following correct IP&C process is to keep both patients and staff safe.

LPF 20/051 ANY OTHER BUSINESS

It was agreed that two items of AOB would be referred to the Workforce Partnership Group for follow up and discussion as appropriate:

- Maximising Attendance at Work Policy Training
- Pay Progression

Action: Dr Pressley

Mr Driscoll noted that this was Dorothy Deborah's last LPF meeting as she was due to retire – he thanked her for all the time and effort she had put into the Forum over the years and wished her well for the future.

LPF 20/052 FUTURE MEETING ARRANGEMENTS

The next meeting is scheduled to take place on Thursday 22 October at 10am, remotely and in Room Nant Fawr 1, Woodland House (with a staff reps pre meeting at 9am)

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – SEPTEMBER 2020

The Welsh Health Specialised Services Committee held its latest public meeting on 8 September 2020 with a 'consent agenda', as described on the WHSSC website. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

Written questions from members and answers had been published in advance of the meeting and would be embedded within the meeting papers.

The papers for the meeting are available at:
http://www.whssc.wales.nhs.uk/2020-21-whssc-joint-committee

Minutes of Previous Meeting
The minutes of the meeting of 14 July 2020 were taken as read and approved.

Action log & matters arising
Members noted there were no outstanding actions or matters arising.

Chair's Report
The Chair's Report referred members to a Chair's Action taken on 14 July 2020 to approve temporary amendments to the WHSSC Standing Orders, which was ratified.

The Chair reported that, as planned, this would be her last meeting and that the Minister had appointed her replacement, the details of which would be announced shortly.

Managing Director's Report
The Managing Director's report, including updates on a new commissioning assurance framework and Radio-frequency Ablation for Barrett's Oesophagus, was taken as read.

TAVI Management of Severe Aortic Stenosis during the COVID-19 Pandemic

Members received a paper outlining the current situation and the impact of the COVID-19 pandemic on the management of severe aortic stenosis and the evidence to support the short term commissioning arrangements for TAVI for the intermediate patient group during the pandemic, together with proposed funding arrangements.

Members (1) supported the recommendation that WHSSC formally changes the commissioning policy to include intermediate risk patients but allows decision making on individual cases to be taken by clinical discretion through the MDT process, and (2) approved the WHSSC position regarding funding in that payments under the block contract and pass through arrangements for TAVI devices will be limited up to 2019-20 outturn levels.

Options Appraisal for a Permanent Perinatal Mental Health In Patient Mother and Baby Unit (MBU) in Wales

Members received a paper that informed them of the options appraisal exercise and scoring of the short listed options for a permanent perinatal mental health in patient MBU in Wales.

It was reported that a letter from the Board of Community Health Councils in Wales had been received that was supportive of the options appraisal process but noted that more further formal public engagement was expected on the options once a preferred option was identified.

Members (1) noted that both options meet the WHSSC service specification, (2) supported the recommendation from the non-financial options that Neath Port Talbot Hospital is the preferred location of a permanent mother and baby unit, and (3) noted that the final preferred option will be subject to the usual business case process to access Welsh Government capital.

Major Trauma Network Readiness Assurance Update

Members received a paper that provided final assurance that the South Wales Trauma Network is ready to go live on 14th September 2020.

Members received final assurance and noted that following a robust assessment process by the Trauma Network Team and as recommended by the Trauma Network Implementation Board all component parts of the Trauma Network are ready and the Network can proceed to launch on 14th September 2020.

Welsh Renal Clinical Network 2019-20 Annual Report

The Welsh Renal Clinical Network 2019-20 Annual Report was taken as read.

Financial Performance Report – Month 4 2020-21

A paper that set out the financial position for WHSSC for month 4 of 2020-21, including a forecast under spend of £6m at year end, was taken as read. The under spend related mainly to months 1-4 underspend on the pass through elements of Welsh provider SLA's, COVID-19 block arrangements with NHSE for Q1 and Q2 below the plan baseline and Q1 2020-21 development slippage.

The Director of Finance reported that, while the full month 5 report was not yet available, the position had continued to improve.

Other reports

Members also took as read the update reports from the following joint Sub-committees and Advisory Groups:

- All Wales Individual Patient Funding Request Panel;
- Integrated Governance Committee;
- Management Group;
- Quality & Patient Safety Committee; and
- Welsh Renal Clinical Network Board.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SPECIALISED SERVICES COMMITTEE JOINT COMMITTEE MEETING – OCTOBER 2020

The Welsh Health Specialised Services Committee held its latest public meeting on 13 October 2020 with a 'consent agenda', as described on the WHSSC website. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:

https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2020-2021-meeting-papers/

Reducing harm due to COVID-19: Stereotactic Ablative Radiotherapy and Brachytherapy

Members received a paper that requested approval for in-year funding to expand the commissioned indications for Stereotactic Ablative Radiotherapy (SABR) and Brachytherapy in order to provide additional, evidence based, treatment options to support the reduction of harm related to the COVID-19 pandemic.

Members (1) noted that clinical evidence favours the routine commissioning of SABR to treat patients with Oligometastatic cancer and Hepatocellular carcinoma; (2) noted treating patients with SABR helps to reduce COVID related harm since the relative benefits of SABR compared with alternative treatment modalities (surgery or systemic therapy) increase when there is risk of infection with COVID-19; (3) noted clinical evidence favours the routine commissioning of Brachytherapy to treat patients with intermediate and high risk localised prostate cancer; (4) noted by substituting for a proportion of external beam radiotherapy, the provision of brachytherapy for intermediate and high risk prostate cancer patients will allow increased radiotherapy throughput, reducing COVID related harm by increasing the ability to treat backlog and manage any future surge of previously suppressed demand; (5) approved commissioning SABR for patients with Oligometastatic cancer and Hepatocellular carcinoma in line with WHSSC's draft commissioning policies as in-year service developments on an interim basis for 6

months; (6) approved commissioning Brachytherapy in line with WHSSC's draft commissioning policy as an in-year service development on an interim basis for 6 months; and (7) noted recurrent funding for SABR for Oligometastatic cancer and Hepatocellular carcinoma, and Brachytherapy for intermediate and high risk prostate cancer, will be considered through the WHSSC ICP process for 2021-24.

Report Title:	**FINANCE COMMITTEE KEY ISSUES REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	26th November 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chris Lewis, Interim Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the 23rd September 2020.

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

The Welsh Government wrote to the UHB on 19th March 2020 to inform it that it had an approvable 2020/21 Plan, however the UHB was also informed that Welsh Government had paused the IMTP process for an indefinite period so that organisations could focus on the challenges of COVID- 19.

Welsh Government is monitoring the UHB against its submitted plan in order to assess the financial impact of COVID- 19. The challenges of managing COVID- 19 continues to drive significant costs in 2020/21 and in this context the main financial focus has been on justifying and scrutinizing additional expenditure incurred in dealing with COVID- 19 and assessing its impact on the reported financial position. The UHB also needs to keep in check its non COVID operational position, particularly as planned workflows come back on line, to ensure that financial control is maintained and to avoid the addition of recurrent expenditure to the underlying position. This is a period of both significant financial risk and opportunity for the UHB

Assurance is provided by the scrutiny of financial performance including the additional cost of managing COVID- 19 undertaken by the Finance Committee.

Assessment and Risk Implications

Financial Performance Month 5

The report updated the Committee on the UHB's financial plan.
The UHB developed plans at pace for managing COVID 19 including the deferral of elective work and an increase to available bed capacity to manage surges in activity.

The Welsh Government had amended the monthly financial monitoring returns to capture and monitor net costs due to COVID 19 that were over and above LHB plans. The financial position reported to Welsh Government for month 5 was a deficit of £27.565m as summarised in table 1 below:

Table 1: Month 5 Financial Position 2020/21

	Month 1 £m	Month 2 £m	Month 3 £m	Month 4 £m	Month 5 £m	Total £m
COVID 19 Additional Expenditure	38.438	17.290	5.330	6.565	10.597	78.220
COVID 19 Non Delivery of Savings Plans	2.118	2.150	2.056	2.094	1.752	10.170
COVID 19 Reductions in Planned Expenditure	(2.522)	(4.241)	(2.921)	(1.626)	(1.885)	(13.195)
COVID 19 Release of Planned Investments	0.000	(0.168)	(0.679)	(0.089)	(0.244)	(1.180)
Net Expenditure Due To COVID 19	38.034	15.030	3.786	6.944	10.220	74.014
Operational position (Surplus) / Deficit	0.191	(0.048)	(0.204)	0.244	(0.361)	(0.177)
Welsh Government COVID 19 funding received			(11.016)	(0.306)	(34.950)	(46.272)
Financial Position (Surplus) / Deficit £m	38.225	14.982	(7.434)	6.882	(25.091)	27.565

The table shows that the key driver of the month 5 financial postion was the impact of COVID 19.

The additional COVID 19 expenditure in the 5 months to the end of August was £78.220m. Within this, the costs of the Dragon's Heart Hospital were significant, especially the set up costs which allow for significant expansion. At month 5 costs of £45.216m related to the Dragon's Heart Hospital (DHH). There was also £33.004m of other COVID 19 related additional expenditure.

COVID 19 was also adversley impacting on the UHB savings programme with underachievment of £10.170m against the month 5 target of £12.283m. This peformance was not expected to significantly improve until the COVID 19 pandemic passed.

Elective work had been significantly curtailed during the first 5 months of the year as part of the UHB response to COVID 19 and this had led to a £13.195m reduction in planned expenditure.

The UHB had also seen slippage as a commissioner of £1.180m on the WHSSC commissioning plan due to the impact of COVID 19.

The net expenditure due to COVID 19 was £74.014m. The UHB also had a small operating underspend of £0.177m and had allocated specific additional Welsh Government COVID funding of £46.272m against COVID costs resulting in a Month 5 deficit of £27.565m.

At month 5, he financial forecast of additional costs arising in 2020/21 from COVID- 19 that are over and above LHB plans was assessed as £148.8m and these costs were offset by confirmed additional COVID 19 funding of £55.2m leaving a forecast deficit of £93.6m as as summarised in the table below:

	Cumulative Month 5 £m	Forecast Year End Position £m
COVID 19 Additional Expenditure	78.220	145.081
COVID 19 Non Delivery of Savings Plans	10.170	24.331
COVID 19 Reductions in Planned Expenditure	(13.195)	(19.430)
COVID 19 Release of Planned Investments	(1.180)	(1.180)
Net Expenditure Due To COVID 19	74.014	148.802
Operational position (Surplus) / Deficit	(0.177)	0.000
Welsh Government COVID 19 funding received	(46.272)	(55.185)
Financial Position (Surplus) / Deficit £m	27.565	93.617

The revised forecast was an improvement of £37.8m compared to the forecast year end position reported at month 4. The improvement was the result of confirmation of an additional £35m Welsh Government COVID funding and a reduction of £2.8m in forecast COVID related costs.

Within the forecast the Dragon's Heart Hospital costs were assessed at £63.3m with a further £2.6m capital costs.

It was noted that the forecast contained some significant variables and was based on a number of volatile assumptions and took no account of any further Welsh Government funding to help meet these costs. It was expected that Welsh Government would be in a position to provide the UHB with further clarity in respect of additional COVID related funding streams during the course of September.

The forecast year end underlying deficit was £25.4m which was £21.4m more than the planned £4m identified in the submitted IMTP as a result of the slippage against savings schemes.

Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 3 of the risks identified on the 2020/21 Risk Register were categorized as extreme risks (Red) namely:

- Reduction in the £11.5m underlying deficit c/f to 2020/21 to the IMTP planned £4m c/f underlying deficit in 2021/22.
- Delivery of the 3.5% CIP (£29m)
- COVID-19 impact on financial plan

The number of extreme risks had been reduced by one in month following a review of the risk around the management of budget pressures which had been re-assigned from an extreme to a high risk in August.

Value Based Healthcare and its Use in Decision Making at Cardiff & Vale UHB

A presentation on the application of the principle of Value Based Healthcare within the UHB was made to the Committee. The presentation outlined the benefits associated with reinvestment from low to high value care within existing resources and highlighted the re-design of the

General Surgery service as a successful example of the application of the concept within the UHB.
Recommendation: The Board is asked to: • **NOTE** this 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	X
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	**X**	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**FINANCE COMMITTEE KEY ISSUES REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	26th November 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chris Lewis, Interim Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the 28th October 2020.

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

The Welsh Government wrote to the UHB on 19th March 2020 to inform it that it had an approvable 2020/21 Plan, however the UHB was also informed that Welsh Government had paused the IMTP process for an indefinite period so that organisations could focus on the challenges of COVID- 19. Welsh Government is monitoring the UHB against its submitted plan in order to assess the financial impact of COVID- 19.

With the operation imperative being managing the impact of COVID 19, the initial financial focus was on justifying additional expenditure incurred in dealing with the pandemic. Welsh Government has now set out the resources available to support the COVID 19 response. There is now an expectation that NHS bodies will manage within these resources to deliver their original planned position, which for the UHB was a break even position by year end.

How the UHB recovers from the pandemic is also key and in this context the UHB needs to avoid adding recurrent expenditure to its underlying position and to embed the many transformation changes that have been delivered at pace.

Assurance is provided by the scrutiny of financial performance, including the additional cost of managing COVID- 19 undertaken by the Finance Committee.

Assessment and Risk Implications

Financial Performance Month 6

The report updated the Committee on the UHB's financial plan.
The UHB developed plans at pace for managing COVID 19 including the deferral of elective work and an increase to available bed capacity to manage surges in activity.

The Welsh Government has amended the monthly financial monitoring returns to capture and monitor net costs due to COVID 19 that were over and above LHB plans. The financial position reported to Welsh Government for month 6 was an underspend of £0.271m as summarised in table 1 below:

Table 1: Month 6 Financial Position 2020/21

	Month 1 £m	Month 2 £m	Month 3 £m	Month 4 £m	Month 5 £m	Month 6 £m	Total £m
COVID 19 Additional Expenditure	38.438	17.290	5.330	6.565	10.597	7.939	86.159
COVID 19 Non Delivery of Savings Plans	2.118	2.150	2.056	2.094	1.752	(1.709)	8.461
COVID 19 Reductions in Planned Expenditure	(2.522)	(4.241)	(2.921)	(1.626)	(1.885)	(0.960)	(14.155)
COVID 19 Release of Planned Investments	0.000	(0.168)	(0.679)	(0.089)	(0.244)	(0.142)	(1.322)
Net Expenditure Due To COVID 19	38.034	15.030	3.786	6.944	10.220	5.129	79.143
Operational position (Surplus) / Deficit	0.191	(0.048)	(0.204)	0.244	(0.361)	(0.094)	(0.271)
Welsh Government COVID 19 funding received			(11.016)	(0.306)	(34.950)	(32.871)	(79.143)
Financial Position (Surplus) / Deficit	38.225	14.982	(7.434)	6.882	(25.091)	(27.836)	(0.271)

The table shows that the key reason for the improvement in the financial postion in month 6 was the receipt of additional Welsh Government funding to cover the additional costs arising from the impact of COVID 19.

The additional COVID 19 expenditure in the 6 months to the end of September was £86.159m. Within this, the costs of the Dragon's Heart Hospital were significant, especially the set up costs which allow for significant expansion. At month 6 costs of £45.125m related to the Dragon's Heart Hospital (DHH)**.** There was also £41.034m of other COVID 19 related additional expenditure.

COVID 19 was also adversley impacting on the UHB savings programme with underachievment of £8.461m against the month 6 target of £14.648m. This represented an improvement of £1.709m on the shortfall at month 5 following the realisation of circa £3.614m non recurrent opportunities. Further improvement is not anticipated until the COVID 19 pandemic passes.

Elective work had been significantly curtailed during the first 6 months of the year as part of the UHB response to COVID 19 and this had led to a £14.155m reduction in planned expenditure.

The UHB had also seen slippage as a commissioner of £1.322m on the WHSSC commissioning plan due to the impact of COVID 19.

The net expenditure due to COVID 19 was £79.143m and this was matched by an equal amount of additional Welsh Government COVID 19 funding. The UHB also had a small operating underspend of £0.271m leading to a net reported surplus at month 6.

Whilst the UHB expects the non COVID related operational position to remain broadly balanced as the year progresses, the additional costs arising from plans to manage COVID 19 are expected to continue. The forecast at month 6 of net expenditure due to COVID 19 in 2020/21 was £153.306m and this is offset by confirmed additional COVID 19 and Urgent and Emergency funding of £153.306m as summarised in table 2 below:

Table 2 : Summary of Forecast COVID 19 Net Expenditure

	Cumulative Month 6 £m	Forecast Year-End Position £m
COVID 19 Additional Expenditure	86.159	153.290
COVID 19 Non Delivery of Savings Plans	8.466	20.502
COVID 19 Reductions in Planned Expenditure	(14.160)	(19.214)
COVID 19 Release of Planned Investments	(1.322)	(1.272)
Net Expenditure Due To COVID 19	**79.143**	**153.306**
Operational position (Surplus) / Deficit	(0.271)	0.000
Welsh Government COVID funding received / assumed	(79.143)	(153.306)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**	**0.000**

The revised forecast was an improvement of £93.617m compared to the forecast year end position reported at month 5. The improvement was the result of confirmation of additional Welsh Government funding based upon the resource assumptions set out in the NHS Wales Operating Framework 2020/21 for Q3 and Q4.

Within the forecast the Dragon's Heart Hospital costs were assessed at £63.2m with a further £2.6m capital costs.

It was noted that the forecast was based on a number of variable assumptions and assumed Welsh Government funding to help meet the additional costs arising from COVID 19.

The forecast year end underlying deficit was £25.2m which was £21.2m more than the planned £4m identified in the submitted IMTP as a result of the slippage against savings schemes.

Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 2 of the risks identified on the 2020/21 Risk Register were categorised as extreme risks (Red) namely:

- Reduction in the £11.5m underlying deficit c/f to 2020/21 to the IMTP planned £4m c/f underlying deficit in 2021/22.
- Delivery of the 3.5% CIP (£29m)

Following confirmation of additional non recurrent Welsh Government funding, the risk in respect of the impact of COVID-19 on the financial plan had been re-assigned from an extreme to a moderate risk in September, thus reducing the number of extreme risks by one in month.

Recommendation:

The Board is asked to:

• **NOTE** this 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	X
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	**X**	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**Quality, Safety & Experience Committee – Chair's Report**										
Meeting:	**Board Meeting**							**Meeting Date:**	**26/11/2020**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**			
Lead Executive:	**Chair Quality, Safety & Experience Committee**										
Report Author (Title):	**Corporate Governance Officer**										

SITUATION

To provide the Board with a summary of key issues discussed at the Quality, Safety & Experience Committee held on 13th October 2020.

Hot Topics

The Committee was advised of small cluster of COVID-19 positive cases at Llandough Hospital involving 3 patients and 1 member of staff. Epidemiology has been done and traced to the same cluster. This is not escalating.

The Committee was advised that it is a difficult phase of the COVID-19 pandemic. There is an increase in community COVID-19 positive cases however this is not being reflected in hospital admissions at present but the Committee was advised to remain alert and plans are in place for the delivery of a COVID-19 response with capacity demand and assessments.

The Committee was advised of a significant event in relation to the commencement of the major trauma service. A patient did not get the treatment required due to a potential gap in service provision for a paediatric vascular surgery sub speciality. The Executive Medical Director attended a meeting prior to the Committee meeting and a reassuring outcome and solution is now in place regarding this.

The Committee noted the affects that the COVID-19 pandemic was having on staff resilience and a discussion was had around the effects of this. The fear of a lack of resilience is more challenging to staff rather than an actual lack of resilience. The Committee was advised that there is confidence that people will step up as they did in previous stages of the COVID-19 pandemic.

The Committee noted that access to the wellbeing service is good.

The Committee was given assurance that the health board have large quantities of PPE in store.

Quality, Safety and Experience Themes and Trends 2019-2020

The Committee was advised that the concept of Never events are becoming increasingly contentious and that the thinking is being challenged.

Serious Incidents (SI) are currently reported to the Welsh Government (WG) and from October 2020 are reported to the Health in Wales delivery unit (DU). All SIs need to be reported to the DU within 24 hours of the incident and the Committee noted that this can be quite challenging.

The Committee was advised that the timeliness of the investigation process for SI needs to be improved and to also strengthen the sharing of any lessons learnt.

The Committee noted that electronic reporting was introduced into the health board in January 2015 and in 2018 a sharp rise in serious incidents was noted due to the WG asking for all pressure damage grades 3, 4 and unstageable to be reported. WG revised this in 2019 and only avoidable grades 3, 4 and unstageable pressure wounds along with other serious incidents were to be reported.

The Committee noted that a decrease in reporting has occurred this year as WG have altered the requirements of what is needed to report on due to the ongoing COVID-19 pandemic.

The Committee noted that there have not been any incidents that are going through the safeguarding process where actions for health have been required and all of the cases have been closed in the safeguarding routes.

The Committee was advised of the increased challenges with the Coroner's inquests due to the ongoing COVID-19 pandemic. The Committee noted that inquests to be held are usually expected from the Coroner within 6 to 9 months of a patient's death however at present the Coroner is listing cases toward the end of 2021. This also has an impact on families of patients.

The Committee noted that an improvement has been made on the risk assessments of patients this year which is encouraging.

The Committee was advised that the falls delivery group continue to meet and excellent community work is underway and it was noted that there will be a refocus on inpatient falls because community work is very well established.

The Committee noted that the Incident reporting mechanism for pressure damage is proving challenging. There are a lot of duplicate incidents due to staff not using the free text option when reporting. The Committee advised that staff need to be made aware of the free text use so that reporting is accurate. It was noted that audit is a much better measure in comparison to incident reporting of what is happening with pressure damage and that it is important for the wound healing team to work in conjunction with medstrom when they do their annual audit and be able to show what the prevalence of pressure damage is.

The Committee noted that there is work ongoing with the North West and South East localities to strengthen the scrutiny panel process which is working well within the Vale locality. The committee would like to see this Vale model replicated elsewhere.

The Committee noted that there is a very strong tracker system in place for the UHB complaints division which they would like to see replicated in other areas so that information can be taken across the themes of incidents being seen in other clinical areas.

The Committee was advised that a new role for patient safety and organisational learning has been created and 2 candidates have been recruited to this post.

The Committee was advised that during the COVID-19 pandemic, other health boards have reported a significant decrease in the number of concerns received, however Cardiff and Vale have not. It was noted that the UHB are in a similar position to last year. The Committee noted that the UHB is much more accessible now in comparison to previous years and social media plays a large part in communication.

The Committee noted the positive response to the CAV 24/7 service. It was noted that there were still patients turning up at the door without phoning ahead so a quick review was done over and afternoon and a morning to determine if patients had phoned prior to attending and if they hadn't what were the reasons for not doing so. The Committee noted that 2 distinct trends were found in the short review of patients not phoning ahead using CAV 24/7.

- Patients with mental health conditions
- Parents with concern for their children.

The Committee was advised that patients on cancer and elective surgery waiting lists have been contacted to make them aware they are still on the waiting list. This has reduced the number of complaints from patients. The Committee noted that part of the reason for contacting these patients is to encourage nudge therapy. This enables a patient to take control of their own health by promoting healthy eating and stopping smoking amongst other things. The Committee was advised that there is an ongoing evaluation of the impact of this.

The Committee was advised that due to the COVID-19 pandemic, there is an expectation to see an increase in clinical negligence claims and personal injury claims.

Analysis of Themes and Trends in Deaths of Patients with Mental Illness - learning, action taken and improvement since last year

The Committee was informed that COVID-19 is playing a big part in the number of total unexpected deaths for 2020 and it is expected this total will exceed the 2019 figure.

The Committee was advised that the theme of people dying 10 to 15 years earlier than expected due to mental health continues.

The Committee was advised that the number of suspected suicides will increase because of the increased amount of people being seen by the mental health teams. It was noted that the traditional patient base has increased enormously.

The Committee was advised that a national pattern was being experienced in Cardiff and Vale in relation to older adult patients and unexpected deaths.

The Committee noted an example of how a patient's experience should be when presenting to mental health services. It was noted that this is not currently the case.
The example noted was that if a patient in the Vale presents to Mental Health services in the Vale, that patient will be assessed and seen by that service, in the Vale. This means that the patient is not going to a number of teams to access services which is the case at present.

The Committee was advised that 2 senior nurses have been appointed to post to lead work on the UHL site. It was noted that the immediate impact has been really positive.

The Committee was advised that the main trend in 2020 for unexpected deaths is that there has been an increase in women suicides. Up from 2019.

The Committee advised that Jane Bell and Consultant Psychologist Miranda Barber have signed up to a training package in suicide prevention. The Committee was advised that stepping away from Mental Health treatment moves things into a more Public Health area for suicide prevention.

It was noted that training will be delivered to GPs and primary care level approaches and there is hope for 3rd sector to be involved as well as own health board staff.

The Committee was advised that the biggest change to mental health services during the COVID-19 pandemic is the increase in digital platforms especially in the younger age group. The use of face to face video conferencing remains very popular. The Committee noted that the older age group may not have access to this in the same way the younger group do.

The Committee advised that the mental health clinical board have a website dedicated to self-help, self-care and guided care. This can be found at http://Stepiau.org.

The Committee noted that in the earlier stages of the COVID-19 pandemic, homeless patients were rehoused which made a difference to their general health and wellbeing and with that a reduction in deaths was noted.

The Committee was advised that people are anxious about things shutting down again, systems changing and the whole issue surrounding COVID-19 generally. It was noted that monitoring staff morale is tricky, however the committee noted that once things start to change people will become the resilient workforce that they were previously. The Committee noted that sickness rates are very good.

The Committee noted that people have accepted social distancing and the PPE as part of daily life and that the health board need to try and support everyone to the best of its ability.

The Committee noted that more formal measures around staff report have been introduced including psychology sessions to support specific areas staff dealing with increased COVID-19 related deaths.

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	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		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	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		Long term	X	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Strategy & Delivery Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**26/11/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair, Strategy & Delivery Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Strategy & Delivery Committee held on 10th November 2020.

Performance Framework Dashboard Update

A verbal update was given by the Director of Digital Health Intelligence (DDHI).

The DDHI committed to bringing an S&D dashboard to January's Committee meeting.

15 strategic measures have been identified and the challenge is how to amalgamate these measures.

CAMHS Update - Neurodevelopmental Situation

The Director of Operations – Children & Women (DOCW) presented to the Committee an update on Neurodevelopmental Assessment services for children and advised that the figures mainly represent children with ADHD and Autism spectrum disorder.

The DOCW advised the Committee that the service seeks to work with these patients with the target set at 80% of patients to be seen and assessed within 26 weeks of referral.

The DOCW advised the Committee that an increase in waiting times and amount of patients waiting has happened due to a local decision being made in May 2019 to stop seeing new patient referrals due a backlog.

The DOCW advised the Committee that at present, there are 19 referrals per month being received, however prior to March 2020, there were 83 per month.

The DOCW advised the Committee that there are currently 741 patients waiting to be seen.

The DOCW advised the Committee that what teams have managed to do is review all the cases on the current waiting list during lockdown.
The DOCW advised the Committee that he's not in a position to give assurance that neurodevelopment will be fixed because a piece of work lasting between 12 to 18 months is

needed.

The DOCW noted that fewer referrals were being sent for a number of reasons including because schools have not been in and people have not been going to the GP.

The Committee would need at least a monitoring report in 3 or 4 months' time.

CAMHS Update - Appointment of Clinical Posts

The DOCW advised the Committee that the clinical posts have been recruited to.

Strategy - Shaping Our Future Wellbeing

a) **Existing Strategy, commitments & forward look**

The Executive Director of Strategic Planning (EDSP) noted to the Committee that in 2015 the Shaping our Future Wellbeing Ten Year Strategy Delivery Programme was published.
The EDSP advised the Committee that a midpoint review was performed in March 2020 and this will be sent around to the Committee Members.

The EDSP advised the Committee that feedback around virtual consultations have been very positive.

The EDSP gave the Committee an example of how the Mental Health service have increased resources in the community which in turn has reduced bed stays.

The EDSP also advised the Committee that there needs to be engagement of wider RPB partners such as care homes and the third sector and noted that the UHB cannot deliver the strategy without these partnerships.

The EDSP advised the Committee that we as an Organisation must learn from Healthcare systems around the world that have good outcomes from transformational change.

THE COO noted to the Committee that on the outcomes framework a sophisticated piece of work is being done and that this will track back to what outcomes matter to people.

The COO added that 1 element of the pathway is to measure at an outcome level and that Primary Care will be one of those elements.

The COO advised the Committee that with CAV24/7, they stood back and asked the clinical teams to come together and design a solution.

The COO advised the Committee that there is a strong voice for the service user in that and a new way to move forward by empowering the people who run the service.

The COO responded that the next step is a Twin Track approach and that on the framework itself what is needed is to bring it into the clinicians which is what has been happening and building out on that framework, looking for clinicians to lead that work in a very practical sense.

b) Primary Care Development Strategy

The OPD advised the Committee that much of the objectives set out on an emphasise for a rebalancing of the system from hospital to community and primary care and that there has been a shift towards preventive work and healthier populations work. He noted that it is a well-accepted and broadly endorsed principle across the UHB and beyond.

THE OPD advised to the Committee that in the context of the primary care strategy, we need to know how to connect the immediate challenges to move forward to that broader strategic direction.

The COO advised the Committee that to move it forward practically as a roadmap, consideration needs to be focused on the principles of rebalancing out of hospital services.

Planning

a) Q3-4 Plan

The EDSP advised the Committee that the plan is going for formal ratification to the Board.

The Q3-4 plan has had no formal sign off by WG as we are in a new planning regime but advised the Committee that a letter has been received from WG endorsing the plan.

Planning

a) Winter Protection Plan

The EDSP advised the Committee that the plan is going for formal ratification to the Board.

Board Assurance Framework (BAF)

a) **Sustainable Culture change**

The DCG advised the Committee that the information had been updated for the next Board meeting at end of November.

The EDWOD advised the Committee that work is still progressing behind the scenes.

The DCG advised the Committee that the overall score is 8 which is still high risk on the BAF.

Social Care and Well Being Act – Partnership with Local Authorities & RPB Update

The EDSP advised the Committee that WG were not expecting to return to a “pre-covid world” and recognising that there are challenges the UHB have to face, especially the economic impact on the more deprived communities.

The EDSP noted to the Committee that this included how we treat the planet and taking serious action to reduce our carbon footprint and become a carbon neutral Organisation.
The EDSP advised the Committee that at present, the working function is for an annual plan and that will be very difficult to develop without knowing the financial situation we are operating in.

Performance Reports: Key Organisation Performance Indicators

- Mental Health performance

The COO advised to the Committee that Mental Health performance had significantly deteriorated with 43% of assessments being undertaken within 28 days down from 84% previously.

The COO advised the Committee that it is a product of 2 things:

1) An increase in volumes of referrals
2) A redesign which took place during COVID as a needs must task, providing counselling services through Primary Care.
   The COO noted that two thirds of the referrals did not warrant a full counselling intervention.

The COO advised the Committee that nobody was waiting for more than 30 days with Patients gaining access within 48 hours.

- Cancer Performance

The COO advised the Committee that the UHB are moving to a single cancer measure pathway which will be formalised on December 1st.

The COO provided the Committee with a rationale for the deterioration being that cancer breaching occurs at the point of treatment and advised the Committee what actions had been taken:

1) Through our GP colleagues ensuring referrals got back to where they were before. Primary care helped with this a lot.

2) By trying to get the treatment levels back to pre-covid levels and by August the UHB had done that.

The COO advised the Committee that there is an issue of streaming patients into the system and the losses given from IP&C.

The COO advised the Committee that there are 40 beds closed because of IP&C.

The COO advised the Committee that up to a third of the Emergency Department (ED) had been transferred from an unplanned event to a planned event.

The COO advised the Committee that during COVID there was a point in Diagnostics & Therapies (D&T) where there were zero waits and wanted to pay tribute to those teams.

The COO advised the Committee that there had been a marked impact in therapies during September primarily due to virtual appointments and noted that there is something there for the Committee to learn about how we can access people.

The COO advised the Committee that the October position for the 2nd wave of covid is starting to become apparent. He noted that until now we have managed to maintain essential and some other services and haven't had to stop these yet but due to staffing issues that may change over next few months.

Performance Reports: Workforce Key Performance Indicators

The Executive Director of Workforce & Organisational Development (EDWOD) advised to the Committee that interestingly, the recruitment has peaked and that there are now around 550 more people working for the UHB in medical, nursing and general areas compared to last year.

The EDWOD noted to the Committee that the work that has been done around retaining people to the UHB is really baring fruit.

The EDWOD advised to the Committee that there are still challenges to face around meeting winter and covid pressures, and that a taskforce is in place to meet weekly to discuss issues.

The EDWOD advised the Committee that an alternative solution for training is needed otherwise there will be a difficult situation in 12 months' time with compliance. The EDWOD advised Committee that training can be done remotely.

The Executive Director of Public Health (EDPH) asked the Committee to add flu data back on and noted that the Staff flu campaign is going really well. She noted that there is a slight delay in getting statistics out due to sheer demand and that it's still a hard copy which is more time consuming.

The EDPH advised the Committee that 56.1% of frontline staff have had their flu vaccination and that this time last year it was 15.7% and that they are aiming for 75% uptake. The EDPH added that they are keen to get the flu vaccination done before a mass covid vaccination plan starts.

Leadership Engagement

The EDWOD advised the Committee that an interactive review of the UHB had been scheduled following on from an Amplify event supported by the UHB in 2019 but this has not been done due to COVID and that now a remote option is being explored, however the finances are challenging.

The Committee was advised of a training and leadership programme for Staff that has been launched which gives staff the potential to move onto greater opportunities in not just our health board but others.

The EDWOD advised the Committee that the Talent Management and Succession Planning work at Executive level supported the UHB in being able to provide HEIW with considered and timely nominations for Talentbury - 18 people have been identified for Talentbury.

The EDPH noted to Committee that executives were able to discuss who each executive had put forward for Talentbury and noted that sometimes there was consensus and that it was really useful and important in terms of succession planning.

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	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		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	
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		Long term	X	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Mental Health Capacity and Legislation Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**26/11/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair, Mental Health Capacity and Legislation Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Mental Health Capacity and Legislation Committee held on 20th October 2020

Patient Story

https://www.youtube.com/watch?v=L4jToe_atjE&feature=youtu.be

The above patient story was received. Future Patient Stories would be from those using UHB services.

Mental Capacity Act

Committee noted that compliance cannot be measured easily.

The Internal Audit 2018 raised significant areas of concern with the Mental Capacity Act, particularly Deprivation of Liberty Safeguards (DoLS).

A new LPS process was due in Autumn 2020 but due to COVID-19 this will now be delayed until April 2022 when resources, systems and processes will need to be reviewed fully.

Mental Health Act

Ian Wile noted that due to COVID-19 there had been bed losses within mental health and this meant the concentration of people being detained had risen. There is a current focus on people not being detained in hospital and this has balanced back out when moving into September and October.

It was confirmed that there had been a 25% increase in young adults going into adult beds from 2019 to 2020 and that this year, the figures reflect this again, meaning that another 25% increase is expected for 2020/21.

The number of S136 in younger people had increased and there is an immerging piece of work with the Police's Crisis Care Concordat.

Audits carried out around section 132 measured good compliance to measure with the Mental Health Act. The health board is aiming for 100% compliance.

Patients have good access to external support via technology. It was noted that the health board have a large amount of tablets for Patients to use.

Mental Health Measure

Due to COVID-19 it has been challenging to measure Mental Health. In August the health board's ability to meet the targets stopped, however this has now improved and it is predicted that target will be met in November.

Mental Health Measure - Care and Treatment Planning

Care plans are currently being reviewed. Alongside this, talks are being held with various Consultants across the health board.

Mental Health Measure - Standard to have access to an IMHA within 5 working days

The Recovery College has been launched in Mental Health and has helped raise the expectations of service users and promote a better quality of interaction.

CAMHS Compliance

Figures on primary assessments are good. COVID-19 has provided challenges on the specialist front but gave the primary front an opportunity to catch up during the COVID-19 prevalent months.

The sudden increase in referrals is challenging.

Feedback on technology being used with patients has been largely positive.

Items to bring to the attention of the Committee for Noting / Information

- **Sourcing & Supporting Patient Stories Update**

Discussion was had surrounding who fills out the Patient Story Submission Form. It was noted that staff will be filling this form in after conversations are had with patients.

The engagement process for Patient Stories, in particular to inclusivity and the BAME community was raised. It was confirmed that there is currently a post out to advert in the Patient Experience team whose role will be to help support this.

Items for Approval Ratification

IMCA Procedure – Approved by Committee
Lasting Power of Attorney and Court Appointed Deputy Procedure – Approved by Committee

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	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		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	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		Long term	X	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Digital & Health Intelligence Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**26/11/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair, Digital & Health Intelligence Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Digital & Health Intelligence Committee held on 8th October 2020.

Digital Strategy – Final Version

This was approved by Board on 30th July. It shows revised governance structures and how implementation of the strategy will be managed. There will be establishment of Delivery Programme Boards which feed into Digital Services Management Board and into this Committee, HSMB, & Management Executive.

Digital Strategy - Plan on a Page

The first draft was presented and the Committee noted the progress being made in developing a plan on a page to support the roadmap for delivery of the Digital Strategy.

Digital Mobile Strategy – Final Version

The mobile strategy was developed late last year ahead of the big changes made due to the pandemic and was focused on the community services component.

