Board Meeting - 30th July 2020

30 July 2020, 12:30 to 16:00
Nant Fawr 2&3 / Via Skype

Agenda

1
Welcome & Introductions
Charles Janczewski

2
Apologies for Absence
Eileen Brandreth - Independent Member
Charles Janczewski

3
Declarations of Interest
Charles Janczewski

4
Minutes of the Board Meeting held on 28 May 2020
Charles Janczewski

1.4. CAJ - Board Mins - 28 05 2020.pdf (18 pages)

5
Action Log – 28 May 2020
Charles Janczewski

1.5 - Action Log - 28.05.20.pdf (2 pages)

6
Chair's Action taken since last meeting
Charles Janczewski

7
Standing Items

7.1
Chair's Report
Charles Janczewski

7.1 CAJ - Chairs report July 2020.pdf (4 pages)

7.1 COVID 19 Decision Log 15-07-2020 -NF.pdf (5 pages)

7.2
Chief Executive Report
Len Richards

7.2 Board Chief Executive Report - July 2020.pdf (6 pages)

7.3
Board Assurance Framework
Nicola Foreman

7.3 BAF Report -July 2020.pdf (4 pages)

7.4

Patient Safety, Quality and Experience Report

Ruth Walker / Stuart Walker

7.4 Patient Safety, Quality & Experience Board Report for 30.07.20 - V9.pdf (13 pages)

7.5

Integrated Performance Report

Steve Curry / Bob Chadwick

7.5 Integrated Performance report July 2020 (v2).pdf (11 pages)

7.5 appendix Financials Board Report Month 3 for Finance Committee 1.pdf (2 pages)

8
Items for Review and Assurance

8.1

Nurse Staffing Act – Update

Assurance

Ruth Walker

8.2 Nurse Staffing Act - Update.pdf (3 pages)

8.2 Appendix 1 - Summary of Agreed Nurse Establishments - Board 23 07 2020.pdf (5 pages)

9
Items for Approval / Ratification

9.1

Service Delivery Plan 2020-21 Quarter 2

Decision

Abigail Harris

9.1 Board Cover Paper- Q2 Plan Approval July 2020.pdf (2 pages)

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

9.2

Wellbeing Hub@Maelfa Full Business Case

Decision

Abigail Harris

9.2 200715 WH@Maelfa UHB Board.pdf (4 pages)

9.2 Maelfa FBC EXECUTIVE SUMMARY ONLY FINAL DRAFT.pdf (23 pages)

9.3

Digital Strategy

Decision

David Thomas

9.3 Board Dig Strategy cover DT.pdf (4 pages)

9.3 CAV_Digital Strategy_2.0_DTv1.pdf (35 pages)

9.4

Standing Orders Amendments

Decision

Nicola Foreman

9.4 Amendments to Standing Orders.pdf (2 pages)

9.4 Changes to Standing Orders appendix.pdf (4 pages)

9.5

Committee Minutes:

Information

Nicola Foreman

9.5.1

Audit and Assurance Minutes – 21 April, 28 May & 29 June 2020

Information

John Union

9.5 i. FinalPublic Audit Mins - April 2020.pdf	(7 pages)
9.5 i. Final Public Audit Mins - May 2020.pdf	(6 pages)
9.5. i. Final Public Audit Mins - June 2020.pdf	(4 pages)

9.5.2

Finance Committee – 29 April, 27 May 2020

Information

John Union

9.5 ii. CONFIRMED MINUTES OF THE PUBLIC FINANCIAL COMMITTEE APRIL 2020.pdf	(5 pages)
9.5 ii. 1.4 CONFIRMED MINUTES OF THE FINANCE COMMITTEE MAY 2020.pdf	(3 pages)

9.5.3

Quality Safety & Experience – 14 April 2020

Information

Susan Elsmore

9.5 iii Confirmed Public Quality, Safety & Experience Committee Minutes - April 2020.pdf	(7 pages)

9.5.4

Local Partnership Forum – 12 February, 21 May 2020

Information

Martin Driscoll

9.5 iv. LPF minutes 12.02.20.pdf	(7 pages)
9.5 iv. LPF minutes 21.05.20.pdf	(4 pages)
9.5 iv. LPF briefing (June 2020) for July 2020.pdf	(3 pages)

9.5.5

Stakeholder Reference Group - 29 January 2020

Information

Abigail Harris

9.5 v. Confirmed Minutes of SRG Meeting 29 January 2020.pdf	(7 pages)

10
Items for Noting and Information to Report

10.1

Care Home Engagement and Support during COVID-19

Information

Fiona Kinghorn

10.1 Board Report Care Home Engagement and Support V1.1docx.pdf	(8 pages)

10.2

Reports from Committee Chairs:

10.2.1

Audit and Assurance Committee – 28 May, 29 June & 7 July 2020

Information

John Union

10.2 i Audit Assurance Chair's Report - May 2020.pdf (2 pages)

10.2 i Audit Assurance Chairs Report - 29 June 2020.pdf (3 pages)

10.2 i Audit Assurance Chairs Report - 7 July 2020.pdf (3 pages)

10.2.2

Finance Committee – 27 May & 24 June 2020

Information

John Union

10.2 ii Finance Committee Chairs Report May 2020 Meeting.pdf (2 pages)

10.2 ii Finance Committee Chairs Report JUNE 2020 Meeting.pdf (2 pages)

10.2.3

Strategy and Delivery Committee – 14 July 2020

Information

Charles Janczewski

10.2 iii Strategy Delivery Chair's Report July 2020.NF.pdf (3 pages)

10.2.4

Quality Safety & Experience – 16 June 2020

Information

Susan Elsmore

10.2 iv Quality Safety Experience Chairs Report - 16 June 2020.pdf (3 pages)

10.2.5

Stakeholder Reference Group - 29 January 2020

Information

Abigail Harris

10.2 v Chairs Report for UHB Board - January 2020.pdf (3 pages)

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Agenda for Private Meeting:

11.1

Private Committee Minutes

Information

11.2

COVID-19 Board Governance Group Minutes

Information

11.3

Corporate Risk Register

Nicola Foreman

11.4

COVID-19 Outbreak - East 2 UHL

Ruth Walker

11.5

COVID-19 Surge Capacity Options

Bob Chadwick

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Review of the meeting

Discussion

Charles Janczewski

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Date and time of next meeting:

Thursday, 24 September 2020 at 1.00pm

Information

Nant Fawr 2 & 3 Woodland House / Via Skype

Charles Janczewski

Unconfirmed Minutes of the Board Meeting
Thursday, 28th May 2020 at 1.00pm

Executive Meeting Room, Woodland House, Cardiff

Present:		
Charles Janczewski	CJ	UHB Interim Chair
Len Richards	LR	Chief Executive Officer
Eileen Brandreth	EB	Independent Member - ICT
Robert Chadwick	RC	Executive Director of Finance
Steve Curry	SC	Chief Operating Officer
Martin Driscoll	MD	Executive Director of Workforce and Organisational Development
Akmal Hanuk	AH	Independent Member - Community
Abigail Harris	AH	Executive Director of Strategic Planning
Michael Imperato	MI	Interim Vice Chair
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Sara Moseley	SM	Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Capital and Estates
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
Secretariat		
Aaron Fowler	AF	Head of Risk and Regulation
Observers:		
Stephen Allen	SA	South Glamorgan Community Health Council
Anne Began	AB	Welsh Audit Office
Apologies:		
Professor Gary Baxter	GB	Independent Member - University
Susan Elsmore	SE	Independent Member – Local Authority
Jonathon Gray	JG	Interim Director of Transformation and Informatics
Geoffrey Simpson	GS	Vice Chair – Stakeholder Reference Group

UHB 20/05/001	WELCOME AND INTRODUCTIONS	ACTION
	The Chair welcomed everyone to the meeting. The Chair asked the group if they had viewed the patient story.	

	The group acknowledged sight of the story and no questions were raised. The Chair invited Executive Directors to share tributes to colleagues who had sadly passed away due to Covid-19. The Executive Medical Director (EMD), Executive Nurse Director (END) and Chief Operating Officer (COO) shared heartfelt tributes to: - Jitendra Rathod; - Gareth Roberts; - Julianne Cadby; - Dominga David; and - Alan Macalalad The Chair shared his deepest and sincerest condolences on behalf of the Board and following the tributes, the Board participated in two minutes silence to remember those colleagues that had passed away.	
UHB 20/05/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted from the Independent Member – University, Independent Member – Local Authority, Interim Director of Transformation and Informatics and the Vice Chair – Stakeholder Reference Group.	
UHB 20/05/003	**DECLARATIONS OF INTEREST** The Chair invited Board Members to declare any interests in relation to the items on the meeting agenda. No declarations of interest were noted.	
UHB 20/05/004	**MINUTES OF THE BOARD MEETING HELD ON 26TH MARCH 2020** The Board reviewed the Minutes of the meeting held on 26th March 2020 and the addendum minutes. The Independent Member (IM) – Third Sector commented on an inaccuracy of minute UHB 20/03/008 of the Addendum minutes. She highlighted that the Mental Health Legislation Committee had met in February that year so it was incorrect to suggest that the committee had not met since before Christmas. **The Board resolved – that:** a) the correction highlighted by the IM – Third Sector be noted; and b) the minutes of the meeting held on 26th March 2020 be	

	approved as a true and accurate record.	
UHB 20/05/005	**BOARD ACTION LOG** The Board reviewed the Action Log following the March Board meeting and it was noted that actions 20/03/014, 20/01/008 and 20/01/016 had be postponed in light of Covid-19 demands. It was agreed that revised dates for completion of those actions would be shared prior to the next Board meeting. The Chair confirmed that Action: 19/01/005 would be marked as complete. The Executive Director for Strategic Planning (EDSP) confirmed that the engagement programme for the Strategic Clinical Services plan would be discussed with the Community Health Council once plans for the engagement process recommenced. **The Board Resolved that:** (a) the action log and updates upon it be received and noted.	
UHB 20/05/006	**REPORT FROM THE CHAIR** The Chair introduced his report which provided an update on key meetings attended, and activities and actions that had taken place since the previous Board meeting. The Chair noted the tributes shared earlier in the meeting and commented that additional tributes would be shared in his Chair's report at the following Board meeting. The Chair discussed the items to bring to the attention of the board. He shared that there were sensitive negotiations ongoing that could not be shared but would be at a future date. The Chair invited questions – none were raised. **The Board resolved that:** (a) the Chair's report be noted. (b) the affixing of the Common Seal be endorsed. (c) the Chair's Actions and the signing of legal documents be approved.	
UHB 20/05/007	**REPORT FROM THE CHIEF EXECUTIVE**	

The Chief Executive (CEO) introduced his report which provided an update on key issues that had arisen since the last meeting.

The CEO expressed gratitude to Health Board staff for their response to the Covid-19 pandemic, which he described as exceptional. It was noted that staff had prepared well, been flexible and taken on additional tasks. It was acknowledged by the Board that the response was notable and something to reflect upon and recognise.

The CEO's Report was taken as read and the following additional comments were made:

- COVID 19 Operating Framework – The Health Board would begin to turn attention to the management of Covid and Non-Covid work alongside each other and how that would be managed operationally. The Framework was still under development but it was noted that the Health Board continued to provide services to the most urgent patients.

  The COO added that providing access to treatment for cancer patients had been a large concern which had to be balanced against the risks posed by Covid-19. 70% of cancer referrals had dropped off which was a significant issue, but referrals were starting to increase by roughly 13% month on month. An early data cut looking at conversion rates suggested that a significant number of patients would have been diagnosed with cancer during the downturn period had services continued to run.

  The backlog for surgical treatments was remarkably low in the circumstances. Cancer treatments and surgeries would slowly be reintroduced and Spire had played a key role in allowing the Health Board to keep cancer patients moving. Over 1000 patients had utilised Spire and the Health Board had been utilising 100% of Spire's endoscopy services. A number of key actions would be put in place to increase referrals, including; working with GP's to ensure that referrals increased, the sharing of public messages to reassure patients that business as usual work would recommence, the right sizing of services and putting in place a central tracking system to pick up key areas of concern. A designated advice line had also been developed to assist cancer patients.

  Whilst there was a backlog of work the COO highlighted that the position was lower than it would have been without the use of Spire and the exceptional work of staff internally.

Stephen Allen (CHC) queried whether the Welsh Government (WG) screening service had been factored into the Health Board's cancer response. The COO confirmed that the Health Board was working on a centralised policy to meet demand but further work would be undertaken in the following weeks.

Independent Member - Community thanked the COO for a reassuring overview and requested reassurance on two points.

1) Were there any budgetary or legal constraints on the continued use of Spire. The COO confirmed that Spire was an independent hospital, the use of which had been commissioned on an all Wales basis through WHSSC. It had been noted by WG that the Health Board had made the maximum use of the service. The Contract with Spire ran for a term of three months which expired in July. The CEO has stressed and continued to stress to WG how crucial Spire was to the Health Board's operational model, its patients and the regional services it provides. There was however no certainty that the Health Board would secure the continued support of Spire, albeit the Executive Team would continue to lobby for its extended use.

IM - Third Sector queried whether the Health Board was getting a sense of when usual work streams would come back and when reporting pathways would be re-established.

The COO responded that the normal IMTP and Performance framework had been stepped back until October 2020. The Health Board would continue to report on occupancy and other issues but the formal reporting hadn't re-commenced. A new process had been established where clinicians identified priority areas. This did not prevent the Health Board from being able to quantify workflows and there would still be an ability to look at 36 week data, backlog figures etc. which remained would continue to be available for review.

The Chair confirmed that he had discussed performance data with the CEO and it was agreed that a performance report would be brought to the June Board Development session and the July Board meeting.

IM - Third Sector further queried whether there would be a patient or public exercise to reassure the public that they were able to return to the hospital. The COO commented that of the 130 patients over 62 days, at least 22 were patients who had not wanted to attend

hospital for treatment. The Health Board had been, and would continue to work closely with GP's to encourage referrals and he understood that an appeal for people to come back to hospital would be launched by the BBC. The Health Board was establishing Green Zones across its sites to encourage patients to come back to areas that were as safe as could be in the circumstances. Spire hospital was the designated green hospital and there were green zones at UHL and a green tower/pathway at UHW which, it was hoped, would instil confidence in patients that there were safe areas to be cared for.

Independent Member - Trade Union queried how long the Health Board would want to continue utilising Spire. The COO confirmed that he would like to have use of the service for a year but that nothing had been agreed. He added that he had provided the CEO with data on the Health Board's use of the service to support the request for an extension. The CEO confirmed that WG would ultimately make a decision on the continued use of Spire. Cardiff and Vale were the only health board pushing hard for the continued use of an independent hospital and there could be a requirement that the Health Board would have to meet the cost of the continued use should WG refuse to extend funding. The Chair confirmed that, if there was a cost to the Health Board for the continued use of Spire then consideration would be given to whether the use was a Covid related costs which would need to be worked through and agreed with WG.

The CEO added two further points:

- The nation was moving into a new phase of the pandemic with the Test Trace and Protect programme being rolled out the following week. It was important to note that the country was not out of the woods and that there was no complacency within the Health Board. The Board were aware that the crisis could re-ignite and the Health Board would remain ready to respond to any peaks in infection.

- The Health Board was beginning to focus its attention to what recovery from the pandemic looked like and how to learn from the lessons encountered. It was believed that the pandemic could be seen as an opportunity to take a big step forward in service provision by capitalising on culture change, in particular by encouraging more clinical engagement and leadership. He noted that external partners were working with the Health Board on innovation, the HR team were looking at agile working and that lots of other work streams would feed into the recovery plan which would drive recovery in a

	strategic sense. Much of what was envisioned would correlate with the existing Shaping our Future Wellbeing plans. The Chair added that there would be a need for the Board to take the opportunity to change and drive plans forward. 2) Independent Member Community raised his second point. He believed that the pandemic may have provided an opportunity to drive through change, including plans for improved digitisation. He suggested that the board might like to strengthen or enhance the CEO's hand in the negotiations with Spire and other opportunities that may become available. He queried whether a letter from the Chair could be prepared to endorse the CEO's position on Spire. The Chair agreed that support should be given to the CEO but added that it would be more appropriate to let the CEO have a free hand rather than provide support by letter. The Board approved the approach. **The Board resolved that:** (a) the Chief Executive's report be noted.	
UHB 20/05/008	**BOARD ASSURANCE FRAMEWORK** The Director of Corporate Governance (DCG) outlined the key Covid 19 risks detailed in the Board Assurance Framework (BAF). At the request of the Executive Director of Public Health an additional risk had been added since the last meeting regarding the Test, Trace and Protect system. It was acknowledged that the DCG would incorporate the Covid 19 risks within the Health Board BAF moving forward rather than having two separate BAF documents. Stephen Allen (CHC) queried whether the Health Board had a plan to digitally open the Board meetings to the public. The Chair confirmed that plans were in train but were not finalised. Independent Member – Trade Union questioned the review period for each risk and whether the risks had to have dates allocated to come back for review. The DCG confirmed that the risks would typically be reviewed on a monthly basis but that the risks could be reviewed on an 'as and when basis' if a shorter or longer time frame would be appropriate. The Chair added that each risk would also be linked to a	

	Committee of the Board for further review. **The Board resolved that:** a) The BAF was approved and that an updated version would be brought to a future meeting.	
UHB 20/05/009	**PATIENT SAFETY, QUALITY AND EXPERIENCE** The Executive Nurse Director (END) shared a Patient Safety, Quality and Experience Report which was taken as read. The END made the following additional comments: - The number of reported incidents had dropped due to a reduction in activity. - The 30 day response time limit for responding to concerns continued to be adhered to at a 78% level. - A piece of work had been undertaken at the Dragon's Heart Hospital to capture the findings from a review of the site. As a result of learning from that exercise patients were moved to the field which increased the patient experience of those on site. - More detailed trends and themes would be shared at the next QSE Committee meeting. **The Board resolved that:** a) the content of the report was considered; and b) the paper was noted and it was agreed that the current actions being taken were sufficient.	
UHB 20/05/010	**PPE** The Executive Nurse Director shared a paper on Personal Protective Equipment which was taken as read. The paper had previously been discussed in significant detail at the last Health and Safety Committee and was therefore shared for the Board to understand the work undertaken in the PPE arena and was not discussed in detail. Specific thanks were given to Claire Salisbury and her procurement team for the phenomenal work undertaken to secure PPE from across the globe. Independent Member – Legal and the Executive Director of Therapies and Health Science expressed thanks to the END for the work that she and the PPE Cell had undertaken to protect staff in difficult and emotive circumstances. The Chair confirmed that the Independent Members endorsed the comments and thanked the team for the work undertaken. The END confirmed that the PPE issue had impacted on the	

	Critical Care Team the most and she shared an update on the work that had been and would continue to be undertaken to alleviate problems and concerns. A psychologist had been allocated to the team to provide emotional support. Heat had been highlighted as a problem by staff in full PPE. The Health Board had therefore sought to locate the most comfortable gowns for staff and was, at the time of the meeting providing the 5th or 6th type of gown in an attempt to reduce heat. It was noted that the PPE cell would continue to take action to resolve problems identified on the front line, including taking steps to make staff comfortable and assured that they had appropriate PPE. **The Board resolved that:** a) the content of the report was considered. b) the approach taken to PPE was endorsed.	
UHB 20/05/011	**ASSURANCE ON THE REPORTING OF DEATHS** The Executive Medical Director (EMD) shared a report on Covid-19 Death reporting and made the following comments: • The question how many people had died of Covid-19 was very difficult and the true number may not be available until the pandemic was resolved and full mortality figures were made available to compare. • The gold standard for death figures come from the Office for National Statistics (ONS). • The Health Board had been reassured that it was following the correct guidelines for reporting deaths. There were two systems reporting to Public Health Wales (PHW) and WG who were happy with the approach taken by the Health Board. Independent Member – Finance queried what process was used to report death figures nationally. It was clarified that: • The ONS compile their data from death certificates – this is why there is a delay in the data being released from this source, as time is needed for that process to occur. • Deaths reported to NHS Wales Informatics Service (NWIS) are used to populate the national NHS dashboard – the COVID-19 data hub; and • PHW dashboard records the deaths reported through the e-form (and other locally agreed mechanisms across Wales) that meet their definition Both NWIS and PHW are rapid mechanisms that allow surveillance of disease activity in order to plan the response. ONS data would be the definitive record of	

	the impact of the pandemic. Independent Member – Community commented that different communities had different burial rights and queried how the reporting mechanisms worked if a deceased person was not taken to the mortuary, were any procedures followed. The EMD confirmed that the gap would only arise if the patient died in a community hospital. If they died in a hospital the death would still be picked up as usual. The EDPH confirmed that funeral directors had specific guidance to follow and that she would look into this further and feedback as an Action following discussions with colleagues who had been working on the issue to ensure that robust processes were in place to ensure that appropriate messages were shared with community leaders. **The Board resolved that:** a) the content of the report was considered and noted. b) the report and assurance provided be noted.	FK
UHB 20/05/012	**TESTING AND CAREHOMES** The Executive Director of Public Health shared an update on testing and Care Homes in the Covid-19 arena. Strategically, a ministerial statement was expected the following day. WG papers had also been shared with the public regarding plans to unlock society and the economy. Within the public health response a public health protection plan had also been prepared which guided public health action over the ensuing weeks. The key message nationally centred on protecting the public with decisions based on the R value. The R value was, at the time of the meeting, circa 0.75. The desire was to keep the R value below 1, which would inform decision making alongside statistical evidence. WG had highlighted that 'normal life' may not return for a number of months and potentially years. To assist with the return to normal WG had been working to align with other home nations to avoid confusion and increase compliance. The vast majority of work over the previous weeks had been to set up the Test, Trace and Protect (TTP) system. The TTP system was a regional programme between Cardiff Council, Vale of Glamorgan Council and the Health Board. The system would be hosted by Cardiff Council with governance roles spread across the three bodies and the CEO chairing the overarching Strategic Group. Testing with the Health Board is headed by the Primary,	

	Community and Intermediate Care Director of Nursing and has followed national strategy. There are two community testing units in Whitchurch and Splott. Over 6000 Tests have been undertake, 213 of which have been undertaken in the homes of those being tested. The Health Board had also provided tests to PHW referrals when Population Testing Unit's had been unable to undertake tests. It was highlighted that a new GOV.UK portal led by NHS England had gone live which would allow the public to access tests directly. A communications push would be circulated on that scheme during the week following the meeting. The Health Board would ask key workers to continue using Community Testing Units and Population Testing Units headed by the Health Board and PHW so that the tests could be more closely monitored and controlled. The Health Board had also been asked to assess how it would be able to assist with Serology Testing in future. This form of testing would require the taking of blood which would be a significant piece of work. Under the TTP System testing would initially be provided to individuals identified as Covid Positive and gradually extended and escalate over the following weeks. The system would start with 1 team and could increase to up to 20 teams over the following months. A digital system for the TTP System would be introduced on the 8th June with a Cardiff Council solution utilised in the interim. A Public Health Response team had been established as a specialist cell with multidisciplinary staff working within closed settings to provide enhanced support in to care homes and other closed settings. The team provides networked response with social services to address and work on outbreaks. A small modelling team had been established to work on surveillance which would be expanded over time. The team would prepare a list of early indicators to highlight hotspots for action to be taken. For the first three months the cost of the TTP System would be met internally by the three bodies but it was understood that additional funding would be provided by WG for additional staff and infrastructure. Staff who are shielding, but could support the system remotely, would be used to staff the system initially. Independent Member – Third Sector questioned whether a timeline had been agreed for staff to being brought online and deliver the TTP System. The EDPH confirmed that recruitment would be undertaken by Cardiff Council through the Cardiff Works temporary staffing portal. The recruitment portal was ready to go pending the resolution of financial issues. The EDPH was confident that vacancies would be filled given the	

	interest conveyed to her. Cardiff Council have a contact tracing unit which would set up recruits to work remotely and provide training. As with any new system it was anticipated that there could be teething problems but the EDPH was assured that the system had all the pillars in place for the system to be a success. Independent Member – Finance questioned whether there would be postal tests and how the data from those tests would be communicated to the Health Board and General public. The EDPH confirmed that postal tests would be provided via the GOV.UK website with logistical support from Amazon. Communications would be circulated on that process the following week and she re-confirmed that key workers would be asked to continue to use Community Testing Units and Population Testing Units. Surveillance would be collected through a variety of resources and would feed into the TTP System and communicated to Health Board and public alike. Independent Member – Community highlighted that there was a suggestion that there may be a stronger wave of infections during winter. He asked whether there was anything to suggest that some of the data collected could be used to prepare and plan for the winter when demand for services would increase alongside the potential for a Covid Spike. EDPH confirmed that the executive team would monitor data and keep abreast of Covid updates so that the Health Board could change systems to meet demand. The Serology tests would play an important role in that as the amount of people who had contracted the virus would impact on the spread leading into winter and what actions would need to be taken. Winter planning was already being discussed and additional vaccinations had been secured. There would also be a need to review what was happening over the following months to plan appropriately. The Health Board would also consider what was happening in the southern hemisphere to see if any lessons could be learnt from their winters, albeit it was acknowledged that the southern hemisphere winters were milder than those experienced in the UK. The EDPH confirmed that she was happy to share Care Home updates with Board members updates offline if they had any queries. In summary she confirmed that nearly 2900 tests had been undertaken in homes over the previous few weeks and it was hoped that all homes would be tested by the 1st June, albeit some homes had refused testing. Independent Member – Trade Union queried, how reliable tests were, what the lab capacity was, and were the Health Board worried that there would be duplicate tests because of lack of faith in test results. The EDPH responded that as long as tests were carried out	

	effectively the test would be accurate. False negative tests had typically arisen because of faulty procedure rather than the test. The EMD confirmed that a report had been prepared which would address the queries raised by the Independent Member and he confirmed that he would share the paper with the Independent Members. It was also confirmed that there was capacity for 5000 tests per day plus additional capacity via the GOV.UK system which would process tests using English laboratories. In terms of confusion from the public and duplication of testing. In Wales there would be one point of contact for testing moving forward which should provide assurance with revised communications being circulated to keep the public informed. **The Board resolved that:** a) the content of the update was considered.	
UHB 20/05/013	**RESOURCES INCLUDING STAFFING AND WELLBEING** The Deputy Chief Executive/Executive Director of WOD (DCEO) shared an update on resources including staffing and wellbeing for noting. The paper highlighted the following points: • At the start of the process we were working within a perfect storm with high absence figures and a requirement for huge numbers of staff. The Health Board brought recruitment in house and were able to recruit 1200 staff members in a very short period of time which was a huge achievement. • Staff were working extremely hard in very difficult circumstances and were in need of physical and emotional support. Physical support had been provided with the provision of accommodation, safe havens and welfare stations. That support was still being provided at the time of the meeting but accommodation support would begin to be reduced. The chair confirmed that recruitment had been a huge positive for the Health Board and he confirmed that he would support a move to internal recruitment and that he acknowledged the risks that would be associated with the move. The DCEO confirmed that difficult discussions with Shared Services would need to be had to relocate recruitment but that his team were aware of the challenge. It was also noted that the DCEO's team were able to recruit 1200 staff members by the time that NWSSP had put forward a proposed staffing solution. Independent Member – Trade Union thanked the DCEO and his team for the work undertaken during the pandemic and singled out the DCEO's leadership for praise. She also	