A high level roadmap shows what is and is not resourced to ensure the resource needed and correct implementation.

Self-assessment of Committee Effectiveness & Forward Action Plan

This was the first report for this Committee and it noted the results of the Committee's self-assessment Effectiveness Review for 2019-20 and approved the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.

GP Pilot Action Plan

The Committee noted and ratified the actions taken to achieve closure on this plan.

Digital Transformation Progress Report (Digital Dashboard)

The Committee noted the progress across the IT Delivery Programme.

IG Data & Compliance (SIs, Data Protection, GDPR, FOI, SARs, Staffing & Mandatory Training)

The number of incidents reviewed continues to be large but the ones reported to ICO is low and a national reporting tool is awaited to ensure there is a consistent approach for IG breaches across Wales. The Committee received and noted the updates.

Clinical Coding Performance Data

This took a dip in February and March due to Covid response however they now have recovered and are above the Welsh Government targets of 95%.

Joint IMT & IG Corporate Risk Register

The Committee noted progress and updates to the Risk Register report.

IMT Audit Assurance Tracker

The Committee noted progress and updates to the IMT Audit Assurance report.

IG Audit Assurance Tracker

It was noted that where actions had been duplicated in the ICO report, these have been consolidated in one action plan. The one action that has not been closed is in relation to FOI structure which is being progressed as part of the overall wider restructure of Digital Health.

ICO Recommendations and Action Plan

The Committee noted the Information Governance Department's action plan which will ensure that the ICO's recommendations are addressed.

IMTP Work Plan Exception Report

The Committee noted the areas of exception which require further attention and consideration.

Schedule of Control Documents (Policies & Procedures)

The Committee was advised of the policies and procedures that require updating. The DDHI had committed to complete this by the end of the financial year.

Minutes of the Capital Management Group 17/08/20

The minutes were noted by the Committee.

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	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		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	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		Long term	X	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Stakeholder Reference Group Report**								
Meeting:	**UHB Board**						**Meeting Date:**	**26th November 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Abigail Harris**								
Report Author	**Geoffrey Simpson, Interim Chair of Stakeholder Reference Group**								

SITUATION

The following report provides Board with a summary of the key issues discussed at the Stakeholder Reference Group (SRG) meeting held on 23 September 2020.

REPORT

BACKGROUND

This is a report provided to the Board by the Chair of the UHB SRG.

ASSESSMENT

The SRG considered the following.

Membership

The SRG was informed that the Vale of Glamorgan Council had nominated Cllr Janice Charles to replace Cllr Rachel Nugent-Finn as its member on the SRG. In addition Tricia Griffiths had resigned from the SRG and a replacement carer member would now be sought. The Chair wished to record his thanks to Tricia Griffiths for her contribution to the Group and wished her all the best for the future.

Major Trauma Centre

The SRG was informed that the Major Trauma Network and Major Trauma Centre at UHW had gone live on 14 September. The first week had been extremely busy and although there had been a number of 'teething' issues the service was generally working well.

CAV24/7

The SRG was informed that since its commencement on 5 August, the service had generally been successful. Significant numbers were using the service and there was no evidence of any patient being harmed as a result of the new model. Some people had self-presented to the Emergency Unit a number of whom had been redirected to other services but they had all been treated with compassion. Staff have been mindful that some individuals including vulnerable groups such as the homeless, might be unable to phone first for a number of reasons including difficulties in communicating, no access to a phone etc. Staff have also been cognisant of safeguarding issues. There have been a few examples of patients being 'ping-ponged' between different elements of the health service and discussions are being held to address this issue. 90-95% of minor injuries are now managed via an appointment. Additional resources have been provided at Barry Minor Injuries Unit and this will continue to be developed. Service users had received a text message requesting feedback. Although only 12% had responded the replies had been generally very positive with no significant area of concern identified. The Community Health Council had also conducted its own survey outside the Emergency Department and had interviewed staff. CAV24/7 was the pathfinder for Wales and would continue to be developed as lessons are learnt. The Minister for Health and Social Services had published a Winter Protection Plan of which CAV24/7 was an important part. In England the national policy was to move towards a similar emergency care model.

On behalf of the SRG the Chair congratulated the UHB on the successful introduction of the service.

Clinical Service Plan
Marie Davies provided the SRG with an update on the UHB's approach to engagement. The UHB would be seeking people's views on a small number of questions on key components of the Strategic Clinical Services Plan including:

- whether there are any other drivers for change we need to consider in designing future service models;
- the rationale put forward for changing the way we deliver acute medicine and planned surgery;
- the emerging models for providing more care closer to home;
- what else should be taken into account as when developing these plans?; and
- how would people like to be involved in this work going forward?

The SRG made a number of suggestions about the engagement process:

- Deprived communities must have a voice in shaping future service provision.
- Engagement should be a continuous and iterative process and not be delayed due to C-19.
- A mixture of on- line and off line engagement methodologies should be adopted
- ProMo Cymru, EYST and Age Concern might be able to provide advice/assistance.
- Consideration should be given to how to capture the views of the 'seldom heard'
- Clear language must be used.

Improving Equality and Inclusion
The SRG received a presentation from Keithley Wilkinson on the UHB's initiatives to improve equality and inclusion. The SRG was informed that each Board member sponsored one of the individual protected characteristics and the Welsh language. The SRG was provided with information on the good practices being adopted within the UHB, the principles that will inform the UHB's inclusion work strategy and further recommendations aimed at improving equality and inclusion. The UHB's Strategic Equality Plan for 2020/24 due to be published in October, would be circulated to the SRG for information. The Plan has been reviewed to identify the key inequalities exacerbated by the C-19 pandemic and the UHB is developing a clear action plan with equality outcomes. The SRG welcomed the progress being made on equality and inclusion but reminded the UHB not to forget other specific groups not directly referenced including women, the gender fluid, and those with learning disabilities. Keithley Wilkinson will provide the SRG with an update on how the UHB had moved from principles to practice in a few months' time.

RECOMMENDATION
The Board is asked to:

- **NOTE** this 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								

Report Title:	**Local Partnership Forum Report**								
Meeting:	UHB Board						**Meeting Date:**	26 Nov 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Executive Director of Workforce and OD								
Report Author (Title):	Workforce Governance Manager								

Background and current situation:

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of Workforce and OD. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum usually meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

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

This report provides Board with a summary of the key issues discussed at the LPF meeting held on 22 October 2020.

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

Cheryl Williams, Principal Health Promotion Specialist from Public Health Wales gave a presentation on the Executive Director of Public Health's Annual Report 'Re-imagining Aging into the Future'. The report looked at the following three areas and how they interacted:

- Purpose and fulfilment in life
- Active and healthy places
- Social connections in life

It included key messages for the public and actions the UHB can lead on.

The Forum received a presentation on the initial learning from Covid-19. It was noted that this presentation only provided a snapshot of the learning and that there was also a 50 page report which would be shared with the Forum. Key points included:

- One of the aims of Amplify had been in increase trust. This had happened almost overnight, with a 'can do' attitude toward decision making
- There had been significant transformational work especially in relation to digital capability (e.g. remote working, teams, virtual patient experience)

- Staff wellbeing was an important priority and a Health and Wellbeing group had been established immediately

This work is continuing and will be opened up to include partners such as Local Authorities and the 3rd Sector.

The Chief Executive updated the Forum on the current position in relation to Covid (incidences, TTP, vaccination preparation and the Surge Hospital) as well as the financial position, car parking and working from home.

The Deputy COO gave an operational update and stated that there had been an increase in admissions but they were still relatively low numbers. We continue to operate with the first principle being covid ready, but there are complexities such as the footprint changing and adapting to meet patient needs. Ms Bird acknowledged the work by staff who are dealing with this and acknowledged the staff support for Cwm Taf and the wider system while we had a formal agreement in place for 999 diverts. We continue to see an increase in demand and activity though still lower than pre-covid levels

The Executive Director of Strategy and Planning reminded the Forum that normal planning processes had been suspended due to Covid and WG had asked us to move to quarterly planning to reflect how quickly things were changing. This has now moved to 6 monthly and the plan for Quarters 3 and 4 had been submitted that week.

It was noted that a staff survey is being launched in early November – it is a smaller version with just 20 questions and it was hoped that the return rate would be high. The Executive Director of Workforce and OD asked members to complete the survey and encourage others to do so.

LPF received the Finance Report, Workorce KPI Report and Patient Safety, Quality and Experience Report for August 2020.

Recommendation:

The Board is asked to:

- **NOTE** the contents of this 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	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	X	Involvement	

Equality and Health Impact Assessment Completed:	Not applicable

Report Title:	**Valuing the Health Board's Relationship with the Third Sector in Cardiff and the Vale of Glamorgan**								
Meeting:	Board Meeting					**Meeting Date:**	26/11/2020		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	Executive Director of Strategic Planning								
Report Author (Title):	Strategic Partnership and Planning Manager								

Background and current situation:

In April 2019, the Health Board and the County Voluntary Councils (CVCs) in Cardiff and the Vale of Glamorgan agreed a Memorandum of Understanding (MoU) between the UHB and the local Third Sector. The MoU was designed to reflect the 'new' partnership arena established via key pieces of legislation and Welsh Government policy, and provides a written statement of our joint commitments and intentions. It replaced the UHB Framework for Working with the Third Sector, recognising that this had embedded a collaborative partnership approach into the way we work together strategically and operationally.

The MoU includes a commitment to an annual review involving the key signatories, namely the UHB Directors of Strategic Planning and Public Health, the Board's Independent Third Sector Member, and the Chief Executive Officers of the CVCs – Cardiff Third Sector Council and Glamorgan Voluntary Services. The review meeting, postponed from its original date in April 2020, was held on 29 September where it was agreed that a refreshed MoU would be brought to Board for information alongside an '18 month in review' publication celebrating the wealth of collaborative work undertaken in 2019 – 2020. This provides an opportunity to demonstrate the added value that the Third Sector brings to the work and vision of the Board, in enhancing the lives of individuals, communities and the wider population in Cardiff and the Vale of Glamorgan.

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

The MoU demonstrates the parties' commitment to working together to deliver the UHB's Shaping Our Future Wellbeing strategy and key partnership plans, recognising that improvements in population health will only be achievable if we work differently and work more collaboratively with communities and partners. The approach reflects shared ambitions for building relationships between the UHB and the Third Sector, working strongly with local authorities and other partners, and is based on a joint agreement of strategic objectives and outcomes and shared ownership of priority areas for co-delivery.

The annual review meeting provided a forum for considering if there have been any changes in policy or political environment or other developments which needed to be reflected in the MoU, as well as to have an honest and open conversation about the opportunities and challenges in the strategic relationship. From a Health Board perspective, this was informed by some earlier discussion hosted by the UHB Chair with the Board Third Sector and Community Independent Members, to draw on their experience of key issues.

As a result, the MoU has been updated to include a new objective reflecting the need to work collaboratively to meet the challenges of operating in an ongoing pandemic. There are also some amendments aimed at strengthening ambitions relating to building capacity, encouraging UHB staff to take on volunteering roles in recognition of the mutual benefit to the individual, the UHB and the community, and exploring digital opportunities. The refreshed MoU is attached for information.

While the focus of the MoU is the relationship between the Third Sector and UHB, it is clearly recognised that much of the agenda is a shared one and that future opportunities need to be set in the context of wider partnership collaboration delivered via the Regional Partnership Board (RPB) and the Public Services Boards. For that reason, the Director for Health and Social Care Integration was also invited to join the review meeting. This enabled an exploration of areas where the role of the Third Sector could be strengthened to support the RPB's shift in approach, putting more emphasis on people and places. These ideas will be progressed through the RPB.

In reflecting on the importance of ensuring that there are ongoing opportunities for optimising the value and potential of the Third Sector, it should be noted that key interfaces where the involvement of the Third Sector is well established and continue to grow include: the Regional Partnership Board and the Public Services Boards and their joint working infrastructures e.g. ICF and Transformation boards; Shaping Our Future Wellbeing: In Our Community programme; UHB business continuity planning mechanisms e.g. winter planning, mass vaccination planning; and UHB Stakeholder Reference Group. The local Third Sector is involved in a host of joint planning, commissioning and service redesign work across public services, demonstrating that a collaborative approach is very much embedded into the way we work together strategically and operationally, in recognition of the Third Sector's unique contribution to improving health and wellbeing outcomes.

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

Assurance is provided by joint agreement of the way forward by key stakeholders following discussions led by the Director of Strategic Planning at the formal MoU annual review meeting.

No risks identified.

Recommendation:

The Board is asked to:

- **NOTE** the updated Memorandum of Understanding between Cardiff and Vale University Health Board and the Third Sector in Cardiff and the Vale of Glamorgan
- **NOTE** the 18 months in review publication

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities	X	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	

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	X
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									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Memorandum of Understanding

Between Cardiff and Vale University Health Board

and

The Third Sector in Cardiff and the Vale of Glamorgan

September 2020

1. Purpose and Scope

1.1 This Memorandum of Understanding (MoU) forms the basis of a shared understanding and a relationship between the Third Sector in Cardiff and the Vale of Glamorgan and Cardiff and Vale University Health Board (UHB). The Third Sector is represented in this context by Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS) as the local County Voluntary Councils (CVCs).

1.2 The MoU is intended to demonstrate the parties' commitment to working together to deliver the UHB's 'Shaping Our Future Wellbeing' strategy and key strategic partnership plans, recognising that improvements in population health will only be achievable if we work differently and work more collaboratively with communities and partners.

1.3 The MoU supports but is independent of any other agreements or contracts signed by or between the organisations concerned.

1.4 The approach reflects shared ambitions for building relationships between the UHB and the Third Sector, working strongly with local authorities and other partners, and is based on a joint agreement of strategic objectives and outcomes and shared ownership of priority areas for co-delivery.

1.5 Key legislation and policy which provide the context for this MoU include 'A Healthier Wales: our Plan for Health and Social Care', the Wellbeing of Future Generations (Wales) Act, and the Social Services and Wellbeing (Wales) Act.

1.6 In signing this MoU, each party undertakes to build on the strength of existing relationships and the strong foundations already established through implementation of the UHB's Framework for Working with the Third Sector 'Working Together for Our Future Wellbeing'.

2. Status of the MoU

2.1 The partners acknowledge that it is not their intention for this MoU to have a binding legal effect. Rather it is a statement of their shared intention to work together in the spirit of partnership and cooperation for the benefits of the residents of Cardiff and the Vale of Glamorgan.

2.2 This MoU is designed to complement and support other key working relationships which operate at a strategic partnership level within the area of Cardiff and the Vale of Glamorgan, including the Regional Partnership Board and the Public Services Boards.

2.3 This MoU will help to optimise the CVCs' role in providing third sector support and development at local level, nurturing local group development, hosting

Volunteer Centres, and engaging with statutory sector partners to improve local community health and wellbeing outcomes.

3. Objectives

To work effectively together to improve services and health outcomes for the people of Cardiff and the Vale of Glamorgan.

3.1 To develop a co-productive approach working collaboratively as equal partners in helping the health and care system make decisions and develop a shared understanding of the ways in which the Third Sector can contribute to improvements and the sustainability of health, care and wellbeing services.

3.2 To promote and use the talent, reach and social value of Third Sector organisations to support prevention and improvement and advocate for people who are otherwise 'seldom heard'.

3.3 To share best practice models between the Third Sector and the UHB, and build evidence of sustainable, scalable solutions to prevent and mitigate inequalities that impact on the health and wellbeing of communities.

3.4 To enable members of the Third Sector to contribute to the development of new models of care, as appropriate, and encourage co-production in the creation of person-centred, community-based health and care which promotes equality for all.

3.5 Through CVC networks, to better understand and involve people and communities in the transformation of health, care and wellbeing services, enabling the voice of people with lived experience and those experiencing health inequalities to inform and shape policy and the delivery of services.

3.6 To involve the third sector in estate management strategies, recognising the added value the sector can bring by offering premises and venues within communities or taking on public buildings through asset transfer.

3.7 To support the H&SC Networks to be the "first point of call" for engagement with the third sector to facilitate the work outlined above, to offer a point of informal policy discussion to key statutory sector partners and to facilitate third sector representatives chosen by their peers to represent them at strategic boards and working groups.

3.8 To work collaboratively to meet the challenges of operating in an ever-changing environment, using existing partnership mechanisms to identify additional opportunities to support vulnerable groups and local communities. *In the 2020/21 context this relates to operating in an ongoing pandemic and the need to work together to minimise its impact on health and wellbeing.*

4. Strategic Principles and Outcomes

4.1 The MoU provides an overview of how the UHB and Third Sector will work together to deliver the strategic principles and outcome ambitions set out in Shaping Our Future Wellbeing and strategic partnership plans:

4.2 **Empower the Person:** The Third Sector plays a crucial role in supporting health and wellbeing and its relationship with the most vulnerable in our communities means it can play a key role in building community resilience:

- We will make the most of third sector relationships and knowledge of communities to influence behaviours and support people in choosing healthy behaviours
- We will optimise opportunities to develop the role of the third sector in the prevention of ill health and the creation of healthy environments and ensure that engagement with the third sector is inclusive, engaging with organisations interested in the life course and whole person as effectively as those working to improve the treatment of individual conditions
- We will work together to unlock the value of volunteering in the community, develop champion roles which support health and wellbeing and support UHB staff to volunteer in recognition of the mutual benefit gained

4.3 **Home First:** Enabling people to maintain or recover their health in or as close to home as possible means we need greater plurality of provision as part of more integrated community delivery models:

- We will work together to commission and deliver third sector services as part of integrated health and social care provision in the community
- We will adopt asset based community development approaches to understand and facilitate connections between people, groups and communities within localities and primary care clusters
- We will optimise opportunities for relevant third sector organisations to become embedded into Whole Care Pathways.

4.4 **Outcomes that Matter to People:** To deliver outcomes that matter to people, we need co-production with citizens to design and transform our services to achieve our vision for seamless care:

- We will draw on third sector expertise to plan and design services with health and social care partners, which are centred around the person

- We will work together to support the involvement of service users and carers in planning health, care and wellbeing services, finding ways to improve engagement with those who are otherwise ‘seldom heard’

- We will optimise collaborative opportunities to establish a social referral model to support access to a wide network of wellbeing services

4.5 **Avoid Harm, Waste and Variation:** The serious health challenges that face our population can only be tackled by taking a long term approach and finding new ways of working with the Third Sector as a key partner in developing solutions that are responsive to local need:

- We will fully use local Third Sector networks and the Health & Social Care Facilitators to create new alliances, build capacity and develop innovative solutions, including digital opportunities, based on rebalancing the existing health and social care system towards prevention, community resilience and self-help

- We will strengthen operational links between Third Sector and front line NHS staff to explore potential collaborations to improve outcomes for people

-We will support adoption of best practice in commissioning and procurement of services, working with CVCs to develop and strengthen underpinning mechanisms and processes, and on implementing social value and social innovation

- We will share learning, resources and skills across the sectors

5. Ways of Working

5.1 The Wellbeing of Future Generations (Wales) Act puts in place a sustainable development principle that describes how public service organisations must meet their duties under the Act. The following five ways of working, which define this principle, will underpin the way the UHB and Third Sector work together: long term; prevention; integration; collaboration; and involvement.

5.2 The relationship will be based on mutual respect and trust.

5.3 The relationship will be based on open, timely and transparent communications.

5.4 There will be a shared commitment to making the best use of resources.

5.5 The CVCs will work together to develop shared approaches across the area of Cardiff and the Vale of Glamorgan, wherever appropriate.

5.6 The CVCs will ensure a continuing relationship with key third sector partners, including Cavamh, the infrastructure agency with responsibility for working with third sector groups with an interest in mental health.

6. Disagreement Resolution

6.1 Any disagreement will normally be resolved at working level between the relevant officers. If this is not possible, it may be referred for discussion

between the Chair and Chief Executive of the UHB and the Chairs and Chief Officers of the CVCs.

7. Duration of the MoU

7.1 All parties accept the dynamic environment in which this MoU operates and that priorities will be subject to change. This is particularly relevant in the context of the evolving integration agenda. In recognition of this, the MoU will be reviewed and amended annually by mutual agreement. The date for the review of the MoU is annually in April of each year. It is recognised that due to the emergence of the COVID-19 pandemic in March, that review was postponed to September in 2020.

7.2 An annual review meeting will be convened by the UHB and will involve:

- UHB Director of Public Health
- UHB Director of Strategic Planning
- UHB Independent Member (Third Sector)
- C3SC Chief Executive Officer
- GVS Chief Executive Officer

Signatories

The MoU is agreed by the following:

Organisation	Name	Designation	Signature	Date
Cardiff and Vale UHB	Abigail Harris	Director of Strategic Planning		
Cardiff and Vale UHB	Fiona Kinghorn	Director of Public Health		
Cardiff and Vale UHB	Sara Moseley	Independent Board Member		
Cardiff Third Sector Council	Sheila Hendrickson-Brown	Chief Executive Officer		
Glamorgan Voluntary Services	Rachel Connor	Chief Executive Officer		

Working Together for Health and Wellbeing Cardiff and Vale University Health Board and the Third Sector

An 18 Month Review
April 2019 to September 2020

18 Months in Review April 2019 – September 2020: Introduction

The Third Sector and Cardiff and Vale of Glamorgan University Health Board (UHB) work together to plan and deliver services and improve the experience of patients, their families and carers. A Memorandum of Understanding (MoU) underpins this relationship, demonstrating a shared commitment to working together. The Third Sector in the context of the MoU is represented by Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS).

The UHB funds a Health and Social Care Facilitator post (H&SCF) in both C3SC and GVS to strengthen the role and contribution of the Third Sector to work in partnership to support delivery of improved health, social care and wellbeing outcomes, in line with the objectives of the MoU. This update has been written by the H&SCFs and gives information about some of the great work which has happened in 2019 – 2020.

While the focus of this publication is to demonstrate how the Third Sector and UHB are working together to put the MoU into action, these efforts are very much set in the context of wider partnership collaboration delivered via the Regional Partnership Board and the Public Services Boards.

Assisting the community during the COVID-19 crisis

Response to COVID-19

During the first few months of lockdown C3SC and GVS had to change how they operate. All staff started to work from home and some were redeployed to new areas of work. The two main areas were volunteering and dealing with general enquires.

3,375 volunteers registered with the Cardiff Volunteer Centre run by C3SC with 1,646 volunteers joining at least one activity between 18 March and 31 August 2020. There remain 284 active opportunities with the three most subscribed volunteering categories being COVID-19 (63.6%), Community (9.3%) and Health and Social Care (6.1%). A number of new mutual groups developed across the City and C3SC along with Cardiff Council worked to support them to ensure that they were aware of key legislation such as safeguarding, domestic abuse and COVID-19 requirements, specifically through the development of a directory of online training to support the Third Sector.

GVS received 991 volunteer enquiries over four months, showing a very positive response and a willingness to help. However, volunteering opportunities decreased dramatically due to the reconfiguration of community services. This situation improved as COVID-19 volunteering groups were set up by communities.

A range of COVID-19 focussed funding streams were overseen by GVS and C3SC. As of August 2020, over £350,000 has been awarded or is in the process of being awarded. These funding streams have been made available by various partners: Vale of Glamorgan Council, Cardiff Council, Public Health, Welsh Government via WCVA, Comic Relief, Cardiff and Vale Health Charity and Integrated Care Fund (ICF) via the Cardiff and Vale Integrated Health and Social Care Partnership.

Vale of Glamorgan

GVS worked with the Vale of Glamorgan Council to set up a scheme where any COVID-19 enquiries that the Council received would be split between GVS and Age Connects Cardiff and the Vale. The enquiries for people over 65 years of age would go to Age Connects Cardiff and the Vale and from those under 65 years of age would go to GVS.

157 general enquiries were subsequently received in the first couple of months when the COVID-19 lockdown started. The enquiries mainly fell into the following categories: Food, General Information, Prescription Pick Up, Shielding Letters, Mental Health, Befriending, Social Isolation, Housing, Money, Carers, Homelessness, Dog Walking and Travel. The biggest number of enquiries received by GVS were in relation to food provision.

A lot of these enquiries were resolved by either calling on behalf of the enquirer or passing along information. Age Connects Cardiff and the Vale and Dinas Powys Voluntary Concern (DPVC) both played a vital role in supporting older people in the Vale, with many other Third Sector organisations providing much needed practical and emotional support.

Due to the increase in enquiries GVS created an up to date directory of Third Sector and community based services. It contained information on various charities, organisations, volunteer groups, pharmacies and food options. This directory was put on the Vale of Glamorgan Council Vale Heroes website.

The Vale of Glamorgan Council has worked with GVS to ensure that small supplies of PPE are made available to front line Third Sector services. In addition, GVS worked with Jane Hutt MS to support distribution of face visors which were made by Ford workers in Bridgend.

It was the relationship that GVS developed with the local community and links with local community groups that has allowed GVS to swiftly respond to the area's needs during this unprecedented time.

Cardiff - Medication/ prescriptions service for vulnerable people
Volunteers are enabling medication and prescriptions to get from the hospitals to pharmacies and to patients across Cardiff. Both of these services have been arranged directly between the UHB and the C3SC Volunteer Centre with just over 800 runs carried out up to the end of August 2020. An App is used to ensure safe delivery. Social distancing is being applied when the medication is delivered to homes and all volunteers involved in delivering controlled drugs and trial drugs have current and clean full DBS.

Cardiff – Food response and directories
The Third Sector has been heavily involved in the provision of food throughout COVID-19. Organisations who had previously not been involved diversified to meet the needs of those needing food. The provision for those shielding who were entitled to the free food parcel were managed by Cardiff Council working in partnership with the Third Sector. Women Connect First for example delivered culturally appropriate food parcels to those in need, Action in Caerau and Ely expanded into food delivery for their pantry and South Riverside Community Development Centre opened their pantry. Joint initiatives were set up in the East of the City between faith communities and local schools to meet the local need. C3SC set up a directory just related to shopping and food delivery. With so many small groups involved as well as some of the larger ones an anchor organization model was developed and trialed and continues to be under development.

Due to the size and complexity of Cardiff, C3SC developed a range of directories which were regularly updated and available on the C3SC website. These covered food and shopping as mentioned as well as: Activities; Additional services; Domestic Abuse and Safeguarding directory; Emotional Wellbeing services; Keysafe, adaptations and handypersons; and transport services directories. A range of briefings were also developed to support the sector and individuals and families including: support for families, children and vulnerable adults; support for organisations and community groups; and support for young people.

Getting to know our communities

Third Sector services play a vital role in supporting people in the area they live. As part of a project in relation to the Welsh Government's Transformation Programme, a number of community engagement events were held to help us understand what is available in different communities in Cardiff and the Vale. The Programme aimed to meet the needs identified in the Population Needs Assessment. Over 90 people attended engagement events in Cowbridge and Llantwit Major in the Vale. Nine community engagement events were held in community venues across Cardiff, these were attended by 147 people representing 93 different organisations. The feedback from all the events was very positive. In addition, an online survey enabled around 400 local community assets to be identified in Cardiff, including local activity groups and venues many of whom were unable to attend the events.

"I found the Cowbridge event to be an exceptional networking opportunity for our service, so thank you for the invite!"
"Great session, thanks all!" – Cardiff event
"…helps to build relationships in the community - very helpful in doing that" – Cardiff event

Making information about Third Sector services available to all

The Third Sector has been active in making sure their details are on the website Dewis Cymru and also helping to create directories such as the Carers Directory and the Directory of Services for Older People, updated by GVS.

"We have found the directory of services for older people really useful when referring existing and new customers to other services and for raising awareness of our services to other groups."

Image: C3SC Dewis Cymru stand at a hub in Cardiff

With over 4,000 Third Sector organisations and groups in Cardiff reaching them all is challenging and also means one directory is not practical. To resolve this C3SC along with Cardiff Council have been promoting Dewis Cymru. The C3SC Dewis Cymru Project attended 57 events and recorded interactions with almost 1,600 individuals up to March 2020. Raising Dewis Cymru's profile to both groups and organisations, as well as the general public and encouraging more groups to register and upload their details.

"Rhydypennau Library is always actively on the lookout for services or activities for their community and we formed a very fruitful partnership that helped both the individuals in the library and Dewis with its brand awareness." Dewis Cymru Project Coordinator

Third Sector Community Liaison Officers (CLOs) helping people access services in the Vale

The GVS Community Liaison Officer is a one stop shop service that is a vital part of the Vale Communications Hub, working closely with health and social care teams to meet the needs of people in the Vale. The aim is to help people access community services and maintain their independence, by pulling together a wide range of Third Sector services that meet their needs. This service is available for families, carers, young adults and those experiencing long term medical conditions, who are aged 18 to 60. The Vale Age Connects CLO helps people over 60 access services. Both CLOs have been particularly active in supporting people during the COVID-19 crisis.

Developing Health and Wellbeing Centres and Wellbeing Hubs and Centres in Cardiff and the Vale

The UHB's Shaping Our Future Wellbeing: in Our Community is a major physical infrastructure programme supporting the delivery of care closer to home and easier access to health and wellbeing services. The Third Sector is an important partner in the development of health and wellbeing centres and wellbeing hubs.

This includes the centres @Parkview/Ely @Maelfa, @CRI, @Penarth and developments at Barry Hospital. There has been a very positive response from Third Sector organisations who are keen to be involved and deliver integrated health and wellbeing services. The Rise, domestic abuse services in Cardiff are the first to be delivering as part of the developments from @CRI.

"Plans to develop a Wellbeing Hub in Penarth, this sounds exciting! I would very much be interested to provide my current or a similar service at this new Hub."

Image above: CF61 building in Llantwit Major, Vale of Glamorgan

CF61 – developing health and wellbeing activities in the Western Vale

GVS has transformed the former Llantwit Major Youth Centre to the CF61 Centre, providing a welcoming community space for a range of health and wellbeing activities benefiting the residents of the Western Vale. These activities have included a Wellbeing Cafe and Fareshare food distribution, Dance and Dementia, a Cwtch Cymru Peer Support Group and Happy Hands and Twinkly Toes.
https://cf61.wales/

Helping the Third Sector access new sources of funding
Third Sector organisations have benefitted from funding which has helped them develop new services or offer additional services in Cardiff and the Vale.

Both H&SCF ran funding schemes during 2019/20 year, ensuring that Third Sector organisations are able to access new sources of funding from a range of funders. These have included the Vale Integrated Care Fund (ICF) Older People's Preventative Interventions Fund in liaison with the Vale of Glamorgan Council, Hau Fund, the Cardiff and Vale ICF Capital Investment Fund, Cardiff and Vale Parents and Siblings of Children with Mental Health Issues Third Sector fund, Cardiff and Vale Support for people with learning disabilities and/or their carers, the Cardiff and Vale Health Charity Third Sector fund and Comic Relief funding.

Projects funded have included accessible dance classes, nail cutting services, a singing group, exercise classes at a day centre, IT equipment, accessible cycles, music workshops, a sensory garden and a BME sewing group.

"Thank you so much for your support and advice about our new bids - we are so thrilled to have been successful in BOTH of our applications. We can't wait to get started on the projects!"

The Hau Fund was opened for applications from the 3 May 2019 until the 27 May 2019. Over 60 applications were requested and issued by C3SC. 25 completed applications were received, 14 organisations were offered funding across the region in 2019/20.

Grow Cardiff, were funded through the Hau Third Sector Fund, to raise awareness of healthy activities. As part of their social prescribing programme they had a garden at the Royal Horticultural show in Cardiff in 2019. Those involved learnt a range of skills including willow weaving.

Image: Grow Cardiff's design for the A Cwtch and a Cuppa garden

Learning Disabilities – Coproduction
The Cardiff and Vale Region agreed to develop a Joint Commissioning Strategy for Adults with Learning Disabilities, which would involve Cardiff Council, Vale of Glamorgan Council and the Cardiff and Vale University Health Board, and in addition Swansea Bay University Health Board (as now known) as the commissioned service for health provision. The consultation was completed through the Learning Disability Partnership Group (LDPG), which includes people with learning disabilities, Third Sector and private providers of support and services. The final document was launched in July 2019 with an event designed to be as inclusive as possible including the provision of a Changing Places facility to allow people to stay for the whole day.

A small amount of funding was made available to support people with learning disabilities and/or their carers through the Learning Disability Partnership Board. At the suggestion of C3SC two workshops were run. The first was with people with learning disabilities and their carers to find out about their experience of COVID-19 and what services they thought were needed as we move towards recovery. A second workshop involved Third Sector providers where the learning from the first was shared and their thoughts were also sought. Applications were then received and three organisations were successful in their request for funding. Another organisation was approached about the possibility of working with statutory partners in regards to improving the health of people with learning disabilities.

Bringing the Third Sector together - Health, Social Care and Wellbeing Networks
The Health, Social Care and Wellbeing networks in Cardiff and the Vale provide a vital link to the Third Sector and an effective way of disseminating information to a wide range of partners.

The Networks reach over 1,000 Third Sector staff and also staff from health and social care. Network meetings and regular e-bulletins make sure that everyone is kept up to date with any developments in health, social care and wellbeing in the region.

"It was a real pleasure to attend the Vale Network event. In fact truly gratifying to feel the swell of support for what we are attempting to add to the citizens experience of Primary Care."

Responding to the voice of unpaid carers in Cardiff and the Vale
Unpaid carers have told us that they sometimes find it difficult to get information which will help them in their caring role. The Third Sector, working with health and social care staff, responded to this by developing the Cardiff and Vale Carers Gateway, which was launched in Spring 2020. The Gateway, provided by Carers Trust South East Wales, provides an easy way for unpaid carers to find the support they need at the time they need it and makes a real difference. This has been especially important as unpaid carers have faced many challenges dealing with their caring role during the COVID-19 pandemic.
https://www.ctsew.org.uk/cardiff-and-the-vale-carers-gateway

Grandparents Raising Grandchildren, Special Guardianship Orders
Grandparents Raising Grandchildren (GRG) have been active members of the Cardiff Health, Social Care and Wellbeing Network (HSCWN) since 2015. GRG supports kinship carers, particularly grandparents, who for a range of reasons, have taken on the guardianship role for their grandchildren. Special Guardianship Orders are awarded by the Courts and provide the legal confirmation that the kinship carer is the legal guardian of a Child.

Following discussion at a Cardiff Health, Social Care and Wellbeing Network meeting and subsequent training delivered by Diverse Cymrufocused on challenging the public sector, GRG provided comments to the UHB who were. updating their Maternity / Paternity/ Shared Parental Leave Policy.. As a result, the UHB changed the policy to include a section on Special Guardianship Orders. Welsh Government have confirmed that Cardiff and Vale UHB are the first Health Board in Wales to include Special Guardianship Orders in their adoption policy. The Welsh Government have asked the Welsh Partnership Forum who agree the all Wales workforce policies to consider including a section to outline the position for Special Guardianship Orders to the all Wales special leave policy which is due to be reviewed in 2020.

Food Vale
The GVS H&SCF has been working closely with the public health team on the Food Vale initiative which is inspiring healthier communities in the Vale to connect with food. This now includes the development of a Community Wellbeing Toolkit which will help community groups develop wellbeing activities and services. https://foodvale.org/

Providing information and advice for our stakeholders
A vital element of the H&SCF role is to provide information about Third Sector services and advice about partnership working. During 2019/20 this involved the H&SCFs having over 320 meetings with people working in health, social care, wellbeing and the Third Sector.

"Thank you so much for meeting with us on Tuesday. We all agree that you are a fountain of knowledge and we're really grateful for your support."

Key Officers who support the strengthening of partnership working between the UHB and the local Third Sector are:
The UHB's Planning and Partnership Team
Anne Wei, Strategic Partnership and Planning Manager, e-mail: Anne.Wei@wales.nhs.uk

In Partnership with the Third Sector Infrastructure Organisations:
Sarah Capstick, Cardiff Health and Social Care Facilitator, Cardiff Third Sector Council (C3SC), email: Sarah.C@c3sc.org.uk

Linda Pritchard, Vale Health and Social Care Facilitator, Glamorgan Voluntary Services (GVS), email: Linda@gvs.wales

Lani Tucker, Vale Health and Social Care Facilitator, Glamorgan Voluntary Services (GVS), email lani@gvs.wales

Image on first page: GVS ReBuild and FareShare, helping to stop food waste event, at CF61 in Llantwit Major.

Report Title:	**Cardiff & Vale UHB Quarter 3-4 Plan**						
Meeting:	Board				**Meeting Date:**	26.11.20	
Status:	For Discussion		For Assurance		**For Approval**	**x**	For Information
Lead Executive:	Executive Director of Strategic Planning						
Report Author (Title):	Jonathan Watts, Head of Stratgeic Planning						

Background and current situation:

In response to the Covid-19 pandemic the traditional planning rhythm for NHS Wales has been paused with organisations, to date, instead being asked to operate within a quarterly planning cycle.

Following guidance from Welsh Government (WG) the system moved into a six month approach to planning- this meant the UHB was asked to develop a plan from September 2020 through to 31st March 2021.

The Health Board's Quarter 3-4 plan had to be submitted to WG by the 19th October 2020. Prior to submission an informal meeting with held with a number of independent Board members in order to offer them the opportunity to shape the plan. The finalised plan was also shared with Board at a recent Board development session.

Whilst there is no formal approval process by WG, the plan represents a key document for the UHB as it looks to further enhance its reputation as a 'trusted' organisation amongst partners and stakeholders.

Direction from WG as to the expected content of the plan was more prescriptive than for previous Quarter 1 and 2 plans, with an additional requirement to submit a detailed minimum data set profiling projected performance and delivery across a very wide range of services to support the narrative of the plan.