	confirmed that she supported the retention of recruitment in house but questioned how long the increased level of support from the HR team could continue. The DCEO confirmed that the HR Team had moved to a rota system to allow the level of support to be provided longer term. Some additional resource had also been recruited to assist. The additional support had been released following the recruitment drive but had since been brought back to support the TTP system and work at the Dragons Heart Hospital. Independent Member – Finance queried to what extent would the Health Board be able to retain Student Nurses and Junior Doctors that had been recruited. The END confirmed that an increased number of nurses had been recruited that year and that the number of nurses who had returned to the NMC register would remain on the register until the Covid Bill was stood down. It was believed that the NMC would be given permission to stand that register down over a longer period of time which would allow the Health Board to keep those nurses who had returned to work for a longer period of time. Independent Member – Capital and Estates questioned what strategy had been agreed in terms of employee rights for temporary staff members and also how the Health Board would had been supporting staff members with childcare and dependency issues. The DCEO confirmed that temporary contracts were issued for three months with a further one month rolling term and that the contracts were in the process of review. He added that crèche facilities had been provided at both Hospital sites and the Health Board had engaged with Cardiff Council to secure additional crèche facilities which, it transpired, were not needed. He also identified that there were in excess of 600 staff who were shielding and that the Health Board were reviewing the position of those staff members to put in place shielding plans moving forward. The DCEO also confirmed that a piece of work was being undertaken on homeworking with a view to establishing what benefit could be derived from home working moving forward. **The Board resolved that:** a) the content of the report was considered and noted.	
UHB 20/05/14 Tolley, Laura 07/27/2020 11:09:35	**THE NURSE STAFFING LEVELS FOR ADULT ACUTE MEDICAL AND SURGICAL WARDS FOLLOWING THE BI-ANNUAL CALCULATION (TO INCLUDE COVID-19 PERIOD)** The END shared a paper with the Board to request endorsement of nurse staffing establishments that had been	

	calculated, based on revised modelling during the Covid 19 outbreak. The END confirmed that updated paper would be brought in the near future as wards would be re-configured to meet emerging operational need. Independent Member –ICT queried what progress had been made in relation Mental Health Nurse staffing levels. The END confirmed that the matter would be discussed at an executive level and progressed. The Board agreed that the matter would be given specific attention as it had been an outstanding item for some time. The END commented that staff had responded extra ordinarily during the course of the pandemic and noted that it was important for the Board to understand the extent of the work that staff had undertaken and the level of flexibility staff had displayed to meet need. **The Board Resolved That:** a) the Nurse Staffing establishments detailed in the paper were approved.	RW
UHB 20/05/015	**CARDIFF AND VALE UNIVERSITY HEALTH BOARD SERVICE DELIVERY PLAN** The Executive Director for Strategic Planning (EDSP) shared the Health Board's Service Delivery Plan for 2020/21. The plan was a document that had to be prepared and submitted to Welsh Government. It was noted that the report had already been submitted following approval of the Health Board's Covid-19 Strategic Group and it had received favourable feedback, with certain practices singled out as examples of good practice. The EDSP added that the Health Board had adopted a very light touch approach to updates on operational plans and that a feedback meeting with Welsh Government had been scheduled for the following week. She had also had a very useful conversation with the Community Health Council which had highlighted gaps that could be worked on during the remainder of the year. The END commented that one of the things that had been communicated by staff in the critical care environment was that they could not picture what the future of the service would look like. She felt that the plan shared the Health Board's plans for the future and she asked how the message and plan would be shared with staff to highlight the positive messages	

	moving forward. Stephen Allen (CHC) added to the END's comment and suggested that the Health Board communicate with the public to highlight the changes that had been made due to the Covid emergency and also to reassure the public that there had been some due diligence for the decisions that had been made. He asked that CHC be engaged earlier in future decisions to ensure that the public felt that their voices would be heard. The EDSP commented that a light touch update would be provided each quarter as agreed with Welsh Government but that she would continue to liaise with the CHC. She also welcomed the CHC's ideas about how communications could be shared with the public. The Chair acknowledged the quality of the paper and thanked the EDSP and her team for the good work undertaken. The Board Resolved that: a) the report Service Delivery Plan 2021 was approved and retrospectively ratified.	
UHB 20/05/016	**EMERGENCY RESPONSE TO COVID 19** The Chair confirmed that Agenda Item 8.9 related to the Emergency Response to Covid 19 and not the Dragon's Heart Hospital. The EDSP introduced the report for noting and it was taken as read. The paper provided assurance that the Health Board had reacted exceptionally well at speed to the Covid 19 outbreak and had been a trend setter during the pandemic having engaged with Independent Hospitals and forged new guidelines on PPE and visiting ahead of the curve. The EDSP added that the report would provide assurance that appropriate governance mechanisms were in place and would demonstrate that the emergency work had come at a cost which had been reviewed and approved by the Health Board's Covid -19 Strategic Group. It was noted that leadership had played a huge part in the response process and the executive team had adopted the approach of permitting clinical teams to take the lead on developments rather than adopting the top down approach taken in a typical gold and silver command approaches. The Executive Director of Finance commented that the financial impact of Covid expenditure at month 1 of the financial year was assessed at £38m, of which £33m related	

	to the Dragon's Heart Hospital. After taking out Covid 19 related expenditure the Health Board forecasted a minor over spend of £191,000. It was agreed that the Health Board's finance position would be included in performance reports moving forward. **The Board resolved that:** a) the content of the report was considered; and b) Assurance was taken from the Health Board's response to the Covid 19 pandemic.	
UHB 20/05/017	**AUDIT AND ASSURANCE COMMITTEE** **The Board resolved that:** a) the minutes of the Audit and Assurance Committee held in March 2020 be ratified.	
UHB 20/05/018	**FINANCE COMMITTEE** **The Board resolved that:** b) the minutes of the Finance Committee held in February 2020 be ratified.	
UHB 20/05/019	**QUALITY SAFETY AND EXPERIENCE COMMITTEE** **The Board resolved that:** a) the minutes of the Quality Safety and Experience Committee held in February 2020 be ratified.	
UHB 20/05/020	**WHSSC COMMITTEE** **The Board resolved that:** a) the minutes of the Welsh Health Specialised Services Committee Joint Committee Meeting held in May 2020 be ratified.	
UHB 20/05/021	**STAKEHOLDER REFERENCE GROUP** **The Board resolved that:** a) the minutes of the Stakeholder Reference Group held in January 2020 be ratified.	
UHB 20/05/022	**AUDIT AND ASSURANCE COMMITTEE CHAIR'S REPORT TO BOARD** **The Board resolved that:**	

	a) The report from of the Chair of the Audit and Assurance Committee be noted.	
UHB 20/05/024	**FINANCE COMMITTEE CHAIR'S REPORT TO BOARD** **The Board resolved that:** a) The report of the Chair of the Finance Committee be noted.	
UHB 20/05/025	**QUALITY, SAFETY AND EXPERIENCE COMMITTEE CHAIR'S REPORT TO BOARD** **The Board resolved that:** a) The report of the Chair of the Quality, Safety and Experience Committee be noted.	
UHB 20/05/26	**ANY OTHER BUSINESS.** Independent Member ICT highlighted that, in her opinion it would be easier for large groups such as the Board to meet in an entirely digital format. The meeting had been held in a hybrid format and the Independent Member highlighted a number of practical considerations that would be picked up by the Chair in advance of the next Board meeting.	
UHB 20/05/027	**Date, Time & Venue of Next Board Meeting:** Thursday 16th July at 1.00pm Venue: TBC	

ACTION LOG
Following Board Meeting
28 May 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
19/01/005	18/119 - Relocation of the Links Centre	The Capital Estates and Facilities team is working with PCIC and Mental Health Clinical Boards	26.03.2020	A Harris	**Complete -** Business case has been approved by Welsh Government and programme for works is being finalised. Work expected to commence end of June – with completion date in Q1 2021/22. Plan is for Drug and Alcohol Treatment Team to be in new accommodation in the Autumn.
20/01/008	Report from the Chief Executive	To provide an update on the programme of work and the development of new services around specialised services	25.07.20	L Richards	**Complete** - Programme of work delivered but implementation suspended in light of COVID-19
20/05/012	Testing and Care Homes	A report on the reliability of Covid -19 tests to be shared with Independent Members.	25.07.20	F Kinghorn	**Complete** – included within agenda item 10.1 Care Home Engagement and Support during COVID 19
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.	24.09.20	R Walker	Discussion to be tabled at Management Executives in mid August then report into September Board
20/05/011	Assurance on the Reporting of Deaths	To share an update on the procedure for the reporting of deaths in the community and within different faith settings.	24.09.20	F Kinghorn	To be shared by the September Board

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
20/03/014	Move More, Eat Well Plan	To ask Public Health how we provide this information to older persons who may not have digital access	15.09.20	F Kinghorn	The Move More, Eat Well programme has been presented to Management Executive and will also be presented to Strategy and Delivery Committee at the next meeting which will include how this information will be provided to older people.
20/01/016	Recognising and Responding to the Climate Emergency	To bring back an action plan to a future meeting	24.09.20	A Harris	Work on hold due to reprioritising workload. Action plan to be brought back in Autumn and included in COVID19 Recovery Programme.
Actions referred to Committees of the Board/Board Development					

Report Title:	**Chair's Report to the Board**								
Meeting:	Board						**Meeting Date:**	30th July 2020	
Status:	**For Discussion**		**For Assurance**	x	**For Approval**		**For Information**		x
Lead Executive:	Chair of the Board								
Report Author (Title):	Director of Corporate Governance								

Thank You

I am very aware of the brilliant work that all of our staff across Cardiff and Vale UHB have been delivering throughout the current pandemic. In addition to the normal very high standards of care and quality of service our staff provide, this difficult period has seen everyone rising to the challenge and working extremely hard for the benefit of our patients over and above any normal expectations. It has been a magnificent demonstration of care, compassion, dedication and remarkable personal sacrifice for the benefit of others. May I thank you all on behalf of the Board and myself for your wonderful commitment to our patients and to each other. Diolch Yn Fawr.

Background and current situation:

The Chairs report would normally provide a summary of events, activities and meetings which the Chair has taken part in since the previous Board Meeting. However, due to COVID 19 Chairs activities have been very different to normal. In the first instance I would like to confirm to the Board that I have now been appointed with effect from 23rd June 2020 as substance Chair of the Cardiff and Vale University Health Board. I can also confirm that the process to commence the appointment of a substantive Vice Chair will commence in September 2020.

Since my last report to the Board I would like to inform the Board that, very tragically, two further members of staff have passed away due to COVID 19. It is important to pay tribute to the two members of staff and I can confirm they are:

Allan Macalalad

Allan Macalalad sadly died after testing positive for Covid 19 on 26 th May in Neville Hall Hospital. Allan was a Theatre assistant working in ophthalmology and had more recently been working in the Short Stay Surgical unit. Many of his colleagues have commented upon his kindness and compassion. Mrs Macalalad kindly allowed the funeral cortege to drive through UHW where I was able to join staff to pay our respects to a much loved colleague and friend. The funeral service was live streamed across Health Board sites and Allan's wife appreciated the number of staff who attended the streamed services. Allan is survived by his wife and son.

Dominga David

Dominga David sadly died in University Hospital of Wales on 26 th May after a long battle against Covid 19. Dominga was such a well-loved colleague being a respected Nurse who joined Cardiff

and Vale in 2004 when she came to the UK to begin her nursing adaptation programme. For the past 16 years Dominga had been part of the Nursing team in University Hospital Llandough. It is evident that Dominga was a well-loved and a highly respected member of the team and her colleagues across the Health Board have commented upon her hard working attitude, kindness and compassion for patients, families and colleagues. On the day of Dominga's funeral the procession drove through UHL where I was able to join staff to pay our respects, the funeral was live streamed across the UHB. Dominga's son resides in the Philippines.

Our condolences and thoughts are with their families and friends at this time.

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

a. COVID 19 Board Governance Group Summary

Due to COVID 19 and the requirement to make effective, robust decisions at pace a COVID 19 Board Governance Group was set up. This was (and still is) a Chairs Action Group and the Members of the Group are the Chair, Interim Vice Chair, Chair of Audit Committee and the Chief Executive. The Director of Corporate Governance also continues supporting the Group in terms of advice and ensuring that decisions which have been agreed at Management Executive (Strategic Group has been stood down) but which require sign off of the Board Governance Group flow through. This group continues to meet however, it has been reduced from a weekly meeting to every other week and this will be kept under review.

This report therefore provides a summary of the decisions which have been taken and the discussions which have happened since the last Board Meeting at the end of May.

21/05/20 – The Group noted the introduction of the Phone First 24/7 Plan presented to ME

04/06/20 – The Group noted the decision to retain full capacity at DHH with ability to step up to 1500 beds should the need arise.

22/06/20 – The Group ratified the upper limit cost of £4.8m for the Test, Trace and Protect Programme prior to Welsh Government approval.

25/06/20 – Proposals for 400 bed surge capacity were ratified by the Group to a value of between £20m-£32m prior to Welsh Government approval.

02/07/20 – Construction costs of green and red schemes were ratified by the Group to the value of £2.5m prior to Welsh Government approval.

All Independent Members have received copies of the minutes from the Board Governance Group in addition to the action log and the decision log from the Strategic Group. An up to date copy of the decision log is attached for Members.

b. 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 not been applied to any documents since the last meeting of the Board.

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

Date Signed	Description of Document	Background Information
16/06/2020	Licence to carry out Arboricultural Assessments & Surveys	Whitchurch Hospital – Velindre (Hugh James)

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

27/05/2020	Equipment set up costs for the COVID-19 UHB Expenditure
29/05/2020	COVID-19 Radiology Equipment
03/06/2020	HCID Unit
03/06/2020	M.O.U Hosting Agreement for the Operational Delivery Network (ODN)
17/06/2020	Retrospective additional value to current purchase of HCID Modular Building

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 ensures that due process has continued to be followed.

Recommendation:

The Board is recommended to:

- **NOTE** the report
- **APPROVE** the Chairs 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:	~~Yes / No~~ / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Decision Log from COVID 19 Strategic Group

Date of Decision	Minute Ref.	Decision	Financial Implications	Lead Executive progressing Decision	Does Decision need to be ratified Yes/No	Decision ratified by COVID 19 Board Governance Group/Chairs Action - Minute Reference		Decision Ratified by the Board	
						Date	Minute Ref	Date	Minute Ref
19.03.2020	CV19SG: 20/03/001	Covid-19 Governance Structure Agreed		Len Richards	Yes	01.04.2020	CV19BGG: 20/04/10/006		
19.03.2020	CV19SG: 20/03/002	Restricted visiting parameters agreed.		Ruth Walker	No				
19.03.2020	CV19SG: 20/03/004	200 Bed plan agreed incorporating Barry Hospital, St David's and the Children's Hopsital.		Steve Curry	No				
23.03.2020	CV19SG 20/03/23/013	Agreed that catering facilities would close to the public to allow a 24 hours catering provision to be provided to Staff		Bob Chadwick	No				
26.03.2020	CV19SG 20/03/26/008	Agreement to proceed with Principality Stadium as the field hospital for COVID 19	Significant revenue costs	Jonathon Gray	Yes	01.04.2020	CV19BGG: 20/04/10/006		
26.03.2020	CV19SG 20/03/26/012	Revised Clinical governance structure agreed. A clinical trimvirate to head up UHW, UHL and Stadium sites. Decision made noted at minute: CV19SG 20/03/26/013		Steve Curry	No				
26.03.2020	CV19SG 20/03/26/007	Temproary Re-location of the Paedeatric E.D to the Children's Hospital during Covid-19 outbreak.		Steve Curry	No				
30.03.2020	CV19SG 20/03/30/008	Agreement to purchase 150 ventilators (will be dealt with via shared services)	Decision deferred to Shared Services which means costs will be met by WG	Stuart Walker	No				
30.03.2020	CV19SG 20/03/30/005	Agreement to move away from PHW PPE guidance.		Ruth Walker	Yes	01.04.2020	CV19BGG: 20/04/10/006		
02.04.2020	CV19SG 20/04/02/008	Revised Risk Register to be prepared for the 4 clinical hubs. Top 5 strategic risks for Strategic Group.		Nicola Foreman	No				
06.04.2020	CV19SG 20/04/06/011	Expenditure of £185209.20(inc VAT) approved for HEPA filtered units at Ward 6, Ward 7, Heulwen and UHL West 1	Significant Expenditure.	Bob Chadwick	Yes	15.04.2020	CV19BGG:20/04/15/013		
09.04.2020	CV19SG 20/04/09/004	To offer vulnerable front line staff another role		Martin Driscoll	No				

09.04.2020	CV19SG 20/04/09/006	Not to open Surge Hospital on 12.04.20 but to continue with build and open discussions as to wider use on the understanding that staff resource must follow		Len Richards	No				
09.04.2020	CV19SG 20/04/09/007	All COVID-19 financial documentation to come to Strategic Group for sign off		Bob Chadwick	No				
13.04.2020	CV19SG 20/04/13/009	A reduction in the number of beds to be commissioned at the Dragon Heart Hospital approved. The number of beds to be commissioned will now total 1500 following the decision not to proceed with areas L4 and L6.	The decision could potentially reduce expenditure by £2 million.	Len Richards	No				
13.04.2020	CV19SG 20/04/13/011	Covid - 19 Financial Governance policy approved for expenditure up to £125,000.00	The valume of expenditure up to £125k without formal governance team approval will increase, although approval systems are included within the policy.	Bob Chadwick	Yes	15.04.2020	CV19BGG:20/04/15/013		
13.04.2020	CV19SG 20/04/13/011	Retrospective approval of MITIE's appointment given by the group alongside approval of enhanced pay rates for domestic staff appointed by MITIE.	MITIE's costs are likely to be significant although a value is not yet know. It is also likely that the enhanced pay rates could cause controversy as hourly rates are higher than centrally appointed staff members. It should be noted that the Union is aware of the position and Martin Driscoll will put together communication to confirm that overall the enhanced pay is not higher that the package received by centrally employed staff.	Bob Chadwick	Yes	15.04.20	CV19BGG:20/04/15/013		
16.04.2020	CV19SG 20/04/16/004	Decision agreed to change the bed plans at the Dragon Heart Hospital. The reduction in beds would remain at 500 but the reduction plans had been revised.	The reduction in build cost is likely to be closer to £300k rather than £2million.	Len Richards	No				
16.04.2020	CV19SG 20/04/16/004	The group agreed fo secure temporary staff accomodation in Cardiff City Centre at a cost of £55,000.00 plus VAT per month.	A rolling cost of £55,000 for the duration of hire which is yet to be determined.	Bob Chadwick	Yes	22.04.20	CV19BGG: 20/04/22/008		
16.04.2020		Open DHH on 21st April to patients	Operational cost	LR	No				

21.04.2020	CV19SG 20/04/21/009	The group agreed that the Executive Director of Finance could authorise the appointment of two Authorised Persons for the management of the oxygen supply at the Dragons Heart Hospital without formal approval being provided by the Health Boards Authorising Engineer. It was agreed that the Health Board would assume the risks associated with not complying with HTM regulations in this regard.	N/A - Regulatory and health and safety risk.	Bob Chadwick	No				
23.04.2020	CV19SG 20/04/23/009	The group agreed a departure from governmental CPR PPE guidelines.	N/A	Ruth Waler	No				
23.04.2020	CV19SG 20/04/23/011	The group agreed that it would approve the service of a joint extension notice for the FUJI PACS procurement process with all other health boards subject to the proviso that CAVUHB would have the option to extend if the procurement exercise had not conculded in time.	Potential procurement issues	Fiona Jenkins	No				
27.04.2020	CV19SG 20/04/27/0006	The group agreed the DHH Operational Model	N/A	Steve Curry	No				
27.04.2020	CV19SG 20/04/27/007	Bob Chadwick and Martin Driscoll arranged for the urgent appointment of fire officers at the DHH following advice from the fire department and Health and Safety team at an increased cost.	Yes, enhanced salary.	Martin Driscoll	No				
27.04.2020	CV19SG 20/04/27/007	The group approved the DHH financial governance structure for the approval of expenditure.		Bob Chadwick	Yes - approval to provide the SRO authority for expenditure up to £125	06.05.20	CV19BGG: 20/05/06/007		
27.04.2020	CV19SG 20/04/27/007	The group noted that Jeremy Griffith, the Operations Lead at the DHH was not an employee of the Health Board but appointed with authority to act on the UHB's behalf pursuant to an all Wales Agreement. Similar appointments had been made at other health boards to assist with the establshment of field hospitals.	Yes - salary cost.	Jonathon Gray	No				
30.04.2020	CV19SG 20/04/30/008	The group noted and approved Covid related non-DHH expenditure and approved Advance Payment figures presented by Bob Chadwick	Yes - although the intention is that the costs will be recovered from WG.	Bob Chadwick	Yes - one payment on the schedule for replacement laptops equating to £584,649. WG agreement already received	06.05.20	CV19BGG: 20/05/06/007		

30.04.2020	CV19SG 20/04/30/011	The group noted that the MITIE contract for the provision of Soft FM services would be terminated at the expiry of the 3 month initial contract.	N/A	Bob Chadiwck	No				
04.05.2020	CV19SG 20/05/04/005	The group agreed that the Health Board would take over the Population Testing Unit established by Deloitte and PHW at Cardiff City Stadium over the coming weeks.	Yes - staffing cost. Additional costs yet to be clarified.	Fiona Kinghorn	No				
04.05.2020	CV19SG 20/05/04/010	The group authorised the acquisition of 100,000 anti body tests produced by Abbot. Abbot are our current Managed Service Provider for Biochemistry labs, and have a very strong International reputation.	Yes - £450,000.00 plus VAT	Len Richards	Yes	06.05.20	CV19BGG: 20/05/06/007		
11.05.2020	CV19SG 20/05/11/007	The group agreed to support the decision of clinicians to depart from BAPEN guidance on PPE for replacement of NG and NJ tubes and swallow assessments so that they aren't classed as AGP's.	N/A	Fiona Jenkins	No	13.05.20	CV19BGG: 20/05/13/010		
14.05.2020	CV19SG 20/05/11/006, CV19SG 20/05/21/004 & CV19SG: 20/05/27/003	The group approved the temporary re-location of Cardiac Surgery to UHL. The support for the move was re-affirmed by the group on the 21st May 2020.	Capital and revenue costs to be confirmed.	Steve Curry	No				
18.05.2020	CV19SG 20/05/18/007	The group approved the purchase of 475 Powered Air Hood Respirators and power units.	£291,019.00 - This would be a replacement cost as equipment would be used in place of face masks and it was assumed thatx the use of the new equipment would provide a cost saving over time.	Ruth Walker	No				
21.05.2020	CV19SG 20/05/21/004	The group approved expenditure totalling £20,000.00 - £21,000.00 for additional Staff Winter Vaccinations.	£20,000.00 to £21,000.00	Fiona Kinghorn	No				
21.05.2020	CV19SG 20/05/21/006	The group supported the introduction of the Phone First 24/7 plan for the setting up of a telephone triage service to reduce the number of attendees at the Emergency Department.	It was belived that initial costs would be submitted to Welsh Government as Covid Expenditure but that ongoing running costs which were yet to be confirmed would need to be met by the Health Board.	Steve Curry	No				

04.06.2020	ME:20/06/04/009	Following the discharge of all patients from the DHH the ME group agreed to retain full capacity at DHH on standby with ability to step up to 1500 beds within 7 days pending further discussion with WG	To be confirmed	Len Richards	No				
22.06.2020	ME:/20/06/18/032	Test Trace and Protect	£4.8 million for Test Trace and Protect requires Board Governance Group to ratify prior to WG approval	Fiona Kinghorn	Yes	01.07.20	CV19BGG: 20/07/01/006		
25.06.2020	ME:20/06/25/005	Proposals for a 400 bed surge capacity hospital were ratified by the Executive Team. The proposals were for a 400 bed capacity modular surge hospital to be located at UHW adjacent to the lake and taking up part of the disabled parking bay.	TBC - But forecasted up to £32 million.	Bob Chadwick	Yes	01.07.20	CV19BGG: 20/07/01/006		
02.07.20	ME/20/07/02/009	The Management Executive have ratified the construction costs of the red to green schemes and this now requires ratification by the Board Governance Group prior to Welsh Government approval	Cost of scheme is £2.5 million	Bob Chadwick/ Abigail Harris	Yes	15.07.20			

Report Title:	**CHIEF EXECUTIVE'S REPORT**						
Meeting:	CARDIFF AND VALE UHB BOARD MEETING				**Meeting Date:**	30.07.2020	
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 fourteenth 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:

Enhancing our urgent care model
We have seen a significant change in demand for urgent care services during the COVID-19 pandemic, which combined with the need to implement safety measures including social distancing has meant that we have needed to adapt and reconfigure services to deliver them safely.

Adapting the service in this way has highlighted opportunities for how we can enhance its delivery in the future. We are currently undertaking some exciting work on how the service model will look going forward.

'Phone First' system: CAV 24/7
The Health Board is introducing a new 'Phone First' triage system for the Emergency Unit (EU). The service will be for people needing urgent care and will signpost the user to the most appropriate medical help.

We've taken the time during this pandemic to review the EU attendance figures and assess how we'll continue to provide our services while co-existing with COVID-19. We cannot return to how patients accessed EU before COVID-19 as this isn't deemed safe for our patients or staff. By introducing a 'phone first' system, we believe this will:

- Help staff and patients adhere to social distancing
- Keep staff and patients safe
- Save patients' time as they get a dedicated timeslot to attend EU
- Allow patients to be seen at the right place, first time (which may not be EU)
- Prevent overcrowding in EU

We aim to go live with this new system by the end of this month.

Cardiff and Vale COVID-19 Rehabilitation Model
In June, we launched Keeping Me Well, the Cardiff and Vale COVID-19 Rehabilitation Model that identifies the significant rehabilitation needs of people recovering from the virus, as well as those whose rehabilitation has been interrupted as a result of the COVID-19 pandemic.

The model identifies four main population groups that we anticipate will have an increased need for rehabilitation arising from the COVID-19 pandemic; people recovering from diagnosed or suspected COVID-19, people with paused planned care, people who have avoided accessing health services, and socially isolated and shielded populations. It will be delivered across five tiers illustrating the different levels of rehabilitation that may be offered.

Volunteers' Week
Volunteers' Week took place during first week of June, and with everything else happening at the moment, we did not miss the opportunity to thank our scores of volunteers for the incredible lengths they go to support us as an organisation as well as the individual needs of our patients. Throughout the week, Cardiff and Vale University Health Board celebrated and highlighted the contribution of our volunteers, who freely give their time, energy and expertise, helping to care for our communities and keeping people well.

The arrival of the COVID-19 pandemic has seen more people volunteering to help within their communities. From doing the weekly shop for a family shielding at home or picking up a prescription for an elderly neighbour, more and more of us have been helping out in lots of different ways.

Service Delivery Plan
2020 has been a year of many challenges so far and the response of the public, essential workers and especially the staff of Cardiff and Vale University Health Board has been exceptional. COVID-19 is a dreadful disease that has affected and claimed many lives and, as a Health Board, we owe it to everyone who has suffered from the pandemic and to our staff who have worked so hard in the response to it to build our services back safely, stronger and better.

As we look to the future, we must consider how we continue to treat COVID-19 patients while delivering our other services safely and look beyond this to a complete renewal of our Health System. We have been very impressed with our staff in their ingenuity in embracing digital technology while treating their non-COVID patients during the pandemic, and have been heartened to hear feedback that our staff feel that barriers between departments have begun to dissipate.

This is something which we must endeavour to retain going forward and this plan sets out how we aim to do so while incorporating the treatment of COVID-19 into our 10-year strategy, *Shaping our Future Wellbeing*.

Update on the Dragon's Heart Hospital
As of 10 June, Cardiff and Vale UHB started using the capacity at its main hospital sites for COVID-19 patients. The Dragon Heart Hospital site will still be retained until the autumn and will be available to admit patients should a surge in capacity be required. This is in line with normal NHS operational bed occupancy plans, to ensure efficiency of services and workforce,

particularly with the onset of winter planning already initiated.

The Dragon's Heart Hospital has been and will continue to be an important part of our response to Coronavirus. The requirement for surge capacity has not gone away and we are working with Welsh Government around what the next few months look like. I think using the Dragon's Heart Hospital over the past month has been invaluable in that we have learned how to care for people in an unfamiliar environment and we have learned some very important lessons in how to use it going forward, if we need it.

We are following the modelling and trajectory of the virus to ensure that should we see a further spike, we will be able to respond quickly and seamlessly to support patients and their families, providing them with the care and treatment required in tackling but also recovering from the virus. The bottom line is that we were and are prepared and that should provide reassurance to our communities.

I would like to say that the team that created the Dragon's Heart Hospital and the teams that have provided the care within it should be very proud. It feels to me like something very special has gone on in Cardiff & Vale UHB over the last couple of months. I have been humbled by the skills, expertise, innovation and downright drive to get this done. My thanks go to all those who have all pitched in and worked together in extraordinary circumstances.

Video Appointments
Throughout the COVID-19 pandemic we have made a number of changes to how we provide services to patients, and as we look forward it's important that we maintain the benefits that many of these new ways of working are providing for them.

One such change has been the introduction of video consultations, which allow patients to attend a range of outpatient appointments from the comfort of their own home. That's been of obvious benefit in recent weeks, but moving forward it will give many patients a much more convenient option for seeing their clinician, avoiding the need to leave home, travel and park on site.

We already have more than 20 services live and a number of others currently in development ready to be introduced soon. More than 50 consultants have already used video appointments to see patients, and I'm looking forward to seeing that number ramp up over the coming weeks and months.

News from the RECOVERY trial
You may have seen the fantastic news that Dexamethasone has been found to improve survival in COVID-19. This is a major breakthrough for COVID-19, which I'm pleased to say Cardiff and Vale has made a substantial contribution to.

The health board was the first in the UK to open the RECOVERY (Randomised Evaluation of COVid-19 thERapY) trial, which found that the low-dose steroid treatment, Dexamethasone reduces deaths of hospitalised patients with severe respiratory complications of COVID-19.

The trial, which was implemented by the University of Oxford, found that dexamethasone reduced deaths by one third in ventilated patients, and by one fifth in other patients receiving oxygen. Based on the results, the drug would prevent one death of approximately eight patients on ventilators, and one of around 25 patients on oxygen, with the 10-day treatment costing

approximately only £5 per patient.

Identifying an inexpensive and widely available drug as an effective treatment for some of the most unwell patients with COVID-19 is a really exciting development, which will hopefully save the lives of many people worldwide.

We have already adjusted our treatment guidelines to incorporate the findings from the RECOVERY trial, so that as many suitable Cardiff and Vale patients as possible can benefit from the treatment, while our Pharmacy team is on the front foot with ensuring our dexamethasone supply.

Cardiff and Vale UHB was a leading recruiter to the RECOVERY trial with more than 180 patients enrolled at the University Hospital of Wales and University Hospital Llandough, and I would like to highlight the huge collaborative effort between clinical teams, ward staff and the research team here at Cardiff and Vale in contributing to this wonderful result.

Appointment of Chair
I was delighted to hear that Welsh Government formally announced the appointment of our new Chair as Charles Janczewski. I look forward to working with him.

Launch of Virtual Stay Steady Clinics
Cardiff and Vale University Health Board's Physiotherapy team launched the 'Stay Steady Virtual Clinics' recently - a service which aims to provide early intervention to individuals who are worried about falling or are a little unsteady on their feet. A team of falls specialist physiotherapists will be on hand to assess individual risk of falling and recommend actions to take. The clinic is delivered 'virtually' by phone or video consultation, and is available to all residents in Cardiff and the Vale of Glamorgan.

Health Service Journal Patient Safety Awards 2020
I am delighted to share that West Quay Medical Centre in Barry has been shortlisted for "Quality Improvement Initiative of the Year" at this year's HSJ Patient Safety Awards.

Their project, *Improving Patient Safety by better Access to Appropriate Healthcare Professionals in Primary Care - a whole-system approach* has been selected based on the ambition, visionary spirit and the demonstrable positive impact that their project has had on patient and staff experiences within the health and social care sector.

Also shortlisted is the UHB's Coeliac team for their project, *Co-Production: Public and Professional working together to redesign and implement a model of care for newly diagnosed Coeliac Disease.*

I would like to offer a heartfelt congratulations to both teams nominated and wish them the very best of luck.

Health, Social Care and Sports Committee – Friday 10 July
On 10 July, Jan and myself gave evidence to the Health, Social Care and Sports Committee on the Health Board's response to Covid-19.

Farewell to Bob Chadwick, Executive Director of Finance
I must announce that Bob Chadwick, our Executive Director of Finance, will be leaving the Health Board at the end of September 2020.

He has had a distinguished career in the NHS and since joining Cardiff and Vale UHB, he has helped steer the organisation's financial position. His input has been invaluable and has enabled us to meet our financial position for 2019/2020 and he has also contributed significantly to the wider agenda and our strategy.

I have enjoyed working with him and wish him all the best for the future.

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:	**Board Assurance Framework (BAF)**							
Meeting:	Board					**Meeting Date:**	30th July 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 end of the Financial Year (March 2020) the Board agreed that the six risks detailed below were the risks which had been in place throughout 2019/20.

1. Workforce
2. Financial Sustainability
3. Sustainable Primary and Community Care
4. Safety and Regulatory Compliance
5. Sustainable Culture Change
6. Capital Assets (including Estates, IT and Medical Equipment)

At the Board Meeting in May 2020 the BAF comprised of the following COVID 19 risks which were impacting upon the delivery of strategic objectives:

1. Staff safety and welfare
2. Patient Safety
3. Decision making, financial control and governance
4. Workforce
5. Delivery of IMTP
6. Reputation
7. Test, Trace and Protect

Moving forward it has been agreed with the Management Executive that there will be just one BAF (rather than a BAF and a COVID 19 BAF) which comprises risks to the delivery of Strategic Objectives – the BAF will still include some risks which transpired through COVID 19 as they are still impacting. The current risks to the delivery of our key objectives are:

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

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

The above risks will be fully reviewed with each Executive Director lead ready for the September Board to ensure that a full BAF can be presented. The BAF will include the controls, assurances and actions we are taking to reduce the risks going forward.

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

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 will include 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 .	**On Track –** This will be presented to the September Audit Committee and Board **(8th September and 24th September)**
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	**On Track** – Once the BAF has been approved by the Board, reporting individual BAF risks to the relevant Committees will continue **(from 24th September)**
Assess the organisation's 'Risk Appetite'	This was reviewed during a Board Development session and approved by the Board in July 2019. This now requires revisiting to see what progress has been made and how our 'Risk Appetite' is being used in decision making. A review of an organisations 'Risk Appetite' should take place annually but has slipped due to COVID 19. Review to take place at Board Development Session in October **(29th October 2020).**
Review Risk Management and Board Assurance Framework Strategy.	This was approved by the Board 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', in November **(26th November)**
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.
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	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.
Move to web based risk reporting	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.
- Draft internal audit providing 'reasonable' assurance.

Recommendation:

The Board is asked to:

- **Approve** the 10 risks to the delivery of Strategic Objectives which will be developed into a full BAF for presentation to the September Board.
- **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:	~~Yes / No /~~ Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Report Title:	**PATIENT SAFETY QUALITY AND EXPERIENCE REPORT – V9**						
Meeting:	Board Meeting				**Meeting Date:**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	Executive Nurse 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 May to June 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 Board should note the following:

- The main themes in incident reporting relate to infection, prevention and control (IP&C) outbreaks and covid-related incidents including those related to Personal Protective equipment (PPE). The details of the IP&C outbreaks are reported in a separate report to Board. A number of issues in relation to PPE have been reported by staff. The UHB has established a multidisciplinary PPE Cell and a multidisciplinary IP&C cell chaired by the Executive Nurse Director that meets weekly. They discuss issues in relation to procurement, infection prevention and control, Fit testing and training and to monitor all reported incidents. Day-to-day operational issues are managed by the Health and Safety Team to ensure that there is prudent use of all available PPE. The Board received a full report on the provision of PPE at the May 2020 meeting.

- The number of SIs reported to WG has fallen in the last three months.

- In May and June 368 concerns were received and the 30-working day performance for June is 79%. The numbers are less than May and June of 2019 when 519 concerns were received.

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

PATIENT SAFETY QUALITY AND EXPERIENCE REPORT
May – June 2020

Serious patient safety incidents (SIs reportable to Welsh Government)

How are we doing?

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

Serious Incidents		
Clinical Board	**Number**	**Description**
Executive Nurse	3	Three incidents have been reported where the Procedural Response to Unexpected Death in Childhood (PRUDiC) has been initiated.
Medicine	2	Two incidents of temporary ward closure at University Hospital Llandough due to Covid-19 were reported. A number of staff and patients were affected by the virus.
Mental Health	4 1	Patients who were known to either Community Addictions or Mental Health services have died unexpectedly. A young adult patient with a personality disorder sustained lower limb fractures following a significant incident of self-harm.
Primary Care & Intermediate Care	1	A prisoner in HMP Cardiff was found suspended from a ligature in his cell. He was initially resuscitated and transferred to Critical Care at UHW where he subsequently died.
Specialist	2	Two issues relating to Covid-19 transmission in Specialist Services Clinical Board were reported.
Surgery	1	Incident related to a dental extraction.

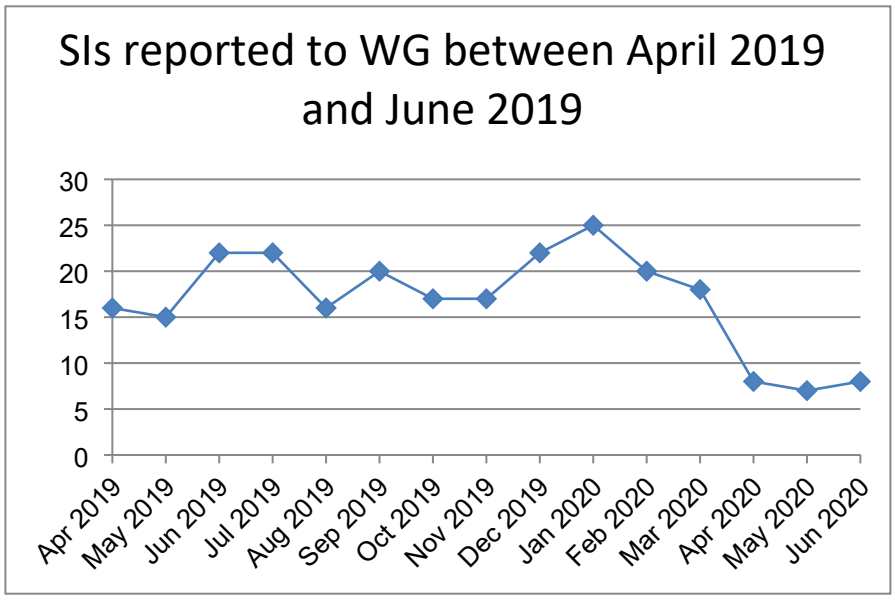
	1	In-patient suicide in a ward bathroom.
Total	**15**	

No Surprises		
Clinical Board	**Number**	**Description**
Executive	1	The Health Board formally reported to WG the tragic deaths of five staff members in relation to Covid-19. The deaths of the staff members were widely reported in the media.
Medicine	1	The Health Board alerted WG to a BBC programme regarding testing for Covid-19 in care homes. There was to be reference made to a patient who had previously received care in the UHB
Total	2	

How do we compare to our peers?

The following graph depicts the number of SIs reported to WG by month between April 2019 and June 2019. Welsh Government (WG) wrote to organisations in NHS Wales on 18th March 2020 to set out SI reporting requirements during the pandemic and this has led to a reduced volume of SI reportable incidents.

Information to compare organisations across NHS Wales is not currently available. In light of the Covid-19 pandemic and the planned review of the SI Framework by WG, they are considering how feedback to organisations will take place in the future.



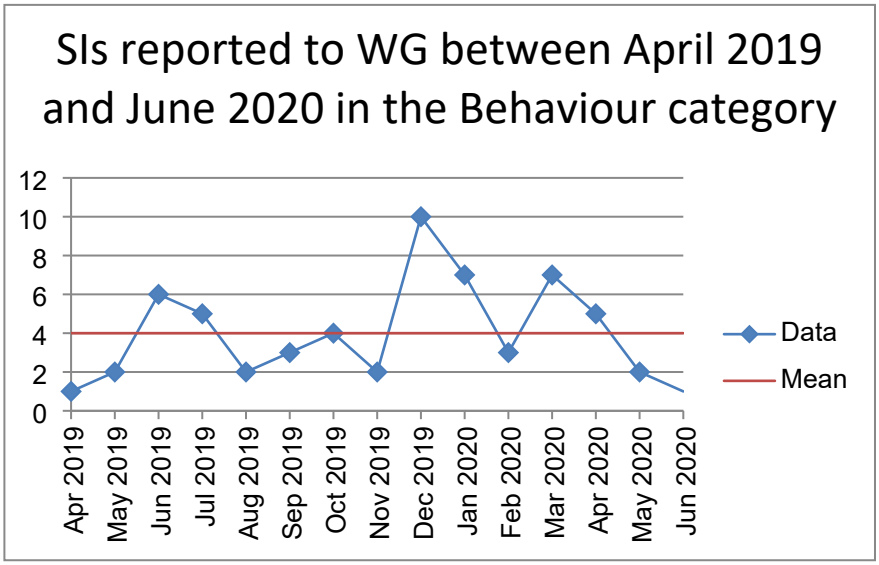
The top three reported categories of Serious Incidents reported overall during this timeframe include:

- Behaviour (including suicide, serious self-harm, absconsion)
- Patient accidents/falls
- Pressure damage

These categories are set out in the graphs below to demonstrate the picture on a monthly basis between April 2019 and June 2020.

Behaviour

With the changing WG guidance in March 2020, only inpatient suicides were specifically required to be reported. The UHB has reported one such incident in June 2020 (Surgery Clinical Board). Other incidents reported relate to circumstances where the PRUDiC process has been instigated, incidents in HMP Cardiff and incidents in Mental Health Clinical Board are unexpected death has occurred. Investigations are underway.



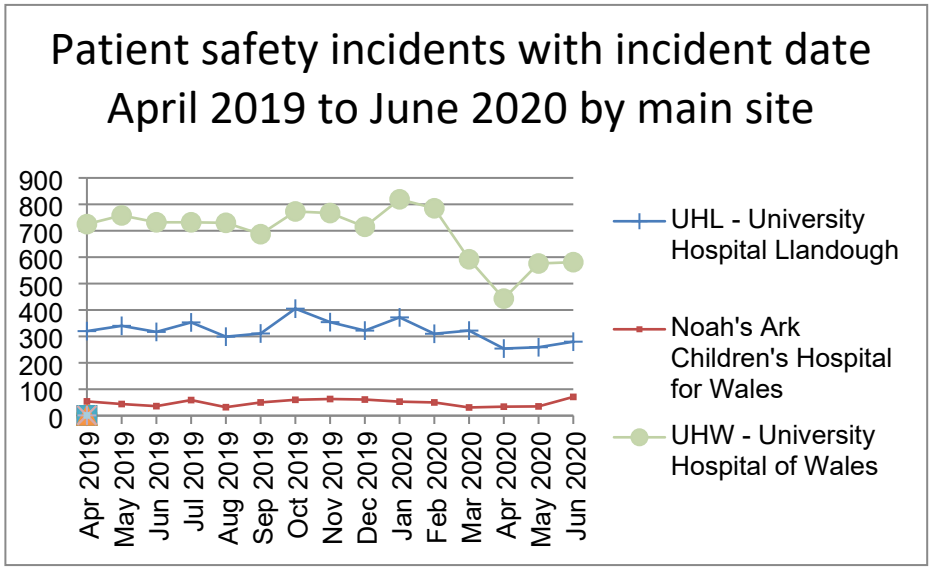
Patient Accidents/Falls and Pressure Ulcers

No patient accidents/falls or pressure ulcer incidents have been reported to WG since their guidance changed in March 2020. The organisation would usually expect to report in the region of four of each such incidents per month. Review of the incident reporting system indicates anticipated numbers of these incidents have however occurred and are under investigation in the Clinical Boards in line with normal processes.

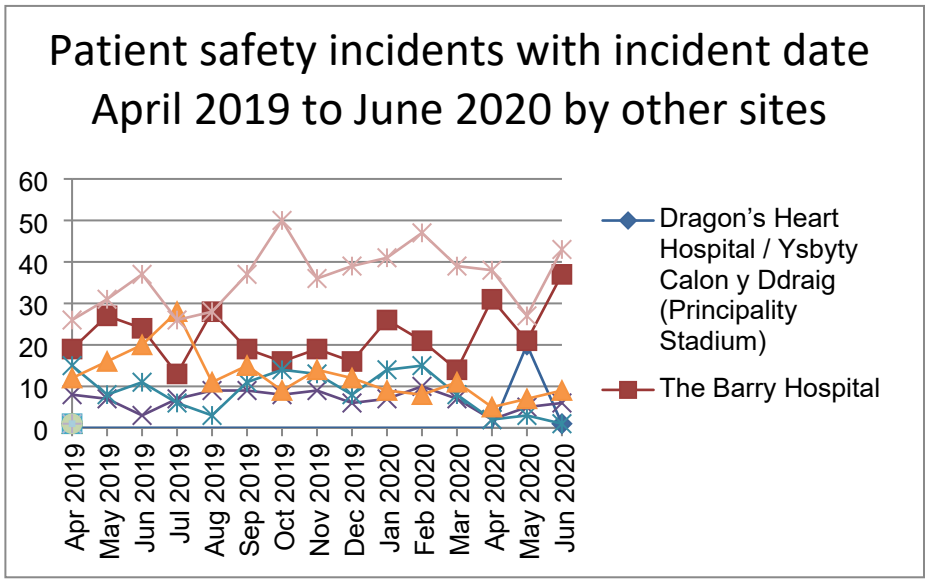
The UHB has put in place a process to record and continue to investigate all incidents which met the previous definition for a Serious Incident.

With regards to general incident reporting, it is evident that incident reporting rates fell initially, especially at UHW. The profile of incidents being reported and the reporting

areas has been largely unchanged and it was believed that reduced clinical activity contributed to the situation. There has been an increase in the number of incidents reported in Noah's Ark Hospital during June 2020 albeit in line with pre-Covid reporting levels. The Clinical Board have been asked to undertake a detailed look at the themes and trends being reported.



Review of incident reporting at other sites is variable. Incidents were temporarily recorded at Dragon's Heart Hospital during the time that patients were located there. The categories of incidents being reported by our smaller sites are unchanged and are predominantly patient accidents / falls and pressure damage.



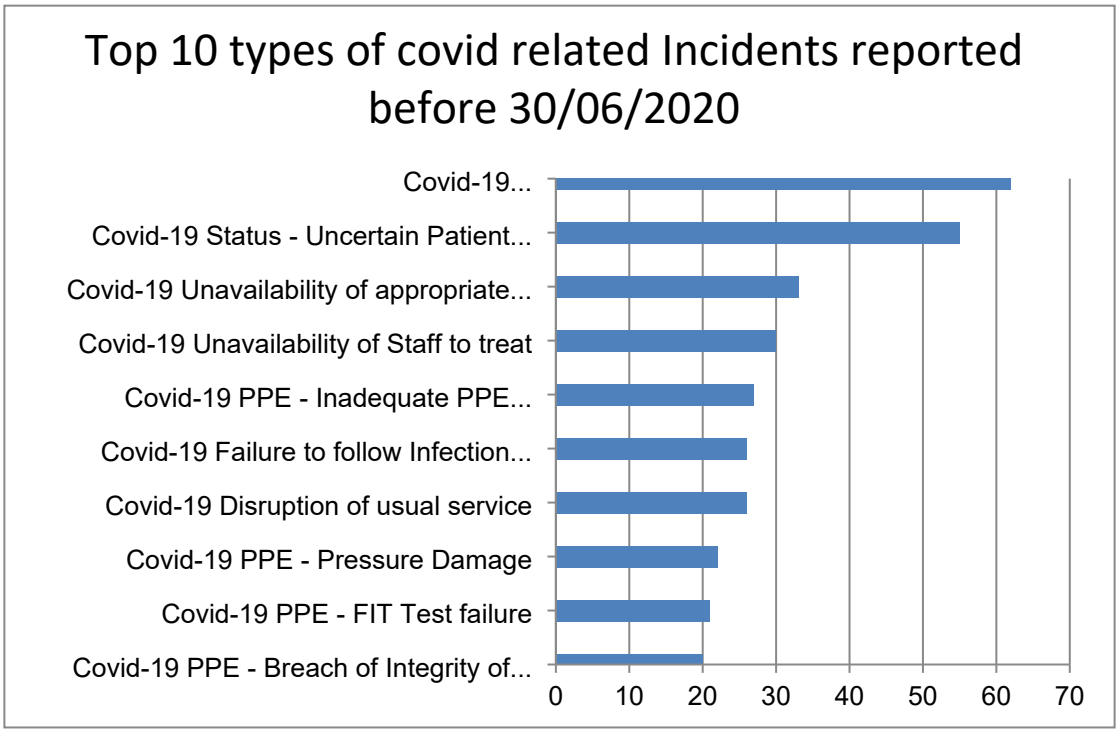
In the previous report to Board, it was explained that some fields were added to the RL Datix system in order to capture incident forms relating to Coronavirus. Prior to the end of June 2020, 590 Covid-related incidents were reported. The top ten categories of incidents are set out in the graph overleaf.

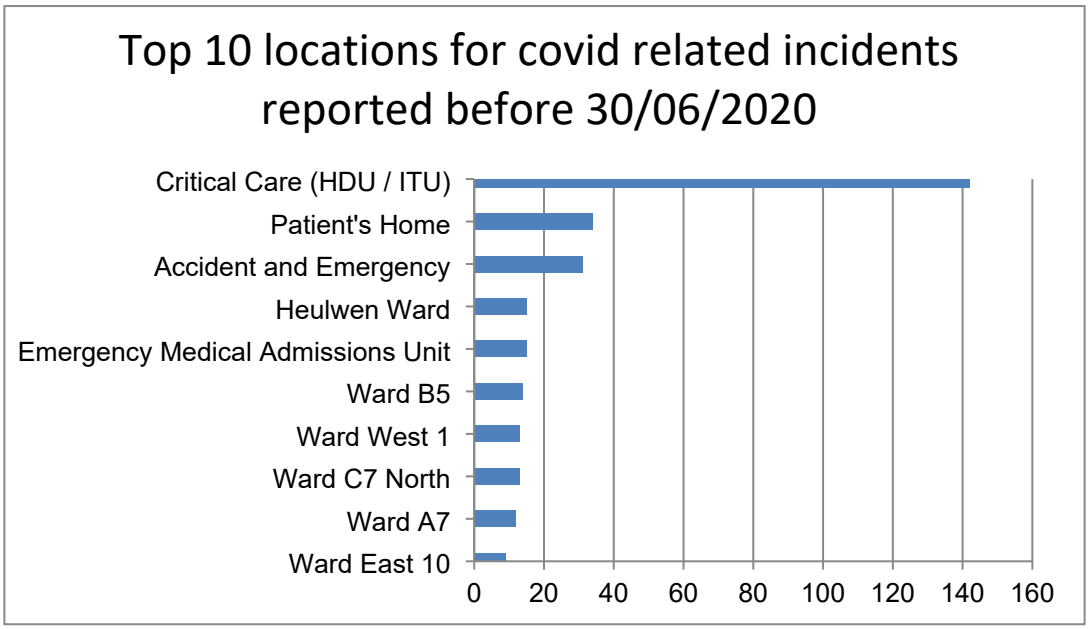
Incidents involving aggressive/inappropriate behaviour were reported between staff and from patients towards staff. The Patient Safety and Quality Department took the opportunity to remind staff of the UHB's values and behaviours in their recent Covid-19 newsletter. Staff have been actively encouraged to report incidents where patients have behaved inappropriately in order that the situation be monitored and action taken where necessary.

A number of incidents were reported during the early stages of the pandemic where there was confusion regarding infectious status of patients that affected transfer between clinical areas. The Patient Safety Team has worked with the Infection Prevention and Control department to devise a transfer checklist.

It can be seen that a number of issues in relation to PPE have been reported by staff. The UHB has established a multidisciplinary PPE cell chaired by the Executive Nurse Director. This meets regularly to discuss issues in relation to procurement, infection prevention and control, Fit testing and training and to monitor all reported incidents. Day to day operational issues are managed by the Health and Safety Team to ensure that there is prudent use of all available PPE. The Board received a full report on the provision of PPE at the May 2020 meeting.

The overwhelming majority of Covid-related incidents have been reported by the Critical Care Directorate. The majority of these incidents report concerns in relation to PPE.





Regulation 28 Reports

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

The majority of inquests have been postponed due to the pandemic and the UHB is awaiting rescheduling of the inquests. There has unfortunately been great disruption to the Coroner's service as a result of the pandemic.

Patient Experience

The Patient Experience Team has worked very differently since 1st March 2020 and have been involved in a number of bespoke studies:

Prehab2Rehab

The team has been involved in the development of feedback tools for the *Prehab2Rehab* programme being led by Dr Rachael Barlow. This involves using an Innovative Behavioral Change Approach to deliver health messages and pre-habilitation style advice for patients on the inpatient waiting list. This is an initiative led by Cardiff and Vale UHB, with a view to be spread and scaled across NHS Wales.

The aim is to provide robust self-management advice to educate, support and inform patients about pre-habilitation style advice (general health and well-being) whilst they wait (and prepare) for their elective operation. The approach will also be used to inform patients about other important health messages to help them during this time.

We will also seize the opportunity of this initiative to collect Patient Reported Outcome Measures and/or Patient Reported Experience Measures to gather an evidence base for a potential new model of working with adding value in mind.

The methodology is to use a novel approach 'Nudge Theory' for this initiative. A report by the Health Foundation in 2015 suggests that nudge type interventions have the potential for changing behaviors', increasing efficiency and reducing waste in health care.

We propose that by using this 'nudge approach' we can communicate directly with often hard to reach populations improving their recovery and rehabilitation following surgery but also potentially giving them the opportunity to contemplate longer-term health changes for them and their loved ones.

All adult patients on the inpatient waiting list will have an information leaflet sent to them either digitally via SMS messaging or via the post. Simple health message alerts will be sent to the patient asking them to divert to the UHB website. A series of podcasts, videos and cartoons will be produced to support this initiative.

An evaluation plan has been developed in conjunction with the value based healthcare team and communication team.

Surgery Clinical Board have contacted 1,600 patients to date, with the plan to contact all 4,500 patients on our surgery waiting lists. We will, as part of this work, be undertaking a series of virtual focus groups and collating patient stories.

The 'All Wales' ENT Outpatient Survey

This was a survey undertaken across Wales as part of the Planned Care Programme Board. The survey related to the pre-Covid appointments system.

Results from our survey
95% of people felt the date and time of their appointments were convenient.
55% of appointments started on time.
85% would be extremely or very likely to recommend our service to family and friends, if they needed similar care or treatment.
21% of respondents considered themselves to have a disability.
61% of people lived within five miles of the hospital.

What was good?
'Service was fast, no delays or long waits at the reception'.
'When I was seen, the process was explained and I felt that the staff were diligent and efficient'.
'Consultant explained things in great detail for me to better understand. My follow-up appointment was booked within the following 3 weeks'.
'Consultant and nurse, very courteous and helpful.'

What areas could we improve?
'Parking a major issue; despite arriving early at the hospital, I was unable to park in the hospital grounds, so had to park outside - this nearly made me late for my appointment'.

'Car parking is still a nightmare, especially in disabled bays'.

'I am 87 years and in a care home [name removed]. I had to travel on a bus which only runs hourly. I have limited mobility and it was not easy, in fact, it is quite stressful. Is there not somewhere I could go to in the town centre? I have a further appointment on 11th of this month and I am not looking forward to the travelling aspect. It takes a few hours waiting around when the bus only runs once an hour'.

'The virtual clinics will help address some of the concerns regarding car parking and accessing the site in a timely manner'.

Personal Protective Equipment (PPE) study

This retrospective study was carried out with Dr Khitish Mohanty and his team and received feedback from 710 patients. The survey asked what is it like to be cared for by staff wearing PPE.

Whilst this study was mainly focused around PPE in Patient Experience, it also provided the opportunity to ask about communication and loneliness. 62% of the patients surveyed felt lonely either sometimes or often during their hospital stay.

The Health Board is aware of the negative psychological affects that not seeing family can have on someone's well-being. In addition loneliness and boredom as highlighted by the Community Health Council, has only been compounded by the Covid situation. A number of initiatives have been undertaken to try and address these issues:

Virtual Visiting

Virtual Visiting Video

We have over 400 tablets in place across the UHB; our IT department worked tirelessly to ensure that the tablets are safe for patients to use and comply with data protection guidelines. Each tablet has been set up with Zoom for virtual visiting, Radio Glamorgan, free magazines from Wi-Fi Spark and a feedback survey. IT have added a range of games and activity apps to help alleviate boredom on the wards.