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

In order to the address the specific requirements of WG, the plan has been designed though the lens of the four harms associated with Covid-19 (below bold). Within these four harms the UHB then sets out its response to the issues raised by WG.

1. **Direct harm of covid-19**
    - Bed Capacity
    - TTP
    - Mass vaccination preparations
    - Our workforce response
2. **Indirect harm of covid-19**
    - Our approach to planned care
    - Essential services
    - Primary care

3. **Preventing our system becoming overwhelmed**
    - Our 'in-extremis' plans
    - Our critical care plans
    - Our workforce 'in-extremis'
    - Working with our partners to protect the system
    - Our approach to winter
4. **The wider harm of covid-19**
    - Mental Health
    - Long Covid
    - Service collaboration

The approach to developing the plan against this architecture involved;

- Undertaking some detailed scenario planning which looked at understanding the worst case scenario, the best case scenario and the 'central ground'.
- This was subsequently followed by understanding the key risks which would face the UHB in the context of these scenarios. The key risks identified included;

  R1: Covid-19 prevalence exceeding modelling
  R2: The impact of R1 on system capacity
  R3: The impact of R1 on finance (above funded plan)
  R4: The impact of R1 on our workforce
  R5: The additionality of a particularly harsh winter

  It was then possible to develop a plan which considered these scenarios whilst mitigating the risks.

- At the same time development of the plan ensured wider system alignment with key policies/frameworks/strategies such as- *The Welsh Government Winter Protection Plan, A Healthier Wales* as well as the UHBs own *Shaping our future wellbeing strategy.*

- The plan was developed to ensure alignment with other proposals which the UHB were developing in relation to accessing a proportion of the £30M urgent and emergency care fund.

- The plan was developed to ensure that the proposed service performance deliverables were clearly underpinned by the integrated finance and workforce sections.

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

The emergence of Covid-19 has brought unprecedented challenges and uncertainties to the operational delivery and operational planning of health services. Latest modelling indicates NHS Wales needs to be in a position to respond to a range of 0 – 68,000 Covid-19 infections per week and 0 – 2000 Covid hospital admissions per week, with Welsh Government requiring the UHB to make up to 795 hospital beds available for Covid-19 patients.

Given this context it was clearly not possible (nor desirable) to set out fixed plans for the forthcoming six months. This represents the key challenge and underlying risk associated with this plan- ultimately an unknown factor being the key driver of activity levels. Activity levels then being the driver for the organisation's workforce and financial planning.

Recommendation:

Board are asked to now formally endorse the Qtr 3-4 plan.

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	**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	
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	**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	

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

Equality and Health Impact Assessment Completed:	**Not Applicable**

CARDIFF AND VALE UNIVERSITY HEALTH BOARD

SERVICE DELIVERY PLAN 2020-21

QUARTERS 3 and 4

Contents

EXECUTIVE SUMMARY

2020 has been a year like no other as we continue to tackle the unprecedented global challenge of Covid-19. Like others this pandemic has tested our organisation and our staff in all manner of ways. As this will unfortunately continue to be the case we have developed a plan for the remainder for 2020/21 which continues to address the challenge head on.

As it is neither possible nor desirable to set out a fixed plan for the coming six months due to the unpredictable nature of this pandemic. As such we have developed three broad scenarios (not predictions or projections) for the coming six months to support in our thinking and help us produce an agile and flexible plan. These scenarios were;

Covid-19 "worst-case"
Covid-19 "best-case"
Covid-19 "central"

For the purposes of writing this plan we have adopted the Covid-19 "central" scenario as our triangulation point. It remains vital though that this is seen within the context of the UHB continuing to adopt its approach to gearing and thus being ready to respond to any eventuality.

To ensure we continue to meet the needs of our local population over the coming six months and beyond whilst at the same time supporting our extraordinary staff we have used what these scenarios have told us to shape the description of our responses around the four harms associated with Covid-19 *(i) Harm from Covid-19 itself, (ii) the indirect harm of Covid-19, (iii) harm from an overwhelmed NHS and social care system (iv) harm from wider societal actions*.

Harm from Covid-19 itself

Our bed modelling shows;

- Total physical bed capacity is likely to be sufficient in all plausible scenarios once the full surge capacity is in place
- Prior to that there remains a theoretical risk that demand in a RWC scenario would exceed bed availability
- The greatest period of risk may well be during December & January, when the totality of the surge capacity is not yet available, in the event of a Covid-19 second wave 2-3 times larger than the first and coinciding with winter
- Specific bed demand and timing of that demand will be determined by both Covid-19 and the extent to which non-Covid-19 returns to normal (both of which are demand-driven and not predictable), with elective activity having a comparatively marginal effect on bed demand
- However modelling suggests that planning for up to 1600 beds will be adequate for all but the worst-case Covid-19 scenario

Harm from an overwhelmed NHS and social care system

Our plan describes the replacement field hospital to the DHH - a temporary modular build which will accommodate up to 400 beds known as 'the lakeside wing'. This capacity will be delivered in 2 phases with phase one due to deliver 166 beds by the 25th November and Phase 2 to deliver the remaining beds by the end of January 2021.

In addition we describe the work we are doing with our wider partners across social care to manage pressures and challenges being faced across 'test, track and trace' and care homes.

Our Workforce

Through scenario planning our plan shows that we understand what our workforce needs are and that workforce is the biggest issue facing us which must be effectively managed.

Covid-19 worst-case – this would involve staffing our internal additional surge capacity beds (106) across critical care and additional IP beds created in UHW, UHL, Barry & St David's. In addition, we would need to staff our additional field hospital capacity of 350 field hospital beds and further 50 IP beds in Lakeside Wing. This represents a total additional bed capacity of 506.

Covid-19 best-case – this would involve retaining existing staffing levels; recruiting temporarily into the 50 additional winter bed capacity; maintaining absence levels at around 5.5%; continuing to recruit permanent posts to manage turnover and; with a focus on returning non-Covid-19 (emergency and elective) to normal levels. This represents a total additional bed capacity of 156.

Covid-19 central scenario – this would involve retaining existing staffing levels; recruiting temporarily into the additional winter bed capacity; temporarily redirecting/redeploying staff from acute non ward areas and service closures to staff the internal additional surge capacity and a further 166 beds in the field hospital facility (116 field hospital beds and 50 IP beds in total). This represents a total additional bed capacity of 272 (50 + 106 + 116).

In-direct harm from Covid-19

In the context of our Planned Care strategic framework we are maintaining a focus through quarters three and four on two key elements of planned care –

Treatments: key activities to increase activity across- Orthopaedics, our second cardiac theatre, day Surgery at UHL and cataract activity
Outpatients: Key activities across Clinical Prioritisation, Adapted ways of working and configuration

In addition we have a plan that sets out how the range of essential services which we provide will be maintained over the coming period.

Harm from wider societal actions

We outline the actions we will be taking in regards to long Covid-19 and specifically our population's mental health and wellbeing along with how we are working with our health partners to deliver sustainable health services collaboratively where clinically appropriate.

Our other critical enablers

Finally we address the other critical enablers and associated actions which will underpin the success of this plan. These include;

- Effective management of our finances
- Our capital and estate
- Our approach to research, development, innovation and technology
- The effective management of winter

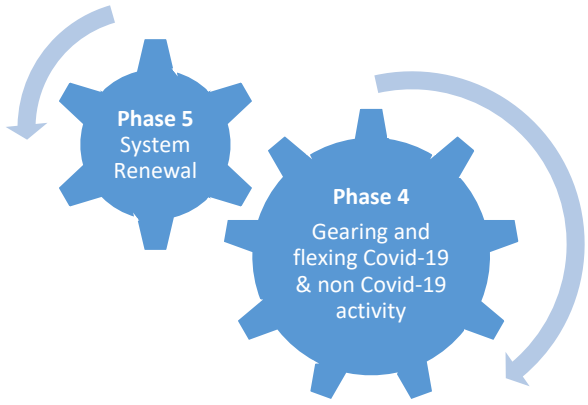
OUR APPROACH TO PLANNING

2020 to date

Our initial 2020/21 plan developed in quarter one and refined in quarter two indicated the UHBs immediate acute response to the pandemic and was described through a series of phases (below) underpinned by a *gearing* approach..

Phase 1	Repurposing capacity and zoning within UHB acute hospitals
Phase 2	Commissioning new infrastructure and additional capacity within UHB facilities
Phase 3	'In Extremis' planning- the commissioning short-term surge capacity outside UHB facilities
Phase 4	The ongoing response to the pandemic- our operating model and gearing approach to ensure that the UHB is able to continue to provide a flexible approach to developing and balancing our capacity to deliver essential services
Phase 5	our proposed approach to system renewal

Quarter 3-4 planning



Unfortunately Covid-19 is going to exist within society for some time and as such our system must adopt and further learn to operate within this context.

Whilst we have moved out of a period of emergency planning (phases 1-3) we now operate in a circular process in order to continually balance phases 4 and 5.

Our core aim in this quarter 3&4 plan has been to describe how we will do this to best affect. To deliver this aim our thinking had to go through a number of initial steps-

i. Scenario Planning

From an early stage in the pandemic the UHB has established the concept of 'gearing' reflecting the need for health services to be adaptable and respond differently depending on the prevalence of Covid-19 and the resulting impact on service provision. The original gearing levels remain extant (see table 1) but of course the breadth of each 'gear' means there are also multiple degrees within each of these levels. Consequently this approach sets the framework for our response and planning, but the position is reviewed multiple times per day with dynamic decision-making.

Table 1

	Post-COVID-19	Significant	Substantial	Severe	In extremis

COVID-19 daily attendances	0	0 – 50	50 – 100	100 – 200	> 200
COVID-19 daily admissions	0	0 – 25	25 – 50	50 – 100	>100
COVID-19 patients in hospital	0	0 – 250	250 – 500	500 – 1000	>1000
COVID-19 critical care	0	0 – 35	35 – 75	75 – 150	>150

The emergence of Covid-19 has brought unprecedented challenges and uncertainties to the operational delivery and operational planning of health services. To exemplify this the latest modelling indicates NHS Wales needs to be in a position to respond to a range of 0 – 68,000 Covid-19 infections per week and 0 – 2000 Covid-19 hospital admissions per week, with Welsh Government requiring the UHB to make up to 795 hospital beds available for Covid-19 patients.

The timing of a second wave (or indeed the reality that we are already in it given the consistent uptake in cases we are seeing within our local population) is uncertain and may coincide with non-Covid-19 winter pressures. In addition it is unknown what impact this second wave will have on non-Covid-19 emergencies, following a substantial drop in demand during the first wave. This uncertainty with emergency demand compounds a substantial backlog of elective work – at historically high levels – and an unquantifiable level of unmet demand resulting from the first wave.

Given this context it is clearly not possible or desirable to set out fixed plans for the forthcoming six months. Rather the task is to clearly articulate how we intend to respond at different levels of Covid-19, i.e. the *gearing* approach, and the potential implications for our service delivery, our workforce and our finances.

To that end we developed three broad scenarios (shown in table 2), representing the range of plausible circumstances (for Covid-19) over the coming months, to test thinking:

Table 2:

Scenario		Gear	Description
1	**Covid-19 "worst-case"**	**Severe**	Utilising the Swansea University RWC model for Covid-19 (although bed figures adjusted) plus typical effects of winter for non-Covid-19.
2	**Covid-19 "best-case"**	**Significant (lower end)**	Equivalent of the situation over the past few months persisting. Low prevalence of Covid-19 remains for the rest of the financial year but does not disappear entirely. IP&C controls still required and minimal Covid-19 capacity in place but otherwise the focus is on returning non-Covid-19 (emergency and elective) to normal levels.
3	**Covid-19 "central" scenario**	**Substantial**	A second (and potentially third) Covid-19 wave occurs of similar size and duration to the first wave.

The specifics of these scenarios are set out in **appendix one.** However it is important to stress **these scenarios are not predictions or projections**. These are purely scenarios to support our planning and provide an indication of the implications for service delivery, finance, workforce etc.

For the purposes of ultimately writing this plan and providing an accompanying minimum data set (MDS) we have used the **Covid-19 "central" scenario** as our triangulation point. However as reiterated at various points this must be acknowledged in the context of the UHB possessing a clear approach to *gearing* which allows us to be both flexible and agile in terms of how we deliver the required level health care services to our population in other scenarios if required.

We also used the collection of MDS information as part of this exercise and to triangulate what the *'art of the possible*' was within these scenarios.

ii. Identifying risk

We then identified the high-level risks presenting themselves in these scenarios (shown below). This allowed us to be clear on where the focus of our plan needed to lay.

Risk 1: Covid-19 prevalence exceeding modelling
Risk 2: The impact of R1 on system capacity- *Covid-19 and non Covid-19*
Risk 3: The impact of R1 on finance (above funded plan)
Risk 4: The impact of R1 on our workforce
Risk 5: The additionality of a particularly harsh winter

At the same time we considered our full Board Assurance Framework and the risks currently identified to ensure a line of sight was not being lost to any wider challenges facing the organisation.

See also **section 8** around our governance.

EU Transition

The risk in relation to EU transition has not been added to the organisations BAF due to the fact that there is a separate document already in place which details all the risks in relation to Brexit. It is acknowledged that it would also be very difficult to wrap 'Brexit' up into just one risk on the BAF.

Our Brexit Risk document is in the form of a Business Continuity Plan and is regularly reviewed by the Brexit Task and Finish Group. The plan details the risks, likely impact and mitigating actions. The Chair of the Group is the Executive Director for Strategic Planning.

iii. Ensuring an internal and external for with the strategic context

Finally we looked to cross reference and 'sense check' with the wider strategic context to ensure alignment.

Internal alignment

Shaping Our Future Wellbeing and its key principles remain our organisational compass and have underpinned the development of this plan. Whilst we are in exceptional times it remain vital that a consistent line of sight is maintained to what was, and still is the best thing for the people we serve;

- Empower the Person
- Home first
- Outcomes that matter to people

- ❖ Avoid harm, waste and variation
- ❖ Promote equity between the people who use and provide services

External alignment

A number of wider strategic drivers continue to help us set the direction of our plan and these are shown in the table below. Whilst these have been guiding principles and 'markers' for us in our planning we have also looked to signpost to specific sections of this plan where their consideration has been particularly pertinent.

The context	The strategic drivers	How and where we reflect this in our plan
The four harms associated with Covid-19	• The direct health impact • The indirect health impact • The health system being overwhelmed • The wider societal impact	Sections – 2,3,4,5
A Healthier Wales	**The quadruple aim** • Improved population health and wellbeing • Better quality and more accessible health and social care services • Higher value health and social care • A motivated and sustainable health and social care workforce **The ten design principles**	Essential services- *section 4* Our regional working – *section 5* Our Workforce- *section 7*
The WG winter protection plan and the Cardiff & Vale RPB winter protection plan	• Preparing for winter • Protecting the people of Wales • Care Homes	Working with our care homes- *section 3* Managing winter – *section 6* Working with our partners- *section 6*
Funding Opportunities	• Urgent and emergency care fund • Discharge to Recover and Assess funding • Eye care sustainability fund	*Sections 4 & 6*

Triangulating these three phases of our thinking then allowed us to describe our response whilst ensuring integration with our workforce and financial planning.

Section 1: OUR CONTINUED RESPONSE to THE DIRECT HARM OF COVID-19

This section focus on the acute setting. We however fully recognise the huge role that primary care have, are, and will, play in our continued response to the pandemic and this is reflected in **section 3.**

Our acute site functional bed capacity

The emergence of Covid-19 brings with it the most significant challenges to hospital bed capacity, possibly in the history of the NHS. There are three main aspects to this:

1. **Scale** - In the worst-case scenarios Covid-19 threatens to overwhelm hospital capacity. The UHB must therefore be prepared for the possibility of having to provide many hundreds of additional beds to accommodate Covid-19 patients.

2. **Uncertainty** - The scale, timing and duration of any subsequent Covid-19 waves are unknown and inherently uncertain, as is the impact that would have on non-Covid-19. In addition it is evident from the first wave that Covid-19 demand can accelerate to very high levels in only a matter of weeks. The UHB must therefore have a plan that is highly responsive and flexible, working in short time horizons of no more than 4-6 weeks.

3. **Complexity** - Irrespective of the level of Covid-19 demand it is necessary to safely segregate inpatients to minimise the risk of hospital transmission. The UHB has previously set out its approach to streaming, with five separate patient pathways (red, purple, blue, orange and green). This inevitably brings with it a different order of complexity to configuring and operationally managing our acute hospital sites.

In order to function within this environment the UHB has previously set out the components of our new operating model:

a) Design principles: to make decisions in a consistent fashion
b) Gearing: to provide the appropriate level of response at the right times
c) Streaming and zoning: to safely segregate patients and minimise risk
d) Surveillance: to closely monitor changes in Covid-19 demand
e) Green zones: to provide dedicated “Covid-19-free” environments
f) Planning cycles: 4-6 operational planning cycles within the framework of the annual plan

The details for each of these have been set out in previous plans and continue to be the approach we are taking.

Within this context the bed plan for the UHB cannot be described in the traditional manner of ‘what and when’. However it is possible to set out how the UHB’s response will change at different levels of Covid-19 (our gearing approach) and stress-test the resilience of plans against different scenarios.

Modelling of bed demand

As described in our *approach to planning* section the UHB’s approach to planning for quarter 3 and quarter 4 has been to establish three high-level scenarios and test our response against each to understand the likely impact and limitations. **These are not projections but plausible scenarios** to *stress-test* our bed plans against.

The detail of the assumptions behind these scenarios is provided in **appendix one**. The results of this modelling is shown below **(graphs a,b,c)** against the available capacity with phase one representing all of the adult, physical health beds available to the UHB prior to Covid-19; phase 2 the additional wards established within the UHB’s estate in response to Covid-19 (e.g. two additional wards in the community hospitals, the converted physiotherapy department, the HCID unit etc); and phase 3 the Lakeside Wing Surge Hospital (for simplicity the DHH capacity is not shown on the charts but is available to the UHB until the 12th November).

The modelling has the following caveats:

- No provision made for loss of capacity due to infection outbreaks
- Covid-19 demand does not include in-hospital transmissions

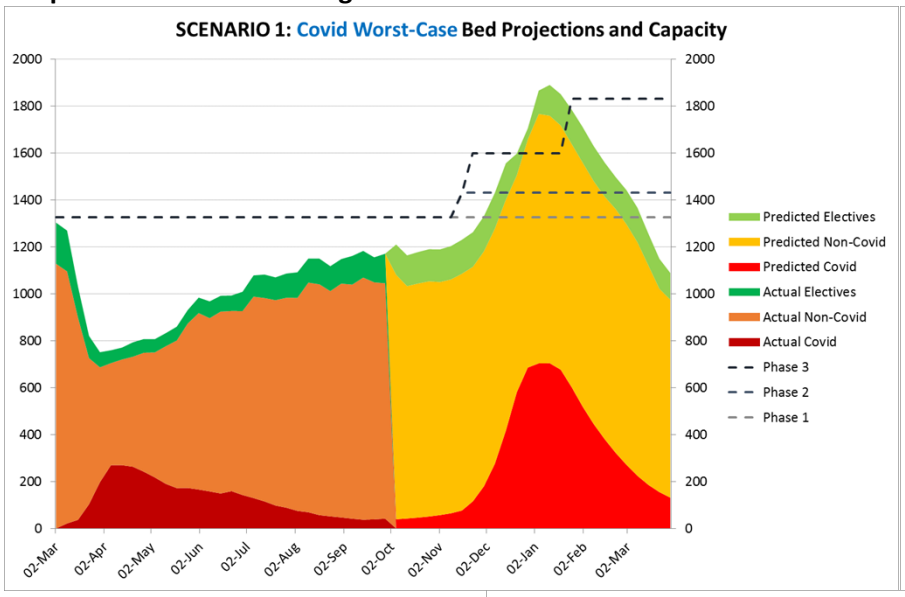
- Modelling concerned with bed capacity only, staffing modelling will need to factor in increased absence due to Covid-19 sickness/isolation
- No bed provision made for non-CAV services to be supported/centralised (e.g. Royal Glamorgan, social care, thoracic etc)
- Plan assumes Spire retained until at least the end of the financial year
- Implicit assumption that discharge flows into community & social care will be maintained
- Makes no provision for further bed spacing

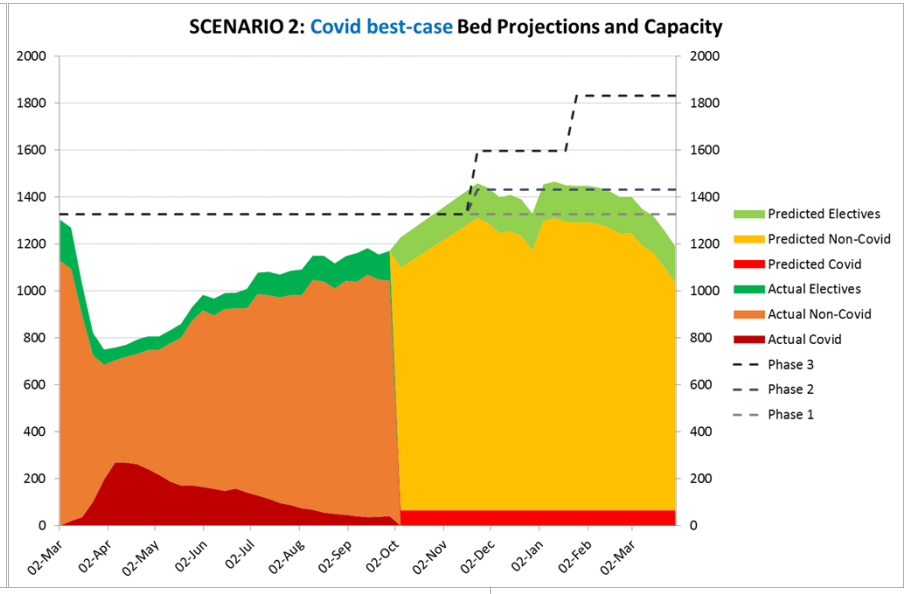
From this analysis we have drawn the following conclusions:

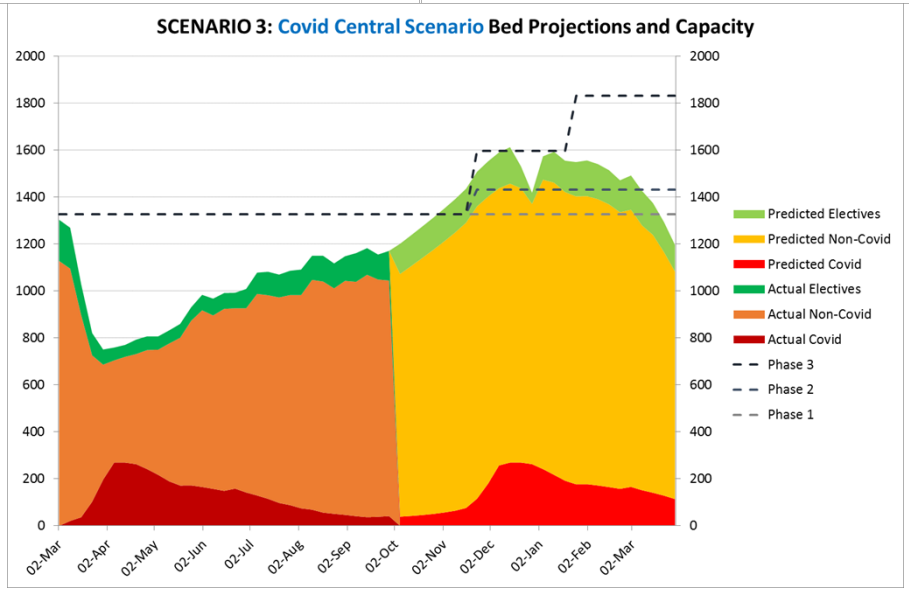
- Total physical bed capacity is likely to be sufficient in all plausible scenarios once the full surge capacity is in place (noting the caveats above)
- Prior to that there remains a theoretical risk that demand in a RWC scenario would exceed bed availability
- The greatest period of risk may well be during December & January, when the totality of the surge capacity is not yet available, in the event of a Covid-19 second wave 2-3 times larger than the first and coinciding with winter
- Specific bed demand and timing of that demand will be determined by both Covid-19 and the extent to which non-Covid-19 returns to normal (both of which are demand-driven and not predictable), with elective activity having a comparatively marginal effect on bed demand
- However modelling suggests that planning for up to 1600 beds - i.e. all of phase 2 plus the first 166 of Lakeside Wing - will be adequate for all but the worst-case Covid-19 scenario

Graphs – *a,b,c*

Outputs from Bed Modelling for Three Covid-19 Scenarios







Zoning of capacity (including Green Zones)

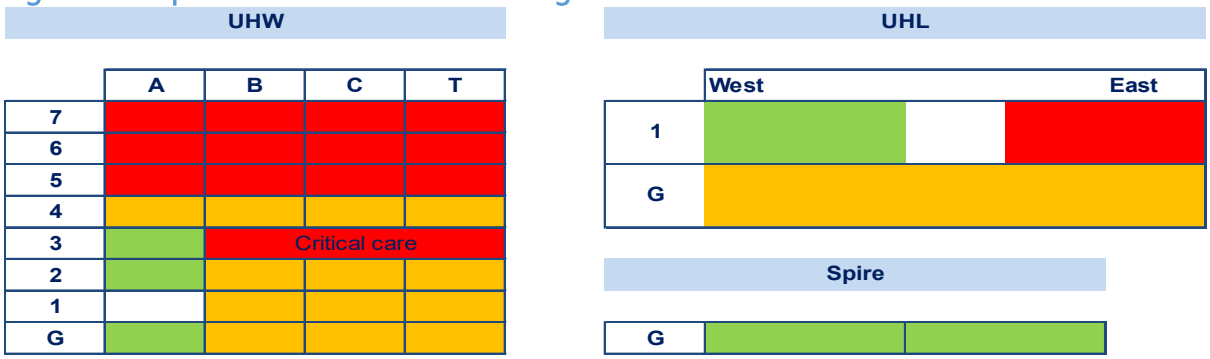
As described in previous plans we have, since the onset of the pandemic, been segregating Covid-19 positive, Covid-19 suspected and non-Covid-19 patients. In addition the Spire hospital and the Short Stay Surgical Unit (SSSU) at UHW have been used as 'Covid-19-free' (Green) facilities to provide essential and urgent operating. Green zones have since been established in main theatres in UHW and at UHL, with further expansion planned to be completed during November.

These green zones operate as a 'hospital within a hospital', including separate access, facilities, processes and staffing. The functioning of the green zones is described in a range of SOPs, with controls tightened as the community prevalence for Covid-19 changes (i.e. the gearing approach).

Over the summer the UHB has, like all Health Boards, seen a significant reduction in Covid-19 patients in hospital and therefore a contraction of the Covid-19 footprint, with wards repurposed to once again provide non-Covid-19 services. Nonetheless, in the event of a significant second wave, the zoning plan remains as previous with Covid-19 patients initially placed on the top floor at UHW and the red zone expanding downwards as necessary; with the East wing, first floor used at UHL.

The Dragon's Heart and Lakeside Wing will continue to have a clinical model based upon step-down, thus facilitating the displacement from these red zones should that be required.

Figure 1: Simplified schematic of site zoning



The fundamental objective of establishing these green zones is to protect patients whilst re-commencing core services. To support this we have a systematic clinical audit process in place to capture the outcomes of all surgical procedures, again this has been in place from the early stages of the pandemic.

The UHB has a role in providing services to patients outside of Cardiff and Vale and we continue to have active dialogue with WHSSC and other Health Boards (Swansea Bay in particular) on the support we can offer through these green zones to ensure time critical services (e.g. thoracic, upper GI and hepatobiliary surgery) can recommence across South Wales.

Test, Trace and 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 TTP service has had to respond to an increase in local cases in recent weeks, particularly in Cardiff. This increase has led to the implementation of additional local lock down measure, and until the effect of this is seen, we expect case numbers to continue to rise.

We continue to devote a large proportion of our capacity to the response, currently focused on delivering TTP in our region and the recent arrival of students to the city also has the potential for additional seeding of infection from other areas, and onward local spread which will require resources to address this.

To respond to this;

- ❖ We continue to work closely with Cardiff University and are supporting the development of a new walk-in testing centre located close to the University and City centre.

- ❖ Cardiff Council have been recruiting and training additional contact tracers and advisors (to which we continue to work in partnership and to provide staff to them via Secondments). The tracing service is now also operating 8am to 8pm, 7 days a week which represents an expansion of hours.

Whilst our performance data over recent weeks has shown response times to be above average in Wales, the recent uptick in cases, compounded with the effects of delays in results from Lighthouse labs resulting in large batches being received at once, has caused some deterioration in performance which we are clear we must try to address.

As the pandemic has progressed and we have worked together as a regional team to manage and minimise local risk and have learned much about how infection spreads within our local population. This learning is shared regularly at the regional board and has informed our local plans, for example in developing local communications to target our higher risk populations. This has also been shared at the Regional IMT, and through the escalation processes agreed locally, to report to Welsh Government.

The Test, Trace and Protect component of the minimum data set which accompanies this plan provides further detail on our position to date and our projections for the remainder of 2020/21.

Our Planning for Covid-19 mass vaccination

Every Health Board in Wales was tasked with submitting preliminary plans for the delivery of the Covid-19 vaccination programme locally by 3 September 2020 to the Chief Medical Officer for Wales. Cardiff and Vale UHB submitted a strategic level plan, approved by the CVUHB Chief Executive Officer. A more detailed operational plan for mass vaccination in Cardiff and the Vale of Glamorgan will be submitted later in October 2020.

We are however progressing a number of activities in this area which includes;

- ✓ Establishment of a Covid-19 Vaccine Programme Delivery Board chaired by the Executive Director of Public Health.
- ✓ Established five work-streams to undertake preparatory work- i) Workforce & Training; ii) Vaccine Considerations, iii) End-to-end Person Journey; iv) Venues and Logistics; v) Communications.
- ✓ Modelling work currently being underway for priority population groups (based on JCVI guidance) and workforce to provide a better understanding of operational requirements
- ✓ Three Mass Vaccination Centres have been identified and agreed.
- ✓ A costed plan being worked up.

We are also working through a number of risks which have currently been identified and these include;

- Funding to support the mass vaccination programme
- The impact of a Second wave of Covid-19 and consequent impact on staffing and resource
- The unknown exact timescales for vaccine availability
- Workforce capacity and training required for vaccination delivery – our workforce hub is supporting the recruitment to the Community Testing Unit in readiness for a vaccine programme.
- Compliance and engagement from eligible groups
- Wider winter pressures

Our workforce response

Our staff are the most extraordinary part of this organisation and we remain extremely proud of their achievements both during the immediate emergency phase of the Covid-19 pandemic and their continued ongoing response both over the summer and as we head into winter combined with the uptick in Covid-19 which we are now seeing in our community.

It is anticipated Scenarios 1, 2 and 3 described earlier will broadly impact on the workforce as follows:

Scenario 1: Covid-19 worst-case – this would involve staffing our internal additional surge capacity beds (106) across critical care and additional IP beds created in UHW, UHL, Barry & St David's. In addition, we would need to staff our additional field hospital capacity of 350 field hospital beds and further 50 IP beds in Lakeside Wing. This represents a total additional bed capacity of 506. This would be beyond the ultimate stretch for our workforce capacity and as we could not supply all the nursing and medical staff it would require the closing down of non-essential services and re-direction of staff appropriately; as well as a fundamental change to the workforce model to use available Therapy staff, Students, Retired Returners; and re-organising medical rotas across the board again to support Covid-19 zones. This could see our absence levels rise to over 9% again and the number of staff shielding rising to over 600.

Scenario 2: Covid-19 best-case – this would involve retaining existing staffing levels; recruiting temporarily into the 50 additional winter bed capacity; maintaining absence levels at around 5.5%; continuing to recruit permanent posts to manage turnover and; with a focus on returning non-Covid-19 (emergency and elective) to normal levels. This represents a total additional bed capacity of 156.

Scenario 3: Covid-19 central scenario – this would involve retaining existing staffing levels; recruiting temporarily into the additional winter bed capacity; temporarily redirecting/redeploying staff from acute non ward areas and service closures to staff the internal additional surge capacity and a further 166 beds in the field hospital facility (116 field hospital beds and 50 IP beds in total). This represents a total additional bed capacity of 272 (50 + 106 + 116). This will mean further extending the Temporary Bank, Facilities Bank and engaging further temporary workers on fixed term contracts in readiness to gear up. This could see an increase in absence to around 6 – 7% as our own staff fall ill with the virus and are required to self-isolate and resilience is low.

We are therefore currently increasing temporary recruitment as part of this readiness plan. The Workforce Hubs remain in place to ensure a fast pace, multi-professional approach to workforce resourcing for the following:

- Winter/Covid-19/Surge (wards)
- Facilities Staff – creating a Facilities Bank
- TTP & Community Testing Units – additional staff due to the increase in demand
- Mass Immunisation – Covid-19 & Flu vaccine

We are undertaking a number of actions to ensure our workforce is best position to respond to the ongoing pandemic. These include;

- ✓ Recruiting 50 Facilities staff (housekeepers, porters) on 12 week contracts and we are establishing a Facilities Bank to enable us to call upon more staff quickly as and when needed. This temporary resource will provide a solid backfill for any gaps and manage absence more effectively. Through Social Media and virtual recruitment we have already appointed 49 individuals.

- ✓ Plans for the out of hospital Community Resource Teams with additional funding to support these teams.

As students are now resuming their academic programmes, or have joined us in substantive posts following graduation we are not building our plan based on large cohorts being available to us. However, all students are offered the opportunity to register with us on our Temporary Banks and will be able to

choose to work for us on a temporary basis as they deem appropriate to fit in with their educational commitments.

Those staff who have returned from former retirement will remain on our temporary registers – although we do not at this stage anticipate relying heavily on this group at this stage. Internal staff who have retired and returned as part of the UHB Policy remain a very valued group of staff who form part of the staffing compliment. The adjustment in the NHS pension policies to support retaining this group has helped bring them back earlier and makes for an easier transition.

See also **section two** regarding our medical surge workforce planning.

Section 2: PREVENTING OUR SYSTEM BECOMING OVERWHELMED

In extremis- Our field hospital

During Q1 the UHB, in addition to reconfiguring existing acute beds to appropriately cohort patients requiring hospital admission, the UHB also implemented a range of community and acute hospital infrastructure schemes to supplement the core bed base of the UHB by a further 106 beds. In addition to this, the Dragon's Heart Field Hospital was also rapidly established at the Principality Stadium to establish a further 1500 temporary beds to provide capacity for an 'in extremis' response to the potential demand predicted in the first wave of the pandemic. As the national lockdown restrictions took effect and the first wave of the pandemic subsided, the options to replace the temporary field hospital capacity with a proportionate and more sustainable option has been developed. The replacement field hospital capacity is being provided on the UHW in the form of a temporary modular build, Lakeside Wing, which will accommodate up to 400 beds. Construction is underway and on schedule. This capacity will be delivered in 2 phases with phase one due to deliver 166 beds by the 25th November and Phase 2 to deliver the remaining beds by the end of January 2021.

The decision to mobilise the capacity in Lakeside Wing will be under continuous review through our daily operational meetings where the flow, cohorting and occupancy of wards on all sites is under continuous review. From an operational management perspective, Lakeside Wing will be treated as an extension of UHW and will therefore be co-ordinated by the UHW Local Coordinating Centre (LCC). In recognition that 350 of the beds are in wards in Lakeside Wing that have been designed as temporary field hospital accommodation, additional operational measures have been taken to mitigate or manage fire safety and IP&C requirements.

The most significant challenge will be the staffing of this capacity in addition to the existing enhanced core and winter capacity. The management of the staffing for the unit will be through the nursing and medical workforce hubs that have been established at UHW. In addition to the appointment of additional temporary and permanent staff, the process for redeployment and skill mixing of teams will be co-ordinated through these professionally led hubs to ensure that patient and staff safety is appropriately assessed and balanced.

Critical Care

Critical Care within Cardiff and Vale UHB has expanded both its footprint and workforce to best meet demand from the outset of the pandemic. It is recognised that as a regional Tertiary centre that critical care activity is very much demand-driven and, as such, significant challenges exist in maintaining a prescribed level of activity. Flow and efficiency of the patient's pathway remain the key determinants of managing demand in an ITU setting and are referenced below- we recognise that both of these factors are within our systems' control.

Therefore, we have a zero tolerance approach to delayed discharges with an escalation policy that aims to keep two staffed admission and stabilisation beds to reduce DTOCs and expedite admission has been agreed by our Executive Team and has been operational since the 28th of September 2020. The efficacy of the revised escalation plan will be audited and amendments made as appropriate in due course.

Nevertheless, we remain relentless in our focus on ensuring that our critical care surge plans can be activated quickly and we have a developed escalation plan **(appendix two)** which is kept under constant review.

We equally recognise the importance of maintaining our Covid-19 and non-areas within our critical care setting- **appendix three** shows a schematic of our critical care footprint.

Critical Care arrangements are reviewed frequently in adherence to the UHB's first principle of remaining Covid-19-ready. Balancing this with a return to essential services requires weekly review ensuring our services are agile in response to demand and Covid-19 prevalence. This is undertaken via a weekly review of the UHB footprint by Directors of Operations and Executives.

Only essential surgery (RCS category 1 and 2) has been taking place at UHW. Plans are being implemented during Q3 as green zones are further developed to extend the scope of operating. It is anticipated that routine surgical patients will be cared for in the Post Anaesthetic Care Unit and as such will not have a material impact on ICU capacity.