Feedback from the virtual visiting has been very positive from both staff and patients, some of whom have not seen family/friends in weeks.

Patient Experience has been working in partnership with Cardiff University, 17 medical and nursing students were placed with the team to support patients and families by contacting next of kin and providing updates, facilitating virtual visiting, ensuring patients had the essentials during their stay and providing activities where needed, to alleviate boredom. The students undertook a robust induction and were placed on wards in the most need of their support. The students are also undertaking patient experience survey work.
'Phoning with updates and progress report'. 'Was happy with the proactive nature of the service'. 'Being given updates and progress report'. 'Phoning to arrange Zoom calls'. 'Being able to face time was very positive'.

When asked what we could have done better: You Said

‘Better security of personal possessions, as some of them went missing during stay’. ‘Not ideal for those with co-morbidities, felt the hospital only cared for Covid, not the patient in a holistic manner’.

‘Phone calls to update regarding discharge’. ‘Clarity whether being discharged and what time’.

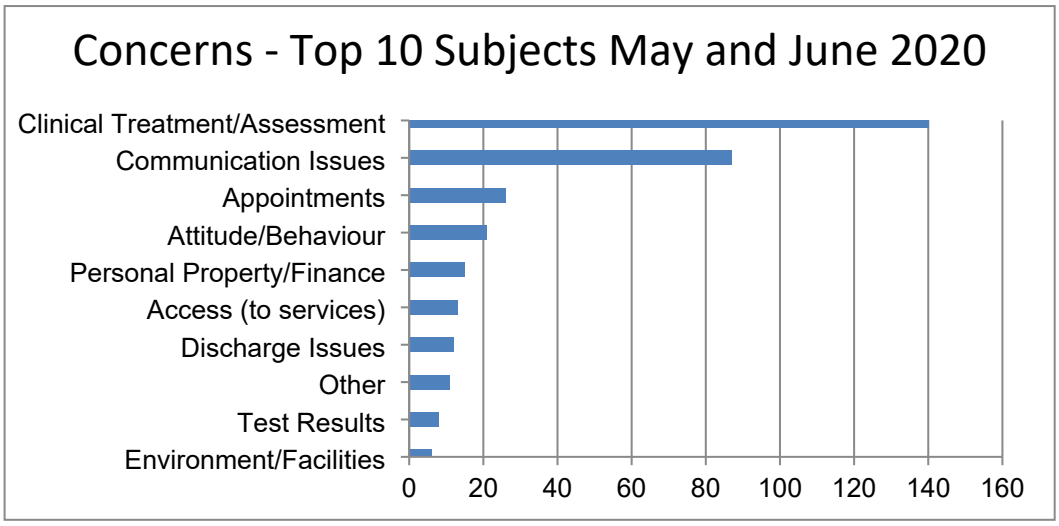
To date the students have provided in excess of 2,500 hours of patient experience support to wards. Staff have expressed how invaluable this service has been to them and students have commented on how much experience they have gained since commencing the role.
We did-Improve communication with the support of technology and our students supporting the activity. A Zoom tutorial for families to help them has been developed and can be accessed here - Zoom Tutorial.

Security of patients’ property remains a concern and we are seeing an increasing number of small claims. Many items have significant sentimental value and money does not replace lost jewellery etc. We have reminded staff of the need to use Cashiers to store valuables and we will pilot the use of some more secure and labelled clear property bags. All claims are investigated and on occasion the lost property is located, or it is deemed lost and on the rare occasion that theft is suspected the incident will be reported to the police.
A detailed report of all small claims is provided to the Special Losses panel which report to the Audit Committee.

Complaints Management/Redress

The central Concerns Team have continued to work in accordance with the Putting Things Right Regulations. In March 2020 a letter was sent to advise anyone who had an active concern with the Health Board, that there may be a delay in responding the their concerns; however we have done our upmost to respond in a timely manner. The team have continued to update all complainants and provide assurance that all concerns will be investigated.

In May and June 368 concerns were received and the 30-working day performance for June is 79%. The numbers are less than May and June of 2019 when 519 concerns were received.



It should be noted that in comparison to the data provided for the last Board Report, there has been a notable decrease in concerns raised regarding communication and a significant increase in concerns relating to clinical treatment and assessment.

You said- you were worried about staff not adhering to social distancing.

We Did-continued to highlight the importance of social distancing in the CEO Connects and 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.

Public Service Ombudsman (PSOW)

In June 2020, the PSOW published - Delivering Justice - The Public Services Ombudsman for Wales **Annual Report and Accounts 2019/20.**
The annual letters will follow later in the summer with more detail in relation to Cardiff and Vale UHB and a report will be provided to the Quality, Safety and Experience Committee.

The table below presents a detailed comparison of new complaints about bodies compared to 2018/19:

Health Board	2019/20	2018/19	% change
Aneurin Bevan University Health Board	140	134	+4.5%
Betsi Cadwaladr University Health Board	227	194	+17.0%
Cardiff and Vale University Health Board	**100**	**102**	**-2.0%**
Cwm Taf Morgannwg University Health Board*	80	75	+6.7%
Hywel Dda University Health Board	92	109	-15.6%
Powys Teaching Health Board	23	26	-11.5%
Swansea Bay University Health Board*	91	139	-34.5%
Total	**753**	**779**	**-3.3%**

It should be noted that the numbers of concerns received in the Health Board overall increased from 2,759 in 2018/19 to 3,228 in 2019/20. Therefore we are pleased to note

the percentage decrease from 3.6 % in 2018/19 of complainants who contacted the Ombudsman has decreased to 3% in 2019/20 despite the increased numbers.

Compliments

In this period the Health Board received 53 compliments. The majority of these were logged with Medicine Clinical Board, split between, Integrated Medicine and EU followed by Surgery.

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	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

Assessment Completed:	

Report Title:	**PERFORMANCE REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	30/07/20	
Status:	**For Discussion**		**For Assurance**	x	**For Approval**		**For Information**		
Lead Executive:	Chief Operating Officer and Executive Finance Director								
Report Author (Title):	Members of the Performance and Information Department - 029 20 745602 Assistant Director of Performance and Delivery (Operations) – 029 21 744120 Deputy Chief Operating Officer - 029 21 741803								

Background and current situation:

Cardiff and Vale University Health Board has faced unprecedented challenges as a result of the COVID-19 pandemic, with demand and capacity across the system directly impacted. In mid-March 2020, as NHS Wales moved from the 'contain' to the 'delay' phase of COVID-19, the Health Board's focus changed to managing COVID-19 and maintaining essential services. Welsh Government relaxed targets and monitoring arrangements and publication of performance was suspended nationally. This largely remains the case but some data submissions to Welsh Government have been re-instated from 9th June 2020. National publication of performance remains suspended until 30th September 2020 at the earliest. In addition, national guidance issued in June extended to Health Board plans to increase activity but delivery of routine services remains a local decision.

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. The overriding principle of both frameworks is the need to minimse harm, balancing risks across the system and the four different types of harm i.e. harm from COVID itself; harm from reduction in non-COVID activity; harm from overwhelmed NHS and social care system; and harm from wider social actions/lockdown.

In light of the above, this performance report differs from the usual format presented to the Board and instead focuses on specific indicators i.e. those that are deemed as essential services and / or continue to be routinely reported. Given the unusual circumstances, the normal actions associated with the measures in this report have been covered in a comprehensive quarter two plan received by the Board. This report should, therefore, be read in conjunction with the quarter two plan. Additionally, following the suspension of national performance reporting, the usual benchmarking data is not available for inclusion.

Whilst this report will set out performance against some key indicators, it is imperative to see these in the COVID-19 context, the impact this has had and, therefore, as a position statement of where the Health Board is.

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

- COVID-19 has had an unprecedented impact on demand and capacity across the system, with resources reprioritised to manage COVID-19
- As a result of the pandemic, Welsh Government have relaxed targets and monitoring arrangements and suspended the publication of performance nationally – to 30 September 2020.
- In line with the overriding principle of minimising harm, prioritisation of need and service delivery is based on clinical stratification rather than time based targets.
- There is a similar picture in levels of demand and activity across unscheduled and planned care, with both decreasing in March and rising again in April onwards, albeit it to lower levels than previously.
- Although the impact has been apparent across system, there is caution that the "first wave" impact for Mental Health is yet to come. Mental Health teams are conscious of this and have been planning accordingly
- The Health Board is continuing to implement plans to recommence some routine services, whilst ensuing the organisation remains able to respond to further increases in COVID-19 demand.

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

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

- Unscheduled Care
- Primary Care
- Mental Health Measures
- Cancer
- Elective access

There are a number of service delivery risks related to the ongoing impact of COVID-19, namely:

- Uncertainty of the demand profile - COVID-19 and non-COVID
- Capacity impact and reduced efficiency as a result of the Infection, Prevention and Control measures in place to minimise COVID-19 transmission
- Extended waiting times as a result of reduced delivery capacity
- Rebuilding confidence for clinicians and patients to re-establish activity
- Working in a new level of complexity ie. up to five new levels of patients flow have been introduced into the system – each requiring its own headroom

The Health Board's Quarter two plan sets out the actions being taken in relation to these.

Appendix 2 provides the Financial report as at 30th June 2020 for the Board.

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

Recommendation:

The Board is asked to **NOTE**:

- The year-to-date position against specific performance indicators for 2020-21 but in the context of the impact of the COVID-19 pandemic and relaxation of Welsh Government targets and monitoring
- The performance report should be read in conjunction with the Health Board's quarter two 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		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		Long term	x	Integration	x	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

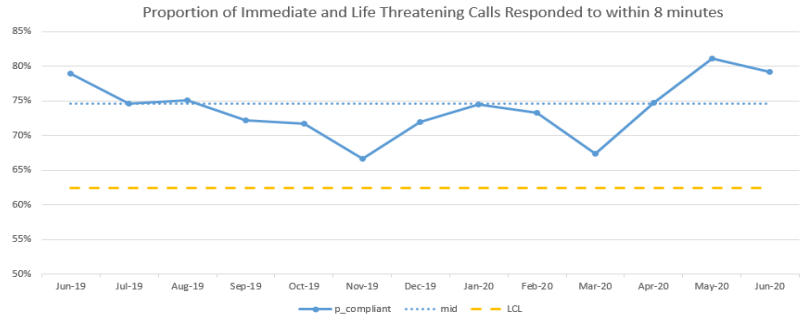
Unscheduled Care

Overview

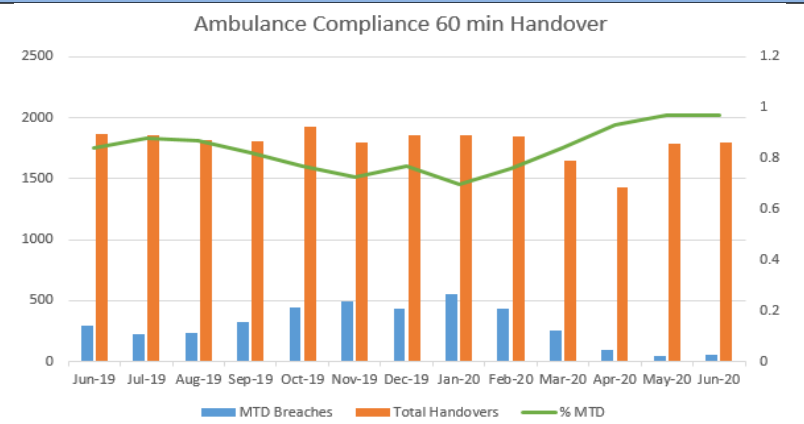
Following a significant decrease in unscheduled care activity during March 2020, A&E attendances have subsequently increased and were back to 75% of previous levels with 9,581 attendances in June 2020. Patients who presented for emergency care experienced more timely access during April to June with improvements seen in 4 and 12 hour waiting times and ambulance handover delays. In June 2020, 79.2% of red calls were responded to within 8 minutes; There were 51 ambulance handovers greater than one hour; 91.2% of patients were seen within 4 hours; and there were 7 patients waiting greater than 12 hours.

Performance

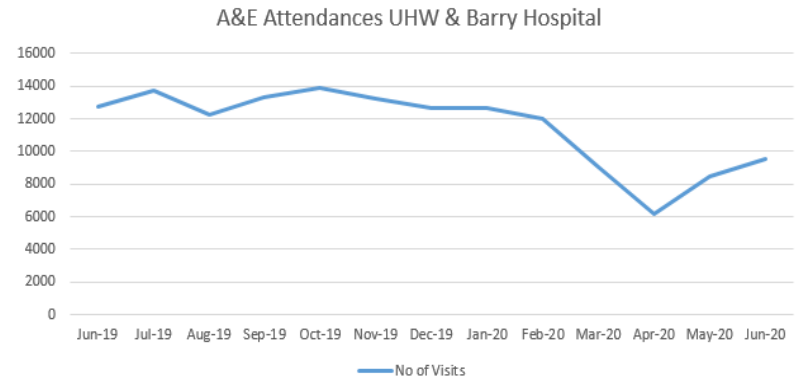
Graph 1: % Red calls responded to within 8 minutes



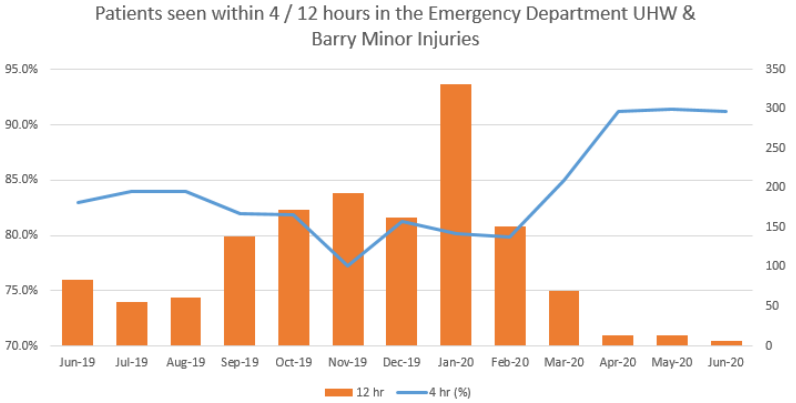
Graph 2: Ambulance handover > 1 hour (number)



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 active applications from GPs to support with the sustainability of their services and there are no lists presently closed to new registrations.
- *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):

- There were no patients prioritised as 'emergency' requiring a primary care centre appointment within 1 hour in June 2020. 100% of patients prioritised in May were seen within one hour.
- 100% of patients prioritised as "emergency" requiring a home visit in June 2020 were seen within one hour

Performance

Chart 1: % of GP OOH "emergency" patients requiring a primary care centre appointment seen within 1 hour

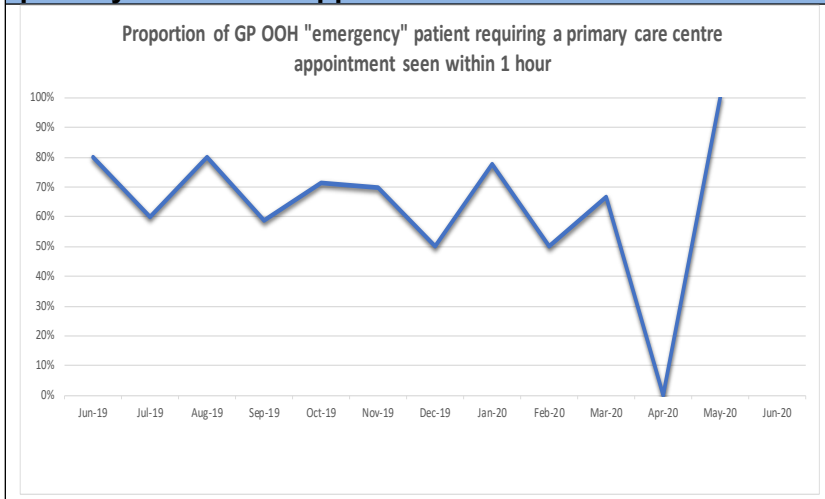
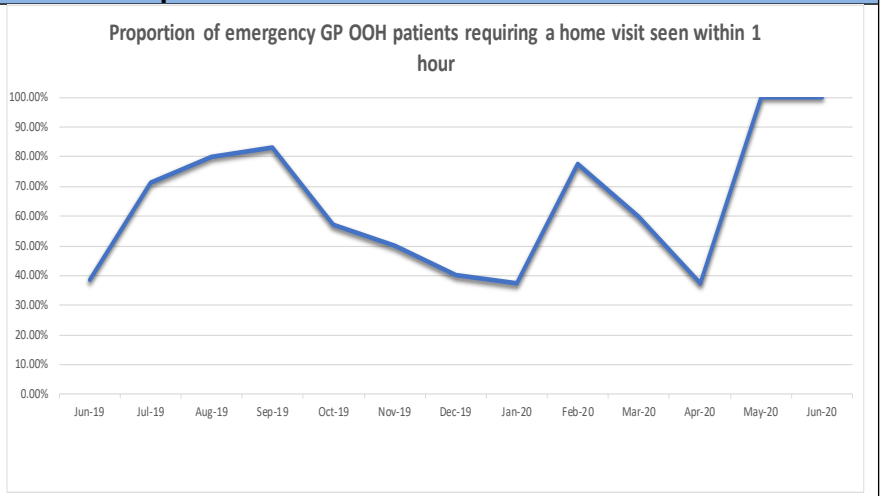


Chart 2: % of GP OOH "emergency" patients requiring a home visit provided within 1 hour



Mental Health Measures

Overview

- Following a decrease in referrals for the Local Primary Mental Health Support Service (LPMHSS) in April 2020, referrals have subsequently increased and are at 76% of previous levels in June 2020.
- Part 1a: The percentage of Mental Health assessments undertaken within 28 days has improved – to 96.4% overall and 91.7% for CAMHS.
- Part 1b: 81% of therapeutic interventions started within 28 days following assessment in June 2020.
- Part 2: 82% of health board residents in receipt of secondary mental health services have a valid care and treatment plan (CTP), as at May 2020
- Part 3: 71% of health board residents were sent their outcome assessment report within 10 days of their assessment in May 2020

Performance

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

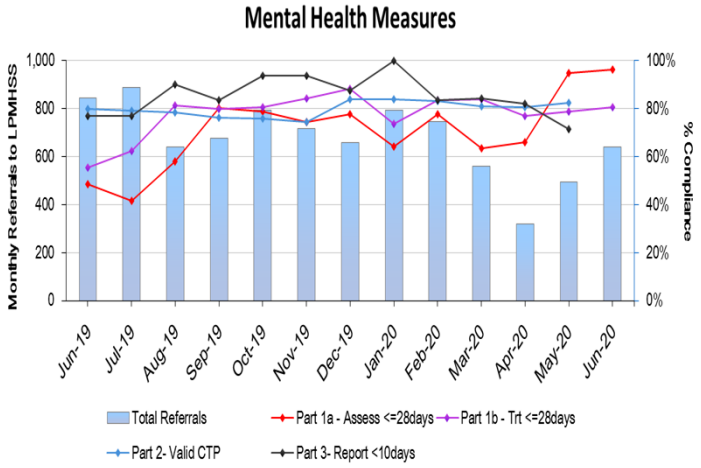
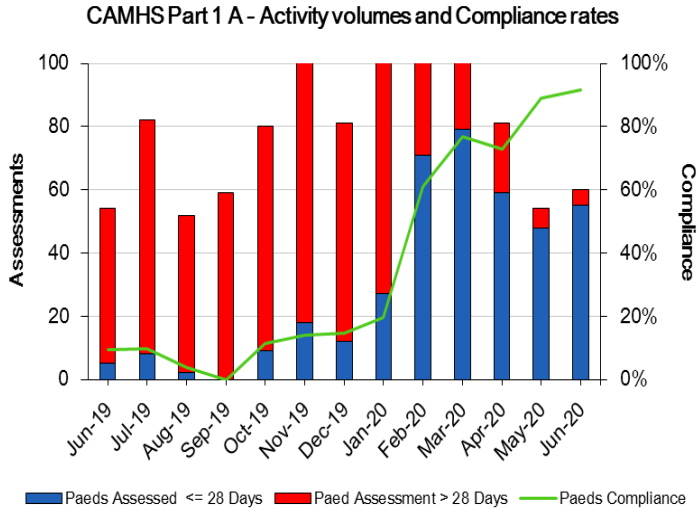


Chart 2: CAMHS Part 1a compliance - %



Cancer

Overview

- Referrals for patients with suspected cancer reduced over the initial period but have increased since April following a targeted communication campaign led by our GP Cancer Lead
- In May 2020:
  - 81.8% of patients on an urgent suspected cancer pathway were seen and treated within 62 days of receipt of referrals
  - 100% of patients on a non-urgent suspected cancer pathway were seen and treated within 31 days of date of decision to treat
  - 79% of patients on the single cancer pathway were seen and treated within 62 days of the point of suspicion

Performance

Chart 1: Cancer referrals

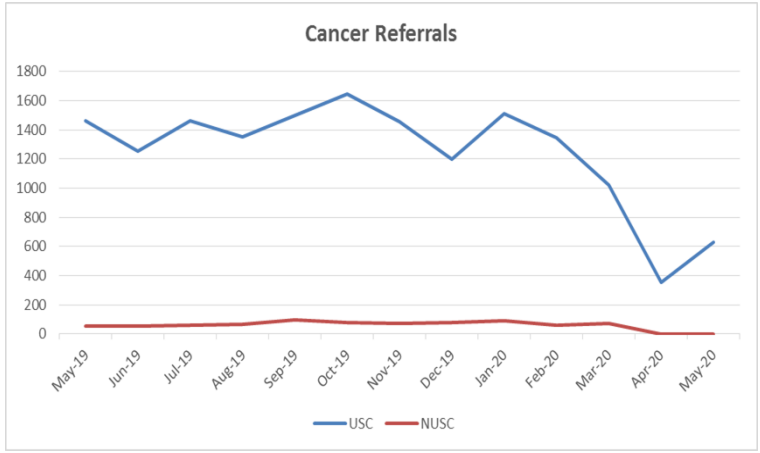
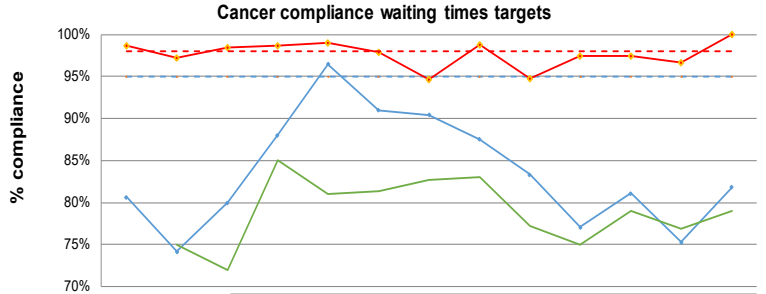


Chart 2: Performance against USC 61 day, NUSC 31 day and SCP performance



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20
62 Day Actual	81%	74%	80%	88%	96%	91%	90%	88%	83%	77%	81%	75%	82%
62 Day Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
31 Day Actual	99%	97%	98%	99%	99%	98%	95%	99%	95%	97%	97%	97%	100%
31 Day Target & IMTP traj	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SPC %		75.0%	72.0%	85.0%	81.0%	81.4%	82.7%	83.0%	77.2%	75.0%	79.0%	76.8%	79%

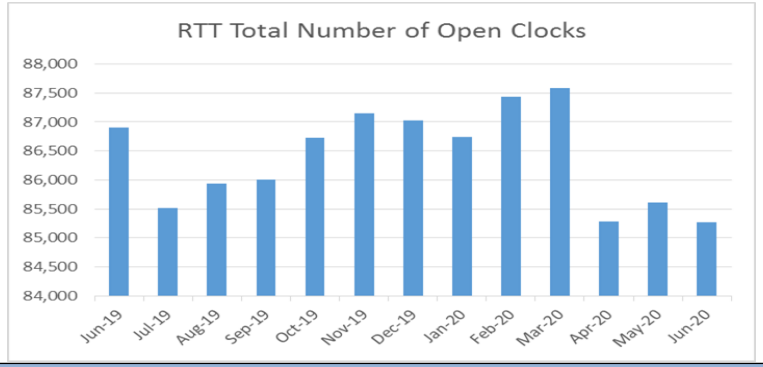
Elective access

Overview

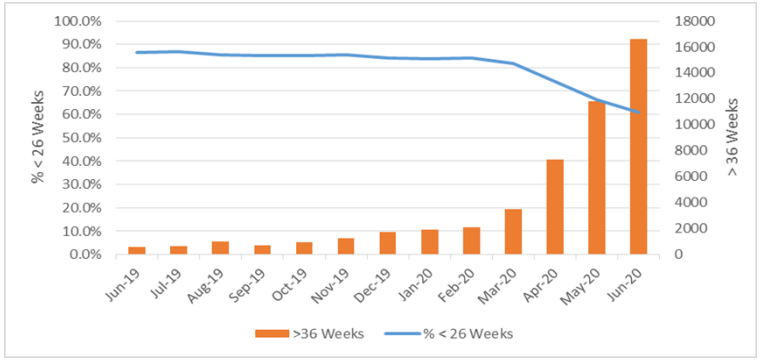
- Whilst the overall Referral to Treatment times waiting list volume has reduced to 85,269 in June 2020, waiting times have deteriorated. In June 2020, 61% of patients were waiting under 26 weeks and 16,622 patients were waiting greater than 36 weeks.
- Patients waiting greater than 8 weeks for a diagnostic have also increased since March 2020 to 9,632 in June 2020. There were, however, 820 fewer patients waiting at the end of June 2020 compared to the previous month.
- The overall volume of patients waiting for a follow-up appointment has reduced to 173,556 in June 2020, although waiting times have deteriorated

Performance

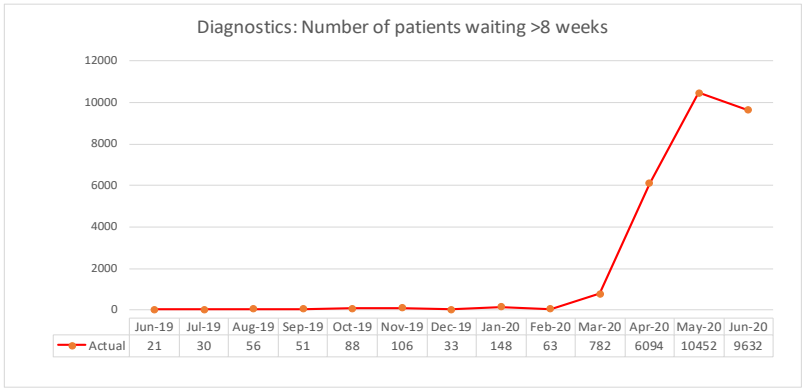
Graph 1: RTT total size of the waiting list



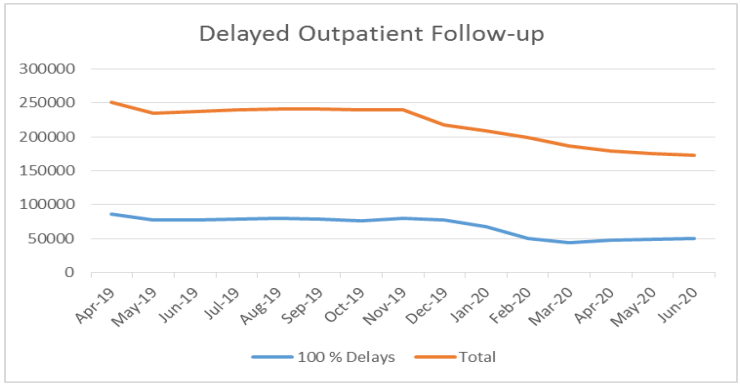
Graph 2: RTT % of patients 26 weeks and number of patients > 36 weeks



Graph 3: Diagnostics > 8 weeks



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



Appendix 2

Financial Report

How are we doing?

The UHB's 2020/21 operational plan included a balanced financial plan which was dependent upon managing the following key challenges:

- delivering a £29m savings target;
- the management of operational cost pressures and financial risks within delegated budgets.

At month 3, the UHB is reporting an overspend of £45.774m against this plan due to net expenditure of £56.850m arising from the management of COVID 19 which is offset by Welsh Government COVID 19 funding of £11.016m and an operating surplus of £0.061m.

Background

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, however, is still monitoring the UHB against its submitted plan with a focus on the financial impact of COVID 19.

Reported month 3 position

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 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 3 is a deficit of £45.774m and this is summarised in Table below:

	Cumulative at Month 3 £m
COVID 19 Additional Expenditure	61.060
COVID 19 Non Delivery of Savings Plans	6.320
COVID 19 Reductions in Planned Expenditure	(9.683)
COVID 19 Release of Planned Investments	(0.847)
Net Expenditure Due To COVID 19	56.850
Operational position (Surplus) / Deficit	(0.061)
COVID - 19 Funding Pay Costs Quarter 1	(11.016)
Financial Position (Surplus) / Deficit	45.774

This shows that the key driver of the month 3 financial postion is the impact of COVID 19.

The additional COVID 19 expenditure in the 3 months to the end of June was £61.060m. Within this, the costs of the Dragon's Heart Hospital are significant, especially the set up costs which allow for significant expansion. At month 3 additional costs of £39.994m related to the Dragon's Heart Hospital (DHH). There was also £21.066m of other COVID 19 related additional expenditure.

COVID 19 is also adversley impacting on the UHB savings programme with underachievment of £6.320m against the month 3 target of £7.196m. It is not anticipated that this will significantly improve until the COVID 19 pandemic passes.

Elective work has been significantly curtailed during this period as part of the UHB response to COVID 19 and this has seen a £9.683m reduction in planned expenditure. The UHB has also seen slippage as a commissioner of £0.847m on its commissioning plan due to impact of COVID 19.

The net expenditure due to COVID 19 is £56.850m. The UHB also has a small operating underspend of £0.061m and has received additional Welsh Government funding of £11.016m to cover COVID related Quarter 1 pay costs resulting in a Month 3 deficit of £45.774m.

Progress against savings targets

The UHBs 2020/21 IMTP included a £29.000m savings target comprising of £25m recurrent and £4m non-recurrent savings schemes. At month 3 the UHB has identified green and amber savings schemes totalling £4.129m to deliver against the £29.000m savings target.

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Unidentified) £m
Total £m	29.000	4.129	(24.871)

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 dependent upon delivering the £25.0m 2020/21 recurrent savings schemes. The latest assessment is that this will be circa £21.7m less than planned and this will increase the underlying deficit to £25.7m.

Creditor payment compliance

Non-NHS Creditor payment compliance was 94.1% for the 3 months to the end of June, marginally below the 95% 30 day target.

Remain within Capital expenditure resource limit

The UHB had an approved annual capital resource limit of £41.736m at the end of June. Capital expenditure for the first 3 months of the year was £16.078m against a plan of £16.204m. The UHB expects the final 2020/21 capital outturn to be broadly in line with its capital resource limit.

Cash

The UHB cash balance at the end of June was £4.051m.

What are our key areas of risk?

At month 3, the key financial risk is managing the impact of COVID 19.

What actions are we taking to improve?

Managing the impact of COVID 19 –the main financial focus is on justifying additional expenditure incurred in dealing with COVID.

Managing down operational pressurres - The UHB needs to keep in check on its non COVID operational position to ensure that financial control is maintained.

Managing down the underlying deficit – The UHB must avoid adding recurrent expenditure to its underlying position.

		STATUS REPORT				
Measure	**n**	**April 2019**	**RAG Rating**	**Latest Trend**	**Target**	**Time Period**
In Year Financial balance: remain within revenue resource limits	36a	£0.658m deficit at month 1.	R	↓	2019/20 Break-Even	M1 2019-20
funding allotted to it over a period of 3 financial years.	36b					
Remain within capital resource limits.	37	Expenditure at the end of the April was £1.660m against a plan of £36.730m.	G	⊖	Approved planned expenditure £36.730m	M1 2019-20
Reduction in Underlying deficit	36a	£36.3m assessed underlying deficit position at month 1. *FYE of identified savings £2.960m short of recurrent target at month 1.*	R	⊖	If 2019/20 plan achieved reduce underlying deficit to £4.0m	M1 2019-20
Delivery of recurrent £16.345m 2% devolved target	36b	£15.298m identified at Month 1	R	⊖	£16.345m	M1 2019-20
Delivery of £14.9m recurrent/non recurrent corporate target	36c	£12.600m identified at month 1.	R	⊖	£14.900m	M1 2019-20
Creditor payments compliance 30 day Non NHS	37a	Cumulative 96.9 % in April	G	↑	95% of invoices paid within 30 days	M1 2019-20
Remain within Cash Limit	37b	Forecast cash surplus of £ 1.219 m	G	⊖	To remain within Cash Limit	M1 2019-20
Maintain Positive Cash Balance	37c	Cash balance = £5.197m	G	⊖	To Maintain Positive Cash Balance	End of April 2019

		STATUS REPORT				
Measure	**n**	**June 2020**	**Rating**	**Latest Trend**	**Target**	**Time Period**
Financial balance: remain within revenue resource limits	36	£45.774m deficit at month 3.	R	↓	2020/21 Break-Even	M3 2020-21
Remain within capital resource limits.	37	Expenditure at the end of the June was £16.078m against a plan of £16.204m.	G	9	Approved planned expenditure £41.736m	M3 2020-21
Reduction in Underlying deficit	36a	£11.5m assessed underlying deficit (ULD) position b/f to month 1. Forecast year end ULD £25.7m	R	9	If 2020/21 plan achieved reduce underlying deficit to £4.0m	M3 2020-21
Delivery of recurrent £25.000m 3% devolved target	36b	£3.328m forecast at month 3. Performance impaired by response to COVID- 19	R	9	£25.000m	M3 2020-21
Delivery of £4m non recurrent devolved target	36c	£0.801m forecast at month 3. Performance impaired by response to COVID- 19	R	↑	£4.000m	M3 2020-21
Creditor payments compliance 30 day Non NHS	37a	Cumulative 94.1 % at the end of June	R	↑	95% of invoices paid within 30 days	M3 2020-21
Remain within Cash Limit	37b	Forecast cash **deficit** of £139.438m	R	↑	To remain within Cash Limit	M3 2020-21
Maintain Positive Cash Balance	37c	Cash balance = £4.051m	G	9	To Maintain Positive Cash Balance	End of June 2020

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9
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Tolley Laura
07/27/2020 11:09:35

Report Title:	**Nurse Staffing Levels Update –** NHS Wales COVID-19 Operating Framework – Quarter 2 (20/21)						
Meeting:	Board				**Meeting Date:**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**
Lead Executive:	**Ruth Walker, Executive Nurse Director**						
Report Author (Title):	**Jason Roberts, Deputy Executive Nurse Diretor**						

Background and current situation:

On the 24th March 2020 the Chief Nursing Officer for Wales issued a letter providing Health Boards/Trust with clarity on what is expected in relation to the Nurse Staffing Levels (Wales) Act, acknowledging that the pressures associated with managing the COVID-19 pandemic have and will continue to disrupt 'business as usual'. However recognising the challenges, the CNO highlighted that the responsibility of minimising risk to patient safety through applying professional judgement will remain fundamental across all areas where nursing care is provided or commissioned.

By way of reminder, under the exceptional circumstances, the Welsh Governments position is:

- Adult medical and surgical wards that have been repurposed to deal with the COVID-19 pandemic would be considered an exception under the definition of an adult medical ward, therefore, would not be subject to the prescribed triangulated calculation methodology.
- If wards remain designated as adult medical and surgical wards, Health Boards will be expected to persist with taking all reasonable steps to maintain calculated nurse staffing levels and undertake the usual mitigating actions where possible.
- Health Boards should ensure they are able to adequately articulate within the first three-year report (due April 2021) the narrative of these extraordinary circumstances.
- Health Boards, through their Executive Nurse Directors, ensure they are informed of any actions being taken to change or recalculate the staffing establishments in line with any service changes

Further advice that has been agreed by Welsh Government to include:

- The Bi-Annual audit due to be undertaken in June 2020 postponed until July 2020
- Bi-Annual calculation of July audit to be deferred until September 2020
- Bi-Annual calculation to be presented to Development Board in October 2020 prior to full Board in November 2020
- Overall compliance to Act (under normal circumstances would have been presented in May 2020) to be presented to Board in September 2020

As COVID-19 has become an established pandemic across the UK, NHS Wales' staff and services continue to experience significant challenges in the planning and re-organising of services in line with NHS Wales COVID-19 Operating Framework - Quarter 2 (20/21). The plan

requires organisations to ensure essential services are returned while confirming the safety of patients and staff while managing the COVID-19 situation.

During these exceptional times, a Paper was presented to Board in May 2020 (for the time period Jan 2020 to May 2020) which outlined Cardiff and Vale UHB plans to ensure that nurse staffing levels were systematically calculated and agreed and provided an overview of how the nurse staffing levels would be managed and maintained during the COVID-19 pandemic period.

However, as the organisation moves forward to realign and recover services, the ward establishments have been reviewed to ensure the staffing levels reflect the changing requirements of repurposed wards (for the time period May 2020 to Jan 2021). This Paper provides information on the revised establishments required going forward, however, it must be acknowledged that this position is evolving as the organisation continues to realign essential services through uncertain times.

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

1. Changes to Nurse staffing establishments from May 2020 in line with the requirements of NHS Wales COVID-19 Operating Framework - Quarter 2 (2020/2021)

Assessment:

In order to comply with the requirement of the Act there is an obligation for the Health Boards to ensure that their Executive Nurse Directors clearly outline any actions being taken to change or recalculate the staffing establishments in line with any service changes. The Chief Nursing Officer also emphasises the needs for Health Boards to ensure that they keep a record of the actions taken during the COVID-19 pandemic. Processes for collating this information and actions taken should be clearly reflected to Board.

This approach takes into account the significant challenges associated with the COVID pandemic while ensuring appropriate staffing levels during this period where capacity needs to be reviewed, the workforce is under considerable pressure and resources are limited. It is for this reason the Health Board will continue to explore a range of options which will include new ways of working, a greater multi-disciplinary approach, increased recruitment, nurses returning to practice, changes to student nurses educational contract and a greater reliance upon Health Care Support Workers to support the nursing workforce and ensure that all areas are staffed appropriately.

It is, therefore, proposed that due to the significant changes that are occurring within the organisation as part of the Realigning Essential Services, NHS Wales COVID-19 Operating Framework - Quarter 2 (2020/2021), that the staffing establishments are constantly being reviewed. This takes into account the current operational service planning and delivery, with the introduction of 'Green and Red' zones.

Within the Health Board, the Directors of Nursing for the Clinical Boards have been reviewing, calculating and agreeing the ward establishments in order to align the staffing to the proposed changes. Many of the wards have been re-purposed in order to deliver the necessary services going forward.

Appendix 1 outlines the agreed Nurse Establishments as of July 2020.

Recommendation:

Board members are asked to agree the revised establishments in line with the Act, acknowledging the continuing service changes to support the delivery of NHS Wales COVID-19 Operating Framework – Quarter 2 (20/21).

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

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

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

APPENDIX: Summary of Required Establishments on Wards during COVID-19 Pandemic

Site	Name of Ward	Previous establishment					Establishment during COVID-19			Current Establishment										
		Specialty	No. of Beds	RN WTE	HCSW WTE	TOTAL	RN WTE	HCSW WTE	TOTAL	Specialty	No. of beds	RN WTE	HCSW WTE	TOTAL	No of Nurses	No of Nurses	No of	No of Mat	No of WTE	No of WTE
UHW	Heulwen Seasonal Ward	Medicine	31	28,85	22,74	51,59	28,85	22,74	51,59	Medicine	20	29,43	22,74	52,17	0	0	29,43	0	4	1 (derm)
UHW	B2 Seasonal Ward	Surgical	18	15,21	11,37	26,58	15,21	11,37	26,58	Surgical	18	15,21	11,37	26,58						
UHW	B2N Emergency Surgery	Surgical	19	15,21	11,37	26,58	15,21	11,37	26,58	Surgical	18	20,09	8,53	28,62	1 UQ	1 UQ	0	0	0	0
UHW	A1	Medicine	38	30,69	17,06	47,75	30,69	17,06	47,75	Medicine	38	30,69	17,06	47,75	0	1	2	0	0	1 CNS
UHW	A6S	Medicine	17	16,21	11,37	27,58	16,21	11,37	27,58	Medicine	19	16,23	11,37	27,6	0	0	16,23	0	0	0
UHW	A6N	Surgical								Medicine	15	23,24	15,06	38,3	1					
UHW	B7	Medicine	38	32,26	17,06	49,32	32,26	17,06	49,32	Medicine	18	23,24	15,06	38,3	2		7,6			4 CNS
UHW	B7	Medicine	38	32,26	17,06	49,32	32,26	17,06	49,32	Medicine	27	31,26	17,06	48,32	2		7,6	0	2	0
UHW	A7	Medicine	31	26	19,44	45,44	32,26	19,44	51,7	Medicine	31	34,33	22,22	56,55	0	4	3	2	2	4 CNS
UHW	C6	Medicine	38	26,79	20,71	47,5	32,26	20,71	52,97	Medicine	38	27,6	19,9	47,5	0	1	5	0	0	1 (rheum)
UHW	C7S	Medicine	38	17,76	8,3	26,06	52,17	28,43	80,6	Surgery	19			0						
UHW	C7N	Medicine								Surgery	38	31,46	17,06	48,52	1 Q 2 UnQ	4 Q 1 UnQ	5.7 Q 1 UnQ	1 Q	0	0
UHL	East 3 (outside SRC)	Medicine								Medicine	9	0	0	0	0	0	0	0	0	0
UHL	SRC	Medicine	32	22,03	27,78	49,81				Medicine	32	22,03	27,78	49,81	4	1	1,88	0	0	2 CNS
UHL	East 6	Medicine	30	20,9	17,06	37,96	20,9	17,06	37,96	Medicine	30	20,9	17,06	37,96	3	3	1,5	0	0	1 CNS
UHL	East 7	Medicine	29	20,9	17,06	37,96	0	0	0	Medicine	29	20,9	17,06	37,96	13	2	2,47	0	0	0
UHL	East 8	Medicine								Medicine	29	16,63	21,32	37,95	4	1	3	0	0	0
UHL	East 4	Medicine	30	20,9	17,06	37,96	20,9	17,06	37,96	Medicine	30	20,9	17,06	37,96	2	4	2	0	0	0
UHL	Gwenwyn	Medicine	8	11,51	2,78	14,29	0	0	0	Specialist	4	0	0	0	1		0			
UHL	CFU	Medicine	8	12,11	2,78	14,89	12,11	2,78	14,89	Medicine	8	12,11	1,98	14,09	1	0	0	0	0	0
UHL	West 6	Medicine	29	20,9	14,21	35,11	20,9	14,21	35,11	Medicine	19	20,9	14,21	35,11	4	4	0	0	0	1 CNS
UHL	West 1	Medicine	28	20,44	13,89	34,33	20,44	13,89	34,33	CLOSED	0	0	0	0	0	0	0	0	0	0
UHL	East 2	Medicine	33	0	0	0	20,9	17,06	37,96	Medicine	30	20,9	17,06	37,96	0	0	20,9	0	0	1 CF CNS 3 GI CNS (retunr 15
UHW	B5N (B5)	Specialist	27	29,89	18,32	48,21	29,89	18,32	48,21	Specialist (B5 Renal)	27	29,89	15,48	45,37	1	2,56	2,85	1	0	0
UHW	T4		18							Specialist	18	38,37	8,53	46,9	2	1,6	4	0,96	0	0
UHW	T5	Specialist	19	30,7	13,64	44,34	30,7	13,64	44,34	Specialist	19	27,31	11,22	38,53	1	6,08	5,81	0,96	0	0

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Site	Name of Ward	Previous establishment					Establishment during COVID-19			Current Establishment									
		Specialty	No. of Beds	RN WTE	HCSW WTE	TOTAL	RN WTE	HCSW WTE	TOTAL	Specialty	No. of beds	RN WTE	HCSW WTE	TOTAL	No of Nurses	No of Nurses	No of	No of Mat	No of WTE	No of WTE
UHW	B4H	Specialist	27	39,13	15,99	55,12	39,13	15,99	55,12	Specialist	27	39,13	15,99	55,12	5	0	3	2	0	2
UHW	TCT	Specialist	8	18,22	5,69	23,91	18,22	5,69	23,91	Specialist	8	18,22	5,69	23,91	2	1	5,69	2	0	1
Rookwood	Ward 4/5	Specialist	26	21,68	23,65					Specialist	26	21,68	23,65	45,33		4,64	6,84	0,64	0	
Rookwood	Ward 7	Specialist	22	20,91	22,39	43,3				Specialist	22	20,91	22,39	43,3		8,56	5,26	1,96	0	
UHW	SSSU	Surgery	33	29,4	11,73	41,13	36,13	13,23	49,36	Surgery	18	23,6	6,9	30,5	1 RN WTE 1 HCSW 0.64	1,53	2.24 QUAL 3.0 HCSW	0.96 QUAL 0.8 HCSW	0	0
UHW	SAU	Surgery	13 spaces	23,74	11,25	34,99	23,74	11,25	34,99	Surgery	13 spaces	23,74	11,25	34,99	1 UnQ	1 UnQ	1.18 Q 0.73 UnQ	0	0	0
UHW	C4N	Specialist	25	18,5	20,41	38,91	0	0	0	Specialist	10	0	0	0						
UHW	C4S	Specialist								Medicine	17	16,23	11,7	27,93	0	1	1	0	0	0
UHW	B4N	Specialist	29	30,66	19,9	50,56	30,66	19,9	50,56	Specialist	29	30,66	19,9	50,56	1	8,56	9,64	1	0	
UHW	A4S (C3/CCU)	Specialist	8&10	35,96	9,54	45,5	28,82	5,69	34,51	Specialist	8	28,82	5,69	34,51	2	2	2	0	0	0
UHW	A4N									Specialist	19	Fluctuating								
UHW	C5	Specialist	38	31,92	8,53	40,45	28,63	18,68	47,31	Medicine	38	27,6	19,09	46,69	1	4	5	0	0	0
UHW	B1	Specialist	38	29,89	10,56	40,45	29,89	10,56	40,45	Specialist	38	29,89	10,56	40,45						
UHW	CITU	Specialist								Specialist	13	63,94	4,06	68	1,96	7,2	4	2	0	0
UHW	PACU	Specialist								Specialist	6	12,55	4,46	17,01	1	0,96	1	0	0	0
UHW	CRITICAL CARE	Specialist	frequently changing	191,4	16,86	208,26	frequently changing	frequently changing		Specialist	32	229.33	22.46	0	3	17,36	19,74	9,84	2 per shift	12 students
UHW	B6	Surgery	38	27,67	17,05	44,72	0	0	0	Medicine	38	27,6	19,09	46,69	0					
UHW	C1	C&W	23 (19 at weekend)	22,08	12,64	34,72	0	0	0	C&W	14	16,91	11,35	28,26	3	3	1	0		
UHL	The Void									Medicine	16	11,37	13,81	25,18	0	0	13,81	0	0	0
UHL	West 3 (Anwen)	Surgery	11	7,8	4,5	12,3	15,53	8,66	24,19	Surgery	18	15,21	11,37	26,58	1	1	1 Q	0	0	1
UHW	Duthie	Surgery	24 was 18 pre COVID	16,48	8,54	25,02	22,93	11,37	34,3	Surgery	24	22,93	11,37	34,3	1 Q 1 UnQ	1 UnQ	6 Q 1 UnQ	1 Q	0	0
UHW	A2	Surgery	38	33,89	15,48	49,37	33,89	15,48	49,37	Surgery	22	29,43	15,96	45,38	1 Q	1 UnQ	3 Q	1 Q	0	0
UHW	B2N (B2)	Surgery	19							Surgery (B2 emergency surgery)	19	20,09	8,53	28,62	1 UnQ	1 UnQ	0	0	0	0
UHW	B2S (B2)	Surgery	19	16,48	8,53	25,01	16,48	8,53	25,01	Surgery	19	16,48	8,53	25,01	1 UnQ	0	0	0	0	0
UHW	A1Link	Surgery	23	22,93	8,54	31,47	22,93	8,54	31,47	Medicine	23	16,23	19,09	35,32	1	2	0	0	0	0
UHL	Bethan (CAVOC)	Surgery	51	38,49	14,21	52,7	38,49	14,21	52,7	Specialist Cardiothoracic Surgery (West 6)	25	33,6	14,21	47,81	2	0	8	2	0	3

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		Specialty	No. of Beds	RN WTE	HCSW WTE	TOTAL	RN WTE	HCSW WTE	TOTAL	Specialty	No. of beds	RN WTE	HCSW WTE	TOTAL	No of Nurses	No of Nurses	No of	No of Mat	No of WTE	No of WTE
UHW	A5N&S	Surgery	0	8,53	15,98	24,51	0	0	0	Surgery	19			0						
UHW	A5N	Surgery	0	8,53	15,98	24,51	0	0	0	Surgery (Regional Spinal Unit)	19	19,32	14,21	33,53	0	1 Q 1 UnQ	5.05 Q	1 UnQ	0	0
UHW	A5S	Surgery	19	8,53	15,98	24,51	0	0	0	Surgery (Trauma)	19	20,01	8,11	28,12	0	1 UnQ	4.84 Q 1.43 UnQ	0	0	0
UHW	A5 Urology	Surgery	19	8,53	15,98	24,51	0	0	0	Surgery	0	0	0	0						
UHL	West 1	Medicine								Surgery	24									
UHL	West 2	Medicine	24	20,44	16,67	37,11				Medicine	24	20,44	16,67	37,11	0	0	0	0	0	2.0 wte memory team - retunr 17th
UHL	West 4	Surgery	22	15,21	11,37	26,58	15,21	11,37	26,58	Surgery	16	15,21	11,37	26,58	2 wte (1 band 2 and 1 band 5)	1 wte band 5 STS and 0.6 wte band 2	1 wte band 5	1 wte band 5	0	0
UHL	West 5	Surgery	29	9,58	20,9	30,48	0	0	0	Surgery	22	17,18	12,79	29,97	2 Q 1 UnQ	1 UnQ	3 Q 1.49 UnQ	0	0	0
UHW	A6N	Medicine	19	14,21	19,32	33,53	0	0	0	CLOSED	19	0	0	0						
UHW	A3Link	Surgery	26	20,9	8,53	29,43	19,32	14,21	33,53	CLOSED	0			0						
HYC	Alder	Mental Health	5 (+4)	13,13	14,41	27,54	13,13	14,41	27,54	Mental Health	5 (+4)	13,13	14,41	27,54	0	0	0	0	0	0
HYC	Ash	Mental Health	10	11,73	23,29	35,02	11,73	23,29	35,02	Mental Health	10	11,73	23,29	35,02	1	6	3,5	1	0	0
HYC	Beech	Mental Health	17	13,13	12,19	25,32	13,13	12,19	25,32	Mental Health	17	13,13	12,19	25,32	0	1	1,21	1	0	0
HYC	Cedar	Mental Health	15	18,75	13,41	32,16	18,75	13,41	32,16	Mental Health	15	18,75	13,41	32,16	0	1	2,75	0	0	0
HYC	Elm	Mental Health	12	11,8	15,13	26,93	11,8	15,13	26,93	Mental Health	12	11,8	15,13	26,93	0	0	3,8	0	0	0
HYC	Hazel	Mental Health	10	10,44	15,12	25,56	10,44	15,12	25,56	Mental Health	10	10,44	15,12	25,56	0	1	0	0	0	0
HYC	Oak	Mental Health	17	13,13	12,19	25,32	11,13	11,19	22,32	Mental Health	17	11,13	11,19	22,32	1	1	3,35	0	0	0
HYC	Maple	Mental Health	13	12,4	12,69	25,09	12,4	12,69	25,09	Mental Health	13	12,4	12,69	25,09	0	0	3,3	0	0	0
HYC	Willow	Mental Health	17	12,4	12,69	25,09	9,4	11,69	21,09	Mental Health	17	9,4	11,69	21,09	0	1	2,86	2	0	0
HYC	Pine	Mental Health	10	12,13	5,04	17,17	27,13	9,04	36,17	Mental Health	10	27,13	9,04	36,17	0	1	0,79	0	0	0
UHL	East 10	Mental Health	14	9,47	17,38	26,85	24,94	40,04	64,98	Mental Health	16	0	0	0	0	0	0	0	0	0
UHL	East 12	Mental Health	14	9,47	16,66	26,13	0	0	0	Mental Health	16	10,47	21,83	32,3	3	0	2	1	0	0
UHL	East 14	Mental Health	14	10,17	21,32	31,49	0	0	0	Mental Health	16	11,69	23,41	35,1	3	7	2	1	0	0
UHL	East 16	Mental Health	14	10,17	21,32	31,49	0	0	0	Mental Health	16	10,49	20,06	30,55	1	2	1,17	0	0	0
UHL	East18	Mental Health	14	11,92	18,59	30,51	0	0	0	Mental Health	16	12,48	24,56	37,04	2	6	2	1	1	0
Comm	Park Road	Mental Health	14	12,47	10,07	22,54	12,47	10,07	22,54	Mental Health	14	12,47	10,07	22,54	1	0	0,74	2	0	0

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		Specialty	No. of Beds	RN WTE	HCSW WTE	TOTAL	RN WTE	HCSW WTE	TOTAL	Specialty	No. of beds	RN WTE	HCSW WTE	TOTAL	No of Nurses	No of Nurses	No of	No of Mat	No of WTE	No of WTE
Comm	Phoenix	Mental Health	8	9,96	8,05	18,01	9,96	8,05	18,01	Mental Health	8	9,96	8,05	18,01	0	3	0	0	0	0
Llanfair	Meadow	Mental Health	14	10,44	10,98	21,42	10,44	10,98	21,42	Mental Health	14	10,44	10,98	21,42	0	1	1,16	0	0	0
Llanfair	Dafodill	Mental Health	14	9,47	16,16	25,63	9,47	16,16	25,63	Mental Health	16	8,05	28,53	36,58	1	1	1	1	0	0
Barry	St. Barrucs	Mental Health	15	15,33	22,43	37,76	15,33	22,43	37,76	Mental Health	15	10,48	23,57	34,05	0	1	3	1	0	0
UHW	Midwifery/Delivery	C&W	N/A	312,21	87,87	400,08	312,21	87,87	400,08	C&W	N/A	312,21	87,87	400,08						
UHW	Theatre Nurses	C&W	N/A	11,33	0	11,33	11,33	0	11,33	C&W	N/A	11,33	0	11,33						
UHW	Gynaecology Outpatients	C&W	N/A	14,8	4,39	19,19	14,8	4,39	19,19	C&W	N/A	14,8	4,39	19,19						
UHW	Colposcopy	C&W	N/A	4,95	2,44	7,39	4,95	2,44	7,39	C&W	N/A	4,95	2,44	7,39						
CRI	SARC	C&W	38	0	0	0	0	0	0	C&W	32			0						
UHW	NICU/SCBU	C&W	32 cots	106,32	11,64	117,96	106,32	11,64	117,96	C&W	32 cots	106,32	11,64	117,96						
UHW	PICU	C&W	7 ITU/4 HDU	62,38	2,37	64,75	62,38	2,37	64,75	C&W	7 ITU/4 HDU	62,38	2,37	64,75						
UHW	Jungle/Island/TCU	C&W	35	54,15	11,62	65,77	54,15	11,62	65,77	C&W	35	54,15	11,62	65,77						
UHW	Seahorse & CIU	C&W	8 flat spaces	9,18	2,78	11,96	9,18	2,78	11,96	C&W	8 flat spaces	9,18	2,78	11,96						
UHW	Pelican	C&W	6	16,08	0	16,08	16,08	0	16,08	C&W	6	16,08	0	16,08						
UHW	Children's Outpatients	C&W	N/A	5,08	4,73	9,81	5,08	4,73	9,81	C&W	N/A	5,08	4,73	9,81						
UHW	Gwdihw/Bumblebee	C&W	37	52,51	13,09	65,6	52,51	13,09	65,6	C&W	37	52,51	13,09	65,6						
UHW	Rainbow	C&W	13	36,41	7,79	44,2	36,41	7,79	44,2	C&W	13	36,41	7,79	44,2						
Barry	Sam Davies	Medicine	23	12,11	19,04	31,15				Medicine	23	12,11	19,04	31,15	5	4	1,94	0	0	0
Barry	Morganwg	Medicine	0	0	0	31,15				Medicine	23	12,11	19,04	31,15	0	0	19,04	0	0	0
St Davids	Rhydlfar	Medicine	23	12,11	19,04	31,15				Medicine	23	12,11	19,04	31,15	1	2	1,79	0	0	0
St Davids	Lansdowne	Medicine	23	12,11	19,04	31,15				Medicine	23	12,11	19,04	31,15	2	1	1,62	1,7	0	0
St Davids	Elizabeth	Medicine	23	12,11	19,04	31,15				Medicine	23	12,11	19,04	31,15	1	0	0	0	0	0
St Davids	Glan Ely	Medicine	20	12,37	17,06	29,43				Medicine	20	12,37	17,06	29,43	0	0	17,06	0	0	0
UHW	Midwifery/Delivery	C&W	N/A	312,21	87,87	400,08	312,21	87,87	400,08	C&W	N/A	312,21	87,87	400,08	7	4	18,9	3		
UHW	Theatre Nurses	C&W	N/A	11,33	0	11,33	11,33	0	11,33	C&W	N/A	11,33	0	11,33	0	0	2	0		
UHW	Gynaecology Outpatients	C&W	N/A	14,8	4,39	19,19	14,8	4,39	19,19	C&W	N/A	14,8	4,39	19,19	2	0	0	0		