As the pandemic evolves, it is clear that Continuous Positive Airway Pressure (CPAP) is critical in the management of some patients with Covid-19. As such specific areas outside of Critical Care at both UHW and UHL continue to have been designated for CPAP provision. This replicates the model employed in response to the first wave of Covid-19 admissions in March.

The environment within critical care, with only a small number of isolation rooms and facilities that do not meet current HBN standards creates a number of challenges that the team are required to manage operationally.

Our workforce response

In keeping with the organisations approach to 'gearing' in order to respond to the ebb and flow of Covid-19 we are making plans across the organisation to ensure the availability of workforce so support the operational change in gears at any given time.

These activities include;

- ✓ Continuing to move registered and non-registered Nursing Bank staff into permanent and fixed term contracts; with 35 HCSW currently recruited with a further 40 moving from the Bank.

- ✓ Ensuring that permanent registered nurse recruitment is ongoing with a recent successful virtual recruitment event yielding over 50 registered nurses who will join us in Q3 and Q4.

Our next virtual nurse recruitment event is taking place at the end of October. We also welcomed a further 12 international nurses during September and a further cohort will start in November.

- ✓ Medical and Dental workforce plans being refined as we intend to open clinical areas and more specifically align any additional trainee resource to these areas rather than across the board.

- ✓ Our deliberate attention to continue permanent Medical recruitment throughout this year is also paying off as new members join us regularly and we are filling a number of hard to fill posts.

- ✓ We are also reviewing the acceleration of recruitment plans for Physician Associates to help supplement the workforce model.

- ✓ Ensuring those additional nursing staff who worked throughout the first wave of the pandemic undertake one shadow shift per month under the supervision of a substantive Critical Care nurse during which they will work through a set of clinical objectives.

- ✓ Allied Health Professionals redeployed during the initial wave continuing to receive update training as appropriate, both speciality specific but also to support other members of the critical care MDT in skills such as oral care and proning patients.

- ✓ Progressing work to create a library of media and digital resources to enable on-going training and as a point of reference for existing staff –these will include identification of clinical emergencies (alerting help and initial management), and pastoral support for staff unfamiliar with a Critical Care environment.

Working with our partners- care homes

The Covid-19 pandemic is proving a particularly challenging time for care home providers- particularly the financial pressures which many face as a result. We recognise that even with the additional support being made available to the sector some care home businesses may become financially unviable through the reductions in occupancy coupled with the fixed capital costs and increasing expenditure on infection control, resident isolation, and staffing.

This poses a significant risk to not only Cardiff and Vale but also the wider functioning of the Health and Social Care system in Wales. Consequently we remain committed to the ongoing national work to clarify the legal, financial and statutory issues regarding the NHS stepping in to support the sector if required. This work is being facilitated by the National Director of Complex Care to support Health Boards to identify the key issues in relation to nursing home contingency planning. The current positon can be seen in **annex four.**

This should also be seen in the context of the Regional Partnership Board overseeing delivery of the action plan developed in response to the WG-commissioned rapid review of care homes conducted by Professor John Bolton. See **annex five.**

Directors of social services have also been asked by Welsh Government to ensure sufficiency of care home provision across the region and to have contingency plans in place.

Section 3: OUR RESPONSE TO MITIGATING THE INDIRECT HARM OF COVID-19

Essential Services

At various points in this plan we reflect on the experience of the first wave where many of our clinical boards were reporting a reduction in referrals across a range of their essential services. In many cases this was owing to the general public not wanting to 'burden' the NHS at time of such pressure and/or being too scared to attend a healthcare setting for fear of catching Covid-19.

As we move deeper into the second peak and the winter months we remain committed to both aligning with national messaging about the NHS continuing to be 'open' and it being safe for patients to present with their healthcare needs as well as developing our own messaging specifically for our local population.

Throughout the pandemic the UHB has maintained core essential services with our 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. However a range of added activity planning assumptions have been factored in, including:

- The extent to which current Covid-19 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.

These activity planning assumptions formed part of the minimum data set return which accompanies this plan.

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 were/are being treated for cancer or for time critical/urgent health conditions. Gynaecological, Gastroenterological, Urological, Breast, Neurological, Haematological, Colorectal and ENT services have all be seen at Spire during the pandemic. An overview of activity seen at is shown below;

Spire Cardiff hospital - C&V UHB activity summary

	Operating Theatres											*Outpatient activity*						*Other Treatments*	
	Cancer					Non Cancer													
w/c	Breast Cancer	Colorectal	Gynae	Urology	ENT	Ophthal	Spines	Orthopaed	AV Fistula	Max Fax	CEPOD lite	Breast	Ophthal	Neuro	Renal	Haem	Other	Endoscopy	Cardiology
10/08/2020	5	10	5	0	2	0	3	7	0	0	8	0	174	0	0	62	24	27	12
17/08/2020	6	9	7	0	0	0	5	4	0	3	10	11	108	0	0	52	0	22	9
24/08/2020	5	7	9	0	4	0	4	12	0	0	4	12	65	0	0	49	22	24	8
31/08/2020	7	3	3	0	0	0	6	3	0	0	4	10	111	0	0	54	0	29	10
07/09/2020	9	5	4	0	0	0	6	8	0	0	6	12	101	0	0	66	24	34	12
14/09/2020	8	3	0	0	0	13	3	4	0	4	5	10	113	0	0	63	22	36	0
21/09/2020	5	5	7	0	0	0	3	10	0	0	6	22	120	0	0	56	21	38	0
28/09/2020	3	5	0	0	3	12	2	11	0	2	0	20	121	0	0	34	23	16	0
05/10/2020	7	15	2	0	0	0	6	6	0	0	4	20	132	0	0	47	24	31	0
12/10/2020	4	10	6	0	0	12	5	9	0	2	0	13	126	0	0	54	11	29	0
Total up to and including 16 October 2020	*151*	*190*	*134*	*21*	*46*	*101*	*92*	*116*	*43*	*21*	*141*	*858*	*3,128*	*106*	*12*	*1,256*	*256*	*697*	*132*
Sub totals					*542*						*514*						*5,616*		*829*
Control total																			*7,501*

The UHB has, since the height of the first wave, been steadily increasing its core theatre activity. This is within the context of theatre cases taking approximately 50% longer post-Covid-19.

As Covid-19 cases continue to increase within our community and we move deeper into a second wave the continued use of the independent sector remains a key dependency for the UHB if it is to continue to *plan for stability* and continue to deliver the levels of non Covid-19 activity which have bene achieved to date during the pandemic.

The remaining section of this plan provides greater detail for a number of essential services with **Annex six** providing a high level position statement for all others.

Cardiac services

With the exception of exercise tolerance testing, all diagnostic and treatment modalities for cardiovascular disease are now fully operational. Urgent treatment and some diagnostic tests have been maintained throughout the pandemic period. Clinicians acted swiftly to identify and prioritise high risk cases to ensure the most vulnerable patients received treatment. The primary coronary interventional services, as well as the structural cardiology service, were again protected throughout the pandemic.

The provision of cardiothoracic surgery has provided one of the biggest challenges to the Health Board during the past six months. Poor outcomes linked to patients contracting coronavirus postoperatively led to the suspension of all but life threatening surgery. The cardiothoracic team have worked hard to develop clinically safe pathways in tandem with national guidance. Limited critical care and ward capacity, allied to the pandemic, restricted the number of procedures that could be carried out on a weekly basis. The

urgent need to increase clinical activity became the main focus for the Health Board and, following a number of clinically-led discussions, the decision to transfer cardiothoracic services from UHW to UHL was agreed. Additional critical care and ward facilities are due to come on line in mid-Quarter 3 which will further increase the level of surgical activity.

We remain confident that the second theatre, additional Cardiac ITU, and ward beds will be available from mid-October enabling activity that exceeds pre-Covid-19 levels, to recover the backlog which we currently have.

In the immediate term due consideration has been given to cross organisational working in this area but to date a move to a full regional MDT has not taken place. However we have always remained committed to the concept of mutual aid and equity of access across the region and as such remain ready and able to accept thoracic patients from Swansea to Cardiff for operative treatment should they be referred- at which point a full regional MDT would be instigated.

Most recently we have been in close dialogue with Swansea Bay Heath Board who have had to suspend routine planned cardiac surgery at Morriston Hospital following a localised Covid-19 outbreak. We will continue to work with the Health Board to ensure essential services can be maintained across South Wales.

Cancer

Throughout the first wave of the pandemic we continued to deliver surgical cancer treatments through the use of dedicated “green” zones including Protected Elective Surgical Units (PESU) within the sites at UHW, UHL and the use of The Spire in Cardiff.

During this time however we saw a reduction in a range of referrals and activity;

- ✓ There was a reduction in the number of referrals received by the Health Board (during April and May the number of GP referrals dropped as low as 30% of normal expected volumes and this had a direct impact on the number of cancer diagnosis and cancer treatments delivered).

- ✓ Due to the severely reduced “routine” referral activity and decreased A&E attendances during Q1/2 the number of incidental cancer findings has also reduced significantly.

- ✓ Historically we expect to commence 180 first definitive treatments for cancer each month (this excludes all tertiary cancer activity). During May 2020 this fell to a low point of 96 treatments.

GP referrals volumes have now returned to near normal pre-Covid-19 levels but we have not yet experienced an increase in referrals to account for potential “suppressed demand”.

The proportion of surgical first definitive treatments compared to all treatments shows that the Health Board has also now returned to a position of over 50% being surgical in type, which is comparable to pre-Covid-19 levels.

When delivering diagnostic services in a Covid-19 safe environment there is a significant impact on the available capacity, the total number of patients that can be seen in any dedicated session. The impact is that there is approximately 70% normal capacity available in Radiology and Endoscopy services. This situation naturally leads to extended waiting times for some patients.

However the Health Board has learnt many things during the initial Covid-19 pandemic including more streamlined approaches to cancer pathways and faster decision making which will support with mitigating the reduced capacity levels described above. These include;

- ✓ Seven day working
- ✓ Working collaboratively across Health Board boundaries and exploring alternative diagnostic tests to enable patients with suspected cancer to have access to the right tests to confirm or discount a cancer diagnosis as soon as possible.

With the current resurgence in CovidD-19 cases in the community plans are already in place to implement similar and better approaches to ensure diagnostic and cancer services can continue within Covid-19 restrictions such as safe delivery of surgical procedures, social distancing, etc.

Active cancer pathways continue to be closely tracked and monitored to ensure that each pathway is progressing towards a diagnosis and/or treatment. Where capacity is affecting the time taken to progress to the next step then plans for recovery including additional sessions are considered where possible. The active number of pathways extending beyond the 62 day standard are reducing as a result however some patients will receive their first definitive treatment beyond 62 days. The Health Board is implementing a Harm Review process during Q3/4 to assess all pathways concluding in excess of 104 days from referral to ensure that no harm took place and that organisational learning takes place to prevent future delays.

We remain supportive of any cross boundary working that improves the effective use of limited capacity, improves patient experience and removes inequities of access to services for patients. Current cross boundary work includes;

- Working closely with Swansea Bay to create a Lung Surgery Regional Tracker where the available capacity across the 2 South Wales lung centres will be fully utilised through joint planning.
- Whilst the Health Board hosts the robot for South Wales, the Urology Consultants have worked closely with Cwm Taf and Aneurin Bevan to ensure that access for patients to robotic procedures across the 3 Health Boards is equitable.
- We are reviewing the processes around Regional MDT meetings in terms of flow of information, actions for local Health Boards and the safeguarding of patients. This work will be ongoing throughout Q3/4.

In addition we are currently also developing a case for internal investment in a *Prehabilitation to Rehabilitation (P2R) programme* which will support and improve cancer outcomes that matter to people.

Diagnostics (Radiology and Pathology)

Summary Position

Within Radiology services there has been ongoing increase in activity levels through quarter 2. Across all modalities the service is now at 79% of pre Covid-19 activity. For Cellular Pathology services during quarter 1 and 2 when demand decreased there was significant changes in both laboratory and reporting processes in order to improve turnaround times. The removal of waste within processes has meant that turnaround times have improved and are being sustained as demand levels increase, currently at 75% of pre Covid-19 levels.

Backlog and Plan

The backlog for the two services need to be considered differently. For Pathology services there is currently no backlog and weekly reviews of performance levels are focussed on maintaining turnaround times as the demand increases.

Radiology has a significant challenge in terms of the overall backlog. This needs to be considered both from an overall perspective and in terms of the risk for patients. The categorisation of risk in radiology is at 6 levels, P1-6, with P1 representing the highest risk level for patients. The risk levels are under regular review by the consultant team and currently all patients within risk levels 1 and 2 are being accommodated with the majority of P3 being seen within 4 weeks.

The overall backlog is monitored based on the numbers of patients waiting greater than 8 weeks being the previous target for radiology:

Modality	Number of Patients greater than 8 weeks
CT	230
MR	2832
Ultrasound	3470

The process of managing these backlogs is through managing risk, activity and demand management. In risk terms the priority levels are determining which patients are prioritised. Activity levels are continuing to increase but are balanced against a process of ensuring that the department is regularly reviewing the IP+C requirements. There is a process of reviewing pathways in conjunction with primary care in order to ensure that we are only undertaking diagnostics that cannot be appropriately managed through other pathways.

The key risk to the delivery of increased activity and decreased backlogs and risk is the availability of scientific staff. The availability of radiography staff continues to present a challenge nationally. However workforce plans are under review within the department to ensure that every opportunity to skills mix has been taken to mitigate this known shortage. There is also an active process of reviewing the IP+C assumptions within the planning for radiology. This will ensure that safely we are maximising the potential to scan patients.

Through the essential imaging services group there is a consideration for the need of commercially available mobile scanners that are staffed. Cardiff and Vale UHB have inputted to this process, and there will be a need to work regionally in the use of this capacity. As an organisation there is previous experience of Cardiff and Vale patients being scanned on a regional basis. Should this opportunity arise, we welcome working with other Health Boards to manage the backlogs equitably on a regional basis.

Children's Services

During the first wave of the pandemic we saw a significant drop in unscheduled demand for children's services and we saw a pattern of late presentation of illness in some children. We worked hard to encourage parents to bring their children to seek hospital care if they were worried. We also temporarily established a separate children's emergency theatre service with dedicated paediatric CEPOD lists.

Should a second wave, potentially compounded by seasonal unscheduled care pressures, we will continue to work closely with primary care colleagues and via direct social media campaigns to avoid this drop in demand once again occurring.

The table below provides a current position statement;

Speciality	Status	Qtr. 3-4 Actions
Paediatric Inpatients	• Growing volumes (10% rise October 2020 vs. Q3 2019/20) • longest length of waits of pts waiting (70% rise October 2020 vs. Q3 2019/20) for Surgery.	• Clinical risk being managed by senior review of patients waiting beyond 52wks • Close working with Theatres & Anaesthetics regarding theatres timetabling.
Paediatric Community	• Growing volumes (19% rise October 2020 vs. Q3 2019/20) • longest length of waits of pts waiting (56% rise October 2020 vs. Q3 2019/20) for Neurodevelopmental assessment.	• Clinical risk being managed by senior review of patients waiting beyond 52wks. • Service redesign work underway
Obstetrics and Gynaecology	• Growing volumes (27% rise October 2020 vs. Q3 2019/20) and longest length of waits of pts waiting (85% rise October 2020 vs. Q3 2019/20) for benign Gynaecological Surgery.	• Clinical risk being managed by senior review of patients waiting beyond 52wks • dialogue with Theatres & Anaesthetics re. Theatres timetabling.

Primary Care

From the outset of the pandemic, during the summer months and as we begin to move into the winter months primary care as made a huge contribution to the organisations response to the pandemic. Some of the highlight achievements include;

- Our Cardiff South West Primary Care Cluster bringing together ten GP practices to work in partnership with Cardiff City Stadium to host a brand new drive-through clinic model for pre-arranged vaccination clinics throughout the autumn and winter months. As of 10th October has delivered over 800 flu vaccinations.

https://cavuhb.nhs.wales/news/latest-news/cardiff-primary-care-partnership-delivers-successful-drive-through-flu-jab-clinics/

- Continued use of telephone triage, e-consult and video consultations
- Continued focus on ensuring primary care support to care homes and those on palliative care pathways through a Directly Enhanced Service (DES) to increase specific support to care homes.
- Utlising eye care sustainability funds through to March 2021 enabling close working between our PCIC and surgery clinical boards to shift suitable eye care activity traditionally taking place in hospital settings to primary care based optometry services.

As we move forward we continue to work set our work against the five priorities of the primary and community care framework and the nationally agreed 'milestones' (see **table three** below) whilst obviously ensuring the Cardiff and Vale 'lens' remains to ensure we are delivering services in the most appropriate manner to meet our local populations needs.

Table 3

Priority	Current Status	Progress against national milestone	Key Risks
Delivery of essential services	In relation to General Medical Services, the requirement for the provision of delivery against full contract requirements commenced on 1 October 2020. There is pressure on the service due to increasing demand but escalation plans have been developed to support and maintain access to core GMS. For General Dental Services the amber status as directed by Welsh Government is currently in place. Phone first is in place with triage to determine urgent cases. There are currently 69 GDS practices providing aerosol generating procedures (AGPs) with appropriate PPE and five Urgent Dental Centres are currently in place to provide urgent access for non-registered patients. Optometry services are now providing routine services. Independent prescribing and ODTCs still in place to provide support in primary care and reduce demand on secondary care. Pharmacy services also business as usual.	*Milestone - Health Boards will use this monthly reporting mechanism to monitor activity against the five essential services categories to be provide an indication of recovery of the primary care system.* In relation to reporting against the milestones, work still being led nationally on reporting against the measures as not all are available centrally. Services are all in place but need to ensure mechanisms in place for capturing activity (usually done retrospectively).	Key risks relate to the demand on GMS, hence business continuity plans being reviewed and additional escalation plans being developed. Awaiting national guidance on position in relation to contractual requirements and whether there will be relaxation. Escalation plans have been developed and include local arrangements to support resilience and sustainability.
COVID-19 local outbreaks or second wave – delivery of services in response to surges and outbreaks	For GMS, all 9 clusters in Cardiff and Vale developed business continuity plans to include: • Establishing robust plans by which to maintain GMS services, should staffing capacity at practice level be severely affected through Covid-19 through development of buddy arrangements between practices. • Developing centralised hub/s within the cluster by which to manage patients who are displaying a level of respiratory symptoms which potentially could be Covid-19 related • Identifying options to deliver a centralised Model should GMS provision at a cluster level prove unsustainable over time.	*Milestone - Health Boards will have plans in place to respond to local outbreaks including the reestablishment of Covid-19 hubs and urgent and emergency care centres for dental and optometry.* All plans in place to respond to local outbreaks. Daily operational meetings were established during Covid-19 (these are currently weekly) and the frequency will be increased as required.	

Priority	Current Status	Progress against national milestone	Key Risks
	• Some practices chose to continue to operate a respiratory hub within their own premises, staffed by their own resources. Arrangements established earlier in the year have all been reviewed and updated based on learning. More detailed escalation plans have been developed for GMS. Whilst GMS Covid-19 hubs have been in place across all clusters, the use has varied across Cardiff and Vale, they are however available to be utilised as required. A Covid-19 hub was established and has remained in use for the Urgent Primary Care/Out of Hours service. There are five Urgent Dental Centres in place and four of the seven Community Dental Centres are able to provide AGPs. Optometry services currently running as normal but previous arrangements can be reintroduced (whereby the 68 practices could redirect to 17 practices across the 9 clusters).		
Care homes – primary and community care service provision Khan Raj 11/17/2020 16:20:13	An action plan **(appendix five)** has been developed between the Health Board and local authority partners in response to the John Bolton rapid review of support to care homes. There are regular multiagency care home position meetings held in each LA area as well as meetings with representatives of the care home and domiciliary care sector. This includes advice, guidance and support in relation to testing, outbreaks, business continuity and PPE, as well as supporting safe discharge from hospital including the commissioning of intermediate care isolation beds. More recently the draft All Wales Care Home Framework has been shared. This has been developed through the National Strategic Programme for Primary Care. This links to the John Bolton work but suggests a model and actions to support Health Boards in providing a standard of consistency across Wales. The framework consists of four main themes: • Access • Consistency	*Milestone- Health Boards will assess their service provision to care homes against the framework with a view to adopt, adapt or justify. This will include: i. an immediate plan for winter 2020/21 ii. a long term plan* An action plan has been developed. Progress will be monitored via the Joint Management Executive Meeting between the Health Board and two local authorities. A market position report is being developed. An initial review has been undertaken in relation to each of the	The key risk relates to the management of outbreaks both in terms of testing capacity and support for the homes.

Priority	Current Status	Progress against national milestone	Key Risks
	• Connectivity • Outcomes The proposed self-assessment framework has eight main areas. An initial review has been undertaken in relation to each of the eight statements and the Health Board is working in line with these. An action plan will be finalised when the All Wales Care Home Framework is formally issued. The current care home directed enhanced service covers 96.6% of beds across Cardiff and Vale. There are 79 patients where the enhanced service does not provide cover but there is access to support from GMS. The key risk relates to the management of outbreaks both in terms of testing capacity and support for the homes.	eight statements and the Health Board is working in line with these. An action plan will be finalised when the All Wales Care Home Framework is formally issued.	
Rehab– recognition of increased demand for rehabilitation across four main population groups	We have developed a rehabilitation framework that mirrors the Welsh Government framework and links to our Shaping our future wellbeing strategy. https://shapingourfuturewellbeing.com/wp-content/uploads/2020/02/The-Cardiff-and-Vale-Rehabilitation-Model-February-2020.pptx In May 2020 we also launched a covId rehabilitation framework. http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/Cardiff%20and%20Vale%20Covid%20Rehab%20model%20May%202020.pdf We have also adopted the national rehabilitation modelling and evaluation tools to work across health and social care system and model rehabilitation needs and a therapy lead for this has been identified See also our approach to 'long covid' described in **section four** which includes the development of a bespoke rehabilitation website keepingmewell.com	*Milestone- Health Boards will assess their rehabilitation services against the framework with a view to adopt, adapt or justify. This will include: i. an immediate plan for winter 2020/21 ii. a long term plan*	

Priority	Current Status	Progress against national milestone	Key Risks
	In addition we are currently also developing a case for internal investment in a *Prehabilitation to Rehabilitation (P2R) programme* which will support and improve cancer outcomes that matter to people.		
Step-up and step down bedded community services to address the issues identified in Right Sizing Community Services	The Health Board, in partnership with local authority partner services has taken action to address issues identified in the review. A Senior Operational Group has been established (chaired by the Director of Ops, PCIC Clinical Board) and regular updates are provided to the Joint Management Executive Team meeting which includes the two local authorities. A plan for winter has been developed and additional capacity is being secured in terms of therapy and domiciliary care. There is also a series of actions underway to improve processes and ensure the most effective use of resources, this includes single assessments as well as regular reviews of existing packages of care. Isolation beds will also be used to help reduce delayed transfers of care as part of the discharge to assess model. A tender has been issued for the joint commissioning of reablement beds supported by the CRT in Cardiff. A tender has been issued for the joint commissioning of reablement beds supported by the CRT in Cardiff.	*Milestone; Health Boards will assess current models against this framework and develop plans to align service models to the national framework. This will include: i. an immediate plan for winter 2020/21 ii. A long term plan* An action plan has been developed. Further work to be undertaken to ensure appropriate capacity across the whole system to meet demand.	
Urgent primary care – an urgent primary care model	An urgent primary care hub was established in Central Vale in winter 2019 as a pilot. The aim was to provide additional capacity for a range of patients with urgent primary care needs to be seen at the hub, or directed to other services as appropriate. Feedback from patients was extremely positive and the model has been shared as good practice by Welsh Government. Proposals have been developed and submitted to extend this hub as part of the pathfinder work for urgent primary care centres. A new phone first triage model has also been introduced since early August. The CAV24/7 model provides access to urgent primary care and also enables people to be booked into the Emergency Unit or Minor Injuries Unit as appropriate. Note more detail provided in 'Managing Winter' (**section five**).	*Milestone- ABUHB, CaVUHB, BCUHB to establish pacesetters for Urgent Primary Care centres.* Proposal being developed and will be submitted by deadline.	

Planned Care

As well as maintaining essential services we have begun to re-introduce more routine services where it is safe to do so. We plan to keep doing this through the next six months.

We have been able to achieve this through:

- Establishment of Protected Elective Surgery Units ('Green zones') in UHW and UHL (**see section one**)
- Use of Spire Private Hospital capacity (see **section three**)
- A refreshed Outpatients Transformation Programme, clinically led across primary and secondary care

We will continue to operate within national and local operating frameworks, with the overriding principle being the need to minimise harm. Our approach to rebalancing planned care entails:

- Remaining 'Covid-19' ready
- Prioritising patients with the greatest clinical urgency – moving from time based targets to clinical risk stratification
- Minimising hospital attendances to keep patients safe
- Using technology and innovation to introduce new ways of meeting needs
- Monitoring demand, as well as activity, given concerns at the start of the pandemic that people may be delaying seeking medical help for serious health conditions

Current position

In Quarter 2, the Health Board took stock of its Planned Care position, viewing waiting lists through four lenses – *volume, age, stage of pathway and risk*. This analysis concluded that the scale of our challenge is significant and cuts across a number of areas;

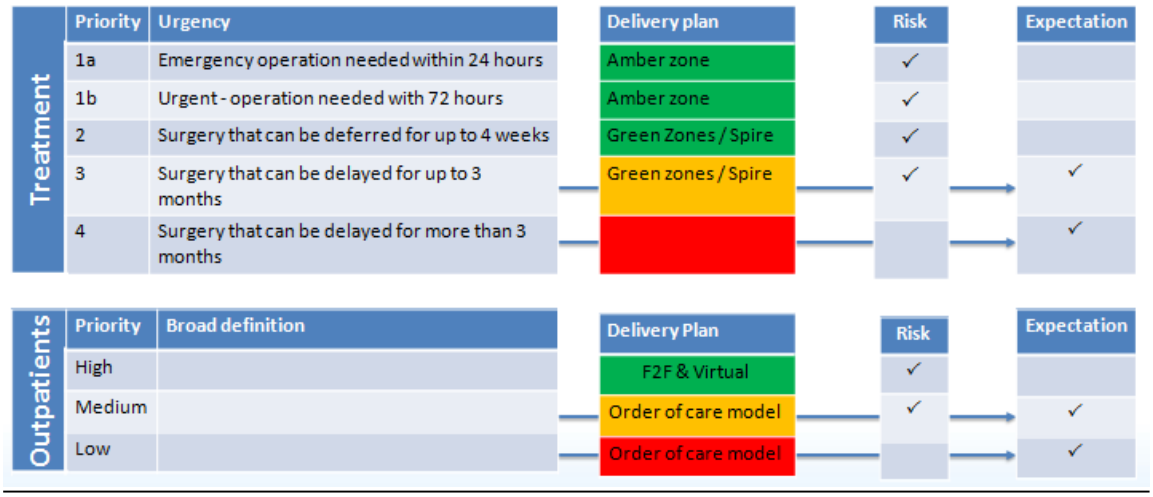
- Pathways- c. 280,000 existing;
- Whilst waiting list growth is currently marginal there has been a significant deterioration in waiting times;
- That we have further work to do on recording risk for treatments and defining risk for outpatients.

We have also enjoyed some success in increasing demand and activity (albeit it back to lower levels than pre-Covid-19) which will support addressing the view that there may have been / is pent up demand within our population. At the end of quarter 2 key statistics were:

- Primary Care referrals into Secondary Care fell to 30% of previous levels at Covid-19 peak – but have recovered to 74%
- Outpatient activity fell to 27% of previous levels at Covid-19 peak – have recovered to 64%
- Elective inpatients and day case treatments fell to 22% of previous levels at Covid-19 peak, now recovering to 62% (This includes activity undertaken at Spire Private Hospital).
- Surgical operations fells below 10% of pre-Covid-19 levels at the start of the pandemic but have recovered to 51%

Looking Forward

Our Planned Care strategic framework (below) focuses on the two key elements of planned care – *treatments and outpatients*. It provides a structured method by which to define how our plan is supporting the management of risk and expectation.



Treatment Prioritisation

The treatment element of the framework is well defined, with prioritisation based on the Royal College of Surgeon definitions. Changes were made to our PMS in Quarter 2 to allow recording of RCOS Level 1 to 4 priorities at a patient level. New patients added to surgical waiting lists are now categorised against these levels. Work is now underway to ensure existing patient waiting list records are updated to include the level assigned via the clinical risk assessment.

Resuming Surgical Activity

Throughout the pandemic the UHB has maintained essential surgical operating. The UHB set out in its annual plan and quarter 2 update the plans to establish and expand green zones to allow the safe increase in surgical operating. As stated above the UHB's elective surgical activity has been steadily increasing over the summer and is currently at just over 50% of pre-Covid-19 levels. In October additional operating sessions have being added to the schedule in UHW main theatres and short-stay surgery unit (SSSU); plus a second cardiac theatre is coming on-line at UHL, limited GA activity is recommencing in the Dental Hospital and cataract operating is re-starting in Ophthalmology outpatients (initially for 3 sessions per week but with the intention to increase this through the quarter). The expectation is these actions will allow overall activity to approach 60% of pre-Covid-19 levels during October.

The final phases of construction for the green zones will be completed in November, facilitating Breast Surgery returning to UHL and the recommencement of Orthopaedic operating. This will bring a further step-change in activity of 50 cases per week, partially offset by the reduction in Spire provision, taking activity to around 70% of pre-Covid-19 levels.

The UHB's ambition for the remainder of the financial year is to further increase elective surgical activity through increasing the number of theatre sessions and, subject to Covid-19, reducing the time between cases. Indicatively this could allow the UHB to reach 80% of pre-Covid-19 levels. All of the above is supported by detailed, speciality-level capacity plans.

Impact of Covid-19 on Surgical Activity

Inevitably the above plans will to some extent be dependent upon the prevalence of Covid-19. The green zones have been designed to allow elective activity to safely continue even when the prevalence of Covid-19 is high. The UHB's bed, finance and workforce plans are also designed with this in mind. Therefore the expectation is these plans will be relatively resilient to increasing levels of Covid-19. Nonetheless there will of course be limits to this. In broad terms the UHB's intentions are as follows:

1. to maintain essential services in all circumstances (up to and including the Covid-19 worst-case scenario)

2. to maintain current levels of elective activity even in the event of a significant second wave (equivalent to the peak period in the central scenario)
3. outside of a peak of Covid-19, to steadily grow elective activity to reach around 80% of pre-Covid-19 levels
4. to work with Welsh Government to secure additional capital investment to expand theatre and diagnostic capacity to reach 100%+ of pre-Covid-19 activity levels during 2021-22 (see below)

Increasing Capacity to Pre-COVID-19 levels & Reduce Backlogs

As stated above the UHB, in common with other providers across the UK, has seen a significant increase in the number of long-waiting patients. Post-Covid-19 it is likely to be many years before the UHB has fully recovered from this position and this will only be achieved through a combination of service redesign and increased capacity. The UHB has, prior to Covid-19, been developing a number of capital proposals which, given the implications of the pandemic, are now even more urgent to support backlog reduction. The UHB would like to work with Welsh Government to prioritise and expedite these programmes to achieve the earliest possible increase in capacity:

Table three: *Priority Proposals to increase Capacity*

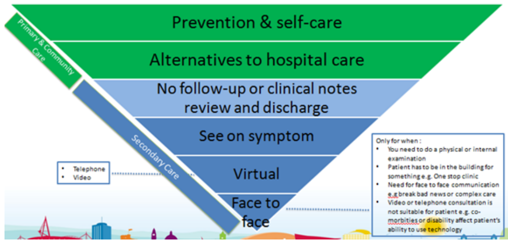
Proposals	Outline Plan	Estimated Potential Capacity
Two theatres at UHL	Permanent replacement for two Orthopaedic theatres in CAVOC	840 cases per year
Stand-alone cataract facility	Off-site, modular twin theatre	5000 cases per year
Endoscopy expansion	2 x additional Endoscopy theatres at UHL, co-located with the existing department	3360 procedures per year

Outpatients

The Outpatient element is being progressed via the Outpatients Transformation programme. Three workstream form this programme:

- **Clinical Prioritisation** – Triaging patients according to their clinical need
- **Adapted ways of working** – accelerating and embedding adapted ways of working e.g. virtual outpatients; see on symptoms; healthpathways
- **Configuration** – Creating environments that (i) minimise in-hospital transmission of Covid-19 but maximises throughput (ii) supports care close to home

These are underpinned by a number of enablers including digital and communications.

<table>
<tr><th colspan="2">Outpatient actions for Q3-4</th></tr>
<tr><td>Defining the risk and ‘default’</td><td>Our clinicians have broadly landed on three categories of risk for outpatients – high, medium and low and have defined an Order of Care model (see below). In the next quarter, further work will be done at a specialty level to further define risk and the Order of Care.
 
</td></tr>
<tr><td>Maximising space</td><td>Work has now commenced on ensuring that the use of this space is maximised - thereby allowing us to safely increasing the number of face to face outpatient appointments (where this is the appropriate method of review).</td></tr>
<tr><td>Creation of a ‘virtual village’ in UHL</td><td>Clinician feedback is that creation of a dedicated physical space to undertake virtual outpatients would have the potential to strengthen governance arrangements and further increase uptake. It is anticipated that the Health Board would set up a number of ‘virtual villages’ across primary and secondary care estate but the initial plan is to establish a virtual village in UHL as a proof of concept.</td></tr>
</table>

The continued uncertainty regarding future demand – Covid-19 and non-Covid-19 – and the new levels of complexity that we are working in does mean that there remains some risk regarding delivery of planned care services. Since the start of the pandemic, a constant balance of risk has been made in relation to the extent to which services continue to operate and can restart versus the potential harm from infection. Going forward, this balance of risk will continue to be applied and our actions will continue to be guided by clinical advice.

The wider public health agenda

We recognise the importance of preventing and responding to both the direct and indirect consequences of Covid-19, including long term impacts on health and social inequalities and as such have agreed revised key public health priorities for 2020-1 in addition to Covid-19, which are set out in full in our revised plan.

These include actions in the following areas: immunisation, tobacco, healthy weight, healthy environment and travel, health inequalities, mental well-being, alcohol, sexual health, falls prevention, dementia, healthy schools and pre-schools.

This is intent is evident through our launch of the *move more, eat well* plan (www.movemoreeatwell.co.uk) which has the full backing of our PSBs and RPB.

We will keep these priorities under review as elements of them may need to be flexed up and down to respond to autumn and winter Covid-19 pressures.

Section 4: OUR RESPONSE TO THE WIDER SOCIETAL IMPACT OF COVID-19

Mental Health

As we continually look to balance our provision of essential services against the ongoing challenges presented by Covid-19 we continue to evaluate and revaluate our mental health service provision to ensure the safe, timely and high quality services continue to be provided.

As we head into quarter 3 and 4 our headline position is one which shows that;

- ✓ We plan to maintain all mental health services including all therapeutic group work through quarter three and four.
- ✓ For the purposes of Covid-19 readiness in Hafan Y Coed, this has not been safely possible in Q2 due to an adolescent admission to PINE ward (Red and purple Covid-19 cohorting area). This adolescent has now been transferred to a smaller unit at HYC releasing PINE ward back for Covid-19 purposes.
- ✓ Mental Health services across Wales via the national commissioning team will no longer make available a block contract for private beds for Covid-19 surge purposes. Local mental health services will monitor and calibrate the need for additional beds through its local Covid-19 response meetings and directly spot contract beds itself.
- ✓ For mental health services for older people we have ensured ward East 10 at UHL remains available for cohorting Covid-19 Purple/Red stream service users who test positive for or require isolation whilst being tested for Covid-19 as per UHB modelling.
- ✓ We are in the process of supporting the establishment of an accommodation commissioning plan for adolescents needing accommodation in crisis. This is being done in conjunction with the Local Authority / Children & Women'[s and Medicine Clinical Boards

Nevertheless, service demand has now returned to, or exceeding, pre-Covid-19 activity. To mitigate the immediate risks and challenges which this presents we are taking the following actions;

- ✓ Continued investment into 'Pre-GP' services along with the ongoing review of recent 3rd sector investment in capacity to provide CCI Therapies model and Silver Cloud (anticipating further WG investment in 3rd sector support to meet tier 0/1 needs and preserve specialist services).
- ✓ Temporary expansion of the Primary care Liaison GP Cluster service. This support is being provided via additional an additional three practitioner posts to secure prevalence rather than population capacity in all clusters, particularly South and East Cardiff areas.
- ✓ We are assessing gaps in the dementia pathway in Primary care in light of 25% increase in dementia referrals to CMHTs. The anticipated investment in 3rs sector provision will be designed to support or partially support this service gap.
- ✓ We are enhancing admission avoidance 'out of hospital services' to offset demand, particularly in MHSOP due to their core bed losses. With investment in community and crisis services – in line with MHSOP and the UHB transformation strategy.
- ✓ Maintain compliance with Parts 2,3 & 4 of Mental Health Measure / CMHT routine RTA 28 day standard / 26 week RTT target for psychological interventions
- ✓ We look to remain a lead user of digital platforms.