APPENDIX: Summary of Required Establishments on Wards during COVID-19 Pandemic

Site	Name of Ward	Previous establishment					Establishment during COVID-19			Current Establishment										
		Specialty	No. of Beds	RN WTE	HCSW WTE	TOTAL	RN WTE	HCSW WTE	TOTAL	Specialty	No. of beds	RN WTE	HCSW WTE	TOTAL	No of Nurses	No of Nurses	No of	No of Mat	No of WTE	No of WTE
UHW	Colposcopy	C&W	N/A	4,95	2,44	7,39	4,95	2,44	7,39	C&W	N/A	4,95	2,44	7,39	0	0	0	0		
CRI	SARC	C&W	N/A	0	0	0	0	0	0	C&W	N/A			0						
UHW	NICU/SCBU	C&W	32 cots	106,32	11,64	117,96	106,32	11,64	117,96	C&W	32 cots	106,32	11,64	117,96	2	13	0	8	0	0
UHW	PICU	C&W	7 ITU/4 HDU	62,38	2,37	64,75	62,38	2,37	64,75	C&W	7 ITU/4 HDU	62,38	2,37	64,75	4	4	5	6,3	0	0
UHW	Jungle/Island/TCU	C&W	35	54,15	11,62	65,77	54,15	11,62	65,77	C&W	35	54,15	11,62	65,77	2	8	3	7	0	0
UHW	Seahorse & CIU	C&W	8 flat spaces	9,18	2,78	11,96	9,18	2,78	11,96	C&W	8 flat spaces	9,18	2,78	11,96	3	2	0	2	0	0
UHW	Pelican	C&W	6	16,08	0	16,08	16,08	0	16,08	C&W	6	16,08	0	16,08	0	0	0	0	0	0
UHW	Children's Outpatients	C&W	N/A	5,08	4,73	9,81	5,08	4,73	9,81	C&W	N/A	5,08	4,73	9,81	0	0	0	0	0	0
UHW	Gwdihw/Bumblebee	C&W	37	52,51	13,09	65,6	52,51	13,09	65,6	C&W	37	52,51	13,09	65,6	7	5	0	5	0	0
UHW	Rainbow	C&W	13	36,41	7,79	44,2	36,41	7,79	44,2	C&W	13	36,41	7,79	44,2	0	2	2	4,5	0	0
UHW	HPV Vaccination Programme	C&W	N/A	0	0	0	0	0	0	C&W	N/A	0	0	0						
C&W	School Nursing (includes HPV Vaccination Programme)	C&W	N/A	19,49	2,13	21,62	19,49	2,13	21,62	C&W	N/A	19,49	2,13	21,62	1	0,26	2,5	0	0	
C&W	CCNS	C&W	N/A	28,37	24,08	52,45	28,37	24,08	52,45	C&W	N/A	28,37	24,08	52,45	2,47	2,73	7,48	3,72	0	
C&W	Special Schools	C&W	N/A	6,02	1,61	7,63	6,02	1,61	7,63	C&W	N/A	6,02	1,61	7,63	included in school nursing					
C&W	Special Needs Health Visiting	C&W	N/A	4,2	0	4,2	4,2	0	4,2	C&W	N/A	4,2	0	4,2	0	0	0	0	0	
C&W	Looked After Children	C&W	N/A	4,2	0	4,2	4,2	0	4,2	C&W	N/A	4,2	0	4,2	0	0,8	0	0	0	
C&W	Youth Offender Team	C&W	N/A	1	0	1	1	0	1	C&W	N/A	1	0	1	0	0	0,8	0	0	
C&W	Continence Service	C&W	N/A	2,04	0	2,04	2,04	0	2,04	C&W	N/A	2,04	0	2,04	0	0	0	0	0	
C&W	Immunisation Team	C&W	N/A	6,19	2,21	8,4	6,19	2,21	8,4	C&W	N/A	6,19	2,21	8,4	included in school nursing					
C&W	St David's Outpatients	C&W	N/A	0	0	0	0	0	0	C&W	N/A	0	0	0	included in CCNS					
C&W	Health Visiting	C&W	N/A	84,55	8,67	93,22	84,55	8,67	93,22	C&W	N/A	84,55	8,67	93,22	4,7	2,7	4	8	0	

REPORT TITLE:	**DRAFT QUARTER 2 UPDATE TO SERVICE DELIVERY PLAN 2020-21**							
MEETING:	Board Meeting					**MEETING DATE:**	**30/07/20**	
STATUS:	**For Discussion**		**For Assurance**		**For Approval**	**X**	**For Information**	
LEAD EXECUTIVE:	Director of Planning							
REPORT AUTHOR (TITLE):	Deputy Director of Planning							

PURPOSE OF REPORT: To approve the 2019-22 Integrated Medium Term Plan for Submission to Welsh Government

SITUATION:

The Board is asked to approve the draft Quarter 2 update to the UHB's Service Delivery Plan for 2020-21 for formal submission to Welsh Government.

As the impact of COVID-19 has created a high degree of uncertainty in the months ahead, there is a recognition that we will need to continue to plan in shorter cycles for the remainder of this year. The guidance requirements for this plan were issued by Welsh Government 2 weeks before the submission deadline so a draft of this plan has already been submitted to Government pending formal Board approval. This plan provides an update to the 2020-21 annual Service Delivery Plan that we submitted in Quarter 1.

REPORT:

BACKGROUND:

The draft plan has been developed based on the 'proceed with caution' approach and continued focus on the four harms:

- Harms from COVID itself
- Harm from overwhelmed NHS & social care system
- Harm from reduction in non-COVID activity
- Harm from wider societal actions/lockdown

In addition, the plan addresses specific areas of interest highlighted by the Quarter 2 guidance. The plan has also been driven by the priorities identified through Clinical Boards and the operational management team as well as with critical input from key internal corporate leads and external stakeholders, importantly our social services and third sector colleagues.

We continue to work closely with WHSSC and partner UHBs through this process to ensure that our plans for service delivery and maintaining essential services at tertiary, regional and local level are prioritised equitably and collaboratively. We have also shared the draft plan with our CHC to secure feedback as part of our final submission.

ASSESSMENT:

The plan has been shared with Executive Colleagues as well as Clinical Board and Corporate leads.

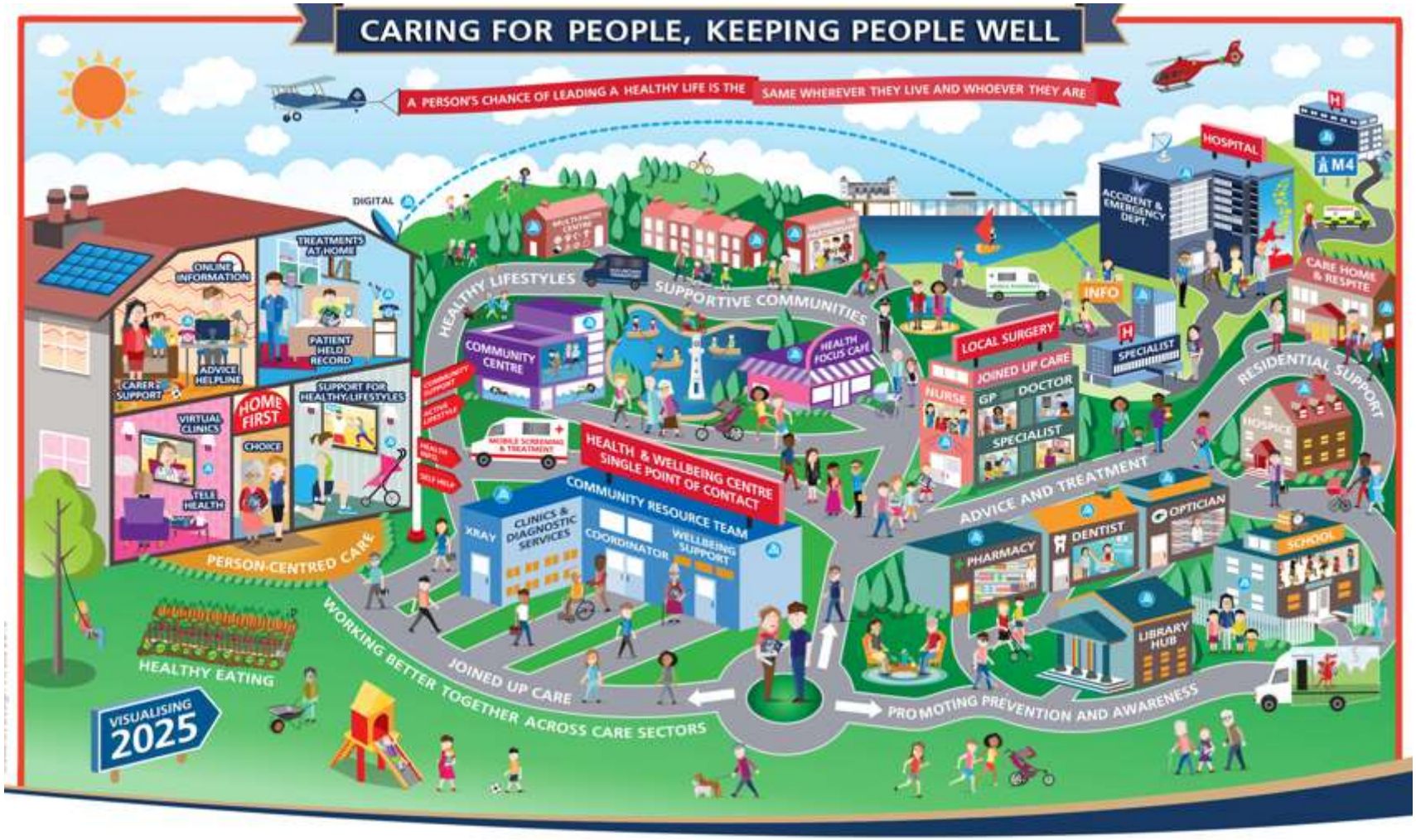
There remain challenges in the plan and there are still significant uncertainties that we will need to resolve during Quarters 3 and 4 particularly in relation to funding, maintaining the wellbeing of our workforce, meeting winter pressures as well as the continuing impact of COVID-19 on the health and social care needs of our population.

RECOMMENDATION:
The Board is asked to approve the draft Quarter 2 update to the UHB's Service Delivery Plan for 2020-21

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
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

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable



CARDIFF AND VALE UNIVERSITY HEALTH BOARD

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

INDEX

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

QUARTER TWO UPDATE

1. PRIMARY CARE AND MENTAL HEALTH

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

1.1. Primary Care and Community Services

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

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

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

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

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

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

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

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

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

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

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

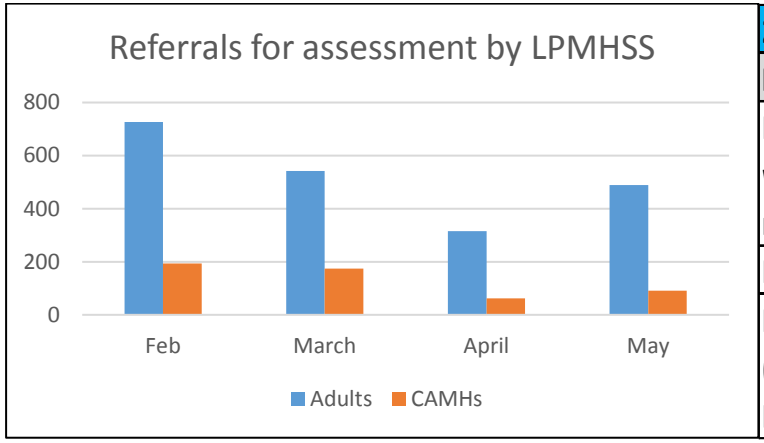
Optometry services reopened at the end June, and with the appropriate IPC are able to provide a near to normal service. This is important in light of the continued suspension of some hospital based eye care. We will be reviewing the pathways for urgent referrals to ensure patients are access the right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

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

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

1.2 Mental Health Services

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



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

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

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

2. SERVICES FOR CHILDREN AND YOUNG PEOPLE

2.1 CAMHS

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

2.2. Children with complex needs

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

2.3 Children's Hospital Services

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

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

3. ACUTE SERVICES – PHASE 4

3.1 Acute Bed Configuration Plan

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

3.2 Capacity Planning

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

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

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

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

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

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

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

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

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

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

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

3.2 Resuming Non-COVID-19 Activity

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

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

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

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

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

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

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

At the beginning of the COIVD-19 pandemic, we reached an early agreement with Spire Healthcare to enable patients with non-complex cancer and other urgent conditions to receive treatment at Spire's Cardiff hospital. This allowed us extra capacity to care for COVID-19 patients at our main sites, in particular to enable space for regional services. The majority of the Health Board's patients at Spire Cardiff are being treated for cancer or for time critical/urgent health conditions and include the following specialties, and the table below confirms the activity undertaken there to date:

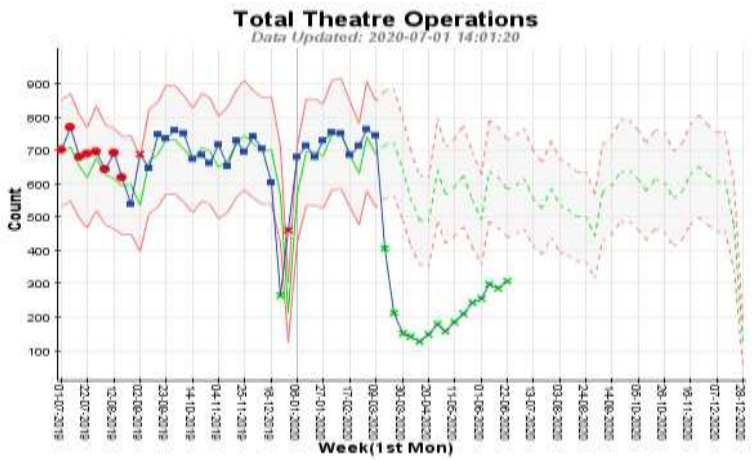
Gynaecological	Urological	Neurological	Colorectal
Gastroenterological	Breast	Haematological	ENT

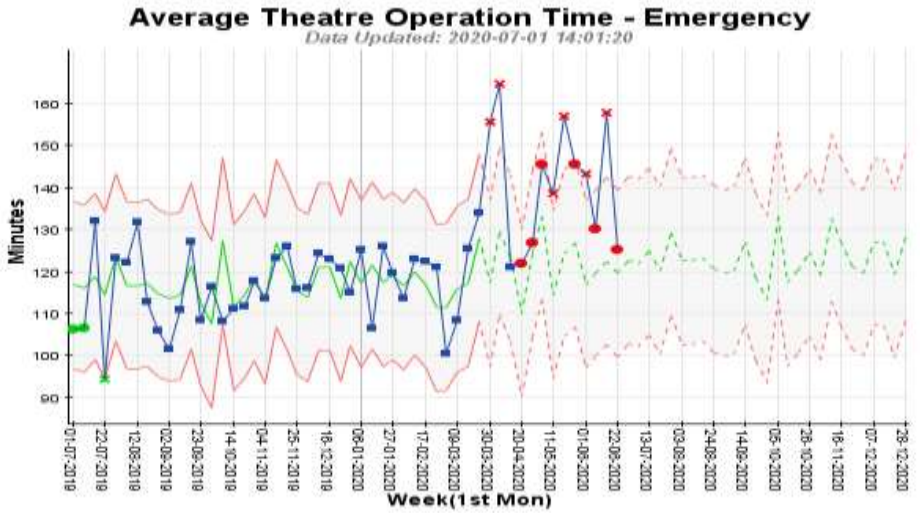
UHB Activity at Spire since 23rd March 2020

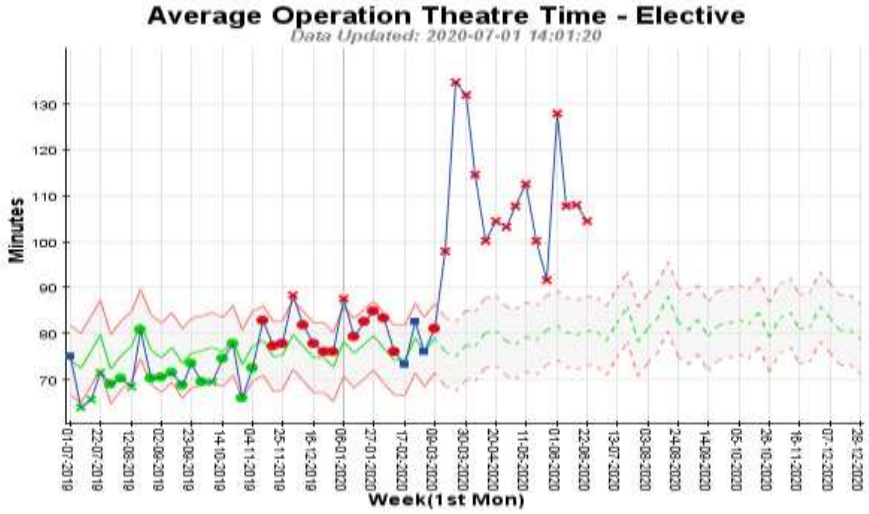
Cancer operations	Other time sensitive Theatre cases (inc 39 eyes)	Outpatients (incl 1,098 eyes)	Endoscopy procedures inc urgent Cancer	Cardiology procedures	Total
262	164	2,023	260	48	2,757

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

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







3.5 Regional Collaboration for the Provision of Acute Services

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

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

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

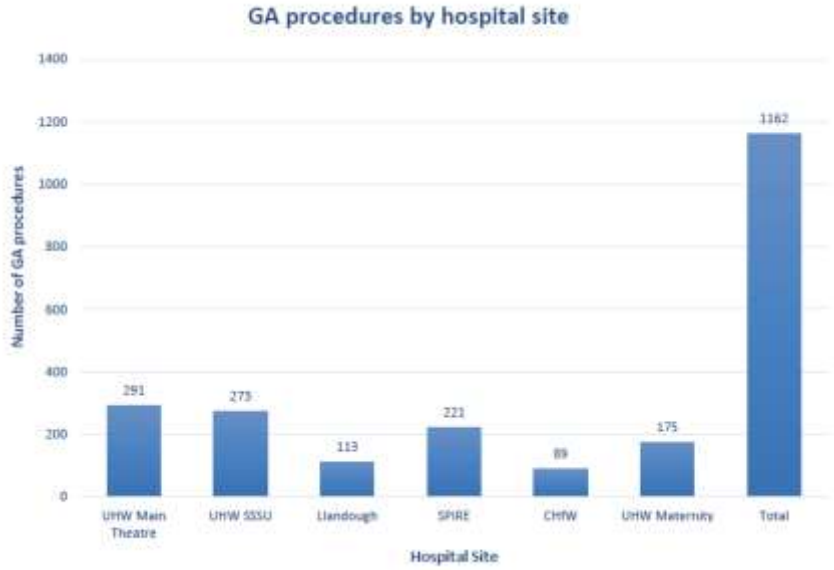
An overview of early Q1 high-level acute demand, activity and performance data can be found at Appendix 6.

3.6 Delivering Compassionate Care Safely

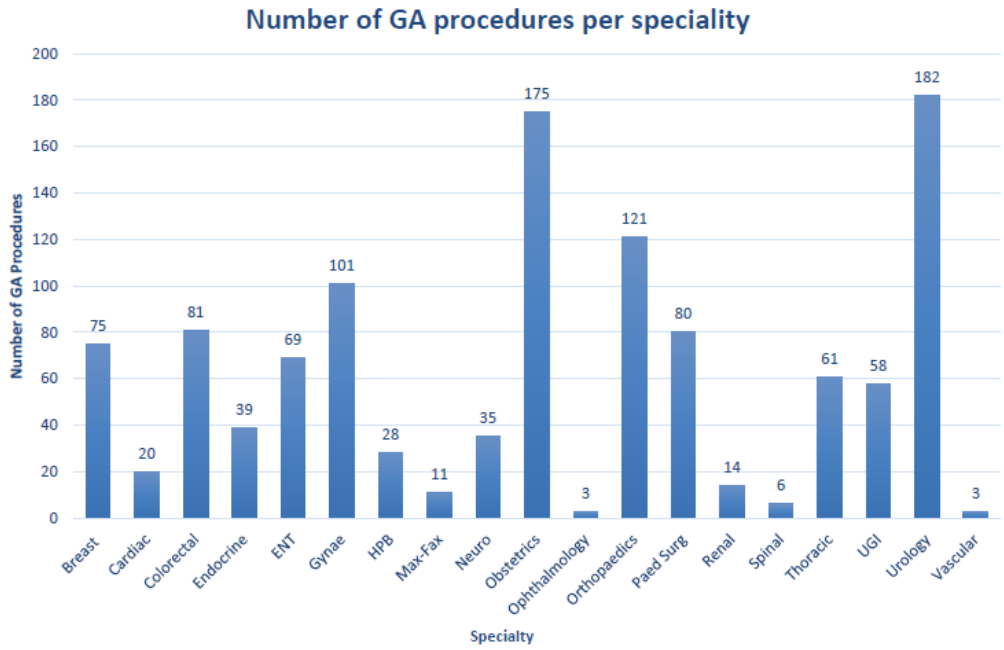
The Nursing and Medical Director's Teams continues to monitor closely the surgical activity that is undertake to enable any issues to be quickly identified an acted upon, and the COVID-19 status of patients in all of our hospitals to identify quickly any issues in respect of hospital acquired infection.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

Elective Care

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



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



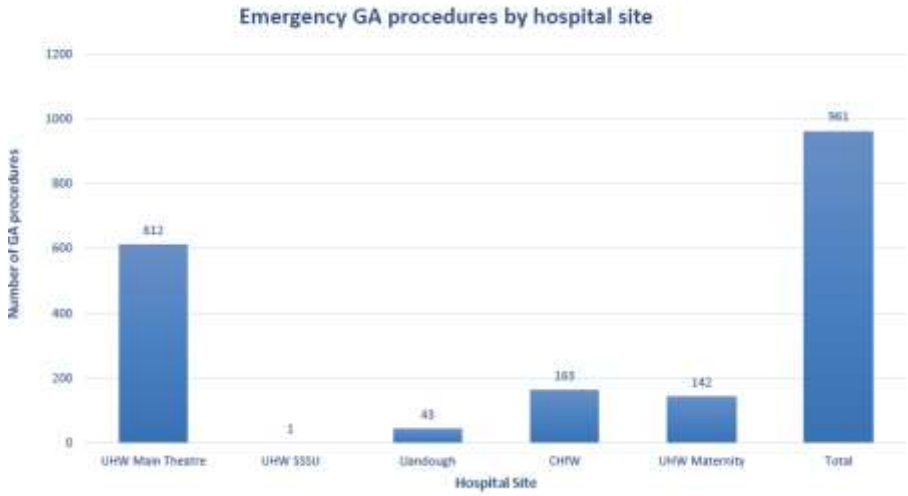
In-patients were swabbed for COVID-19 if they developed possibly COVID-19 symptoms only. Of these, there were around 16 positive swabs (1.4%) for COVID-19 within 30 days of the procedure (the vast majority in March and April). There were about 77 negative swab results over the same period.

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

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

Emergency Care

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



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

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

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

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

PPE

The provision of Personal Protective Equipment (PPE) for our staff has been one of our top priorities from the outset. Ruth Walker, the Executive Nurse Director, is the nominated Executive Lead in the Health Board. We established a multi-disciplinary PPE Cell that has met on a weekly basis for many weeks. This has proved to be a very effective decision making group and has representation from clinical staff (including surgeons and anaesthetic staff) and also from a staff side representative. At each meeting a range of issues is discussed including:

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

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

CEO connects is a daily briefing that is produced for staff and has regularly contained updates on the provision of PPE. In the last few weeks we have started to issue a regular PPE Safety Briefing to keep staff as up to date as possible with the situation. An intranet site on PPE has also been developed as a useful resource for staff. This contains latest national guidance, information in relation to training and Fit testing, instructions for ordering PPE, guides on how to 'Don and Doff' as well as FAQs. We have now secured continuity and sustainability of both gown and mask supply. The 1863 is now the primary pandemic mask and currently within C&V there are sufficient stocks and additional stock in Wales if needed. An All-Wales order for 1.8 million 8833 masks has also been placed. While these are currently being held in Turkey we are hopeful that they will soon be available and will also give us about a 6 months' supply. A £500k order for additional gowns to secure a medium terms supply, has also recently been placed. The Health Board has also invested in a 1000 powered hoods and an order submitted. This follows some joint working with medical colleagues in critical care and in theatres. This provides a long term solution for colleagues in these areas. The Health and Safety Department are currently deploying available powered hoods to identified staff who have failed qualitative and quantitative fit testing on all available half masks.

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

Patient Experience

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

Virtual Visiting

Due to the restrictions on visiting 400 tablets have been set up by our IT department to ensure that the tablets are safe for patients to use and comply with data protection guidelines. Each tablet has been set up with Zoom for virtual visiting, Radio Glamorgan, free magazines from Wi-Fi spark and a feedback survey. IT have added a range of game and activity apps to help alleviate boredom on the wards. We trained medical and nursing students to support the Virtual Visiting. Feedback from the virtual visiting has been very positive from both staff and patients, some of whom had not seen family/friends in weeks. In April a messages from Loved ones e mail and phone line was set up to ensure that patients and families had a way to communicate during these difficult times. The message was then printed and any photos laminated and sent to the patient on the ward.

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

Bereavement

In April a bereavement helpline was implemented, members of the Patient Experience team contacted all people who had suffered a bereavement. The aim was to provide someone to listen, signpost to other organisations and initiatives, such as our Chatter line, and address any queries where possible around the death of their loved one. To date the team have supported over 280 bereaved families. We have also established a system to return property to bereaved families. Whilst we have a condolence card, with a message form the Executive Nurse Director, it was recognised that during these difficult times one of the key issues for families, who cannot be with their loved ones, is who was with them when they died. The condolence card, which was adapted from one developed by staff on C7, stated who was with the patient when they died. The knowledge that their loved one was not alone when they died will hopefully be of some comfort to the family.

Feedback

Due to COVID 19 the Infection, prevention and control advice was to withdraw the monthly paper feedback surveys and feedback kiosks across the UHB. This led us to adapt the way we receive patient/service user feedback. In relation to COVID19 specific feedback, we have undertaken a PPE inpatient survey.

This study involved in patients completing an online survey of their experiences of staff wearing PPE and their stay. In total, 102 patients were surveyed.