Addressing long COVID-19

We recognise that the impact of Covid-19 is likely, but not solely, generational. The consequences of the virus will last well beyond the arrival of any vaccine. It is acknowledged that these consequences will be manifested in a number of ways including; the financial impact, the long-term impact upon our current (and future) workforce, the impact of pent up demand following into our system as well as, most importantly, the long term health impact upon people who have been severely affected by the virus might subsequently experience- mental and physical and the demand this will place on our system.

Early steps we have made include;

- A 'long covid' rehabilitation model has been developed by a team of AHPs, with a lead GP and input from secondary care clinicians

- The creation of an online resource – www.keepingmewell.com a new digital rehabilitation resource with information specifically developed to support rehabilitation, with an initial focus on COVID-19 rehabilitation that anyone can access anywhere to help keep themselves well and aid recovery from COVID-19.

- Working with GP clusters to develop a Long COVID rehabilitation service

- Working with the *SilverCloud* online therapy service to provide free online mental health and wellbeing therapy without needing to wait for a referral from a GP

See also the rehabilitation in **section three** of this plan.

Service Collaboration

We continue to work closely with commissioners and partner health boards to ensure that together we are protecting and strengthening fragile regional and tertiary services where we have the biggest challenges.

Focussed work continues to take place in a number of specialities including:

- Interventional radiology,
- Vascular surgery
- Ophthalmology surgery
- Upper GI cancer surgery,
- Paediatric gastroenterology and
- Paediatric neurology,
- Cochlear Surgery
- Oral & Maxillo Facial Surgery – out of hours

The UHB has established executive partnerships with both Swansea UHB and CTM UHBs to co-ordinate the collaborative scoping of sustainable service plans that will need be delivered in partnership to strengthen existing fragile services – implementing urgent interim measures where necessary – and planning for improved future sustainability of services in response to meeting national clinical service standards and making effective use of our specialist workforce. Where this collaboration involves tertiary service provision, area, we are also working closely with WHSSC to align planning and commissioning discussions.

These regional planning partnership arrangements supplement the SE & SC Wales Regional planning programme which relates to services provided across the AB, CTM, South Powys and C&C UHB catchments.

In addition, we are liaising with individual and the Board of CHCs to ensure that engagement and, where appropriate, consultation activities are appropriately addressed.

Section 5: MANAGING WINTER

We know that this winter is going to be an especially challenging time for the organisation. We also know that mitigating the impact of the season is not an excise which can be done in isolation. There are actions which are within our exclusive gift whilst there are also actions which need to be progressed in collaboration with our wider health and social care partners.

In parallel to the development of this plan has been the multiple emerging opportunities to access emergency winter funds confirmed via letters such as that from Stephen Harrhy, Director, National Programme for Unscheduled Care on the 02 October 2020. Where appropriate in the subsequent sub sections we look to signal where our emerging proposals will support our direction of travel described.

Internal action- *addressing our unscheduled care system*

We continue to shape our unscheduled care plans around the goals of the national *urgent and emergency care framework* and specifically the four priority areas which the unscheduled care board have identified for quarter 3-4 (bold below)

1. **111 / contact first models to enable patients with urgent care needs to be signposted to the right place, first time**

CAV 24/7 went live on the 5th August 2020. This was Wales' first phone first approach to Unscheduled and Urgent Care. Patients are able to phone CAV 24/7 prior to attending the Emergency Unit and receive a clinical triage via the telephone. If, after the telephone triage, it is felt that the patient needs to attend the Emergency Unit, they will be given a timeslot to arrive. This not only provides a much more amenable experience for the patient but also allows the department to conform to social distancing. If a patient rings CAV 24/7 and it is felt they do not need the Emergency Unit, they are referred in to specialities, or signposted to Primary Care services.

Around 150-250 calls a day are being received by CAV24/7 (in addition to the usual Urgent Primary Care/Out of Hours calls). Around 64% are being booked into EU/MIU and others dealt with or signposted to other primary care services.

Feedback from clinicians and operational managers has been extremely positive. Whilst the number of attendances to EU has not reduced as originally expected, they have remained fairly flat, whereas prior to introduction of CAV24/7 attendances were increasing. With the booking facility it also means it has been easier to manage as these are now planned attendances.

Feedback from patients has been extremely positive. A survey has been completed by more than 650 people with the key messages:

- ✓ 87% would be happy to use the service again.
- ✓ 86% happy with the time taken to answer the call.
- ✓ 86% satisfied with the service from the call handler.
- ✓ 78% had the call back on time, or earlier from a clinician.
- ✓ 87% satisfaction with the service from the clinician.
- ✓ 81% seen within 1 hour of appointment given.

We are looking to develop a retrospective proposal for CAV24/7 in order to access emergency winter funds that have been identified to support 111/contact first models.

2. **24/7 same day / urgent primary care models of care to enable people to access care in their local community, preventing unnecessary attendance at Emergency Departments and admission to hospital.**

Work across this theme remains highly complementary to the objectives outlined within the primary and community care framework (**see section three**)- we have ensured close working between our primary care/ community teams and our unscheduled care teams.

We have submitted an urgent primary care pathfinder proposal to further develop the Central Vale hub and to extend the model to cover the whole of the Vale locality by developing a hub model in both the Eastern and Western Vale clusters which is proposed to start (Central Vale) from the 1 December 2020 and the Western Vale and Easter Vale to from mid-December 2020.

3. **Ambulatory emergency care to enable patients to safely bypass the Emergency Department and prevent unnecessary admission (Goals 3 and 5).**

UHW has a Medical Admissions Emergency Care Unit (MAECU). This operates 5 days a week (Mon-Fri) from 0900 – 2200. MAECU takes medical patients who are referred in by a GP for further investigations. Pre Covid-19 it would see between 30 – 60 patients a day, with Mondays being the busiest day of the week. Approximately 85% of patients would be discharged home the same day and avoid admission into the hospital. Amb scoring at triage in the Emergency Unit is also used to enable patients to be streamed directly into MAECU and avoid the Emergency Unit.

4. **Embedding the four discharge to recover then assess pathways to prevent unnecessary admission and enable a home first approach to improve experience and outcome (Goals 3 and 6).** *See also our c*ollaborative action – *Working as part of the Cardiff and Vale of Glamorgan Regional Partnership Board*

For patients who present to the department we have a number of pathways for the medically well patients this includes- The Frail Older Persons Assessment Liaison (FOPAL) service.

Established at UHW in 2014 to deliver Comprehensive Geriatric Assessment (CGA) to frail older people in the Emergency Unit (EU) and Assessment Unit (AU). This team consists of a consultant geriatrician and nurse supported by colleagues in the EU/ AU department. Early input from the FOPAL team has shown to successfully increase the number of people returning home and reduce the 30-day readmission rate.

Pathway 1 – when a frail older person presents at the front door they will be reviewed and provided with comprehensive geriatric assessment. The FOPAL team has close links with intermediate care services therefore if a person is medically well but unable to cope at home and requires review of their social support, the team will make the necessary arrangements in the community to facilitate discharge home with adequate support. This will prevent unnecessary admission to an acute medical ward.
For people who are medically well and safe to return home but require treatment or a period of rehabilitation, they can be referred to the Elderly Care Assessment Service (ECAS) for medical review and a planned programme of rehabilitation. They can be seen as early as the following day if required. This will maximise a person's functional independence and psychological wellbeing, whilst supporting people to optimise their recovery and maintain their independence in the community.

For people who are medically unwell, they will continue their admission to an acute medical ward. However the provision of rapid CGA will reduce hospital associated clinical decompensation. This should result in a reduced overall length of stay for those who require admission.
Whilst on the acute ward, a person's potential ongoing care needs will be identified to ensure adequate support is provided at home when discharged.

During their ward admission, once a person is medically well and if they are safe between care visits they will return home to continue their care and rehabilitation at home/ usual place of residence. This will be achieved with support from the Community Resource Teams (Discharge to Recover and Assess-Pathway 2

If a person is not safe between care visits and unable to return home they will transfer to a 'step down' bed (Pathway 3) at St David's Community Hospital at the earliest opportunity for further assessment, rehabilitation and recovery.

Frailty Intervention Team (FIT)

During January to mid-February 2020, the Frailty Intervention Team (FIT) was piloted on both the UHL and UHW sites using RPB winter funding. This multidisciplinary team (nurses, OT, physios and support from FPOC team) led by a consultant geriatrician, built on the success of the FOPAL Service by providing an enhanced service 7 days per week. The Medicine Clinical Board continues to work closely with colleagues across CD&T and PCIC clinical boards to establish a full multidisciplinary FIT team at both UHW and UHL sites on a substantive basis.

We are in the process of evaluating the full impact of the FIT. Some early headlines include:

- The FIT team at UHW saw a total of 1024 patients in EU and AU during the intervention period. This equates to 115 patients a week who received intervention from the FIT team, compared with 47 patients a week seen by FOPAL.

- The FIT team facilitated discharge directly from EU/AU for 219 patients. This equates to an additional 14 patients discharged a week when compared with the FOPAL team, despite no change in the number of patients aged ≥75yrs attending urgent care.

- EU re-attendances and 28 day readmissions were stable during this period, suggesting that additional discharges were safe and appropriate.

- After the implementation of the FIT teams at UHW and UHL there was a consistent reduction in occupied beds for patients aged ≥75yrs for seven consecutive weeks from 20th January, with an average of 12 fewer occupied beds per week for this cohort.

As RPB funding ran out and the pandemic hit, FIT was suspended after 9 weeks. The FOPAL team was later reinstated in UHW in July (2wte frailty nurses and five morning geriatrician sessions).

Internal action- *our Flu Vaccination Programme*

Ensuring we have an effective flu vaccination programme is a key action we are progressing as part of not only protecting the more vulnerable members of our population but also to support mitigating the risk that our system could become overwhelmed during the winter months.

In our Community

GPs and Community Pharmacies experiencing unprecedented demand for flu vaccine amongst at risk groups and are currently implementing innovative delivery models to at-risk groups such as drive throughs to support social distancing. The first (national) fortnightly reporting for flu uptake (IVOR) is due to commence imminently and once available, the Local Public Health team will share this information with Cluster Leads and GPs practice throughout the season. This along with regular newsletter updates for Primary Care Providers and a public-facing campaign with ensure we have a robust media campaign regarding the flu vaccination.

In addition planning is underway to extend a pilot undertaken in Flying Start areas during 2019/20 to increase uptake amongst two, three and four year olds who attend flying start childcare settings. This is in addition to the established primary School vaccination programme that has once again commenced and is also seeing high uptake rates to date.

The vast majority of flu vaccine will be administered before the Christmas break with our school programme being completed by the second week of December with catch–up sessions for year groups who have missed their scheduled school sessions due to self-isolation requirements, being planned for

half term using hubs and appointment system. Fortnightly uptake monitoring will be shared with Clusters and GP practices for each risk group. Our expanded programme (to people aged 50+) is also expected to conclude by the end November.

Across our staff

As part of our commitment to we are delivering a flu vaccination to at least 75% of health care workers we have taken a number of actions which includes;

- ✓ 20% extra vaccine ordered at the start of the season
- ✓ New Flu Champions recruited and trained
- ✓ Proactive uptake being monitored at departmental and Clinical Board level
- ✓ Extra staff / vaccinating capacity put in place across all our Clinical Boards
- ✓ Mass Vaccination / drop in sessions arranged regularly by Occupational Health Service
- ✓ New incentives introduced (including a weekly raffle for staff)
- ✓ Extra staff / vaccinating capacity put in place across all our Clinical Boards
- ✓ Staff communications ongoing

Collaborative action – *Working with our health system partners*

We received a helpful letter from the WAST CEO on the 14 October which alerted all Health Boards to firstly the potential impacts on emergency ambulance response times during the winter period, in particular, the risk to patient safety in your populations and secondly to seek support for the actions that need to be taken to mitigate some of these risks.

We recognise that ensuring flow through our system, particularly in winter, will involve close working with the Welsh Ambulance Service NHST (WAST) and are thus fully committed to working together not only with the service but also the National Collaborative Commissioning Unit (NCCU) who act on behalf of the Emergency Ambulance Services Committee (EASC) on the issues described within the letter.

In relation to WASTs Non-Emergency Patient Transport (NEPTS) service we are led understand that the first cut the NEPTS Demand & Capacity Review report will be available in Dec-20, which will include a sensitivity analysis of the impact on NEPTS capacity of reduced patients per journey. In the interim we also understand work will be undertaken in October to model the impact on NETPS capacity of reduced journeys and reduced patients per journey.

Clearly there is a dependency between these pieces of work and the UHB being in a position to articulate what additionality (or not) discharge activity we may require over the winter and indeed during the rest of the pandemic.

Collaborative action – *Working as part of the Cardiff and Vale of Glamorgan Regional Partnership Board*

Cardiff and Vale of Glamorgan Regional Partnership Board is preparing a Winter Protection Plan that provides an overview of arrangements mobilised to protect our citizens and health and care system from the impact of winter, in the context of ongoing Covid-19 infection. The plan addresses the six goals set and cross references to this plan for Health Board-specific elements, particularly the response to goal 5: Great hospital care. *Discharge to Recover and Assess funding* will provide additional capacity and capability within the system to expedite flow out of hospital for people who are medically fit and ready for the next stage of their rehabilitation. This will therefore support the Health Board's ability to respond to increased demand on unscheduled care.

The partnership is currently modelling likely demand and assessing the additional capacity required across the system. *Discharge to Recover and Assess funding* for the region will be used to offset the increased costs, which are significantly in excess of the funding available. Partners are currently mobilising services at risk to ensure that the system is ready before significant increases in demand.

The main focus of the plan is ensuring that our local system is able to ensure that people receive the care and support in the most appropriate place for them. In the main this will be their home, including where this is a care home and that admission to hospital is only for situations where the care and treatment required cannot be provided elsewhere.

Our system's integrated Winter Protection Plan sets out how our partners are working together to mitigate the impact of winter, in the continuing presence of Covid-19. Partnership with our two local authorities is particularly critical to ensure we have a safe system of support:

- People in care home settings and the staff who support them, including access to personal protective equipment, infection prevention and control and access to expert advice on managing infection in closed settings
- Children and young people needing support with emotional wellbeing and mental health needs
- Discharge home from hospital, including robust protocols to ensure no-one is discharged from hospital with a Covid-19 positive diagnosis
- Discharge to recover and assess ensuring people have access to rehabilitation and reablement to regain their health, wellbeing and independence following a hospital admissions and to ensure no decision about the future long-term care needs are made within a hospital setting when the person has not fully recovered
- Prevention of avoidable admissions to hospital through our Cardiff Community Resource Team and Vale Community Resource Service
- Cardiff Council First Point of Contact officers and Vale of Glamorgan Age Connects staff ensuring 'what matter's to you?' conversations take place on wards to ensure proportionate support is put in place and connections made to the wide array of third sector support resources
- Ensuring the domiciliary care sector (both in-house and independent) is mobilised to meet the additional demand created by winter
- Significant levels of support from the Third Sector to people who have been shielding or remain unable to access food and other support and are at risk of social isolation

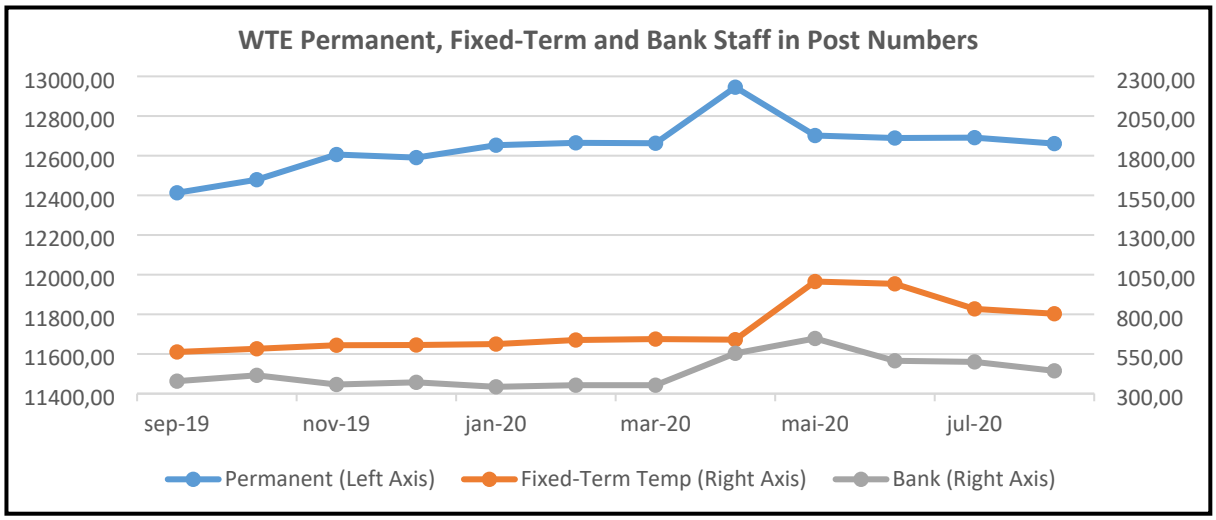
The following capacity is being extended which will materially support the wider delivery of this quarter 3-4 plan as we have recognised that effective flow is a key dependency for the 39rganisation:

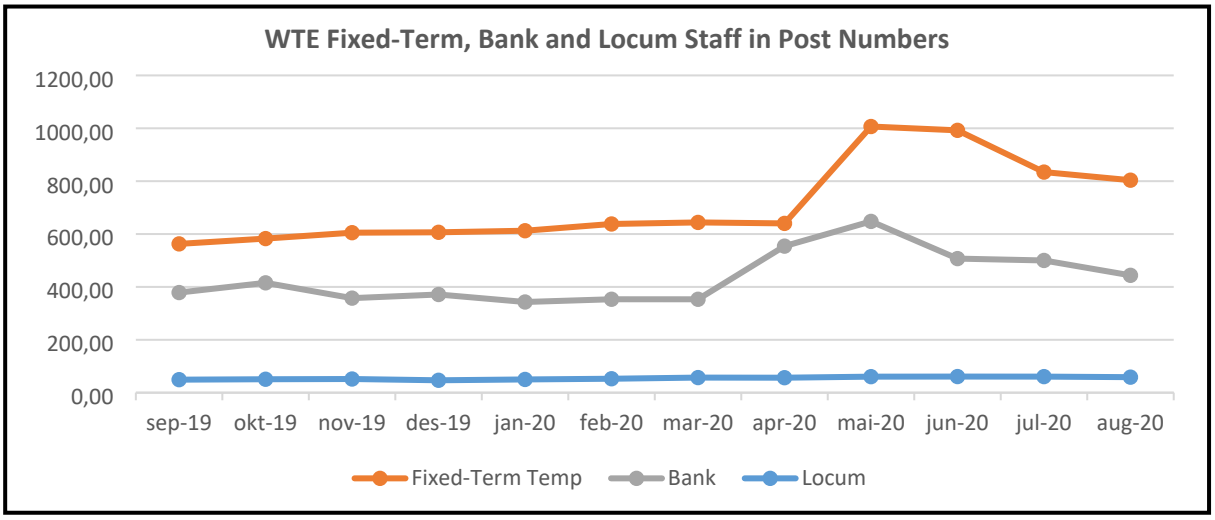
Initiative	Initiative descriptor	Timescale
Step down community bed capacity	Ensuring there is adequate community bed capacity to enable people to be discharged for further recovery and rehabilitation to ensure decisions about long-term care are made at the right point in the person's recovery. To ensure that people are able to leave the acute setting as soon as they are medically fit to be discharged. • Covid-19 isolation capacity • Residential reablement (pathway 2) • Discharge to assess nursing beds (pathway 3)	Additional capacity between Nov'20 – March '21
Increased intermediate care step down capacity	• Get Me Home plus capacity (pathway 2) • Additional care capacity • Additional therapy and nursing capacity	Additional capacity between Nov'20 – March '21
Increased in-hospital discharge capacity	Ensuring flow through the hospitals is optimised through additional: • First Point of Contact Officers • Discharge liaison nurses (supporting self-funders) • Social work single point of access and triage	Additional capacity between Nov'20 – March '21

Section 6: OUR WORKFORCE

Headcount and Temporary Staffing

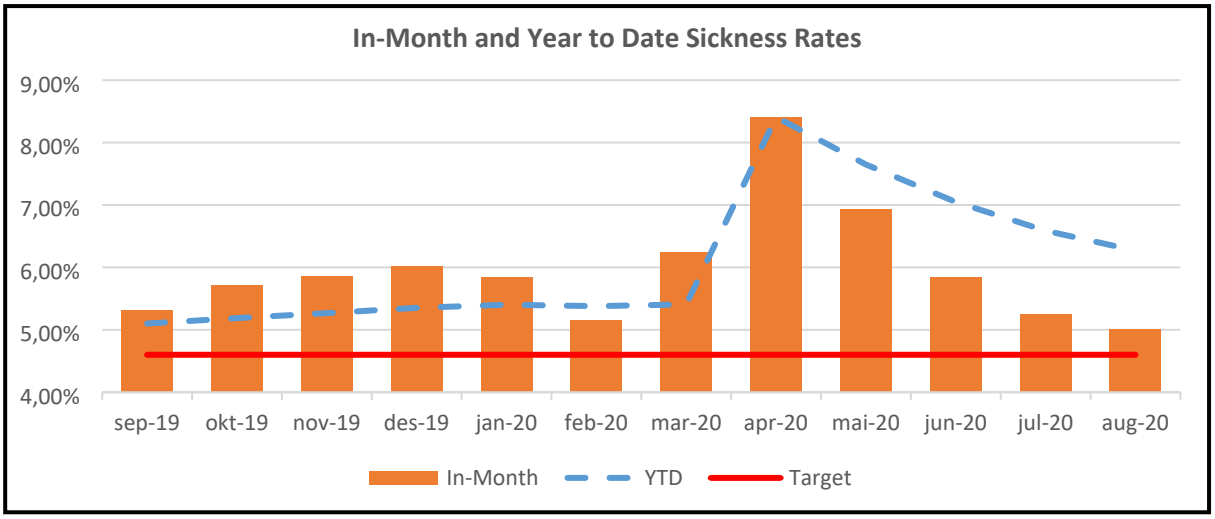
The Tables below illustrate our staffing journey since last September and the spike in whole time equivalent temporary staffing during April and May which then dipped back. As reported in Q1 and Q2 we have constantly recruited to the temporary bank registers and although a number of individuals have remained on our bank we are now recruiting more. Those temporary healthcare support workers that have remained on our bank are now being moved to fixed term and permanent roles which will help us sustain the workforce and also reward individuals with more stability as they have been loyal to us.





Staff Absence & Shielding Staff

The Table below shows the sickness actuals up to August 2020. This includes all sickness absence, including Covid-19. At our peak in April we were reporting absence of 8.41% which came back down to 5.24% in July and 5.01% in August.



As at 3rd August 2020, we had 637 staff shielding. Fifty percent of individuals were working from home or working on TTP, however, over 300 were not working from home. During the summer Clinical Boards managed to safely return staff to either working from home, working in alternative roles or working in Covid-19 safe environment/zones. There only remain under 20 staff who are not able to undertake meaningful work due to their individual circumstances and health.

The established Shielding Working Group meets regularly, in partnership with trade unions, and has developed clear Principles and principles for supporting the returning staff following Pausing.

Supporting Positive Culture Change

During the past 18 months prior to Covid-19, Cardiff and Vale UHB has strived to implement a system of leadership and culture which inspired a high level of trust among staff and allowing them to operate within low levels of bureaucracy. In 2019, the Health Board began its Amplify 2025 programme, which was based on what it had learnt from its partnership with New Zealand's Canterbury District Health Board. As part of this programme, staff were given the permission to innovate and act where they saw fit in order to make healthcare services better, more sustainable and more efficient in order to meet the goals as set out in the Health Board's 10-year strategy, Shaping Our Future Wellbeing, which was published in 2015.

The Amplify 2025 programme also had the goal of breaking down organisational barriers and bring leaders from across the health system together with a shared vision of improvement. We want to learn from each other and share ideas for a whole-system approach to culture and leadership transformation. Similarly, in 2019 the Health Board was instrumental in establishing and hosting the Spread and Scale Academy in Wales, which offered healthcare staff training and support in order to take a small-scale improvement project and develop it into something that can affect large-scale change.

These initiatives provided a cultural context in which the UHB was operating and, as such it wanted to drive change which was clinically-led rather than coming from the top down in response to the pandemic.

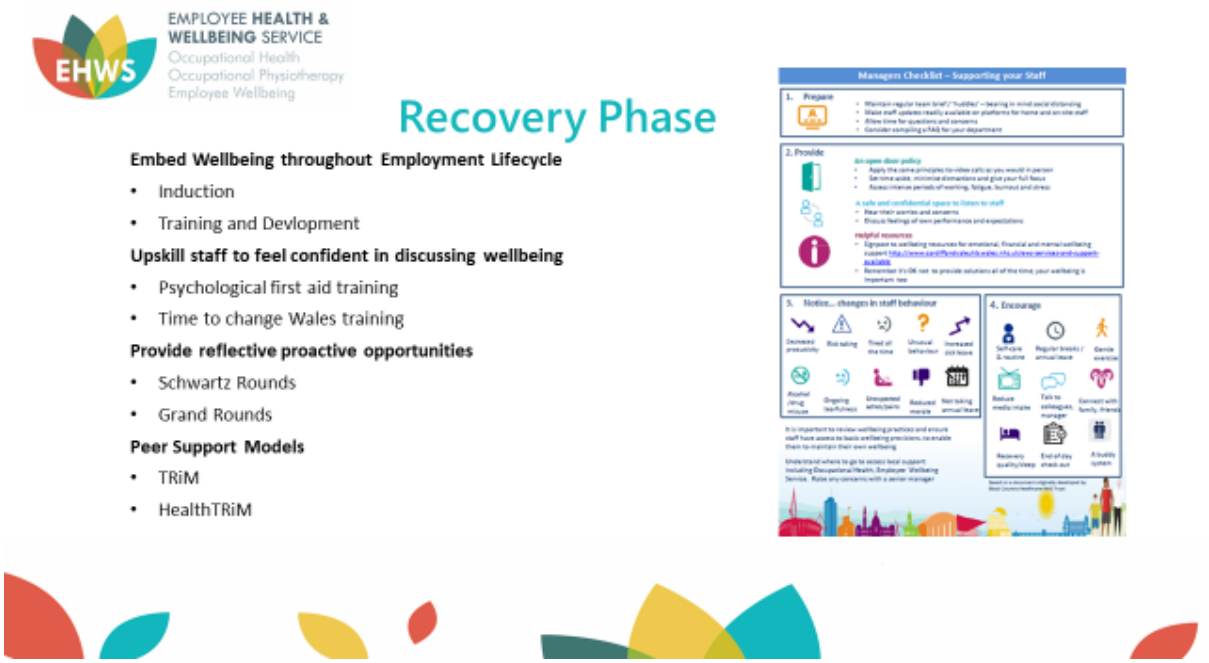
A new leadership structure and staff movement across traditional boundaries broke down barriers between clinical teams and silos. Staff have reported that traditional hierarchies were in some places flattened and that silos were broken down as colleagues came together to work collectively on the solutions to the challenges posed by Covid-19. Staff have been more accepting of change and willing to adapt as the pandemic focussed their attention. The ability to work on one project, towards one goal, with the understanding that it is for the common good was transformational for staff and services. Despite feeling tired and anxious, staff reported feeling as though they were included, trusted and energised by their work.

During Q2 we undertook a rapid feedback exercise with staff across the whole of the organisation to understand the impact of Covid-19 on our leadership capability and capacity, identifying what has really worked well, to understand what transformational changes have happened and to ensure this is embedded within the organisation although understanding any potential barriers. The last four months have presented many individuals 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. A discovery report has been produced illustrating what Cardiff and Vale achieved during the pandemic.

The Organisational Development team now have the opportunity and responsibility to harness the clarity and energy felt by staff during the pandemic and establish how the Health Board can keep this momentum going forward, so that staff have an active input into the health system's future direction.

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.



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

During the next 6 months – the immediate priority is the seasonal flu campaign which commenced in September. Following on from this will be the implementation of the Covid-19 vaccination programme once the vaccine is available.

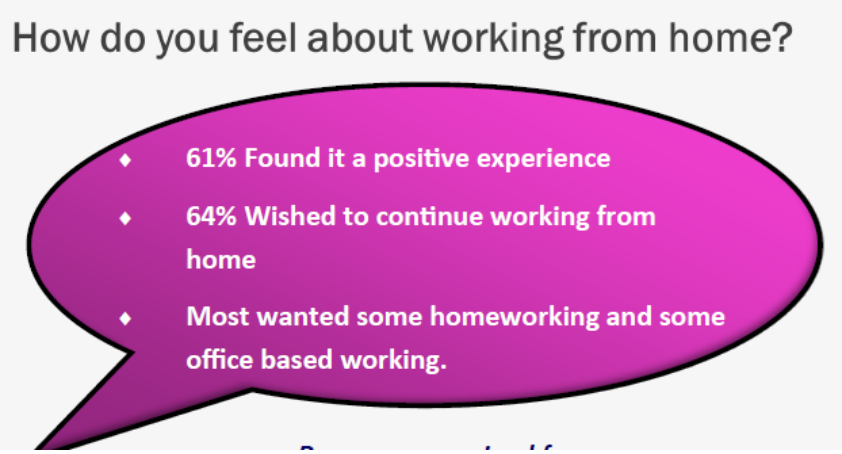
From a psychological well-being perspective we are currently in discussions with Remploy to develop a free mental health vocational rehabilitation programme which will provide non clinical mental health support for staff for up to 9 months. A bid has been made to the UHB Health Charity to fund the provision of a number of resources to support psychological wellbeing including Wellbeing Co-ordinators to deliver these programmes. An outcome of this bid is as yet unknown.

Helping staff with fatigue – the UHB has an existing Occupational Health Musculoskeletal pathway for staff, however this was not developed to deal with the effects of long Covid-19. The UHB has developed the Keeping Me Well platform which provide a range of resources to support Covid-19 Rehabilitation **https://keepingmewell.com/.** Although originally developed for patients, it is also applicable for staff.

A number of resources were developed during the initial stages of Covid-19 including free access to wellbeing Apps, online CBT resources, virtual exercise classes along with a number of bit size information leaflets. These are all currently available and are regularly being advertised via the communication team to ensure that staff know how to access them when required. The Head of Employee Health and Wellbeing and the Lead Counsellor for employee Wellbeing are continuing to offer proactive support to Line Manager to help them support the wellbeing of staff in the workplace

Wellbeing and Working from Home

We recently undertook a survey to gather the views and experiences of those who have worked from home during the pandemic. We received a fantastic number of responses; Highlights of the survey can be seen on the below attached.



It is clear that there are some lessons to learn and we are thankful for the open and honest views of our staff; largely the responses were positive and the majority of staff welcomed the opportunity to work from home although we know that working from home is not for everyone and some of our staff have found it particularly challenging.

We also recognise that there is a great deal of uncertainty surrounding the future and what our working arrangements will be. It is clear that, whilst Covid-19 has posed huge challenges to how we work and provide care to our patients it has also opened up several opportunities to allow us to question what we considered to be our routine way of working and to instil some real positive changes.

For the organisation, homeworking has certainly been one of those changes that we regard as being a positive change in direction and something that we would like to see continuing. At present we continue to encourage and support staff to work from home where they can. As well as supporting social distancing, the benefits to homeworking can include, a better work-life balance, avoiding the daily commute, and reduced travel costs. For the Health Board benefits include, better productivity, reduced requirement for office space and car-parking and a reduction in the carbon cost of delivering health and care services. There are also many benefits across the broader community including the reduction is road congestion, air pollution and the strain on public transport services.

It is acknowledged that there can also be negatives to homeworking, particularly around matters of employee well-being and health & safety, such as loneliness and loss of team contact, risk of domestic violence, difficulty keeping boundaries between home and work life, or simply the fact that IT capabilities may not be enhanced enough for employees to access everything that they need. We want to support this by helping to up-skill managers and staff to work effectively in a culture that values outcomes, not physical attendance.

It is important that we retain the benefits of homeworking. We want employees to have more opportunities to work from home – not less. We are currently exploring how we can embed homeworking into the organisation in a successful and sustainable way. Our aim is to introduce a recognised homeworking or remote working model that allows our staff to work from any number of different locations, including their home and office.

Supporting our Black, Asian and Minority Ethnic workforce

We have been actively involved in working with the National Black, Asian and Minority Ethnic 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.

Recently our CEO asked members of staff from Black, Asian and Minority Ethnic backgrounds to share their experiences of working in the UHB and the issues of inequality they have faced. Our CEO has spoken with staff who shared their experiences, the learning from which we have found invaluable. We will now build upon this agenda to ensure that as a Health Board we are as inclusive as possible.

While we've seen the occasional inspiring story of grass-roots transformation initiated by employees looking to drive change, the truth is, diversity and inclusion has to come from all levels of an organisation. Therefore, all our Executives will each be taking a leadership role across the nine protected characteristics stipulated in the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation), and our CEO has chosen to lead on race. This is a complex area and his interactions with colleagues so far have illustrated how there are a variety views and opinions on how we can make sustainable and meaningful change, such as the establishment of a Black staff network or Forum.

Risk Assessments

At the start of the pandemic we introduced a risk assessment for our employees. We also had a separate assessment for Pregnancy. This was superseded as we introduced the Welsh Government Risk assessment process. Staff have been encouraged to undertake the self-assessment process and record this within the ESR system. Managers are required to undertake regular risk assessment conversations with all staff; especially those in vulnerable groups. Mitigating actions are being taken which mean staff are supported to work from home, moved to alternative duties, work in non-Covid-19 secure environments.

Section 7: OUR FINANCES

The Welsh Government wrote to the UHB on 19th March 2020 to confirm that whilst the UHB 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 UHB continues to progress its plans and is forecasting a breakeven year end position based upon the resource assumptions set out in NHS Wales Operating Framework 2020/21 for Q3 and Q4 and a continuation of LTA block arrangements for the rest of the financial year.

The Financial forecast is based on the UHB COVID-19 "central" scenario.

At month 6 the UHB is forecasting net expenditure due to Covid-19 to be £153.306m. The Covid-19 year-end forecast position is breakeven following receipt/confirmation of £153.306m Welsh Government (WG) funding that includes Urgent and Emergency Care funding. This is summarised in the following table:

Summary of Forecast COVID-19 Net Expenditure

	Forecast Year-End Position £m
Total Additional Operational Expenditure	153.29
Total Non Delivery Of Planned Savings	20.502
Total Expenditure Reduction	(19.214)
Total Release/Repurposing Of Planned Investments/Development Initiatives	(1.272)
NET EXPENDITURE DUE TO Covid-19 £m	**153.306**
Welsh Government COVID funding received / assumed	(149.256)
WG Urgent and Emergency Care Fund	(4.050)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**

- The breakeven financial forecast is dependent upon LTA block arrangements continuing for the rest of the financial year.
- The forecast position reflects the assessed Covid-19 costs included within the MDS;
- It is assumed additional forecast costs will be supported by Welsh Government Covid-19 funding and the UHBs capitation share of both the Welsh Government Sustainabilty fund and Urgent and Emergency Care fund.

- It is assumed Independent Sector Spire activity is funded to 31st March
- The current forecast excludes the cost of a mass Covid-19 vaccination programme which is currently being assessed.

This forecast includes funding received/assumed from Welsh Government totaling £153.306m as oulined below:

Welsh Government COVID-19 Funding supporting the forecast year end position as at September 30th 2020

Welsh Government additional COVID & Urgent & Emergency Care Funding	£m
Dragons Heart	(60.789)
Allocation Share 13.5% of £371.4m	(50.100)
Reflecting COVID Workforce Months 1 -3	(11.016)
LA TTP	(7.300)
PPE	(6.632)
UHB TTP	(3.081)
NHS and jointly commissioned packages of care	(3.024)
Independent sector provision (Spire)	(2.700)
Flu vaccine extension	(2.650)
Transformation Discharge	(1.251)
Mental Health Services	(0.503)
GMS DES	(0.210)
Urgent and Emergency Care Funding	(4.050)
Total Funding received / assumed £m	**(153.306)**

Key financial planning assumptions:

Dragons Heart Hospital

Within this forecast the Dragon's Heart Hospital costs are now assessed at £63.248m with a further £2.686m capital costs. The revenue cost of £63.248m represents set-up, decommissioning and consequential losses costs of £60.789m and running costs of £2.459m. This is based upon the DHH going on standby from 5th June and retention until 10th November 2020. The UHB continues to work to maximise value for money in the remaining occupancy, removal and reinstatement phases of the project and is hopeful that this will continue to reduce the overall cost of the project.

Dragons Heart Hospital consequential loss compensation costs for the WRU and Cardiff Blues of £3.659m are included in the 2020/21 forecast. These costs represent the best forecast that can be modelled at this time for events that might reasonably have been held at the Principality Stadium and Cardiff Arms Park in the period May 2019 to January 2020 but cannot be due to the continued occupancy of the Dragon's Heart Hospital to 31 October 2020. The forecast includes £8.537m of decommissioning costs for the DHH including reinstatement of the stadium.

COVID-19 and Winter Surge Capacity / Lakeside Wing

The UHB has developed alternative plans which have been shared with Welsh Government to establish a facility for surge capacity on the UHW site – Lakeside Wing. The plans have now been approved by Welsh Government. In addition to providing Covid-19 surge capacity, it will provide the surge beds that the UHB would need to commission for this winter, recognising that predicting winter demand this year is particularly difficult. The UHBs 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 there was a significant demand. The UHB's bed capacity plan maintains some of the initial bed expansion created in the UHB's 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 the UHB brings back on line more non-Covid-19 activity.

Aligned to the Covid-19 "central" scenario the forecast includes additional staffing costs relating to additional Covid-19 capacity at UHW, UHL and St. David's (106 beds) coupled with additional winter capacity requirements (50 beds)

Additional workforce requirements relating to the utilisation of a further 116 beds within the Lakeside wing would need to be reviewed looking at utilisation of staff already in post, temporally redirecting / redeploying staff from acute non ward areas coupled with the availability of bank and agency staff if this additional surge capacity was to be required.

Resuming Non-Covid-19 Activity

Throughout the pandemic the UHB has maintained core essential services with our 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

As well as maintaining essential services we have begun to re-introduced more routine services where it is safe to do so. We plan to keep doing this through the next six months.

We have been able to achieve this through:

- Establishment of Protected Elective Surgery Units ('Green zones') in UHW and UHL
- Use of Spire Private Hospital capacity
- A refreshed Outpatients Transformation Programme, clinically led across primary and secondary care

The reductions in non pay costs due to reduced elective capacity is now assessed and forecast to be £19.214m over the year. This represents activity steadily increasing throughout quarter 3 and quarter 4 aligned to the Covid-19 "central" scenario through the use of established green zones at UHW and UHL but not returning to pre-Covid-19 levels.

At the beginning of the Covid-19 pandemic, the UHB reached an early agreement with Spire Healthcare to enable patients with non-complex cancer and other urgent conditions to receive treatment at Spire's Cardiff hospital. This allowed the UHB extra capacity to care for Covid-19 patients on its main sites, in particular to enable space for regional services.

As Covid-19 cases continue to increase within our community and we move deeper into a second wave the continued use of the independent sector remains a key dependency for the UHB if it is to continue to plan for stability and continue to deliver the levels of non Covid-19 activity which have bene achieved to date during the pandemic.

Costs of Spire are included in the forecast to the 31st of March totalling £2.700m. Funding up until 31st December has been confirmed by Welsh Government and it has been assumed that this arrangement will continue for the rest of the financial year. As such the UHB has assumed a further £2.7m Welsh Government funding for this.

Regional Test, Trace and Protect (TTP)

Working with its local authority partners the UHB has established its 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 Local Authority.

The TTP service went live on 1st June 2020. The forecast includes TTP costs (separately identified on TTP template) of £10.620m. This includes Local Authority costs of £7.539m that are £0.239m higher than the confirmed £7.300m income for local authority costs. Heath Board TTP costs totalling £3.081m are included within the forecast and assumed to be funded.

Enhanced Flu Vaccination Programme

A further pressure arose in month 5 around the cost of an enhanced flu vaccination programme. The costing of the programme is based on fees payable to GPs as this is the main delivery route for immunisations. The estimated cost which is estimated at £2.650m and is assumed to be funded. This has been calculated in line with the recent guidance and includes the provision of an additional 111,000 vaccines.

The forecast of costs outlined **exclude** the cost of a mass Covid-19 vaccination programme which are currently being assessed.

Personal Protective Equipment

In line with the planning guidance the UHB is assuming that its Covid-19 costs of PPE will be fully funded. At month 6 forecast costs are assessed to be £6.6m.

Urgent and Emergency Care Funding

We continue to shape our unscheduled care plans around the goals of the national urgent and emergency care framework and specifically the four priority areas which the unscheduled care board have identified for quarter 3-4:

I. 111 / contact first models to enable patients with urgent care needs to be signposted to the right place, first time
II. 24/7 same day / urgent primary care models of care to enable people to access care in their local community, preventing unnecessary attendance at Emergency Departments and admission to hospital.
III. Ambulatory emergency care to enable patients to safely bypass the Emergency Department and prevent unnecessary admission.
IV. Embedding the four discharge to recover then assess pathways to prevent unnecessary admission and enable a home first approach to improve experience and outcome

Funding has been assumed within the forecast totalling £4.05m reflecting the UHB allocation formula share of the £30m Urgent and Emergency Care Fund.

- £1.350m allocated to RPB for discharge to recover and assess pathways
- £0.540m for urgent primary care centres
- £2.160m for 111/contact first and Ambulatory Care

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

Further bids against this fund are currently being progressed in line with set timescales.

The forecast does not include any additional costs to support the WAST tactical seasonal plan. This will be considered and prioritised against other expenditure plans.

Savings Programme 2020-21

The assessed slippage against the UHB £29m savings plan is forecast to be £20.502m and this includes the release of non-recurrent opportunities in month 6. A number of the UHB's high impact schemes were based on reducing bed capacity, improving flow coupled with workforce efficiencies and modernisation. It is not anticipated that significant progress will be made to improve this position until the pandemic passes. However, the UHB continues to identify and maximise all potential savings opportunities

available. Schemes that are continuing to develop and progress include procurement and medicines management.

Underlying Financial position

The 2020/21 opening underlying deficit was £11.5m. If the financial plan was fully delivered this would have reduced the underlying deficit to £4.0m by the year end. The achievement of this was very much dependent upon delivering the full year impact of 2020/21 savings schemes. The latest assessment is that as a result of the impact of Covid-19 this is £21.2m less than planned and this would increase the underlying deficit to £25.2m.

What is key for the Board is how it recovers from this Covid-19 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 necessity. This is a period of both significant financial risk and opportunity for the UHB.

Financial Risks and Uncertainties

The financial plan sets out our best assessment of income and costs based upon alignment of capacity, activity, service and finances of the Covid-19 "central" scenario. The key financial risks and uncertainties are:

- Assumed Q4 funding for the independent hospital provision which has yet to be confirmed. This is assessed at £2.7m.
- Bids against the Urgent and Emergency Care Fund are yet to be confirmed.
- Continuation of block contract arrangements in Q3 and Q4. The NHS is unable to undertake the same levels of elective activity that it did pre Covid-19 19. Any movement away from block contacts to previous cost and volume contracts will significantly impact upon the delivery of this financial plan.
- The financial plan has been based upon the UHB Covid-19 "central" scenario, and the actual scale of impact will largely determine the resource requirements linked to workforce availability.

Dependent upon clarification of resource assumptions and the scale of a second Covid-19 wave, further mitigating actions may be required to manage these and other risks. Likewise it will be equally important to highlight any financial opportunities as early as possible.

Section 8: OUR CRITICAL ENABLERS

Infrastructure and Estates

Much of the focus of the capital and estates planning team for the last 2 quarters has been developing and implementing a range of enabling schemes to redevelop and/or reconfigure existing infrastructure to enable essential services to be delivered safely in a Covid-19 environment. These Green schemes and other major infrastructure enablers (e.g. Augments Oxygen infrastructure, whole service transfers from one site to another) are due to be completed during Q3.

The current major challenge for the team in Q3 & 4 is the development and delivery of the UHW-based surge capacity known as Lakeside Wing. This modular-build facility will be opened on a phased basis with 166 beds being available from the end of November and the remainder by the end of January. This development is progressing as we complete the decommissioning of the Dragon's Heart Field Hospital

temporary beds that were provided at the Principality Stadium. This facility is due to close on the 10th November.

In order to address some of the elective backlog pressures that have built considerably during the last 6 months the UHB has a number of capital schemes that are in different stages of development but all of which could be accelerated to provide fast-tracked, protected elective surgical and diagnostic capacity in specialities which are currently significantly constrained by existing capacity. These include:

- Acceleration of UHL orthopaedics theatres (All Wales Capital Programme SOC already submitted) – see Major Capital Schemes in Development table below
- Production of BJC for 2 offsite modular build cataract theatres – initial design plan agreed with clinicians
- Production of BJC for 2 theatre endoscopy suite expansion at UHL - – initial design plan agreed with clinicians.

In terms of the UHB's current Major Capital Programme the principal existing infrastructure schemes are outlined in the **table 4** below.

Table 4: *Major Capital Schemes in Construction*

Scheme (Capital value)	Current Position Update	Key Milestones
Acute Infrastructure		
Neuro & Spinal Rehab Unit at UHL – (£31m AWCP)	Relocation of Rookwood specialist spinal and neurological rehabilitation services to fit for purpose new build at UHL. Construction in progress.	Build end: Feb 2021 Service Occupation: May 2021
Cystic Fibrosis Unit – UHL. (£3.5m AWCP)	Replacement & expansion of current facilities in fit for purpose accommodation in new unit at UHL. Construction in progress.	Build end: Dec 2020 Service Occupation: Feb 2021
MRI Fit Out – (£5.63m AWCP)	2 scanners installed and 3rd in commissioning – training ongoing.	2 in service 3rd in commissioning
MTC Enablers (carried fwd from 19/20) ED CT scanner (£1.5m AWCP) Resus – additional bay (£0.462m AWCP)	Replacement scheme due to complete 2nd week in Dec. Awaiting final completion date – minor works outstanding.	CT installation complete mid Dec Resus – TBC
Community Infrastructure		
CRI Chapel development (£3.5m – ICF funded)	Integrated space for library & community services. Construction ongoing.	Completion due Jan 2021
CRI – Blocks 11 & 4 – 2nd floor (£5.132m AWCP)	Urgent remedial H&S works & relocation of MH community services and other Global Link occupants. Construction in progress	Completion due March 2021.

Major Capital Schemes in Development

Scheme (Capital value)	Current Position Update	Key Milestones
Acute Infrastructure		
Hybrid/Vascular & Major Trauma Theatre – UHW (£TBC)	OBC in final stages of development – Key enabler for SW Major Trauma Centre and SE Wales Vascular Surgical Network service delivery	Submit OBC to Board in Nov and await WG decision to proceed to FBC
UHL – Replacement theatres and additional ward facility (Est £11m – AWCP)	Replacement of 2 orthopaedic theatres at UHL that are no longer useable. SOC submitted.	Awaiting approval of SOC & funding to proceed to OBC
Genomics Centre For Wales (est £8m AWCP)	OBC in final stages of development for this joint infrastructure scheme in PHSW – critical enabler for national Genomics strategy	Submit OBC to Board in Nov and await WG decision to proceed to FBC

Scheme (Capital value)	Current Position Update	Key Milestones
Radio Pharmacy Unit Replacement (est £12.756m)	OBC in final stages of development for the replacement of inadequate accommodation – MHRA statutory compliance requirement	Submit OBC to Board in Nov and await WG decision to proceed to FBC
Mortuary Essential Upgrade works (est £1.6 - £2m)	HTA statutory compliance requirement. Scheme scoping currently under way to inform BJC.	BJC to be produced – timescale TBC
Critical Care UHW (£TBA) –	Scoping work being undertaken by C&E team for expansion and improvement of current accommodation (at risk – using discretionary capital). Business case route to be determined. Major Capital from AWCP required.	Scoping options to be concluded end Q3
UHL – Electrical and Oxygen (£4m AWCP)	New substation to address single point of failure and second VIE to augment existing oxygen plant. BJC under development	BJC to board end Q3
Main Theatre Refurbishment – UHW (est £10-£15m AWCP)	SOC being developed for 'Do Minimum' option – phased refurb in situ – to address significant inadequate and obsolete plant and modernisation requirements	SOC to Board June 2021
Community Infrastructure		
Wellbeing Hub – Maelfa (£12.881m AWCP – Primary Care Pipeline)	FBC submitted.	Awaiting WG decision to fund construction costs
Wellbeing Hub Penarth (£11.553m AWCP – Primary Care Pipeline)	FBC on hold – Alternative project options being explored	TBA with partners.
Wellbeing Hub Ely (Parkview) (£16 – 20m AWCP)	SOC approved. OBC no longer being progressed at risk and SCP stood down	Awaiting WG decision to fund OBC costs
SARC Hub – CRI (£10m AWCP)	SOC approved (Jan 2020) – awaiting WG decision to fund OBC planning costs. Essential accreditation compliance required to meet ISO requirements by 2023.	Awaiting WG decision to fund OBC costs
Health & Wellbeing Centre – CRI (£93m AWCP)	OBC on hold pending discretionary capital availability to support planning fees.	On hold.
CRI – Safeguarding Works (£? AWCP)	FBC on hold pending capital availability to support planning fees	Awaiting WG decision to fund FBC costs

PPE

We have an internal PPE cell which continues to meet weekly and is very closely linked into the wider NHS Wales PPE governance arrangements regarding the procurement and supply of PPE. In the context of this plan no new risks or issues are being reported meaning that PPE could be a rate limiting factor in the delivery of this plan.

Research, Development, Innovation and Technology

In ensuring long term system renewal it remains important that the organisation remains focused on both 'non Covid-19' innovation and technology as well as 'Covid-19' innovation- the schemes, projects, ideas which have been bought forward and/or emerged as a direct response of the pandemic.

Covid-19

From the outset of the pandemic we have taken a leading role in the research and development needed to fight Covid-19 including the now internationally known 'recovery' study where the UHB had nearly 200 participants. **Annex seven** provides more detail on the scale of the UHBs contribution to date across the Covid-19 R&D landscape.

Non Covid-19

Innovation 2025

Midway through *Shaping our Future Wellbeing* strategy the organisation is in the final stages of developing Innovation 2025. A plan for investment in innovation as a central pillar for realising our vision as a University Health Board.

Innovation 2025 continues to align innovation to the biggest challenges and service priorities set out in the UHB's ten-year strategy.

The Innovation Multidisciplinary Team (Imdt) conceived by our core innovation team remains at the heart of our innovation process and its success has led to adoption in other Health Boards and attracted attention from John Hopkins and the Mayo Clinic in the USA. The Imdt has an unprecedented level of expertise across the full innovation spectrum. As at July 2020 there have been 105 projects supported by the (Imdt)

Digital Innovation

We retain a digital transformation roadmap through to 2025 and whilst much of our immediate digital capacity is supporting the organisations immediate response to we recognise that it remains important that we set these immediate developments within the context of where digital across the Cardiff and Vale health community needs to be by 2025.

Appendix eight provides a schematic of our digital transformation. Some of the early steps which we will be looking to make on this journey include;

- ✓ Password for life
- ✓ Automated password reset
- ✓ Up to date internal directories
- ✓ New intranet with fresh content and search capability
- ✓ Workflow e.g. links and flow between EU work station and ward workstation; for job/task management
- ✓ Access almost everything on any device including your own
- ✓ Email accounts for all staff (including students, facilities etc)
- ✓ Roster / rota solutions for all staff

Communications

Our communications and engagement has largely been centred on responding and supporting the UHB operational response to the Covid-19 pandemic and the establishment of the Dragon's Heart temporary Field Hospital. As the first peak subsided much proactive work has been undertaken in reassuring our communities, getting some of our key services online and providing communications around the options available to patients across our range of communication channels, internally and externally.

The Communications and Engagement team has wherever possible continued with business as usual across all clinical and service boards in supporting the operational delivery of *Shaping our Future Wellbeing*. As we enter the annual cycle of winter communications, CAV247, the flu vaccination programme as well as a second peak of Covid-19 the team will be agile and respond to priorities seeking to inform, educate and reassure our communities as far as possible on accessing local health services.

The team has provided communications to targeted priority groups, such as those from Black, Asian, Minority Ethnic (BAME) groups and students and a range of stakeholders to ensure that our reach and information sharing is as far ranging as possible.

The Communications Team has also focussed on improving internal communications to staff and stakeholders and an additional series of newsletters and blogs are released regularly to keep people informed and updated with the latest health board position and operational information at a high level. There has also been a significant emphasis on communicating staff wellbeing and the availability of online and other services.

The feedback from surveys is that communication and speed of communication has improved and the team have identified the need to streamline and simplify information in a crowded information space.

Good Governance

We have had 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 currently reviewing its governance arrangements to ensure Welsh Government guidelines issued during Covid-19 continue to be implemented in an effective way.

Independent Board members had an informal session with the Health Boards Executive team and members of the Planning and Strategy team to support with the shaping of this plan. A final draft of the plan was also shared with the CHC, feedback was received and acted upon. We will also look share the final document with PSB and RPB partners

Upon submission this plan will be formally retrospectively approved at the next Board Development session and ratified in following formal Board of November.

The Board will receive assurance from the Strategy and Delivery sub-committee on progress with delivering the key elements of plan recognising it will continue to evolve and develop with each quarter refresh and update.

The Audit Committee will review and have oversight of governance and risk arrangements to ensure these remain robust. The strategic risks which Cardiff and Vale UHB are facing are described in the BAF see **appendix nine** and these are reported to every Public Board Meeting.

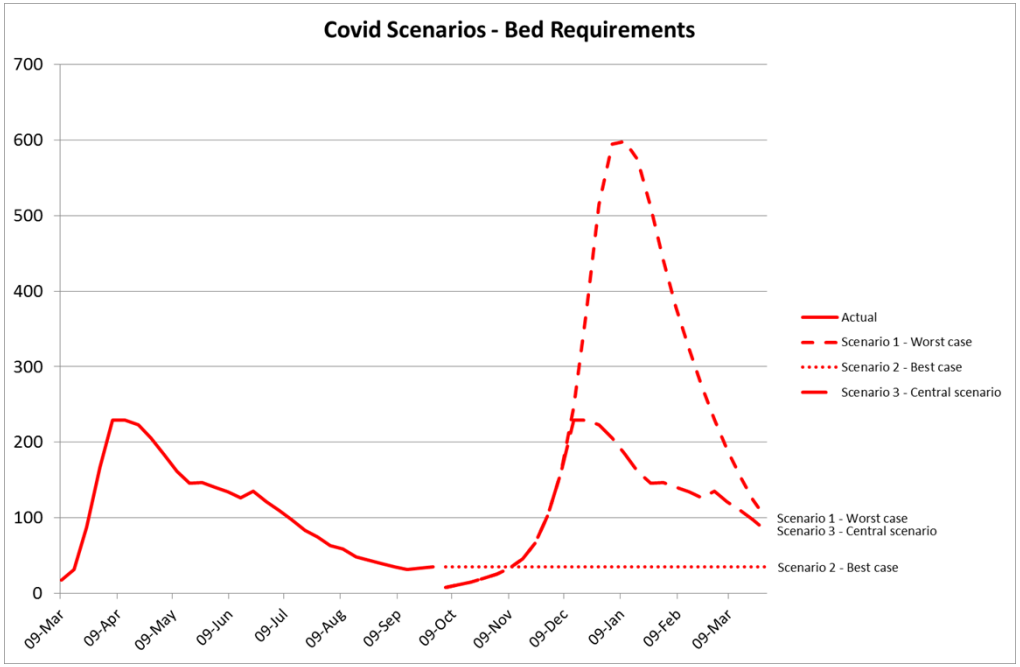
APPENDICIES

Annex One: *The UHBs three scenarios*

Scenario 1: Covid "Worst-Case"		
Covid	**Non-Covid emergencies**	**Electives**
1. Utilises the Swansea University RWC, adopted by WG, as the basis for the number of cases and admissions 2. LOS adjusted to reflect our actual LOS from wave 1 (note: LOS recognised as too short in Swansea model – revised version expected to be issued shortly) 3. Bed occupancy planned @ 85%	1. Utilises SfN (Lightfoot) forecast for non-Covid, with projection averaging 84% of last year 2. It has increased back to 83% of pre-Covid levels but has stabilised over past month 3. Note: in first wave non-Covid occupancy reduced to c.40% 4. Bed occupancy planned @ 85%	1. Utilises SfN (Lightfoot) forecast for electives, with projection averaging 82% of last year 2. It has currently increased to 67% of pre-Covid levels but is steadily increasing and Green Zone expansion planned during October & November 3. Note in first wave elective occupancy reduced below 30% 4. Bed occupancy planned @ 90%

Scenario 2: Covid "Best-Case"		
Covid	**Non-Covid emergencies**	**Electives**
1. Assumes total Covid bed demand is minimal and contained within Heulwen only 2. Bed occupancy planned @ 85%	1. Assumes occupancy of non-Covid emergencies returns to 100% of pre-Covid levels, at the rate of increase seen between April – August 2. This reaches 100% at end of November 3. Bed occupancy planned @ 85%	1. Assumes elective occupancy returns to 100% of pre-Covid levels, at the rate of increase seen between April – August 2. This reaches 100% by mid-December against pre-Covid 3. Bed occupancy planned @ 90%

Scenario 3: Covid Central Scenario		
Covid	**Non-Covid emergencies**	**Electives**
1. Assumes second wave initially follows trajectory of Swansea RWC but peaks at level of first wave 2. Recovery phase follows same trajectory as first wave 3. Bed occupancy planned @ 85%	4. As per Covid best-case	5. As per Covid worst-case



Annex Two- *Critical care escalation plan*

Ask this question every 2 hours, or every time an ICU bed is filled or allocated:

Can ICU admit 2 critically ill patients within the next hour?

	ICU Capacity Status	Actions:
Yes, ICU is able to admit 2 critically ill patients within the next hour*	**Planning Needed**	Take **planned action** to ensure a third critically ill patient can be admitted within 4 hours**.
No, ICU is unable to admit 2 critically ill patients within the next hour*	**Urgent Action Needed**	Take **urgent action** to ensure capacity to admit critically ill patients is created.

*Zone Leaders are not included in this calculation. Beds allocated to referred patients count as occupied.
**The goal for all patients is discharge to ward within 4 hours of being declared fit for discharge. If discharge would occur after 10pm, the ICU Consultant may choose to defer discharge until 7am in the patient's best interest. A ward bed must ring-fenced for this planned 7am discharge.

Urgent Action Needed: Order of actions	Who?	Is service now green? If not, keep going down.
1 If all rostered nurses have allocated patients, seek agency support.	Nurse Co-ord, ICU Manager	Yes / No
2 If still red: Shift Co-ordinator and Duty Consultant +/- Manager should decide how capacity can be created: a) Short term (1-4 hours): identify / reconfirm patients suitable for ward discharge / repatriation b) Medium term (4-48 hours): repatriation, or expediting key interventions such as tracheostomy	ICU Cons, ICU Manager, Bed Manager	Yes / No
3 If still red: Ensure bed manager and duty manager aware service is red, and aware of potential discharges **Next ICU DTOC has priority for ward admission over ED / MAU etc.**	Nurse Co-ord, ICU Manager	Yes / No
4 If still red: Escalate to Specialist Services Clinical Board Alert Neurosurgery, Vascular & Cardiology of limited admission capacity	ICU Manager, Site Manager	Yes / No
5 If still red: Authorise use of zone leaders	Nurse Co-ord	Yes / No
6 If still red, ACTIVATE A SURGE (within ICU footprint if possible, Recovery if not) ICU Cons & Nurse Co-ord to decide safest distribution of patients. a) Inform Site Manager / SMOC on call to discuss and authorise plan b) Direct 16-18 year olds to PICU c) Transfer within Critical Care network d) Review of PACU major surgery / Redeployment of Anaesthetic staff e) Seek additional senior and medical ICU staff for expected duration of surge	ICU Cons, Nurse Co-ord, Site Manager, SMOC, Anaes on call	Yes / No
7 If still red / black, DECLARE BUSINESS CONTINUITY INCIDENT a) Double up nursing ratio for stable level 3 patients b) Consider redirection of specialist patients to other centres c) Redirect critically ill admissions to other centres (EMRTS / WAST) d) Cancel elective cardiac surgery to create capacity e) Escalate to other Health Boards	ICU Cons, Nurse Co-ord, Site Manager, SMOC, Exec on Call (only if required)	Yes / No

ICU Service Capacity Audit:

AC= Admission capacity

DTOC= Patients suitable for discharge

	Example	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
00:00 to 02:00	AC= 2 DTOC=2	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
02:00 to 04:00	AC= 2 DTOC=2	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
04:00 to 06:00	AC= 2 DTOC=2	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
06:00 to 08:00	AC= 2 DTOC=2	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
08:00 to 10:00	AC= 2 DTOC=2	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
10:00 to 12:00	AC= 0 DTOC=0	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
12:00 to 14:00	AC= 1 DTOC=1	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
14:00 to 16:00	AC= 2 DTOC=0	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
16:00 to 18:00	AC= 2 DTOC=1	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
18:00 to 20:00	AC= 2 DTOC=1	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
20:00 to 22:00	AC= 2 DTOC=1	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=
22:00 to 24:00	AC= 2 DTOC=1	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=	AC= DTOC=

Date: W / C / /

Green=

AC 2 or more for whole 2 Hour block

Red=

AC 0 or 1 for 15 mins or more

Accepted= time accepted

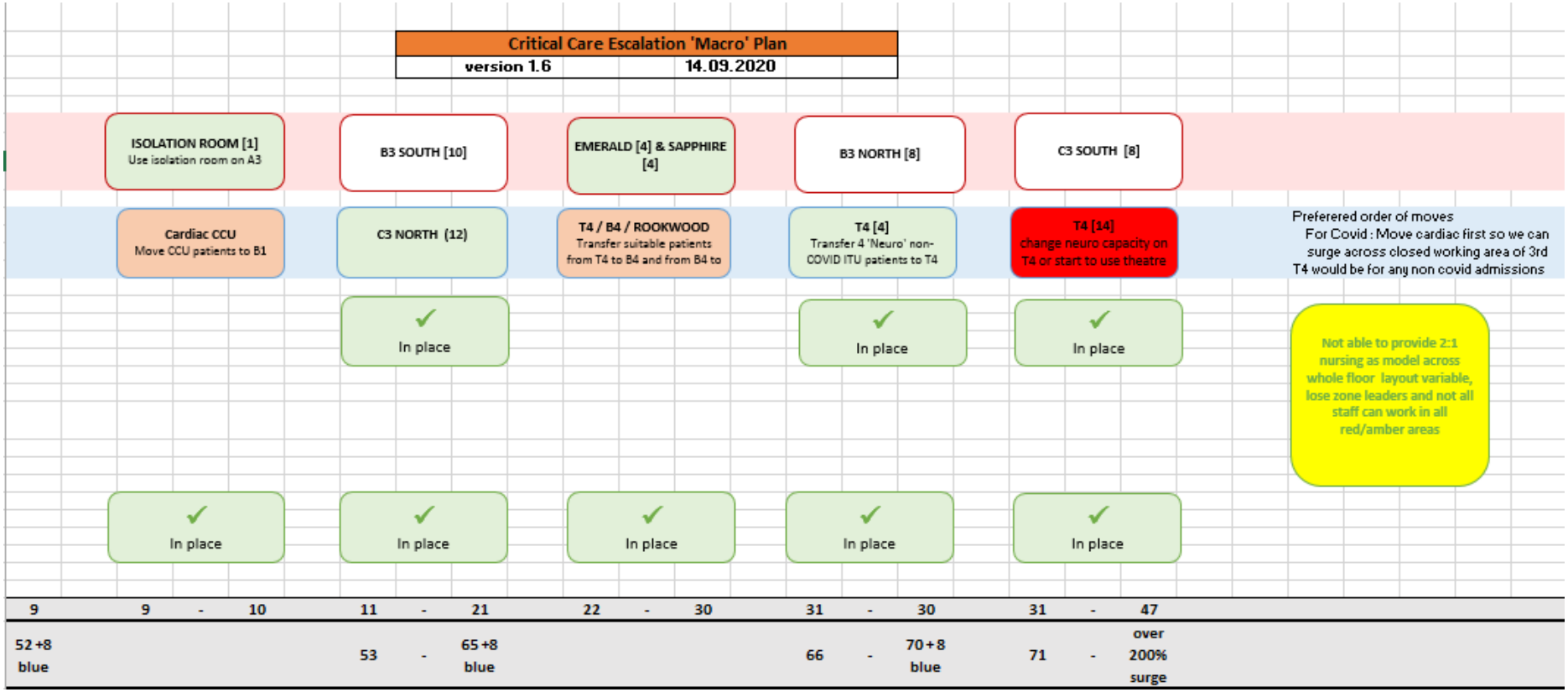
Ready= patient ready to come to ICU (eg patient recovered post laparotomy), time may be same as accepted if patient is ready to move)

Arrived= arrived in ICU

Datix if ready to arrived is >240 mins

	Mon	Tues	Weds	Thurs	Fri	Sat	Sun
Admission 1	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:
Admission 2	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:
Admission 3	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:
Admission 4	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:
Admission 5	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:	Initials: Accepted: Ready: Arrived:

Annex Three – *Schematic of our critical care footprint*



Annex Four- *Care Home support and escalation issues*

Issue	Response
An overarching contingency plan that could be applied to any nursing care home closure must be developed in readiness for the winter period.	Home Closure procedure already in place and would be initiated in conjunction with partners
Clarify Regulatory Requirements	Clarify the role of HIW and other regulatory bodies
To enable ownership, a clear legal position and implementable action plan must be in place. LHBs working with Las as appropriate, are asked to consider the following as part of their overarching care home failure contingency planning.	Legal advice is requested– can a HB take 'ownership' of a privately owned business and what are the legal obstacles or supportive legislation to enable that to happen.
Determine clear legal advice for how a nursing care home could be run either solely by the LHB or jointly with the LA in line with legislation including NHS (Wales) Act 2006, Social Services and Well-being (Wales) Act 2016 and Local Government Act 2000;	Legal advice is requested to confirm HB position : If a home is nearing failure then administrators may already be involved. Can HBs purchase a business that is actively failing to this extent? Clarify if the suggestion of ownership if it applies to all Care Homes not just those deemed to be required to meet demand
Determine potential availability of capital funding to purchase and update buildings (if necessary), Determine understanding of potential pooled budgets ;	Funding source to secure " ownership" HBs required to assess capital/buildings requirements within the context of NHS buildings and maintenance standards
Compliance issue re building regulations and health and safety regulations	HBs have to assess and determine any capital/buildings requirements within the context of NHS buildings and maintenance standards? Consideration of Health and Safety legislation requirements
Human resource issue to be consider	TUPE of staff Ongoing funding resource for staff Management resource Professional Regulation and competency
Consideration of Charging Process particularly self-funding arrangements	Determination of charging element, financial assessments invoicing payment etc.
Safeguarding	What is the legal position re HBs purchasing care homes where there may be significant escalating concerns/safeguarding issues in that home?

Annex Five: *Care home partnership action plan*

070920ActionPlanT
oSupportResidentia

Annex Six: *Summary of all other essential services*

GREEN	AMBER	RED
<75%	50-75%	>50%

Essential Service	Status- Expected capacity for Q3-4 compared to pre-Covid-19	Action being taken to improve situation and/or action being taken to manage resulting risks (ONLY if amber or red)
Renal Dialysis	*Confirmation to follow*	
Solid Organ Transplantation	*Confirmation to follow*	
Thoracic Surgery		
Haematology	*Confirmation to follow*	
Neurosciences		

Essential Service	Status- Expected capacity for Q3-4 compared to pre-Covid-19	Action being taken to improve situation and/or action being taken to manage resulting risks (ONLY if amber or red)
Major Trauma Centre		
Stroke	*Confirmation to follow*	
Gastroenterology		**Endoscopy** Quarter 3 Capacity likely to be around 65-70% of pre COVID-19 **Mitigation:** Insourcing Continued use of Spire Look at use of FIT as an upfront diagnostic Micro managing capacity to ensure all capacity is utilised affectively Validation Review of complex patients with consultants (long waiters ie >52 weeks) Review of patients waiting greater than 26 weeks Validation – both clinical and administrative
Acute Oncology		
Lung Cancer		
Skin cancer		Micro managing capacity to ensure all capacity is utilised affectively. Undertaking one stop see and treat clinics within current capacity
HPB Cancer & Urgent		

Essential Service	Status- Expected capacity for Q3-4 compared to pre-Covid-19	Action being taken to improve situation and/or action being taken to manage resulting risks (ONLY if amber or red)
GI Cancer & Urgent		
Head & Neck Cancer & Urgent		2 x Dental theatres planned to open within Dental Hospital in November. Activity plans being drawn up to predict amber zone capacity.
Breast Cancer		
Spinal Urgent		
Urology Cancer		
Ophthalmology R1 & R2		3 x amber zone additional cataract sessions per week to go live in October. This will help free up some green zone theatre list space for R1&2 patients (glaucoma or VR). Additional 2 x GA green theatre sessions available from October also.
Emergency Surgery		
Trauma		
Emergency Ophthalmology		

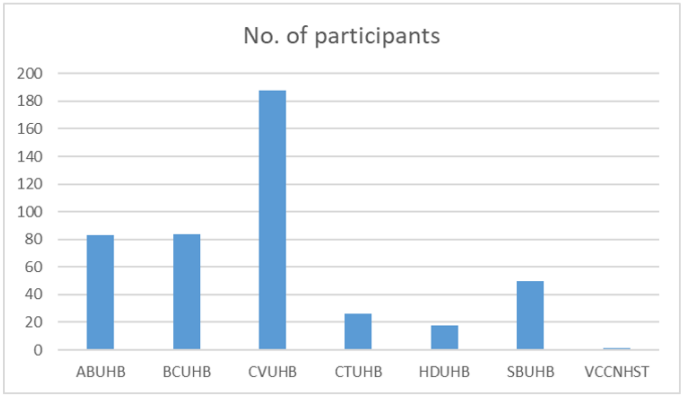
Annex Seven: *Cardiff & Vale UHBs Covid-19 Research and Development contribution*

Opened 43 Clinical Studies opened to date (10 CTIMP trials – over 200 patients enrolled) offering 17 different therapies to clinicians/patients

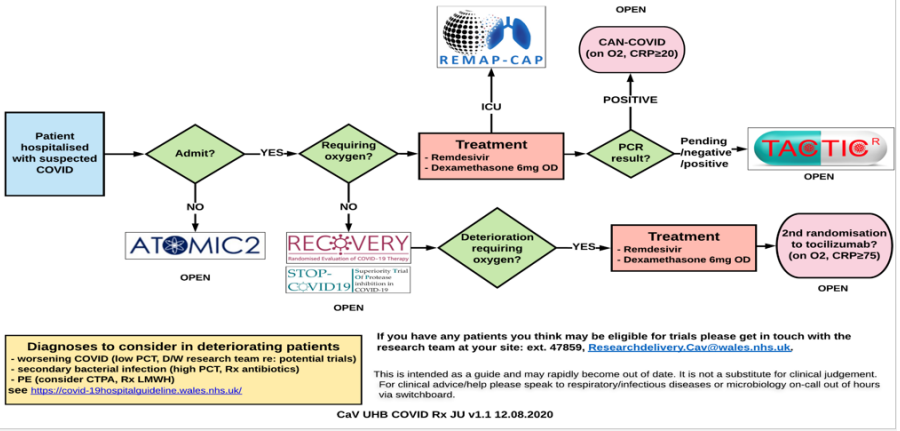
- **RECOVERY**
  - Dexamethasone, Hydroxychloroquine, Lopinavir/Ritonavir, Azithromycin, Tocilizumab (anti-Il-6 monoclonal antibody), Convalescent Plasma
- **GILEAD EAP – ITU Only**
  - Remdesivir (anti-viral)
- **TACTIC**
  - Ravulizumab (anti-complement monoclonal antibody), Baricitinib (anti JAK2/Il-6)
- **REMAP – ITU plus CPAP patients**
  - **Dexamethasone, Azithromycin, Lopinavir/Ritonavir, Anakinra (anti-Il-1 receptor), Interferon β (antiviral), Convalescent Plasma**
- **Stop Covid**
  - Brensocatib (Dpp1 inhibitor)
- **CanCovid**
  - Canakinumab (Anti Il-1 receptor monoclonal antibody)
- **CATALYST – Monoclonal antibodies**
  - Namilumab (anti-GMCSF), Infliximab (Anti TNF), Myelotarg (anti CD33) + others to follow
- **ATOMIC**
  - Azithromycin for A&E patients not admitted to hospital
- **Principle**
  - Azithromycin for GP patients not sent to hospital
- **Copter –** CVUHB Sponsored Convalescent Plasma
- **LFG316 –** Compassionate use anti-complement monoclonal antibody

Two other studies – never came to fruition as Sponsor withdrew.