- *PPE discharged inpatient survey*. This study involved recently discharged inpatients completing an online survey of their experiences of staff wearing PPE and their stay. To facilitate this, a message/survey link was texted to those for whom we had a mobile phone number. We had over 700 responses, with a completion rate of 87%.
- *Prehab booklet feedback survey.* This is a study into the wellbeing of patients currently on the waiting list, which due to COVID19, may/will have had their procedure delayed. The concept is to promote preparation rather than waiting lists and promoting well-being and health optimisation.
- *Boredom and isolation survey*. This is a study looking into aspects of patients' wellbeing, while currently admitted. The survey centres on being bored and the feeling of isolation, due to visiting restrictions/limited activities. The online survey is available to patients via the tablets

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

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

4. HEALTH AND SOCIAL CARE PARTNERSHIP WORKING

4.1 Social Care Interface

Since the start of the pandemic, the Executive Team has met jointly with the two Directors of Social Services and Cardiff Council's Corporate Director of Communities. This has supported timely and open communication, the sharing of issues and risks and joint problem solving. There was early recognition of the need to support care homes jointly with our social services colleagues. Our primary care and local public health teams will continue to provide extended support to care homes in Q2 to reflect the additional needs of residents with COVID-19 symptoms, and the additional operational consequences on staff, supplies and occupancy levels. The weekly joint executive meetings have enabled us to execute strategy and unblock issues including:

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

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

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

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

4.2 Discharge support

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

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

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

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

4.3 Homelessness

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

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

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

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

4.4 Accommodation with care

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

4.5. Regional Partnership Board

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

5. TEST, TRACE, PROTECT

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

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

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

Contact tracing aims to identify those who have had significant contact with someone who has tested positive for COVID-19 in the 48hrs before and 7 days after they became symptomatic, and asking them to self-isolate for 14 days with the objective of halting the onward chain of transmission. A significant contact includes not only those they live with during that time period, but also anyone they have had a face to face contact with, or have touched, coughed on, or been within one meter of in any other way for over a minute. It also includes those who have shared a car or who have had contact within two metres for over 15 minutes; this can be in smaller but repeated time periods that add up to over 15 minutes in total.

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

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

6. RESEARCH COLLABORATION

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

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

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

<u>R&D Preparedness</u>

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

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

Communication

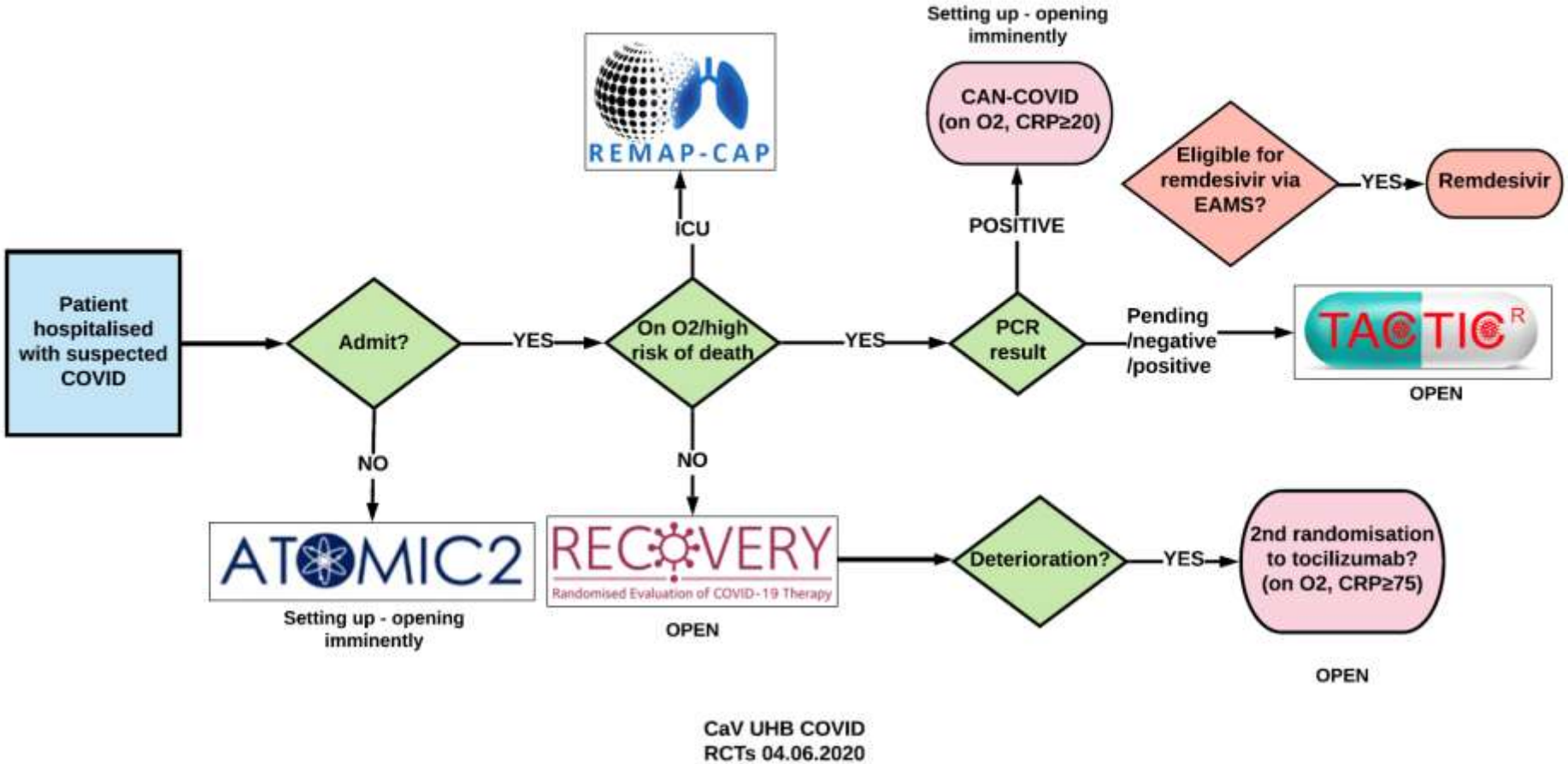
- Teams set up with a coordinated approach for covering UHL, Heulwen/A&E, COVID-19 medical wards and ITU.
- The team, including pharmacist support, had an extensive role in educating the doctors (consultant and juniors), nurses and ward pharmacists who were potentially naïve to research.
- IT solutions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

Ward interaction

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

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

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



7. PHASE 5 UPDATE - SYSTEM TRANSFORMATION PRIORITIES

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

7.1 Unscheduled Care – CAV 24/7

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

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

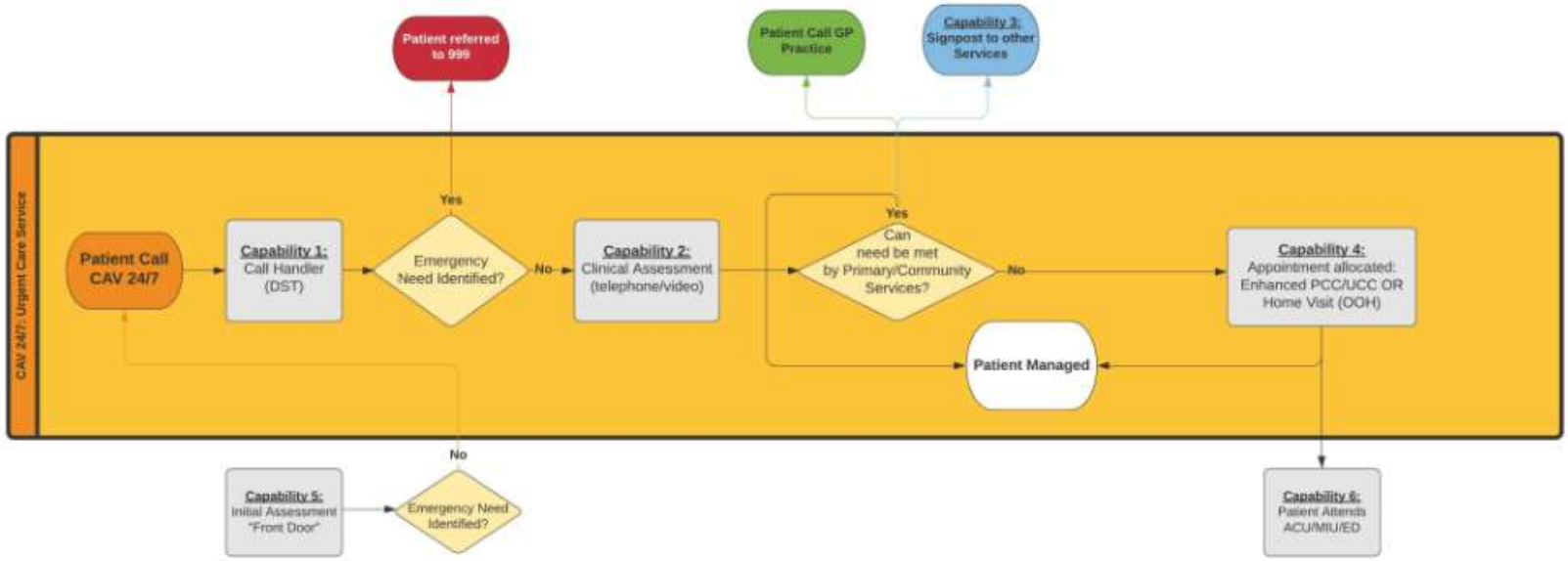
The 24/7 number will:

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

- Signpost to other services as appropriate

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

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



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

7.2 Outpatients Transformation Programme

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

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

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

8. WORKFORCE

8.1 Overview

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

8.2 Shielding Staff

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

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

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

Emerging Principles:

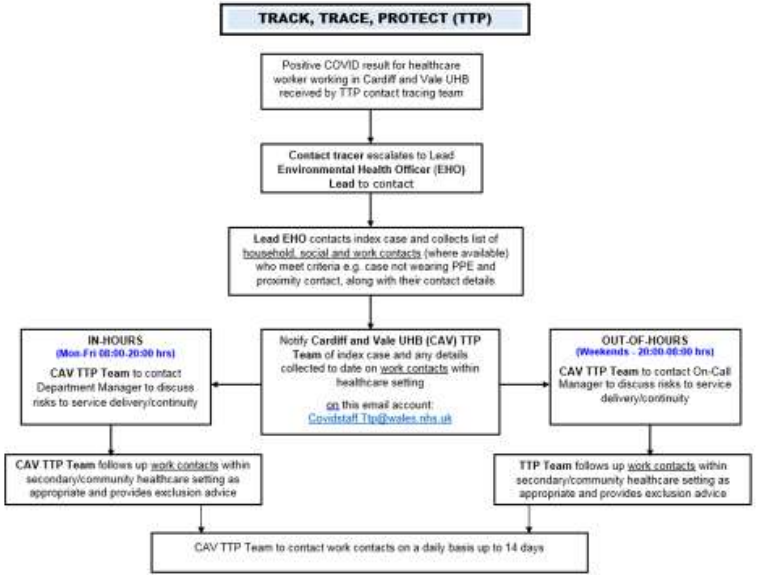
- People Shielding are not off sick
- Managers/Supervisors should fully understand the circumstances of each **individual** in order to establish why they are off and how they can be best supported to undertake work.
    - This is best achieved by completing a risk assessment with the individual
   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

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

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

8.2 Test Trace Protect- Staff

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



8.3 Supporting our BAME workforce

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

8.4 Continued Staff Wellbeing Support

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

8.4 Supporting Positive Culture Change

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

9. INFRASTRUCTURE AND ESTATES

9.1 COVID-19 Infrastructure and capital enabling works*

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

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

**Excl Dragon's Heart Hospital*

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

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

9.2 Strategic Capital Investment Planning

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

10. ENGAGEMENT

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

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

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

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

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

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

11. FINANCE

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

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

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

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

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

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

Key financial planning assumptions:

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

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

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

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

12. GOVERNANCE AND RISK

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

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

13. PLANNING AHEAD

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

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

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

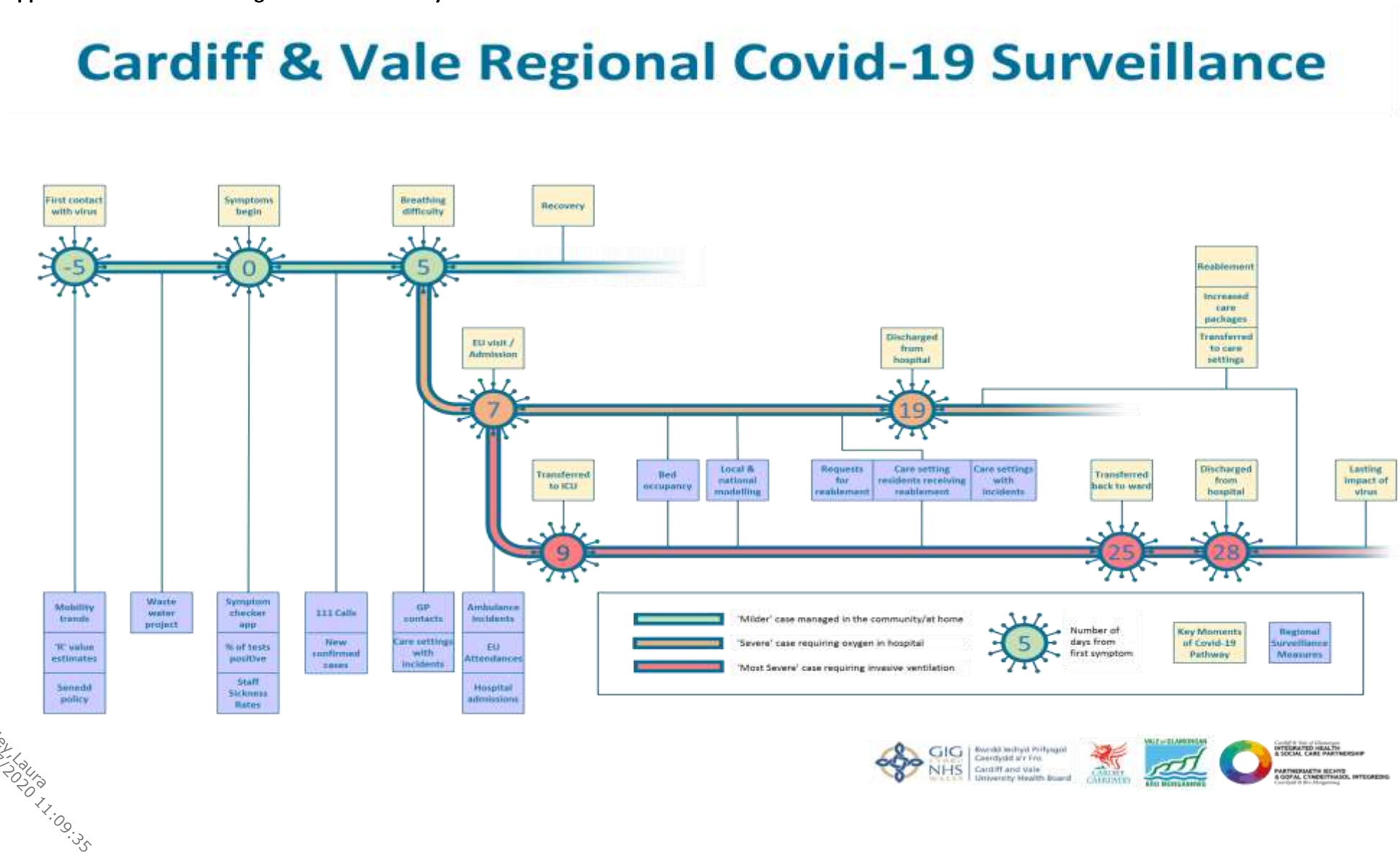
the impact may have been more positive – for example more people taking advantage of exercise outside. Whilst recognising the need to continue to support TTP and manage any localised clusters and incidents, within the Health Board and with our PSB partners we are looking at how we can reprioritise and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

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

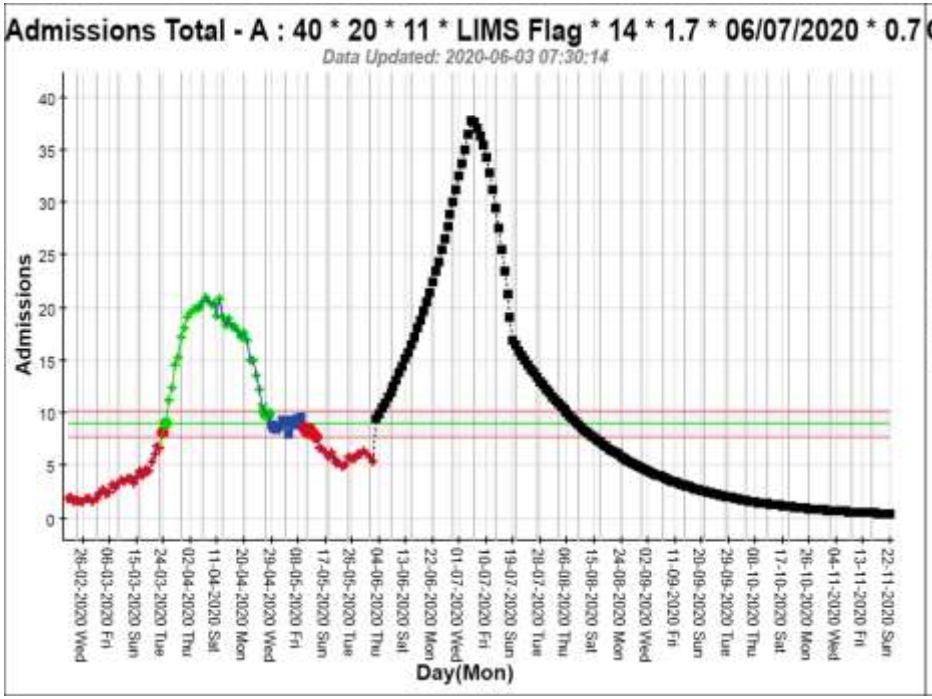
In January our Board signed up to a commitment to tackling climate change and work on developing our sustainability action plan is restarting, recognising the opportunities seen during COVID-19 to work in ways that reduce our carbon footprint. We see this as a key programme of work going forward.

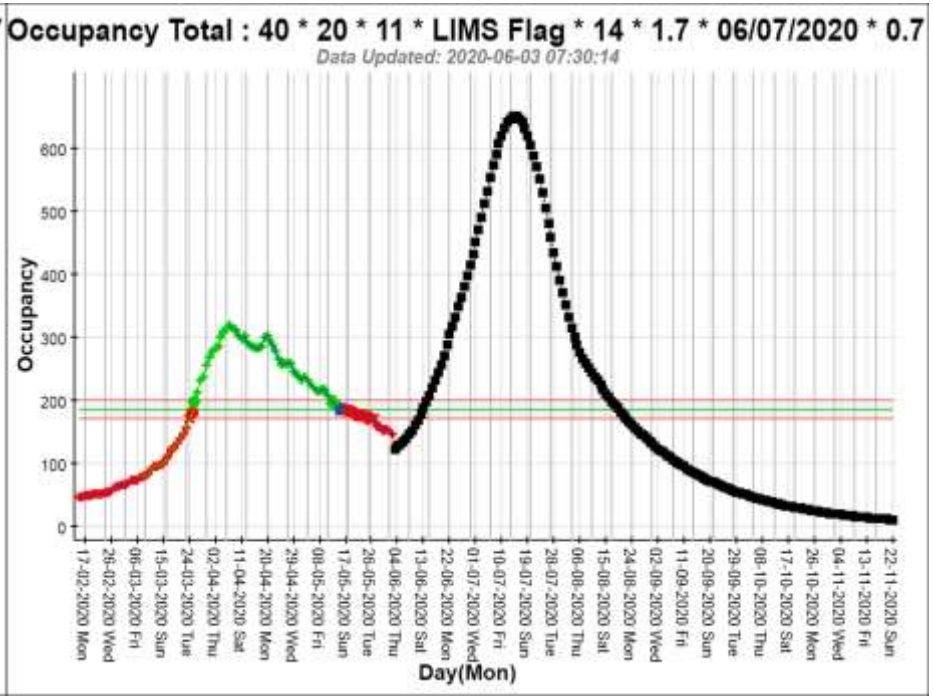
We are capturing all of these workstreams in our COVID-19 'recover/renewal' programme which outlines the likely impact of the pandemic, and the opportunities to be capitalised on and risks to be managed. The programme sets out the key milestones for rising out from COVID-19 over the next 12 – 18 months.

Appendix 1: Schematic of Regional Surveillance System



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





Appendix 3: Overview of Essential Services

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

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

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

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

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

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

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

APPENDIX 5

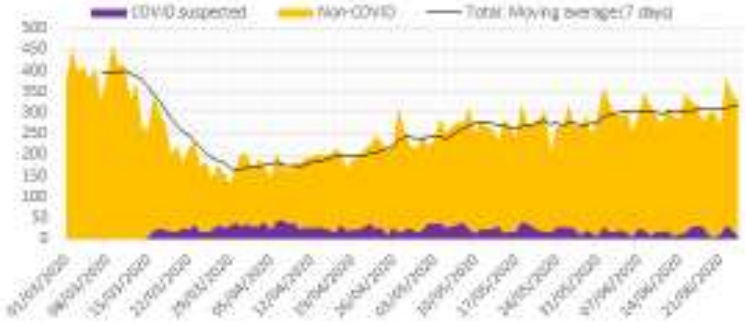
High Level Risk Summary

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

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

Unscheduled Care

EU activity:



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

Performance:

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

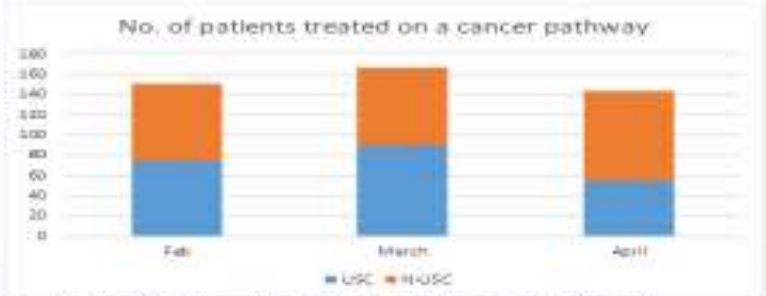
- *Over the last two months, performance has improved across all unscheduled care measures*

Cancer

Demand:

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

Activity:



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

Performance:

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

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

RTT & Diagnostics

Demand:

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

Activity:

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

Performance:

2020/21		Mar	Apr	May
Planned Care				
RTT - 36 weeks (Target = 0)	20/21 Actual	9515	7330	11814
RTT - 26 weeks (Target = 95%)	20/21 Actual	81.7%	74.1%	66.3%
Total Waiting list	20/21 Actual	87579	85287	85611
Diagnostics > 8 weeks (Target = 0)	20/21 Actual	780	5,048	10,476
Eye Care				
% R1 ophthalmology patients waiting within target date or within 25% beyond target date for OP appointment	20/21 Actual	66%	59%	54%
98% of patients to have an allocated HRF	20/21 Actual	98%	98%	98%

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

Appendix 7 – Wellbeing Resources Guide

Report Title:	**Shaping Our Future Wellbeing: In Our Community (SOFW), Wellbeing Hub@Maelfa – Full Business Case**							
Meeting:	**UHB BOARD**					**Meeting Date:**	**30 July 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	✓	**For Information**	
Lead Executive:	**Director of Planning**							
Report Author (Title):	**Service Planning Project Lead – 029 2183 6071**							
PURPOSE OF REPORT	**The Board is asked to authorise the submission of Wellbeing Hub@Maelfa – Full Business Case to Board, for approval to submit to Welsh Government as part of the process to access capital funding from the Primary Care Pipeline Fund.**							

SITUATION

This paper sets out a summary of proposals and associated capital and revenue implications for the Wellbeing Hub @ Maelfa. It is provided to the Board to agree the submission of the Full Business Case (FBC) to Welsh Government (WG) for £14.1m* capital funding from the Primary Care Pipeline Fund. A draft version* of the Executive Summary is attached (and the draft FBC will be available on request).

**Welsh Government advised on 10/07/20 that additional funding is available to add COVID-19 mitigation measures into the design. These measures are being identified and costed. The FBC Financial and Economical cases will then be recast to include the additional COVID-19 funding. This additional funding will not affect the option appraisal.*

BACKGROUND

The proposed Wellbeing Hub@Maelfa (WH@Maelfa) will form one element of the network of community infrastructure set out in the SOFW: In Our Community programme, which was endorsed by Welsh Government (WG) in 2019.

WG has provisionally allocated Primary Care Pipeline capital funding for the development of the WH@Maelfa. The proposals and supporting rationale are set out in the draft FBC, required by WG as the final stage of three in WG's capital investment business case approval process.

The Board has received regular progress reports on both the Programme and Projects throughout the development of this scheme.

ASSESSMENT

The proposed WH@Maelfa will be co-located with the local authority community Powerhouse Hub, Llanedeyrn. Proposals have been developed in partnership with local GPs, the local authority, local community and the third sector with a **primary focus** on:-

- improving access to community services and assets,
- improving health outcomes, and

- setting the tone for coproduction, ultimately reducing health inequalities.

The **service scope** for the wellbeing hub has been revised to bring the design to within an affordable level as agreed with WG, while maintaining the maximum delivery of planned clinics and activity. In brief, services will include:-

- A range of wellbeing services delivered alongside the community activities and social services delivered by the local authority at the adjoining Powerhouse Hub, including health and wellbeing information, advice and signposting, group activities such as eating for life and diabetes management, mindfulness and carers' support;
- Llan Healthcare GP Surgery. Should further provision be required to support the local services e.g. GMS, the design of the building has the potential for future development;
- A range of health and local authority services and clinics, some of which will relocate from other facilities, e.g. Llanedeyrn Health Centre. Services will include district nursing, child health, podiatry, dietetics, physiotherapy, midwifery, heart failure, pulmonary (COPD) rehabilitation, mental health, and early intervention & support services;
- Team bases and drop-in, remote working facilities, to promote collaborative working;

The design will seamlessly integrate with the existing local authority Powerhouse Hub to incorporate a wellbeing area; clinical facilities; and multi-functional, flexible spaces which offer the potential for shared use within the facility and with third sector and community groups. The site for the preferred option is owned by Cardiff City Council and agreement of the land transfer arrangements is almost finalised with Cardiff City Council.

A summary of the projected capital costs is shown below:

	Option 1 Do Nothing (backlog maintenance only) £	**Option 2 Do Minimum (refurbish and expand existing Health Centre) £**	**Option 3 (new build on existing Health Centre site) £**	**Option 4 (new build co-located and integrated with Powerhouse Hub)** *PREFERRED OPTION* **£**
Capital Cost (incl. VAT)	1.7m*	15.5m*	16.3m*	£14.1m*

Impairment and depreciation costs are being finalised. The FBC, like all WG capital investment business cases, assumes all capital charges and depreciation will be funded by WG.

The **revenue implications*** across the options are being finalised for inclusion in the FBC prior to being submitted to WG. It is anticipated that service transfers into the new facility will be cost neutral. Facilities costs are also being finalised for inclusion in the FBC.

Key Benefits

- Deliver local facilities in which to provide health and wellbeing information, advice and education in a variety of formats;
- Work with our local authority and third sector partners to support people to choose healthy behaviours and encourage self-management of conditions.
- Develop fit for purpose, shared and flexible community based facilities to support local delivery of collaborative multi-agency services to meet the health and wellbeing needs of local residents.

- To develop an holistic environment which promotes the physical, mental and social wellbeing of local residents.
- Co-ordinated and collaborative multi-agency service delivery with a focus on improving health outcomes for the identified Cluster priorities, including:-
    - Podiatry;
    - School Nursing;
    - Physiotherapy;
    - Pulmonary Rehabilitation;
    - Smoking Cessation.
- Work with local GPs to deliver shared facilities where appropriate and where it will support continued delivery of GMS to local residents.
- Focus on:-
    - improving public access to digital health and wellbeing information;
    - enabling people to connect with health and social care more efficiently and effectively improving mobile working for staff.

ASSURANCE is provided by:
The combined SOFW: In Our Community programme and project governance structure established for the development and reconfiguration of our community infrastructure.