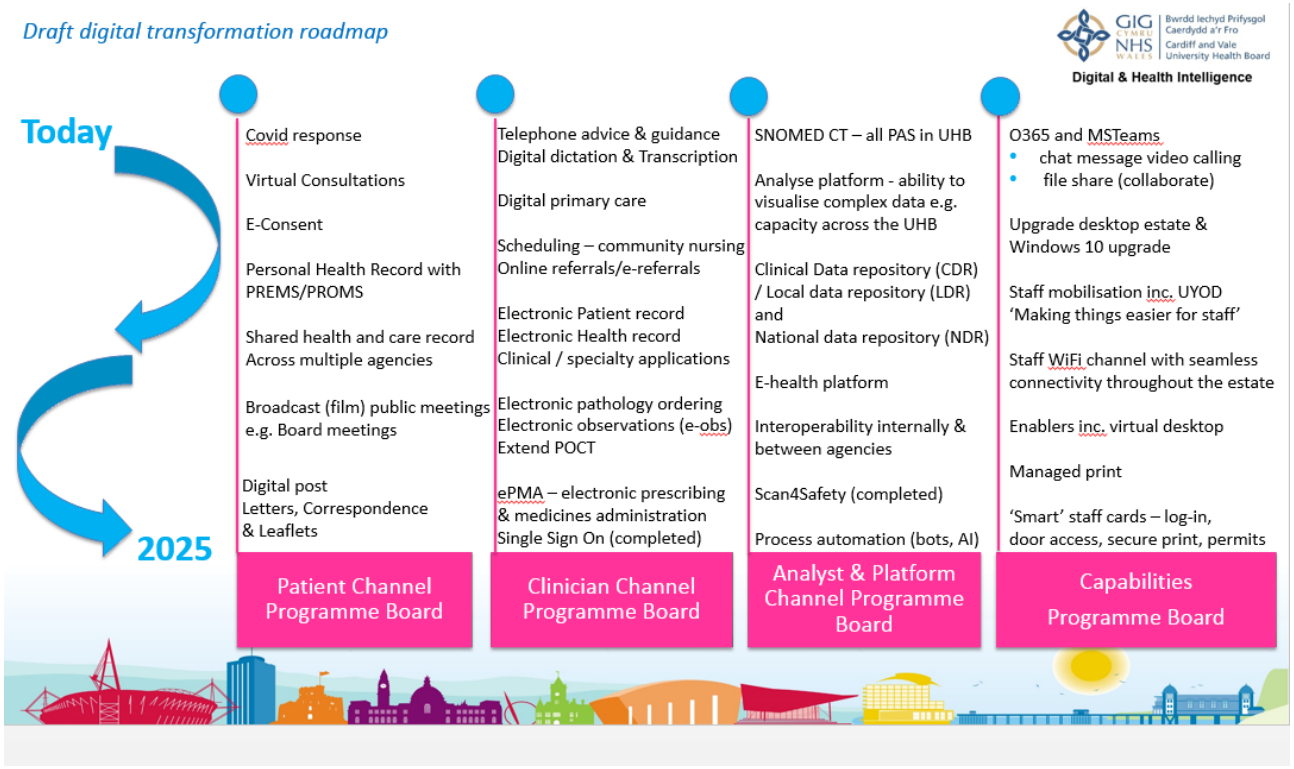
RECOVERY Study



Medical management of patients with COVID-19 and available RCTs - July 2020



Annex Eight: *Draft digital transformation roadmap*



Annex Nine: *September 2020 Board Assurance Framework*

6.3 BOARD ASSURANCE FRAME'

Report Title:	**Cardiff and Vale Regional Partnership Board Winter Protection Plan**								
Meeting:	Board Meeting						**Meeting Date:**	26/11/2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Executive Director of Strategic Planning**								
Report Author (Title):	**Executive Director of Strategic Planning**								

Background and current situation:

Following the publication of the Welsh Government's Winter Protection Plan, RPBs were required to produce local Winter Protection Plans to set out how the partnership would work together to ensure that the local health and care system is able to respond to the challenges expected this winter as well as possible, recognising the continued uncertainty presented by the COVID-19 pandemic. WG provide an additional funding allocation for RPBs to support delivery of the winter protection plan, with the expectation that the funding was focused on timely discharge of patients from hospital.

The RPB was required to submit the Winter Protection Plan at the end of October, and should be read in conjunction with the Health Board's Quarter Three/Four Plan which was submitted to WG on 19th October.

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

All partners in the RPB have worked together under the leadership of the RPB Director of Health and Social Care Integration to produce the Cardiff and Vale RPB Winter Protection Plan. The plan sets out actions that are being taken to increase capacity in our discharge support services, the care home sector (for discharge to assess) and our community resource teams – including domiciliary care capacity.

The costed plan requires a resource investment of £2.4m against an allocation of £1.3m. It is understood that the plans of other RPBs also set out actions that require an investment above the allocations. In signing off the Winter Protection Plan, the RPB partners have acknowledge the potential financial risk associated with the plan if no additional funding is made available over the course of the winter. The statutory partners in the RPB have agreed to proceed with implementing all elements of the plan. It is inevitable that there will be some slippage in the programme and therefore the full financial risk will not materialize if no further funding were to be forthcoming. If not further funding was available, the health board with the RPB partners would review the impact of the interventions within plan and prioritise which would continue through quarter four in order to ensure the financial risk was managed.

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

As set out above.

If there isn't additional funding to support the Winter Protection Plan, there could be an impact on the Health Board's ability to manage demand we anticipate during the winter, particularly if there is a third wave of COVID-19 in the New Year. January will potentially be the most

challenging month – and the full capacity of the new surge facility (Lakeside Wing) will not be available until the end of January.

Recommendation:
The Board is asked to:

- Note the content of the RPB Winter Plan and acknowledge the potential financial and service risks.
- Acknowledge the rapid work undertaken by the RPB Partnership Team under the leadership of the Director of Integrating Health and Social Care (Cath Doman), with the RPB partners.

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	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	

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

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.*

Cardiff & Vale of Glamorgan
INTEGRATED HEALTH
& SOCIAL CARE PARTNERSHIP

PARTNERIAETH IECHYD
& GOFAL CYMDEITHASOL INTEGREDIG
Caerdydd & Bro Morgannwg

Cardiff and Vale of Glamorgan

Regional Partnership Board

Winter Protection Plan 2020-21

30th October 2020

Contact: cath.doman@wales.nhs.uk

Contents

Executive Summary

This is the Cardiff and Vale of Glamorgan Regional Partnership Board Winter Protection Plan for the winter of 2020/21.

There are a wide range of activities across the statutory, third and independent sectors that contribute to ensuring a safe winter period for people across the region. This plan therefore draws together planning activities relating to:

- Protection of public health
- The Health Board's Service Delivery Plan for quarters 3 and 4
- Care homes
- Third sector
- Carers

It sets out the region's response to the 6 goals set out in the Minister's national Winter Protection Plan. This includes:

a) Existing statutory NHS and local authority social services
b) Existing third sector support
c) Extra capacity required to meet the anticipated additional demand arising from cold and inclement winter weather alongside the ongoing threat of the COVID19 pandemic.

The region's comprehensive plan for ***goal 5 great hospital care*** can be found in the Cardiff and Vale University Health Board's Service Delivery Plan for quarter's 3 and 4, submitted to Welsh Government on the 19th October.

To further enhance the ability of the RPB to play a key role in leading the development of an integrated health, social care and third sector plan for the 2021/22 season, the RPB would encourage Welsh Government to fully align seasonal planning requirements, particularly those of the Health Board which currently remain separate.

The plan sets out how the additional £1.35m *Discharge to Recover and Assess* short-term funding has been deployed to provide additional capacity within the system to enable people to return ***home first when ready***, from hospital and to deliver ***goal 6***.

The current funding allocation of £1.35m will provide additional winter capacity to mid-January.

The total cost for the winter period is £2.774m and we would therefore like to request a further £1.424m from Welsh Government to enable the region to meet the predicted increase in demand over the winter period.

The plan also sets out the current short-term funding gap to further enhance the delivery of the remaining four goals (excluding goal 5, great hospital care), in particular additional capacity to enhance our ability to prevent avoidable hospital admissions.

1. Introduction and governance

This is the Cardiff and Vale of Glamorgan Regional Partnership Board Winter Protection Plan for the winter of 2020/21. The period covers November 20 to March ’21.

The plan sets out our understanding of the additional demand arising from the winter period, in the context of the ongoing impact of COVID19 on the population’s health. The focus of the plan is on ensuring people do not remain in hospital longer than is necessary to a) protect them from the negative consequences of admission and b) to protect capacity in the hospital system when demand is rising rapidly as a result of the pandemic. Welsh Government *Discharge to Recover and Assess* (D2RA) funding will support the additional capacity in the community to enable people to recover and rehabilitate.

The plan responds to the anticipated demands as we understand them now, in October. As the actual impact emerges, the plan will flex and change accordingly, with funding redirected as necessary. This will be overseen by the Strategic Leadership Group on behalf of the RPB. A multi-agency operational management team will monitor delivery and impact of the plan and make adjustments as necessary.

The £1.35m D2RA funding is very welcome and will enable the partners in Cardiff and the Vale of Glamorgan to commission additional capacity to respond to anticipated increased demand until the beginning of January 2021.

To enable us to meet the additional demand for the entire winter period to March ’21, we will need an additional £1.424m. There is however, a funding gap of £1.424m against the services eligible for D2RA funding.

Our evidence from previous winter periods shows that demand peaks early in January and discharge delays increase.

2. Protecting public health

Test, Trace and Protect

✱ Goals 1, 2 and 3

Across our region 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 TTP service has had to respond to an increase in local cases in recent weeks, particularly in Cardiff. This increase has led to the implementation of additional local lock down measure, and until the effect of this is seen, we expect case numbers to continue to rise.

We continue to devote a large proportion of our capacity to the response, currently focused on delivering TTP in our region and the recent arrival of students to the city also has the potential for

additional seeding of infection from other areas, and onward local spread which will require resources to address this.

To respond to this, Cardiff Council has been recruiting and training additional contact tracers and advisors, with the Health Board providing staff to support this service through secondments. The tracing service is now also operating 8am to 8pm, 7 days a week which represents an expansion of hours.

Whilst our performance data over recent weeks has shown response times to be above average in Wales, the recent uptick in cases, compounded with the effects of delays in results from Lighthouse labs resulting in large batches being received at once, has caused some deterioration in performance which we are clear we must try to address.

As the pandemic has progressed and we have worked together as a regional team to manage and minimise local risk and have learned much about how infection spreads within our local population. This learning is shared regularly at the regional board and has informed our local plans, for example in developing local communications to target our higher risk populations. This has also been shared at the Regional IMT, and through the escalation processes agreed locally, to report to Welsh Government.

The Test, Trace and Protect component of the minimum data set which accompanies this plan provides further detail on our position to date and our projections for the remainder of 2020/21.

Our Planning for Covid-19 mass vaccination

✱ **Goals 1, 2 and 3**

Every Health Board in Wales was tasked with submitting preliminary plans for the delivery of the COVID-19 vaccination programme locally by 3 September 2020 to the Chief Medical Officer for Wales. Cardiff and Vale UHB submitted a strategic level plan, approved by the CVUHB Chief Executive Officer. A more detailed operational plan for mass vaccination in Cardiff and the Vale of Glamorgan will be submitted later in October 2020. Plans cover NHS and social care staff as well as the broader population.

We are however progressing a number of activities in this area which includes:

- ✓ Establishment of a Covid-19 Vaccine Programme Delivery Board chaired by the Executive Director of Public Health.
- ✓ Established five work streams to undertake preparatory work- i) Workforce & Training; ii) Vaccine Considerations, iii) End-to-end Person Journey; iv) Venues and Logistics; v) Communications.
- ✓ Modelling work currently being underway for priority population groups (based on JCVI guidance) and workforce to provide a better understanding of operational requirements
- ✓ Three Mass Vaccination Centres have been identified and agreed.
- ✓ A costed plan being worked up.

We are also working through a number of risks which have currently been identified and these include:

- ✓ Funding to support the mass vaccination programme
- ✓ The impact of a Second wave of COVID-19 and consequent impact on staffing and resource
- ✓ The unknown exact timescales for vaccine availability

- ✓ Workforce capacity and training required for vaccination delivery – our workforce hub is supporting the recruitment to the Community Testing Unit in readiness for a vaccine programme.
- ✓ Compliance and engagement from eligible groups

Our Flu Vaccination Programme

✱ **Goals 1, 2 and 3**

Ensuring we have an effective flu vaccination programme is a key action we are progressing as part of not only protecting the more vulnerable members of our population but also to support mitigating the risk that our system could become overwhelmed during the winter months.

Our staff

A full immunisation programme is in place for NHS and social care front-line staff. Most social care staff with be vaccinated via Mass Vaccination Centres. Care home staff will be vaccinated by mobile teams going on-site from mid-December.

We have a working group for social care worker flu vaccination with representatives from both LAs, Community Pharmacy, Immunisations Co-ordinator and the local public health team.

Care Home staff and domiciliary carers can obtain flu vaccination from 90 Community Pharmacies across Cardiff and the Vale. We are working with care homes to raise awareness of their eligibility for flu vaccination; we have recently produced a video with Community Pharmacy to encourage uptake. Around 10 Care Homes have made specific arrangements with a Community Pharmacies to obtain flu vaccination for their staff.

For frontline social care workers (who are not working in care homes or domiciliary carers), the Vale of Glamorgan Council is offering flu vaccination via their Occupational Health Service. Cardiff Council has been unable to obtain flu vaccination for their frontline social care workforce during 2020/21. We are working with both Cardiff and Vale of Glamorgan Councils with the aim of delivering a Community Hub for social care workers to obtain vaccination, who have not already done so.

In our Community

GPs and Community Pharmacies experiencing unprecedented demand for flu vaccine amongst at risk groups and are currently implementing innovative delivery models to at-risk groups such as drive-throughs to support social distancing. We are monitoring demand locally.

The first (national) fortnightly reporting for flu uptake (IVOR) is due to commence imminently and once available, the Local Public Health team will share this information with Cluster Leads and GPs practice throughout the season. This along with regular newsletter updates for Primary Care Providers and a public-facing campaign with ensure we have a robust media campaign regarding the flu vaccination.

In addition planning is underway to extend a pilot undertaken in Flying Start areas during 2019/20 to increase uptake amongst two, three and four year olds who attend flying start childcare settings. This is in addition to the established primary School vaccination programme that has once again commenced and is also seeing high uptake rates to date.

The vast majority of flu vaccine will be administered before the Christmas break with our school programme being completed by the second week of December with catch–up sessions for year groups who have missed their scheduled school sessions due to self-isolation requirements, being planned for half term using hubs and appointment system. Fortnightly uptake monitoring will be shared with Clusters and GP practices for each risk group. Our expanded programme (to people aged 50+) is also expected to conclude by the end November.

3. Existing core services ensuring Cardiff and the Vale of Glamorgan is ready for winter

This winter protection plan provides the additional capacity and capability required to ensure the system is able to respond to additional demand as a result of cold weather. It is in the context of existing statutory, third sector, independent sector and housing support services.

The following highlights some key areas of existing activity that enable statutory health and social services to operate within primary, secondary and community care settings:

Third sector

✱ **Goals 1, 2, 3 and 6**

Voluntary, community and faith sector organisations provide a vast array of support in the winter, reaching people and communities not eligible for statutory support or extending its reach. The emphasis is often on prevention, low level support, advice and information that enables people to remain safe and independent. Examples include:

- Bad weather transport
- Support to CRT/VCRS patients newly discharged hospital
- Care and repair enabling discharges and helping to keep people at home with
    - Rapid response adaptations
    - Personal safety, independence and wellbeing for people with sensory impairment
- Delivering food or providing a central point for collection.
- Christmas gifts and cards for people living in poverty, in difficult circumstances e.g. domestic violence or homeless so they have a meal at Christmas and gifts
- Christmas and New Year directory of services and support open over the holiday period, including Christmas day.
- Falls prevention through strength and balance activities

During 20/21 the RPB has committed funding to increase support for loneliness and isolation and created a capital fund for third sector organisations to access small grants to improve access to services.

Supporting carers

✱ **Goals 1, 2, 3, 4 and 6**

Supporting unpaid carers throughout the winter period remains critical, including younger carers. The following slide provides a brief overview of the work of the Carers Trust and YMCA.

Adult and Young Carers

Progress for 2019-20

The Integrated Care Fund has been used to launch the Carers Gateway for Cardiff and the Vale of Glamorgan. Led by The Carers Trust South East Wales, the team provide information and support to unpaid carers, helping them to make the most of their life alongside their caring role and maintain their independence.

The team helps carers with things like:

- Understanding what support is available for carers
- Signposting and supporting carers to access local services
- Identifying new services that are needed to help carers
- Raising awareness on the issues carers face
- Providing training and development opportunities for carers

Pauline Young, Independent Carers Representative and Carolyne Ryan, Young Carers Representative as they present an update on our Carers Strategy to the RPB in February 2020 along with third sector and Local Authority members of the Carers Partnership.

YMCA (Cardiff) are providing support for young carers. The joint work between the local authority and YMCA as a provider of services for young carers has developed into a positive partnership throughout 2019/20, laying the foundation for a co-produced pilot service for young carers in April 2020.

Cardiff Council Independent Living Services

✱ Goals 1, 2, 3, 4, 5 and 6

Cardiff Council operate a wide range of Independent Living Services aimed at early intervention, keeping people connected, well and independent and preventing, delaying or reducing the need for a package of care. The service includes community occupational therapy, the joint equipment service and the hospital-based First Point of Contact service or *pink army*.

Working with care homes

✱ **Goals 1, 3, 4 and 6**

The Covid-19 pandemic is proving a particularly challenging time for care home providers and the continuing financial pressure which many are facing to continuing operating in the current environment. We recognise that even with the additional support being made available to the sector some care home businesses may become financially unviable through the reductions in occupancy coupled with the fixed capital costs and increasing expenditure on infection control, resident isolation, and staffing.

This poses a significant risk to the functioning of the health and social care system in Wales. Consequently we remain committed to the ongoing national work to clarify the legal, financial and statutory issues regarding the NHS stepping in to support the sector if required.

Should this support need to be progressed we are conscious that this represents a significant piece of work. As such an early piece of work has been undertaken to identify what issues exist and the possible response of the Health Board. This can be found in appendix 1.

Our system recognised at an early stage of the pandemic the risk to residents and staff within care home settings. Significant support has been mobilised including:

- Ensuring access to personal protective equipment and infection prevention and control support
- Rigorous pre-discharge testing and risk assessment processes
- Commissioning of care home isolation beds to ensure that no person is discharged as COVID19 positive to a care home following admission to hospital
- Ongoing access to medical and nursing support to people in care homes

The rapid review of care homes commissioned by Welsh Government and undertaken by Professor John Bolton has provided a focus around which we have planned and delivered support to care home partners. The delivery of our regional action plan is overseen by the Regional Commissioning Board can be found in appendix 2.

The Joint Management Executive continues to monitor and oversee support for the care home sector, ensuring a rapid and coordinated response when needed.

There are regular multiagency care home position meetings held in each LA area as well as meetings with representatives of the care home and domiciliary care sector. This includes advice, guidance and support in relation to testing, outbreaks, business continuity and PPE, as well as supporting safe discharge from hospital including the commissioning of intermediate care isolation beds.

The current primary care Directed Enhanced Service for care homes covers 96.6% of beds across Cardiff and Vale. There are 79 patients where the enhanced service does not provide cover but there is access to support from GMS.

Home first when ready

✱ Goals 1, 2, 3, 5 and 6

Cardiff and the Vale of Glamorgan already have well-established *Get Me Home* discharge support and intermediate care services aimed at ensuring no-one remains in hospital beyond the point when they are medically fit to be discharged and everyone has the opportunity to reach their optimal level of independence. Additional capacity is required for the winter period due to increased demand.

Discharge support *What matters to you* conversations take place on the wards and staff connect people with community-based, independent living support. This prevents the need for more lengthy assessment which can delay progress in discharge arrangements. This is delivered through Cardiff First Point of Contact officers and Age Connects for Vale of Glamorgan residents.
Intermediate care step down Cardiff Community Resource team and Vale Community Resource Service: Multi-disciplinary health and social care teams providing care and rehabilitation post-discharge to optimise independence. Therapists 'right-size' care packages as people regain independence. Additional support for people needing significant initial care packages to get home is provided through our *get me home plus* arrangements.
Discharge to recover and assess community beds A *discharge to recover and assess* model is in place to provide more appropriate interim placements after discharge for people to continue to recover and regain their independence. • For people whose long-term needs are unclear, this provides an appropriate environment to avoid decisions being made too early in their recovery. • For people likely to need a permanent placement rather than to return home, this provides a safe space to take time to adapt and adjust and for arrangements to be made. People will move to the their long-term home wherever this is possible • COVID19 isolation beds are also available where care homes are unable to provide isolation facilities following a hospital admission

4. Understanding changes in demand

4.1 Population needs assessment – COVID19 impact

We are refreshing our population needs assessment to understand the impact of COVID19 on our population and initial findings have been factored into our Winter Protection Planning.

The current surge in COVID19 and the policy response to that surge, including the imminent all-Wales 'fire-break' lockdown, will have further impact on the health and wellbeing of our population. The nature of this and our understanding of the implications will emerge over time and be included in the development of the next iteration of our area plan.

Much of the response required will need to be undertaken across the Public Services Boards and the Regional Partnership Board as the impact has been as much on the public health determinants of health and wellbeing - notably the economy and employment - as it has been on people's actual health and social care needs.

Public Health Wales have published a COVID-19 Health Impact Assessment Summary and our initial findings at a local level chime with the national picture:

Interim PNA – emerging priorities for Winter 2020-21

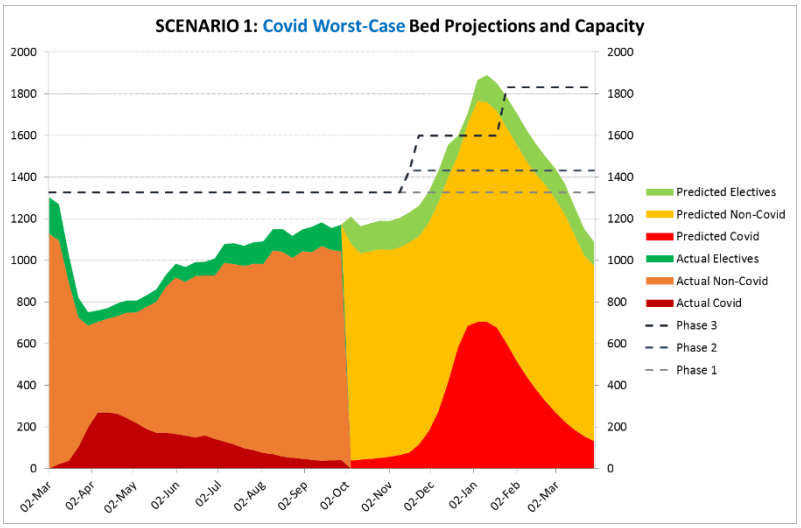
Theme	Specific
Populations at Risk	Specific mention of people with Dementia, Asian and minority ethic groups, children and young people at risk, carers and older people.
Mental health	Support for vulnerable groups experiencing potential loneliness and isolation
Physical health	Reduced access to physical activity and consequent deterioration in health
	Managing the long term recovery of people who have had COVID-19 / 'Long COVID'
Abuse / addiction	Increase in physical abuse: domestic, child, substance and alcohol
Family / carer relationships	Impact of family breakdown and lack of respite care.
Financial Hardship	Rise in unemployment and debt increase placing additional pressure on vulnerable groups.
Sensory impairment	Increased physical barriers for people with sensory impairment as a result of social distancing requirements.
Virtual Workforce	Impact of Virtual and Social Distanced working measures – need to ensure effective IT and Training together with enhanced employee wellbeing practices.
Workforce resources	Ensuring effective availability of staff / services to meet demand.

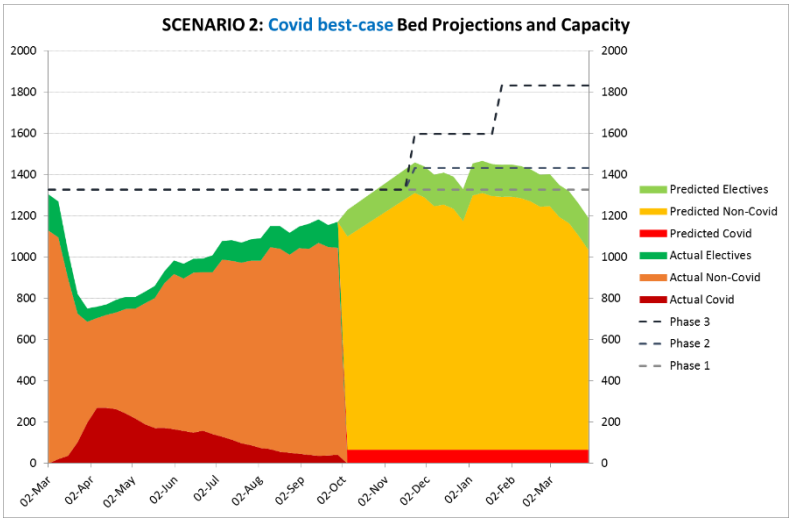
Interim PNA – emerging priorities for 2021 onwards

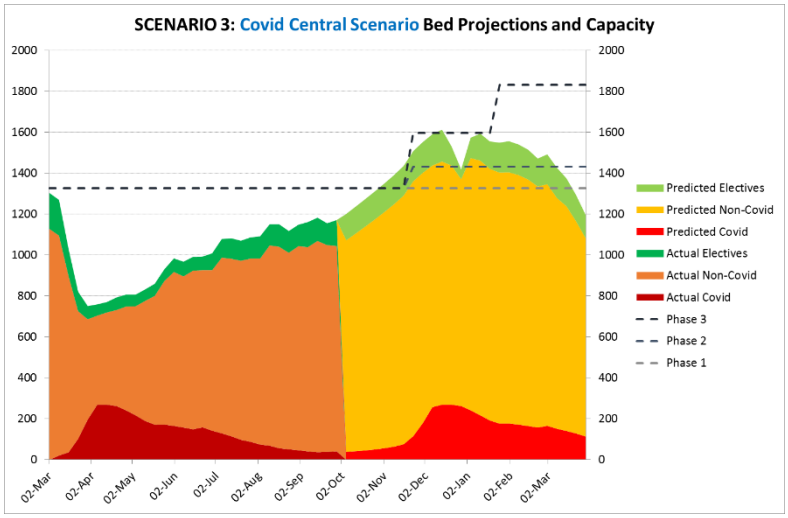
Theme	Specific
Populations at Risk	Specific mention of people with dementia, black, Asian and minority ethic groups, children and young people at risk, carers and older people.
	Young people aged 16-25 years are a particular concern re. potential consequent long term impact re. employment opportunities, underlying mental health needs, etc.
Mental and physical health support	Increased service demand at all levels (primary to tertiary) due to limited access in 2020-21.
	Managing the long term recovery of people who have had COVID-19 / 'Long COVID'
	Deterioration in health due to lack of activity, limitations on healthy eating, etc and consequent impact on preventative health approach.
Abuse / addiction	Long term impact of increase in physical abuse: domestic, child, substance and alcohol
Family / carer relationships	Long term impact of family breakdown and lack of respite care.
Financial Hardship	Long term impact of rise in unemployment and debt increase, particularly for vulnerable groups
Sensory impairment	Increased physical barriers for people with sensory impairment as a result of social distancing requirements.
Virtual Workforce	Impact of Virtual and Social Distanced working measures – need to ensure effective IT and Training together with enhanced employee wellbeing practices.
Workforce resources	Ensuring effective availability of staff / services to meet demand.

4.2 Understanding demand

To understand the demand flowing into community services from the hospitals we need to first understand the anticipated changes in admission to hospital. The graphs on this page outline three potential scenarios of hospital admissions in Cardiff and the Vale of Glamorgan from October 2020 to March 2021 as a result of COVID-19. These have been used to inform the hospital's winter/COVID19 capacity planning as set out in the quarter 3 and 4 plans.







- Scenario one: worst case, with a peak of approximately 1900 hospital admissions
- Scenario two: best case, with a peak of approximately 1450 hospital admissions
- Scenario three: COVID-19 central, with a peak of approximately 1600 hospital admissions

Using the early March 2020 data point of approximately 1300 hospital admissions as a baseline figure, this equates to an additional 150-600 hospital admissions at the respective peak periods of demand.

The Delivery Unit work led by Professor John Bolton on right-sizing community services modelling gives us an indication of the proportion of people leaving hospital who will need further rehabilitation and support. The modelling suggests that:

- 50% of people being discharged will not need any further support
- 20% will need community support
- 30% will need step-down intermediate care, of which
  - 5% will be bed-based
  - 25% will be home-based

Benchmarking indicates that we need to increase our intermediate care capacity. We are engaged in a longer-term piece of work to right-size our intermediate care services and we continue to work with the Delivery Unit to refine our modelling, particularly with regard to step-up/admission avoidance capacity. In the short-term, we are able to use the Health Board's demand modelling in combination with our understanding of the predicted utilisation of each of the four discharge pathways to increase capacity in the right parts of the community-based

health and social care system. The *Discharge to Recover and Assess* funds will be deployed accordingly.

Given the uncertainty over the coming months in terms of future COVID-19 infection rates, hospital admissions and the size and severity of flu, regular monitoring of actual activity will take place and our response will be adapted.

5. Additional capacity required for winter – discharge to recover and assess funding

To ensure that increased demand arising from COVID19 and winter pressures can be addressed, Welsh Government *Discharge to Recover and Assess* (D2RA) funding for 20/21 is being used to increase capacity across:

- ✓ In-hospital discharge support (all discharge pathways)
- ✓ Intermediate care home-based capacity (pathway 2)
- ✓ Discharge to recover and assess community beds (pathways 2 and 3)

The additional capacity and investment required is set out below.

	Function	Cost	Additional capacity	unit	Period (mths)	Start	End
Discharge coordination	First Point of Contact	£114,906	7	WTE	5	01.11.20	31.03.21
	Single Point of Access triage	£147,000	4	WTE	5	01.11.20	31.03.21
	Discharge liaison	£25,200	2	WTE	5	01.11.20	31.03.21
D2RA/intermediate care step-down							
	Care hours	£1,357,311	2087	Hours	5	01.11.20	31.03.21
	Rehab skill mix	£369,293	24	WTE	5	01.11.20	31.03.21
						01.11.20	31.03.21
Community beds	Residential reablement	£293,750	11	beds	5	01.11.20	31.03.21
	D2RA nursing home beds	£166,667	10	beds	5	01.11.20	31.03.21
	EMI-specific isolation beds	£300,000	8	beds	5	01.11.20	31.03.21
		£2,774,127					
	D2RA funding available	**£1,350,000**					
	Funding gap	**£1,424,127**					

6. Funding gaps

6.1 Funding gap D2RA funding-eligible services

Cardiff and Vale of Glamorgan RPB has been allocated £1.35m by Welsh Government to deliver D2RA pathways.

Partners have assessed the additional capacity required in this area as costing **£2.774m**.

The D2RA funds will therefore address 48.7% of the region's assessed additional D2RA capacity requirements, leaving a funding gap of **£1.4m**.

Partners have already commenced mobilisation of services at risk.

The £1.35m will enable partners to provide the additional capacity required until the second week in January, assuming the additional capacity is mobilised from the beginning of November.

6.2 Funding gap – for services not eligible for D2RA funds

With the exception of goal 5, *great hospital care*, the additional capacity required to deliver the other four goals remains unfunded.

WPP goal	Additional capacity required	Funded	Unfunded gap
1. Co-ordination, planning and support for high risk groups.	Vale of Glamorgan rapid response (telecare) service		£88,000
	Vale of Glamorgan Mental Health Older People capacity to support EMI care		£25,645
2. Signposting, information and assistance for all	Vale of Glamorgan Contact1Vale additional specialist capacity at front door (OT and mental health social worker)		£51,290
3. Preventing admission of high risk groups	Falls programme including Stay Steady clinics additional capacity		£132,700
4. Rapid response in crisis	Primary care urgent care response (see CAVUHB Q3/4 plan)	✓	
5. Great hospital care	See CAVUHB Q3/4 plan	✓	
		Non-D2RA funding gap	**£297,653**

5.3 Total funding gap

	Funded	Gap
Services eligible for D2RA funding	1.35m	1.42m
Services not eligible for D2RA funding	0	0.3m
	£1.35m	**£1.72m**

7. Measuring impact

During this period of potentially unprecedented demand as a result of cold or inclement weather and increases in demand on the health and care system as a result of COVID19, it is even more important to track the system's response and the impact of the additional investment and capacity.

The partnership is developing mechanisms to enable close process-monitoring so that issues can be identified rapidly and addressed operationally.

The partnership needs to be assured that there is flow through the whole system: from hospital to D2RA and from D2RA to long-term arrangements.

The following system impact metrics will be monitored:

	Hospital discharge →	**D2RA support** →	**Post-D2RA arrangements**
Cohort definition	People needing support to be discharged from hospital	People accessing all forms of intermediate care step-down care (CRT/VCRS, community hospitals, residntial reablement beds, D2A nursing beds)	Onward arrangements following D2RA/intermeidate care support
	Length of stay (# and %) • >7 days • >14 days • >21 days *(denominator: total adult admissions)*	# and % of people admitted directly to a care home for D2RA. • Nursing home • Residential (denominator: *total adults needing support to be discharged from hospital)*	# and % of people returning to their usual place of residence. *(denominator: people accessing D2RA/intermediate care services)*
	# and % discharged within 48 hours of being declared medically fit. *(denominator: total adult admissions)*	# and % of people accessing each discharge pathway: • Pathway 1 • Pathway 2 • Pathway 3 • Pathway 4 *(denominator: total adults needing support to be discharged from hospital)*	Outcome for each pathway, # and % of people: • Home, independent • Home with support • Permanent admission to care home • Death *(denominator: total number of people in each pathway*)

Appendix 1

Cardiff and Vale University Health Board care home support and escalation issues

Work is being facilitated by the National Director of Complex Care to support Health Boards to identify the key issues in relation to nursing home contingency planning. The issues are currently being worked through nationally, including seeking legal advice. The current positon can be seen below.

Directors of social services have been asked by Welsh Government to ensure sufficiency of care home provision across the region and to have contingency plans in place. In addition, the Regional Partnership Board is overseeing delivery of the action plan developed in response to the WG-commissioned rapid review of care homes conducted by Professor John Bolton. The plan can be seen in appendix 2.

Issue	Response
An overarching contingency plan that could be applied to any nursing care home closure must be developed in readiness for the winter period.	Home Closure procedure already in place and would be initiated in conjunction with partners
Clarify Regulatory Requirements	Clarify the role of HIW and other regulatory bodies
To enable ownership, a clear legal position and implementable action plan must be in place. LHBs working with LAs as appropriate, are asked to consider the following as part of their overarching care home failure contingency planning.	Legal advice is requested– can a HB take 'ownership' of a privately owned business and what are the legal obstacles or supportive legislation to enable that to happen.
Determine clear legal advice for how a nursing care home could be run either solely by the LHB or jointly with the LA in line with legislation including NHS (Wales) Act 2006, Social Services and Well-being (Wales) Act 2016 and Local Government Act 2000;	Legal advice is requested to confirm HB position : If a home is nearing failure then administrators may already be involved. Can HBs purchase a business that is actively failing to this extent? Clarify if the suggestion of ownership if it applies to all Care Homes not just those deemed to be required to meet demand
Determine potential availability of capital funding to purchase and update buildings (if necessary), Determine understanding of potential pooled budgets ;	Funding source to secure " ownership" HBs required to assess capital/buildings requirements within the context of NHS buildings and maintenance standards
Compliance issue re building regulations and health and safety regulations	HBs have to assess and determine any capital/buildings requirements within the context of NHS buildings and maintenance standards? Consideration of Health and Safety legislation requirements
Human resource issue to be consider	TUPE of staff, ongoing funding resource for staff, management resource, Professional Regulation and competency
Consideration of Charging Process particularly self-funding arrangements	Determination of charging element, financial assessments invoicing payment etc.
Safeguarding	What is the legal position re HBs purchasing care homes where there may be significant escalating concerns/safeguarding issues in that home?

Appendix 2

Cardiff and Vale of Glamorgan Regional Partnership Board care home rapid review local action plan

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Report Title:	**Board Effectiveness 2019-20 Self-assessment**								
Meeting:	Board						**Meeting Date:**	26.11.20	
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:

It is good practice and good governance for the Board and its Committees to undertake a self-assessment of their effectiveness on an annual basis, in line with the requirement of Standing Orders.

For the 2019-20 self-assessment, a survey was disseminated via Survey Monkey to all Board members enabling an efficient yet effective refection on Board effectiveness and mirroring the method used for the Committees. This was a different approach to the previous year, where a self-assessment review was conducted by the Director of Corporate Governance and shared with all Independent Members.

The next self-assessment will be done at the end of the financial year to feed into the 2020-21 Annual Governance Statement.

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

These assessments are normally conducted towards the end of the financial year and results collated to include in the Annual Governance Statement. Due to COVID-19, the self-assessments of Board and Committees for 2019-20 have been delayed nevertheless it was important to still undertake this process to reflect on what is working well and highlight areas for improvement.

Each Committee Effectiveness Review undertaken has been or will be reported to their respective Committees. In addition to this an action plan for improvement is produced which is also compared to the previous years reviews where these took place. There are two outstanding reviews relating to the Remuneration and Terms of Service Committee and Health and Safety Committee which will be completed before the end of the year and reported to their respective Committees with an action plan for improvement. An overview of the Committee self-assessment process was provided to the Audit Committee on 17 November 2020.

Of note, Committees were asked 2 questions in relation to the Board:

- Was the Board active in its consideration of Committee composition?
  All surveyed Committees responded 100% “Strong” apart from DHIC (66% “Adequate”), Finance (80% “Strong”) and MHCLC (50%).

- Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and challenge management on critical and sensitive

matters?
All surveyed Committees responded 100% “Strong”.

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

Attached at appendix 1 are the results for the Board effectiveness review. Out of the 14 questions posed, room for improvement was identified in 9 areas and particularly around:

- Strategy and scrutiny of its delivery;
- Engagement of stakeholders;
- Benchmarking and identifying / sharing best practice.

Attached at appendix 2 is a proposed action plan to improve the areas in which the results fell below 100%. It is suggested that this action plan be progressed via Board Development sessions. Assurance is provided by work already in train in many of these areas as referenced in the action plan.

Recommendation:

The Board is asked to:

- Note the results of the Self-assessment Effectiveness Review for 2019-20;
- Note the action plan for improvement to be progressed via Board Development sessions.

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	x	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	

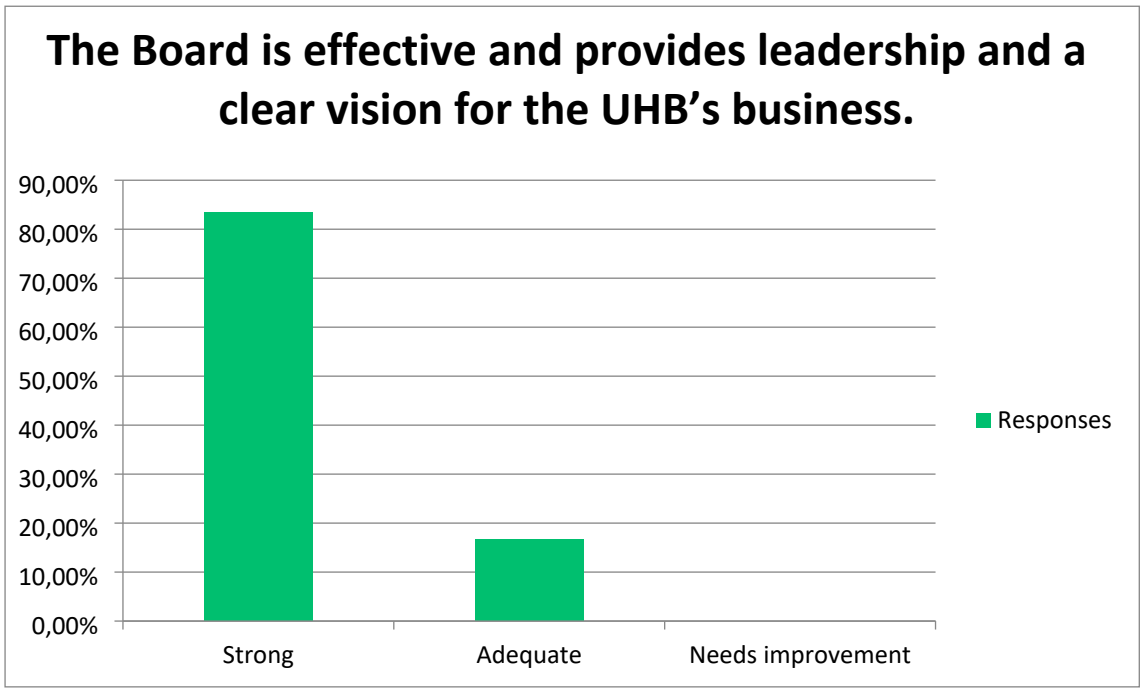
Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

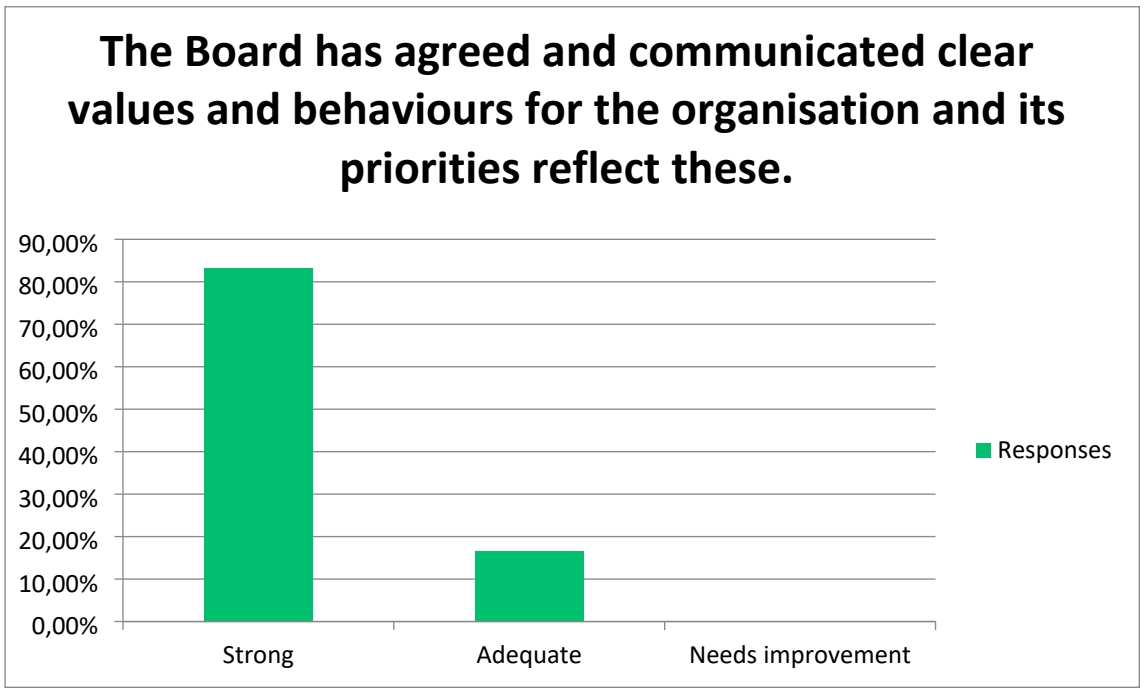
Prevention		Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

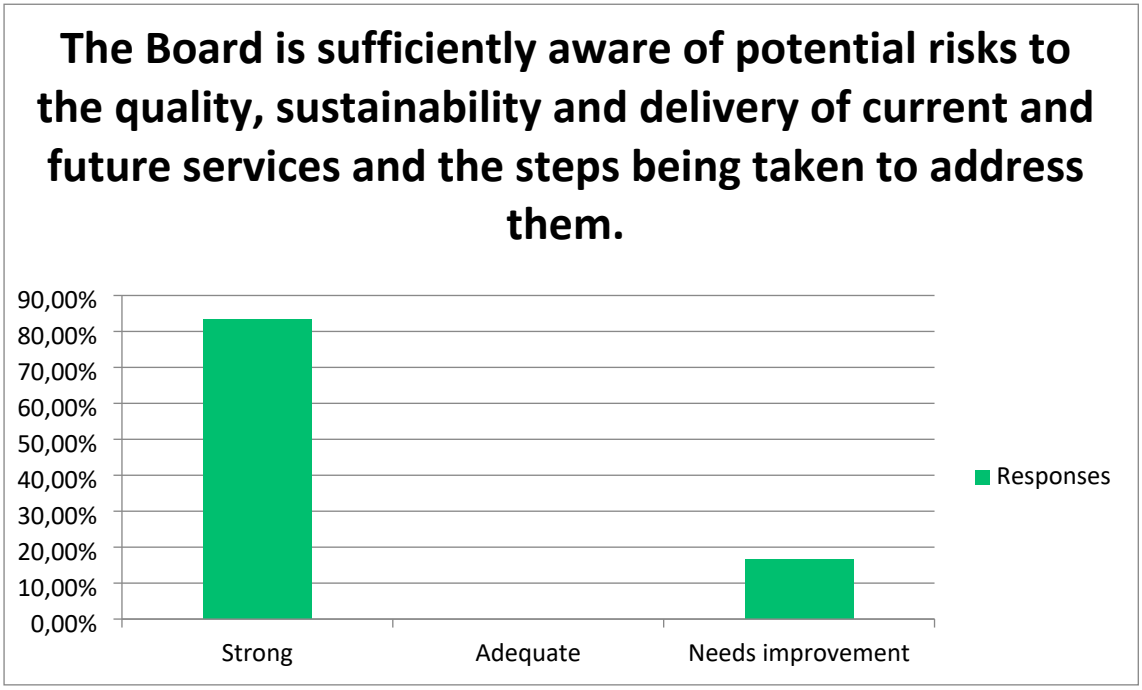
Board Effectiveness Results 2019-20





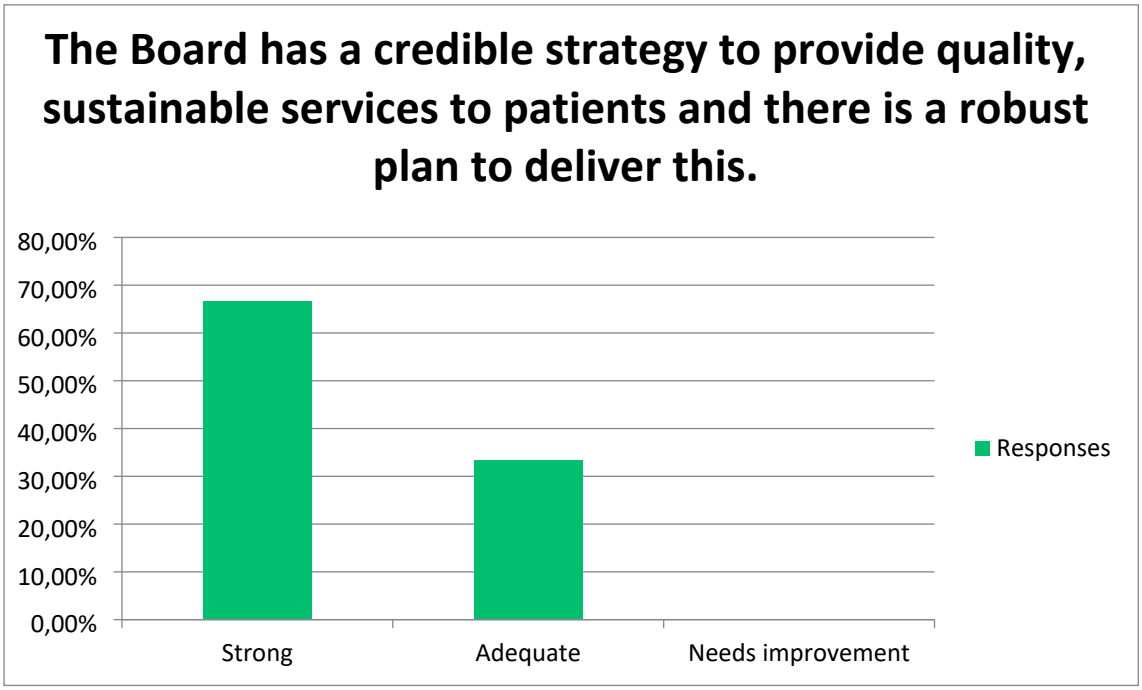
Appendix 1

Board Effectiveness Results 2019-20



Comments

"The Board is well informed on key risks with a well-developed assurance framework in place. Acknowledge that we have more work to do with our risk registers".

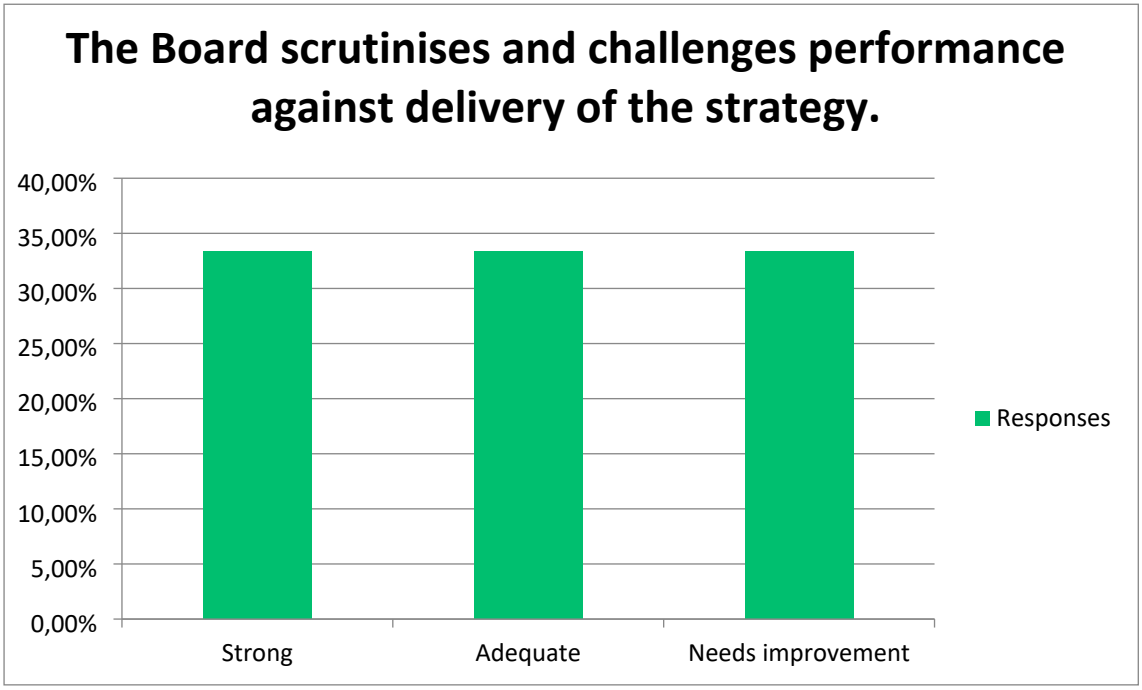


Comments

"SOFW is well established with a growing focus on development of effective milestones to facilitate monitoring of progress".

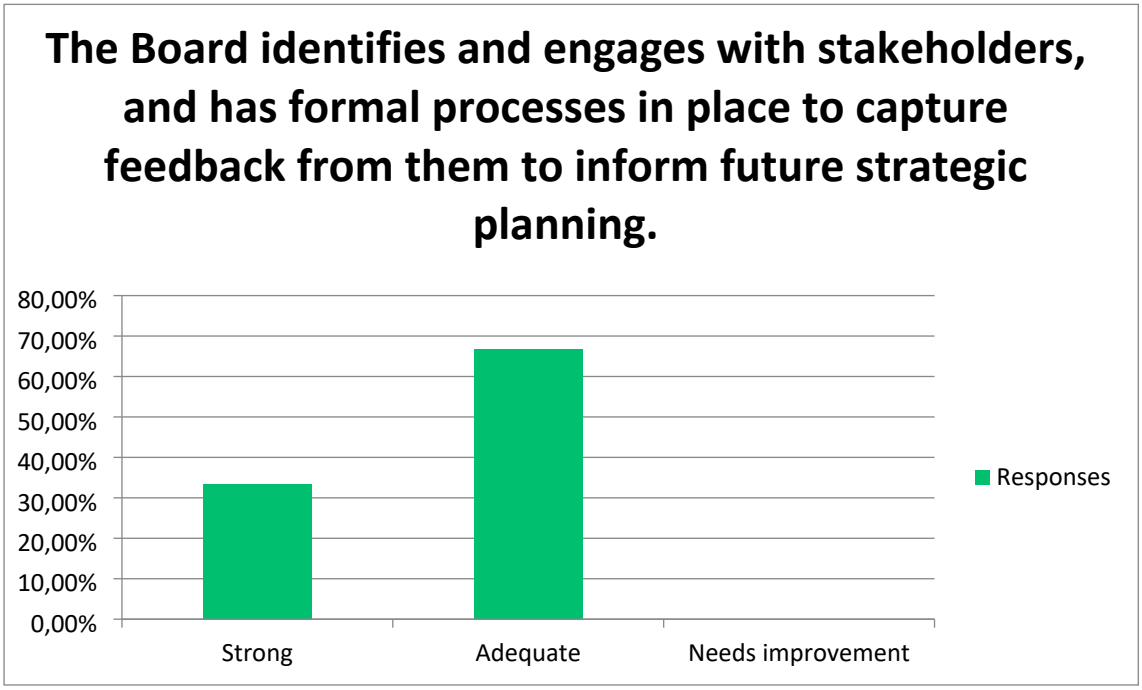
Appendix 1

Board Effectiveness Results 2019-20



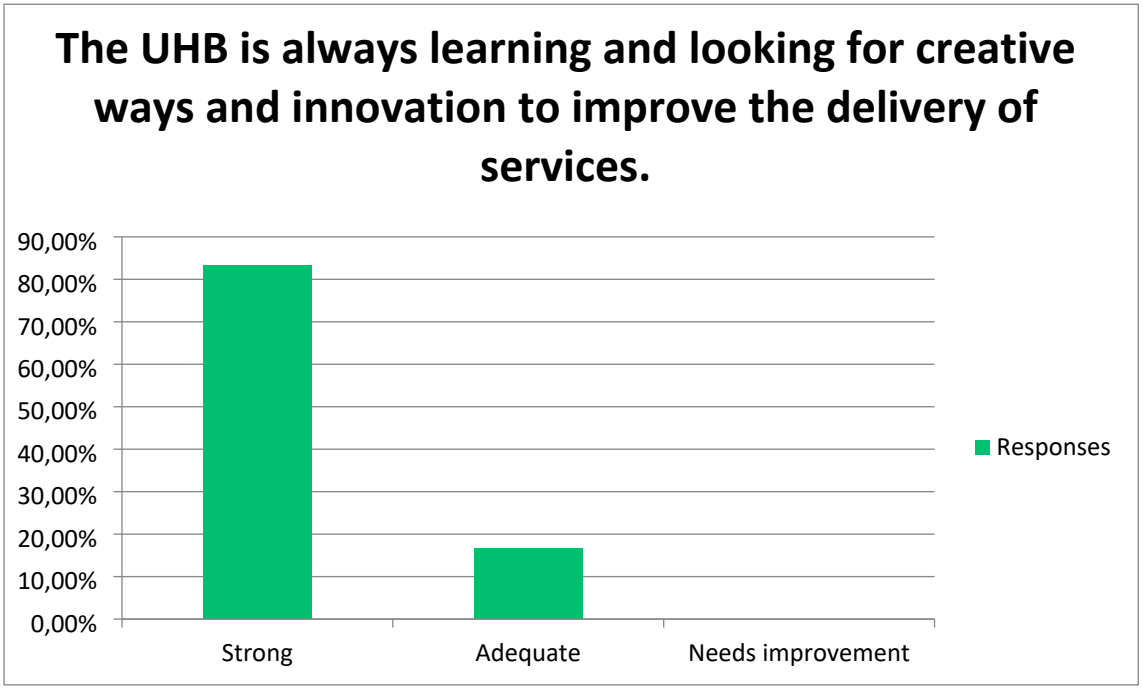
Comments

"An area that is reasonable but would benefit from increased attention".



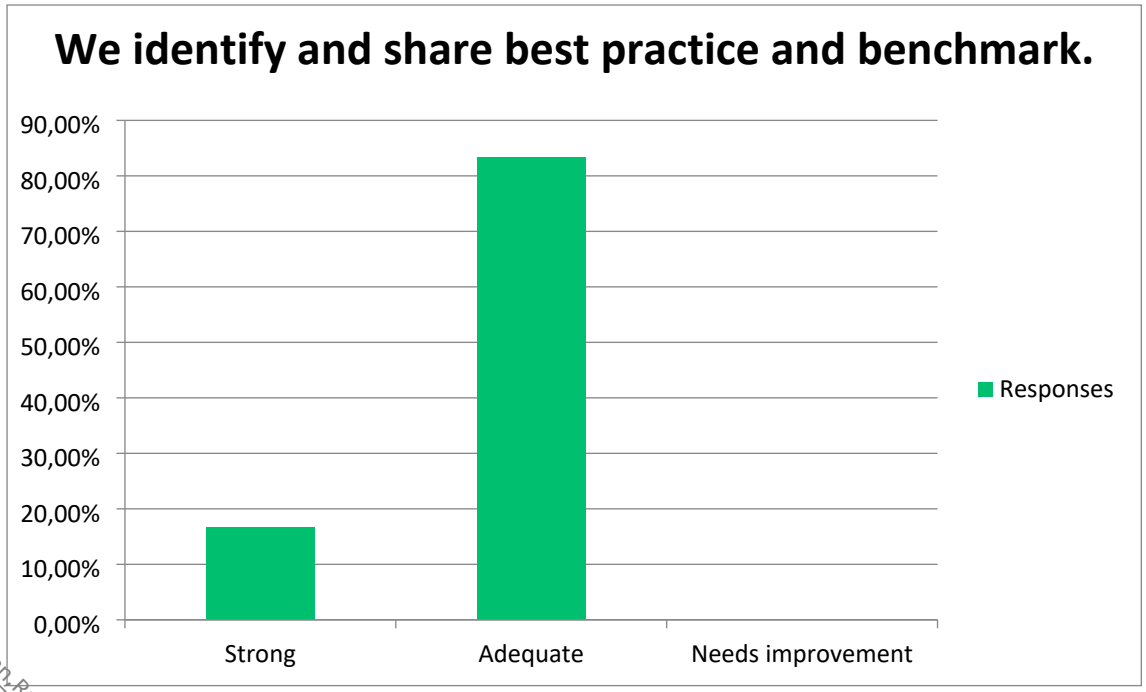
Comments

"Good engagement processes in place but we have not always delivered successful outcomes".



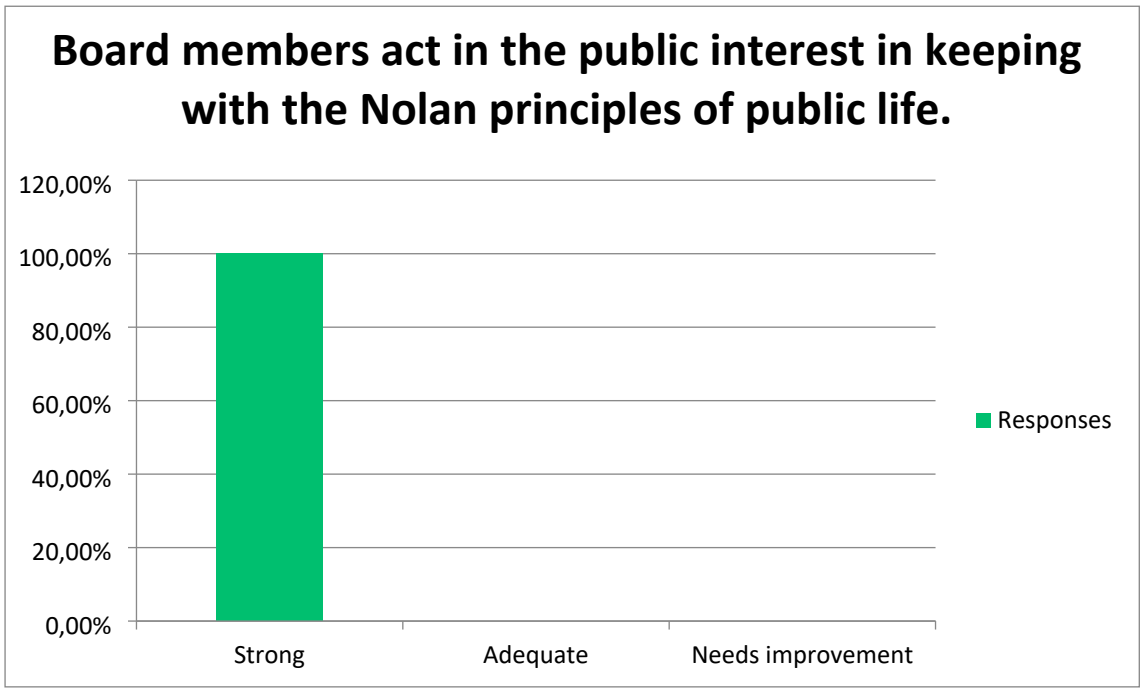
Comments

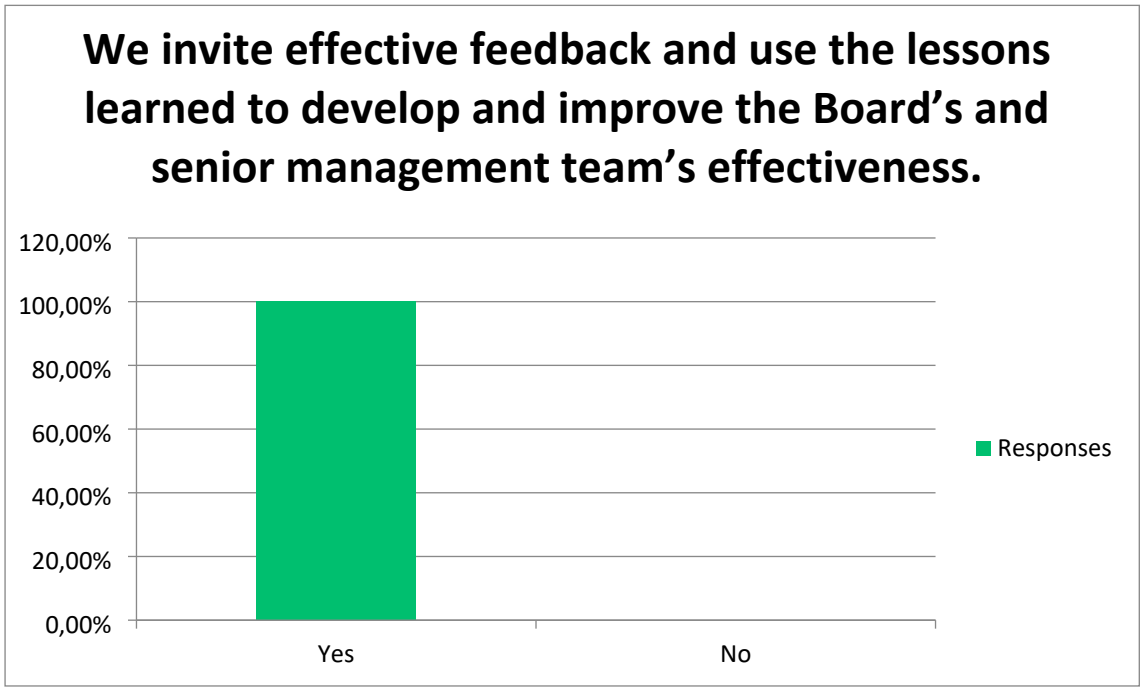
"A positive aspect".



Appendix 1

Board Effectiveness Results 2019-20





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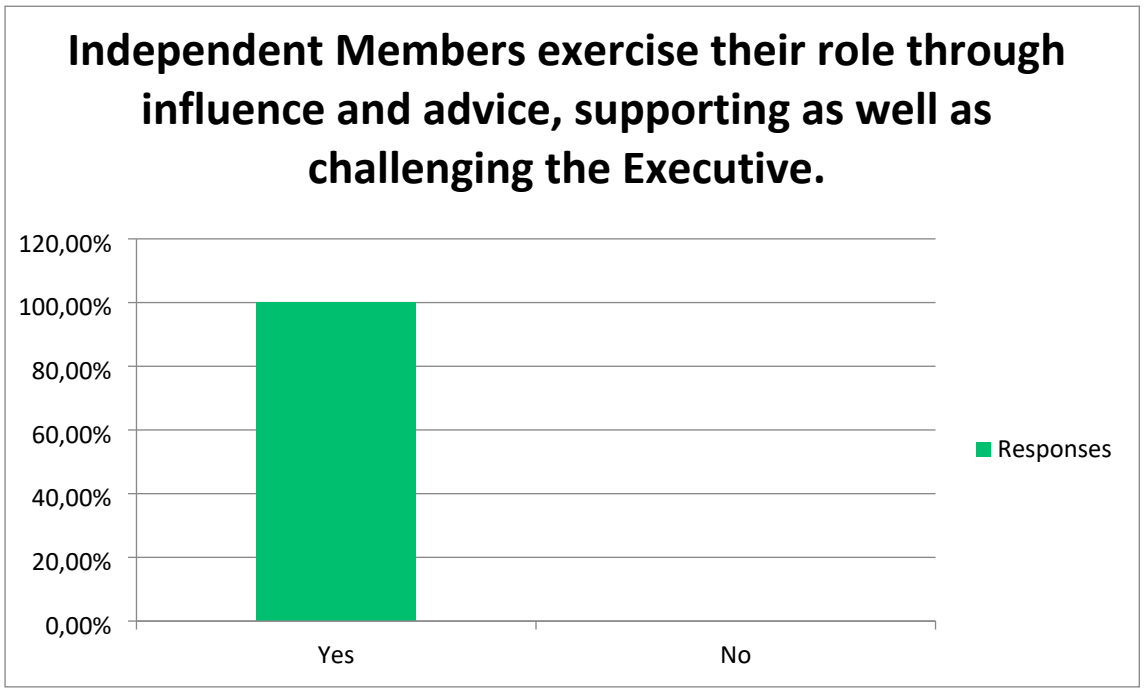
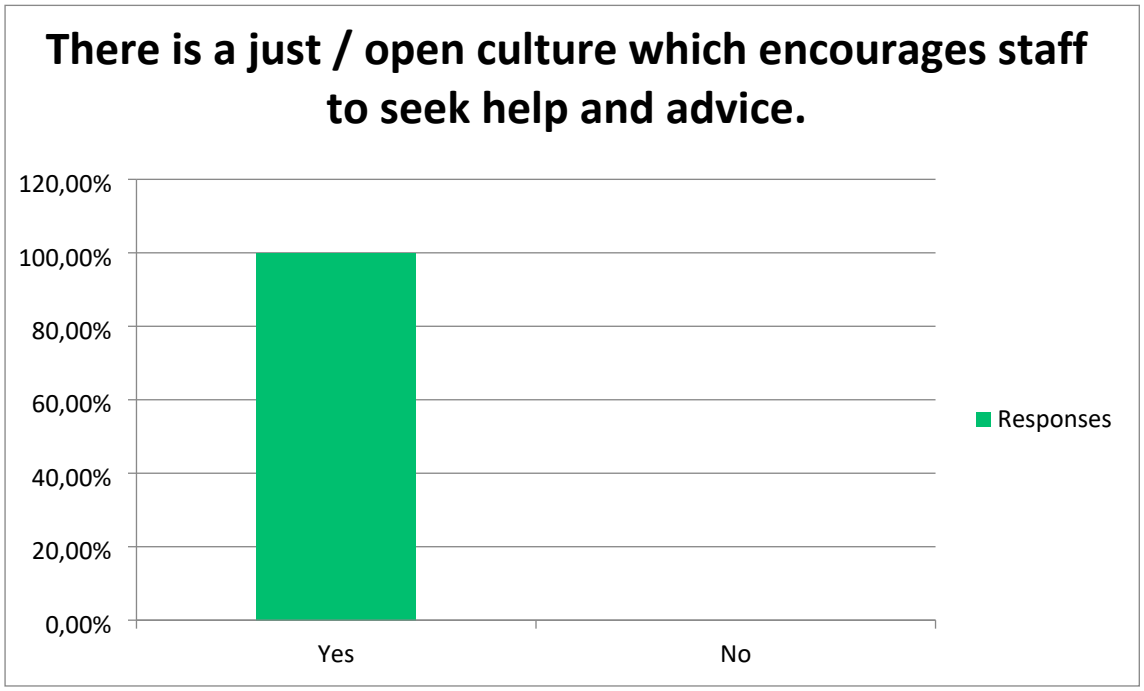
Board Effectiveness Results 2019-20





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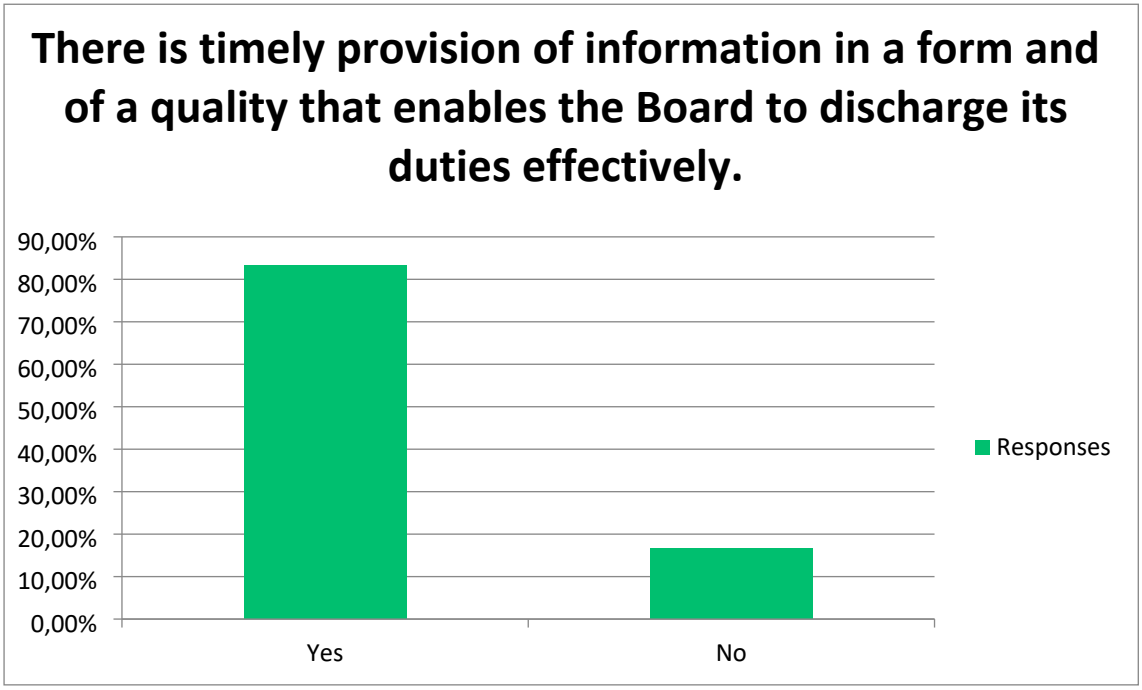
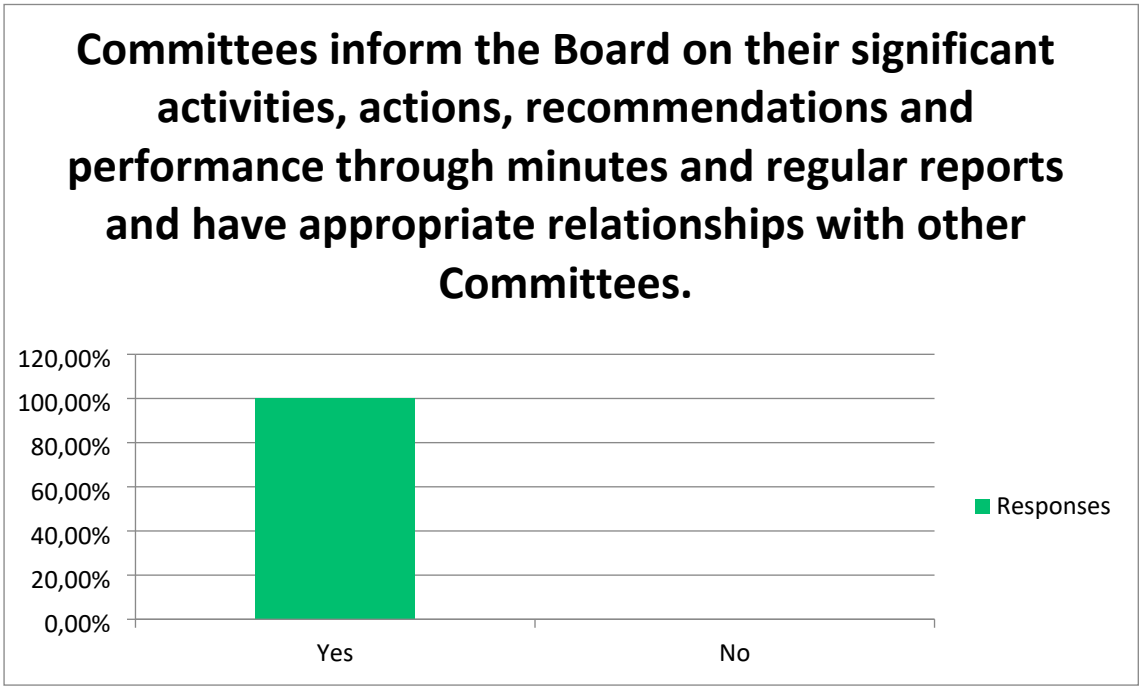
Board Effectiveness Results 2019-20



Comments

"Sometimes deadlines are not met with the preparation of Board and Committee papers but the quality is very good".



Appendix 2

Board – Self Assessment 2020 Action Plan

Question asked	Action Required	Lead	Timescale to complete
The Board is effective and provides leadership and a clear vision for the UHB's business	This work is being taken forward by Mike Farrar and the actions related to this work need to be reviewed and taken forward	Chair/Chief Executive	March 2021
The Board has agreed and communicated clear values and behaviours for the organisation and its priorities reflect these.	A communications plan regarding the values of the organisation to be developed to reinforce this area	Director of Corporate Governance and Director of Communications	March 2021
The Board is sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services and the steps being taken to address them.	This work is in place and is being taken forward. A new Risk and Regulation Officer has been appointed to roll out the risk training within the Clinical Board which will result in a more robust Corporate Risk Register being presented to the Board.	Director of Corporate Governance	March 2021
The Board has a credible strategy to provide quality, sustainable services to patients and there is a robust plan to deliver this.	This work is taking place with the Executive Team supported by the Director of Transformation. Once the programme is finalised there will be clear milestones associated with it which will facilitate the monitoring of progress in a comprehensive and robust way.	Executive Director of Strategic Planning	From December 2020
The Board scrutinises and challenges performance against delivery of the strategy.	Linked to the above action a framework has now been agreed with the Executive and once the programmes have been agreed performance against the delivery will be easier to monitor in a more structured way.	Executive Director of Strategic Planning	January 2021
The Board identifies and engages with stakeholders, and has formal processes in place to capture feedback from them to inform future strategic planning.	A Board Development session has been undertaken which provided clear direction on engagement and consultation with stakeholders therefore going forward this	Executive Director of Strategic Planning	From December 2021

	processes relating to this will be more robust and informed to achieve successful outcomes. There has also been learning from previous engagement taken on board.		
The UHB is always learning and looking for creative ways and innovation to improve the delivery of services.	The Intensive Learning Academy will vastly improve this area particularly around innovation.	Director of Transformation	From January 2021
We identify and share best practice and benchmark.	The Executive need to consider what areas the Health Board could provide better bench marking on. This work could be linked to the development of the integrated performance report.	Executive Team	January 2021
There is timely provision of information in a form and of a quality that enables the Board to discharge its duties effectively.	There is a need to ensure that this process is working effectively and deadlines for receipt and publication of reports are adhered to. Now that the Corporate Governance Team is up to its full capacity this should improve going forward.	Director of Corporate Governance	From November 2020