RECOMMENDATION

The Board is asked to:

- **APPROVE** the submission of Wellbeing Hub@Maelfa – Full Business Case to Welsh Government for capital funding from the Primary Care Pipeline Fund

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 is available (working document version 4)								

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

Development of a Wellbeing Hub at Maelfa

Full Business Case (FBC): Executive Summary

July 2020 – Final Draft v3

Overview

1.0 OVERVIEW

This business case seeks the approval for a capital investment of £14.371m to enable the development of a Wellbeing Hub at Maelfa to provide fit for purpose primary care facilities in support of the Cardiff and Vale University Health Board's (CVUHB) vision for primary care and community services outlined within *The Shaping Our Future Wellbeing Strategy* (SOFW). The development will be progressed as one of the first tranche of projects described in the *Shaping Our Future Wellbeing: In Our Community Strategy* (SOFW:IOC) Programme Business Case (PBC).

1.1 Progress Since Development of the OBC

The Outline Business Case (OBC) was approved by Cardiff and Vale University Health Board in May 2019 and Welsh Government (WG) in December 2019.

During the development of this Full Business Case (FBC) the outputs within the OBC have been reviewed and this review has reaffirmed the assumptions and outputs of the OBC. The result of this is that the rankings of the non-financial option appraisal, economic appraisal and unquantifiable risk appraisal remain unchanged, however due to increased inflation costs and the impacts of COVID-19 there is an increase in the overarching capital costs.

The capital investment of £14.371m sought within this FBC includes £263k (including VAT) for the hard surface multi use games area (MUGA), £310k (including VAT) for revised working practices to comply with Covid-19 Health & Safety requirements, and £192k (including VAT) for the Decarbonisation Measures agreed with WG. Full details are included within later sections of this business case.

1.2 Welsh Government (WG) Comments on the OBC

The Health Board received several comments and queries from WG upon submission of the OBC. The Health Board has responded to these queries during the OBC approval process and during the development of this FBC any further queries have been considered with the full details included within each relevant section of the document as necessary.

1.3 Structure and Navigation of the FBC

This document describes the Full Business Case for this investment. It has been developed to reflect the guidance set out in HM Treasury's Green Book (a Guide to Investment Appraisal in the Public Sector) and the Infrastructure Investment Guidance for the NHS in Wales.

The approved format is the Five Case Model, which comprises the following key components:

- The Strategic Case section. This sets out the case for change, together with the supporting investment objectives for the scheme;

- The Economic Case section. This demonstrates that the organisation has selected the most economically advantageous offer, which best meets the existing and future needs of the service and optimises value for money (VFM);
- The Commercial Case section. This section identifies the contractual arrangement and risks associated with the preferred option for procurement, together with payment implications and accountancy treatment;
- The Financial Case section. This confirms funding arrangements, affordability and the effect on the balance sheet of the organisation;
- The Management Case section. This details the plans for the successful delivery of the scheme to cost, time and quality.

Executive Summary

2.0 EXECUTIVE SUMMARY

2.1 Introduction

This Full Business Case (FBC) seeks the approval for a capital investment of £14.371m to enable the development of a Wellbeing Hub at Maelfa to provide fit for purpose primary care facilities in support of the Cardiff and Vale University Health Board's (CVUHB) vision for primary care and community services outlined within the *Shaping Our Future Wellbeing Strategy* (SOFW). The development will be progressed as one of the first tranche of projects described in the *Shaping Our Future Wellbeing: In Our Community Strategy* (SOFW:IOC) Programme Business Case (PBC).

The capital investment of £14.371m sought includes £263k (including VAT) for the hard surface multi use games area (MUGA), £310k (including VAT) for revised working practices to comply with Covid-19 Health & Safety requirements, and £192k (including VAT) for the Decarbonisation Measures agreed with WG.

The new Wellbeing Hub will enable the Health Board to focus on delivering new clinical pathways and service models to promote physical, mental and social wellbeing through the integration of primary, community and ambulatory secondary care services not only within the Health Board but also in partnership with other key stakeholders within the Local Authority and Third Sector.

2.2 The Strategic Case

2.2.1 The Strategic Context

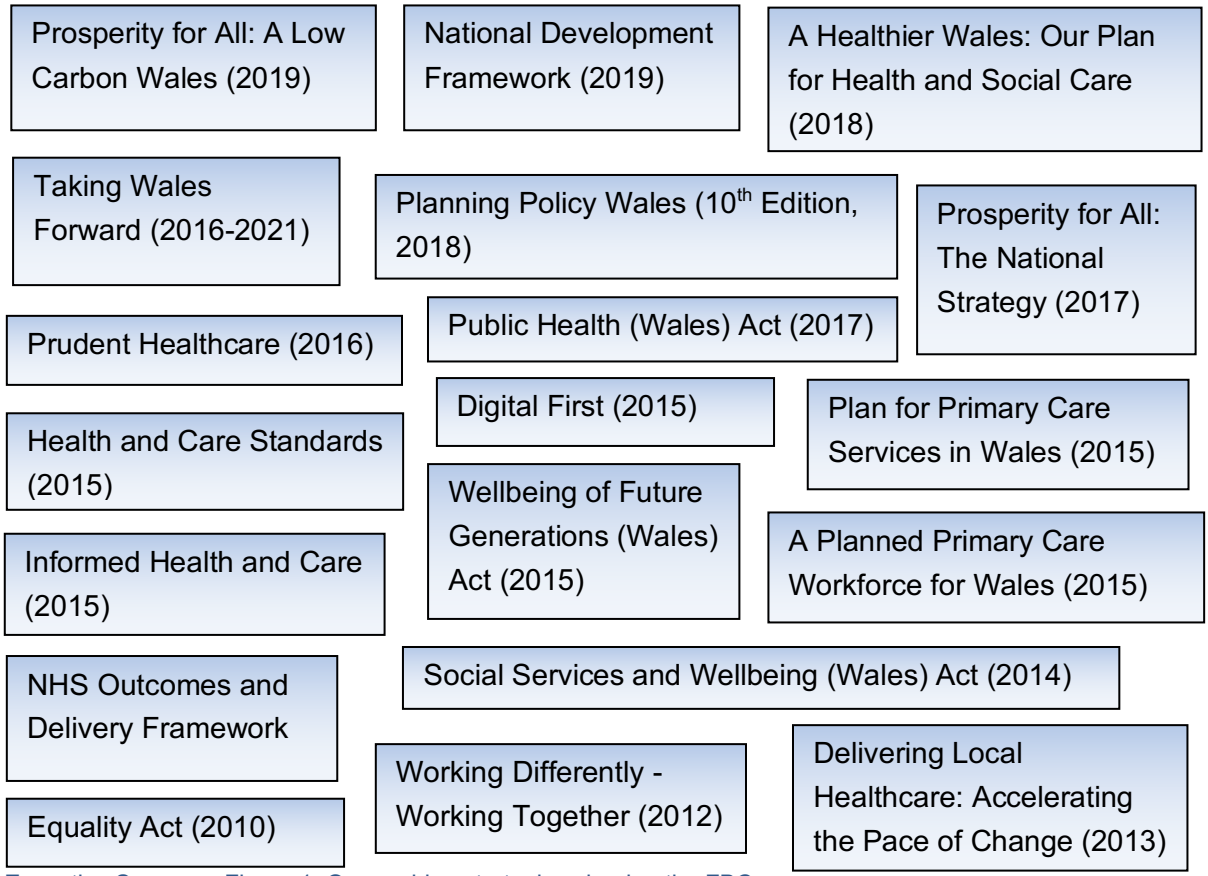
Throughout the development of this FBC, the Health Board has been mindful to ensure it continues to consider and take account of local and national drivers for the health and wellbeing of the community.

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 pharmacies) 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 population served by the Health Board is growing rapidly in size and 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 FBC are:



Executive Summary Figure 1: Overarching strategies shaping the FBC

The more key recent publications outlined in the diagram above confirm and strengthen the future direction for health and social services namely:

- A Healthier Wales: Our Plan for Health and Social Care (2018);
- Prosperity for All: The National Strategy (2017);
- Taking Wales Forward (2016-2021);
- The Wellbeing of Future Generations (Wales) Act (2015).

Alongside these national policies, relevant local strategies to the Health Board such as the *Strategic Clinical Services Plan 2019 - 2029* and *Shaping Our Future Wellbeing Strategy 2015-2025* (SOFW) have been a constant focus as it promotes the Health Board vision of *"Caring for People; Keeping People Well, a person's chance of leading a healthy life is the same wherever they live and whoever they are"*.

To achieve a greater focus on developing integrated services aimed at improving health and wellbeing outcomes for each locality and cluster population, a transformation to a 'social model of health' is required.

Transforming services through redesigned clinical pathways and service models, to enable traditional hospital based services to be delivered in the community, close to where people

live is paramount and there is a focus on those conditions where change will have the biggest impact in shaping the future health and wellbeing of the population.

To satisfy the requisites of the SOFW strategy, many improvements are required to increase the effectiveness and capacity of the community based infrastructure to provide a network of flexible multi-functional accommodation solutions across Cardiff and the Vale of Glamorgan.

It is proposed that a Local Health & Wellbeing Centre will be located in each of the 3 localities of the Health Board's geographical area supported by a more local network of Cluster based Wellbeing Hubs, which will where possible be developed alongside Local Authority Community Hubs and other appropriate facilities.

In identifying the best locations for Wellbeing Hubs, the Health Board used a simple algorithm to apply to each Cluster and the results of this assessment suggested that a Wellbeing Hub in the Maelfa area would be a suitable location to serve the residents of Llanedeyrn and Pentwyn.

The proposed development also takes account of the Key Population Needs identified in the *Cardiff and Vale of Glamorgan Area Plan for Care and Support Needs 2018-2023 (Me, My Home, My Community)* and the priorities developed in response by the Cardiff and Vale of Glamorgan Regional Partnership Board (RPB).

Other key strategies taken into consideration within this FBC are:

- Integrated Medium Term Plan 2019 / 2022;
- Cardiff Wellbeing Assessment 2018 – 2023;
- Cardiff and Vale UHB Estates Strategy;
- Cardiff and Vale UHB Informatics Strategy and "Delivering Digital: a 5 year strategy".

2.2.2 The Case for Change

This Full Business Case focusses on the population of Llanedeyrn and Pentwyn and within this community, there is an existing Health Board facility, namely Llanedeyrn Health Centre.

The current Llanedeyrn Health Centre is managed by the Cardiff East Cluster, however 98% of the residents served are located in the Cardiff North Cluster and geographically the Health Centre is isolated from the rest of the Cardiff East Cluster by the major A48(M) route.

The Cardiff North cluster is the largest cluster in Cardiff in terms of population and land area. The cluster is approximately 40% larger (land area) than any other cluster in Cardiff and Vale. Although it is generally perceived to be a less deprived and a generally healthy area, according to most social economic, health and deprivation indicators there are significant pockets of deprivation, including areas of Llanedeyrn and Pentwyn of which 31% of the population live in an area of deprivation. Just under a third of the Pentwyn Lower Super Output Areas (LSOA) are in the 10% or 10-20% most deprived decile of deprivation in Wales.

Llanedeyrn Health Centre GP Practice merged in October 2017 with Llanrumney Medical Group to form Llan Healthcare but wish to continue to operate from the two premises. However, the existing Llanedeyrn Health Centre has three main areas of failure:

- Accommodation that is not wholly fit for purpose. The building is in very poor condition with the latest Estates Condition report describing it as follows:
  - Physical condition - D: Very poor. Extensive internal modernisation and external refurb required. Damp/water penetration issues;
  - Space - First floor predominantly empty due to the poor quality of environment;
  - H&S/Fire - D: Fire compartment concerns, combustible materials in corridors and poor Disability Discrimination Act (DDA) compliance;
  - Function - DX: Narrow circulation routes, no access to a lift;
  - Quality - D: Very poor quality internally and very poor quality external aesthetics. GP Practice staff work hard however to make up for lack of quality environment.
- A limited range of clinical services:
  - The deteriorating accommodation is constraining the practice's ability to increase the range and scope of services delivered within primary care, impeding support for the concept of "home first" and impacting on GP sustainability especially at a time when the GPs are looking at an alternative skill mix, with the Health Board's support, to address wider primary healthcare needs;
  - The Practice is a training practice and the building currently constrains the Practice developing its capacity to train future GPs.
- A restricted model of healthcare delivered in isolation from partners:
  - The current arrangements do not allow for delivery of a social model of health in collaboration with partners to providing a holistic, seamlessly integrated approach to meeting the needs of the community as per the Health Board's aims and objectives of the SOFW: IOC strategy.

The facility was built in 1972 and requires extensive external repair, there are also major concerns around the current parking and access arrangements for patients as there is no obvious main entrance.

The Llanedeyrn Health Centre building is located adjacent to the Maelfa Shopping Centre in Llanedeyrn and opposite The Powerhouse Community Hub. The area is currently being developed by Cardiff Council and their development partner, Cardiff Community Housing Association (CCHA) to revitalise the heart of one of the most deprived estates in the city. It also provides the opportunity to create an innovative solution that includes a health facility that would support collaborative working between partner organisations delivering a range of associated health and wellbeing needs.

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 will take forward the maximum scope which is to provide a fit for purpose community based facility that supports General Medical Services (GMS) sustainability, meets all statutory requirements and best practice models but will also support improved access to a range of community based services therefore delivering an improved social model of care focused on the physical, mental and social wellbeing of people in the community.

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

Investment Objective	Main Benefits
1. To work with partner organisations to deliver local and convenient access to health and wellbeing education, information and advice (in relation to: physical activity; healthy eating; smoking; alcohol; weight; and social loneliness)	Increased access to wellbeing group activities for the Cluster Increased uptake of social prescribing within the Cluster
2. To develop facilities which support local delivery of collaborative multi-agency services for Cluster residents	Increased uptake of flu immunisation for over 65 year olds Increased uptake of flu immunisation for clinical at risk groups
3. To develop an environment within the Cluster which promotes a social model of care	Improved wellbeing and reduced social loneliness of residents within the Cluster
4. To work with partner organisations to provide a range of locally delivered health and wellbeing services, tailored to meet the identified needs of local residents	Improved access to GPs supported by Multi-Disciplinary Team (MDT) working and available health and wellbeing services for the Cluster
5. To support the sustainable delivery of GMS for local residents through provision of appropriate shared facilities	Improved stability for Llan Healthcare
6. To implement/ incorporate innovative technology which improves access to digital tools and information, enables effective communication between clinicians and citizens and supports mobile working	Improved staff working practices within the Cluster

Executive Summary Table 1: Investment Objectives and Main Benefits

2.3 The Economic Case

2.3.1 The Long List

A long list of options was generated during the development of the OBC and were evaluated in accordance with best practice contained in the Infrastructure Investment Guidance. The evaluation was based upon how well each option met the investment objectives and CSFs. By systematically working through the available choices for what, how, who, when and funding some options were discounted, others carried forward and thus provided the recommended approach to identify the preferred way forward.

The long list shown within the OBC has been revisited in the context of the FBC and it has been confirmed that no changes are required since the evaluation of those options presented within the OBC.

The table below provides the detailed findings from the long list appraisal undertaken:

Option	Finding
1.0 Scope	
1.1 Do Nothing – status quo	Discounted
1.2 Do Minimum – Current Maelfa services and increased delivery of Health Board wellbeing services for the local population	Discounted
1.3 Social model of health – All health and wellbeing Maelfa services and collaborative services delivered with partner organisations (LA and 3rd sector)	Preferred
1.4 Maximum Scope – Social model of health – As 1.3 plus potential for pharmacy	Possible
2.0 Service Solutions	
2.1: Extend and refurbish the existing Health Centre	Possible
2.2: New build facility on the existing / development site	Preferred
2.3: Lease/buy an existing facility elsewhere in Maelfa	Discounted
2.4: New build facility elsewhere in Maelfa	Discounted
3.0 Service Delivery	
3.1 In House	Preferred
3.2 Outsource	Discounted
3.3 Strategic Partnership	Discounted
4.0 Implementation	
4.1 Big Bang	Preferred
4.2 Phased	Discounted
5.0 Funding	
Primary Care Pipeline fund - it has been agreed with Welsh Government that this project will be supported	

Executive Summary Table 2: List of Inclusions and Exclusions at Long List

2.3.2 The Short List

The findings from the table above allowed the development of the preferred way forward at OBC stage by taking forward those options which were described as either "possible" or "preferred" into a short list of options. All dimensions and options listed as 'discounted' were then excluded at that stage with the exception of the Do Minimum option which was carried forward for comparative purposes only.

The overview of the short listed options shown below is also taken from the OBC:

	Scope	Service Solution	Service Delivery	Implementation	Funding
Option 1	Do Nothing (potential to provide backlog maintenance only for existing Llanedeyrn Health Centre)				
Option 2	Social model of health – all health and wellbeing Maelfa services and collaborative services delivered with partner organisations (LA and 3rd sector)	Refurbish and extend existing Llanedeyrn Health Centre	In-house	Big Bang	Primary Care Pipeline Fund
Option 3	Social model of health – all health and wellbeing Maelfa services and collaborative services delivered with partner organisations (LA and 3rd sector) with potential for pharmacy for maximum scope if required	New build facility on the existing development site	In-house	Big Bang	Primary Care Pipeline Fund

Executive Summary Table 3: Short Listed Options

Within option 3, however it must be noted that there are two potential site locations that are available to the Health Board:

- On the same site as the existing Llanedeyrn Health Centre;
- Located on existing green space/ play area facility that could provide a direct link to The Powerhouse Community Centre.

This evaluation has been revisited in the context of the FBC and it is confirmed that no changes are required and therefore the following confirmed shortlisted options remain valid (they have however been re-numbered for ease of reference and consistency within the economic and financial appraisals):

- Option 1 – Do Nothing: Provide backlog maintenance to Llanedeyrn Health Centre;
- Option 2 – Refurbish and extend the existing Llanedeyrn Health Centre;

- Option 3 – New build facility on the existing Llanedeyrn Health Centre site;
- Option 4 – New build facility on site located on existing green space/play area directly adjacent to the Powerhouse Community Hub.

2.3.3 Qualitative Benefits Appraisal Key Findings

The evaluation of the qualitative benefits associated with each of the shortlisted options was taken to the Project Team during October 2018 as part of the development of the OBC, the results of which are shown for completeness within this FBC.

Benefit Criteria	Weighted Scores			
	Option 1	Option 2	Option 3	Option 4
1. How well does the model and facilities promote collaborative working across health, local authority and third sector services?	20	40	140	200
2. Does it promote a social model of health and wellbeing from the patients' perspective?	16	32	128	160
3. How well does the range of services meet the health and wellbeing needs of the local population?	22	66	176	220
4. Does the option provide potential for flexible, multi-functional facilities, to deliver services in response to future need?	36	108	162	180
5. Does the solution make the optimum use of human, capital and estates resources?	56	98	126	126
6. Can the option be implemented in a timely fashion, with minimal disruption to services and staff?	40	30	20	90
TOTALS	**190**	**374**	**752**	**976**
RANK (weighted)	**4**	**3**	**2**	**1**

Executive Summary Table 4: Non-Financial Option Appraisal Results

Sensitivity analysis was undertaken on the non-financial option appraisal 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 no scenario in which Option 4 is not the preferred option due to its site location and means for complete collaboration with local authority and third sector partners.

The findings of the option appraisal has been reviewed during the development of this FBC and it was agreed that the critical success factors, benefit criteria and scoring of the options remained relevant and the option appraisal continued to reflect a realistic outcome.

2.3.4 Economic Appraisal Key Findings

The economic appraisal of the shortlisted options that was undertaken at the OBC stage, concluded with a clear preference for Option 4. That appraisal has now been refreshed for the FBC to reflect the impact of the agreed final cost plan costs for Option 4.

The refreshed economic appraisal incorporates the following cost inputs:

- Capital costs at PUBSEC index 274 in line with the cost plan figures for the preferred Option 4;
- Cost plan figures for Option 4 show a forecast outturn cost of £14.371m including VAT. This is equivalent to 96.3% of the total cost at the OBC stage;
- For the purpose of the FBC appraisal, it is assumed that Options 2 and 3 would have shown a proportional cost reduction (3.7%) from OBC levels had they been developed to the same level of design detail as Option 4;
- Lifecycle Costs based on standard NHS replacement cycles provided by the Health Board's cost advisers for Option 4 and are assumed to be similar for Options 2 and 10% higher for Option 3, in line with OBC assessments;
- Revenue costs for the options as described in the Financial Case:
  - Pay and Non-Pay Service costs at £2,745k for 2020/21 and 2021/22, with an assumed 3% transformational saving from 2022/23;
  - FM costs at £96k for the first two years, and £200k for the development options from 2022/23;
  - Under Options 2, 3 and 4, Non-Cash Releasing benefits of £136k per annum effective from 2022/23 to reflect potential savings in GP time on 4,397 Mental Health Liaison and MSK appointments, at £31 per appointment.

The capital costs are summarised in the table below:

Capital Costs at PUBSEC 274	Option 1	Option 2	Option 3	Option 4
	£'000	£'000	£'000	£'000
Works Costs	1,209	8,033	8,011	8,672
Fees	212	1,932	1,774	1,858
Non-Works	0	3,173	3,173	542
Covid-19	0	258	258	258
Equipment Costs	0	161	161	161
Planning Contingency	142	665	655	558
Subtotal excluding VAT	**1,563**	**14,222**	**14,032**	**12,050**
VAT @ 20%	0	2,844	2,807	2,321
FBC Total Capital Cost	**1,563**	**17,066**	**16,839**	**14,371**

Executive Summary Table 5: Capital Costing Summary at Approvals PUBSEC Index 274 – (£'000)

The capital investment of £14.371m includes £263K (including VAT) for the hard surface multi use games area (MUGA), £310K (including VAT) for revised working practices to

comply with Covid-19 Health & Safety requirements, and £192K (including VAT) for the Decarbonisation measures.

The economic appraisal outputs are summarised below:

Economic Cost	Option 1	Option 2	Option 3	Option 4
Net Present Cost (NPC £000)	57,633.6	90,211.1	89,710.3	87,789.5
Equivalent Annual Cost (EAC £000)	2,919.9	3,401.9	3,383.0	3,310.6
Ranking of Options	1	4	3	2
Ranking of Development Options		3	2	1
EAC Margin Development Options (£000)		91.3	72.4	0
EAC Switch Value (£000)		(91.3)	(72.4)	72.4
EAC Margin above preferred %		2.8%	2.2%	0.0%

Executive Summary Table 6: Summary of Economic Appraisal Outputs

On the basis of the economic appraisal undertaken:

- Option 4 is preferred by a margin of 2.2% over Option 3 and 2.8% over Option 2.

Sensitivity Testing indicates that:

- Capital cost inputs would have to change by nearly £2m (15%) differentially between Options 3 and 4 to switch the economic preference in favour of Option 3. A change of this magnitude, broadly comparable to the decant cost in Option 3, is not considered likely.

Option 4 is therefore re-confirmed moving forward and is the preferred FBC option from a quantitative appraisal perspective.

2.3.5 Risk Appraisal Key Findings

A risk appraisal was undertaken during the development of the OBC to evaluate the risks associated with each shortlisted option using the method included in the WG template for business cases.

Risk Category	Option 1	Option 2	Option 3	Option 4
Business Risks	61	63	60	43
Service Risks	36	40	33	12
Design Planning & Construction Risks	32	40	32	24
Project Resource Risks	4	4	4	4
Total	**133**	**147**	**129**	**83**
Ranking	**3**	**4**	**2**	**1**

Executive Summary Table 7: Risk Appraisal Results

The risk appraisal has been reviewed during the development of the FBC and has been agreed that the scoring of the options remained relevant.

2.3.6 Overall Findings – Conclusion

Having re-assessed the non-financial, financial and risk appraisals of the shortlisted options, the preferred option as outlined within the OBC remains as Option 4 due to its capability of meeting the various criteria of the project as set out within the economic case.

2.3.7 The Preferred Option

Option 4 provides a fit for purpose new Health Centre at Maelfa (*Wellbeing Hub@Maelfa*) adjoining the existing Powerhouse Community Hub, that meets all statutory requirements and best practice models. The facility will provide high quality accommodation and support improved access to a seamless integration of social, health and wellbeing services therefore delivering an improved social model of health for the residents of Llanedeyrn and Pentwyn.

Proposals have been developed in partnership with local GPs, the local authority and third sector organisations and will focus on 'prevention' and 'wellness' rather than 'illness' supporting the Wellbeing of Future Generations (Wales) Act wellbeing objectives by:

- Prosperity – improved health outcomes leading to greater opportunity to contribute to society. Development of sustainable community facilities which use energy efficiently, generate energy and aim for carbon footprint neutrality;
- Resilience – use of adjacent green outdoor space to support individual and community activities to develop a strong and resilient community e.g. community garden, sports activities;
- Health – people's physical, mental and social wellbeing needs met through collaborative service delivery with partner organisations;
- Equal – reduced health inequalities through targeted provision of services/ interventions which meet the health and wellbeing needs of local population;
- Cohesive communities – promote co-production, co-design and co-ownership to nurture the development of a strong community spirit and consequent positive outcomes such as improved public health and social resilience;
- Culture – community focused wellbeing facilities which support people to participate in a variety of sport and social activities.

The new Wellbeing Hub will include:

- Relocation of services from Llanedeyrn Health Centre and GP Practice.
- Wellbeing and community facilities including group/ community rooms, an information/ advice area, shared café and children's library. These spaces, in collaboration with existing facilities within the adjoining Powerhouse Community Hub, will support health, local authority and third sector groups to deliver wellbeing advice, education, support and signposting that can be personalised to support independence in the local community;
- A range of specialised health clinics delivering seamless care closer to home along with proactive improvement of health and wellbeing services including access to District Nurse treatments, Counselling services, Podiatry, Dietetic services,

Community Addictions, Health Visitor Baby Clinics, Primary Mental Health services, Early Intervention & Support Services for Children & Younger People, Stop Smoking Wales advice and information, Antenatal care, Audiology and Heart Failure services.

- Office and administrative facilities to support team working, which will be evidence driven, using lessons learned from Health Board and partners' experience of delivering merged services.

This project also supports the ten national design principles to drive change and transformation and deliver the Quadruple Aim as described in "*A Healthier Wales: our Plan for Health and Social Care*".

2.4 Commercial Case

2.4.1 Procurement Strategy

The construction of these premises 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) Willmott Dixon 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 using the NEC contract as prescribed under the Framework. For the Project Manager and Cost Advisor, the NEC 3 Professional Services Contract has been used, and for the SCP, the NEC Option C (Target Cost) contract has been used.

It is anticipated that the total construction duration will run for 22 months although the start date for this is dependent on the approvals process.

2.4.2 Required Services

The scope of services required remains valid and continues to be for the project management, cost advice and the design and construction of a Health and Wellbeing Hub at Maelfa adjoining the Powerhouse Community Hub in Llanedeyrn comprised of a GP practice (Llan Healthcare), outpatient and community clinical accommodation, wellbeing zone, team base, support accommodation.

2.4.3 Land Transfer / Acquisition

The site identified for the *Wellbeing Hub@Maelfa* is owned by Cardiff Council (CC), the site of the existing Llanedeyrn Health Centre is owned by Cardiff & Vale University Health Board.

During development of the OBC, there were ongoing discussions regarding the transfer / acquisition of land required for the development including the relocation of the existing play area and utilisation of land regarding the existing Health Centre. It has been agreed however during development of this FBC by both the Health Board and the Council that the land required for the Wellbeing Hub will not be sold to the Health Board, and as a consequence a "long lease" is to be entered into, with the Heads of Terms outlined within the Estates Annex that accompanies this document. CC have also confirmed they do not have an interest in

purchasing any part of the existing Health Centre site and therefore the new multi-use games area (MUGA) will be constructed as part of the main contract commencing in November 2020, which will mean the loss of the current play area for circa 3 months.

The Council is fully supportive of the development as indicated in their letter of support.

2.4.4 Agreed Risk Transfer & Payment Mechanisms

The Health Board have indicated that it will apportion risk in the design and build phase as per the following table, however this will be appraised and reviewed at subsequent stages of the scheme to ensure there is an appropriate allocation of risk:

Risk Category	Potential Allocation		
	Public	Supply Chain Partner	Shared
Design Risk			✓
Construction & Development Risk			✓
Transition & Implementation Risk			✓
Availability and Performance Risk			✓
Operating risk	✓		
Variability of Revenue Risks	✓		
Termination Risks	✓		
Technology & Obsolescence Risks			✓
Control Risks	✓		
Residual Value Risks	✓		
Financing Risks	✓		
Legislative Risks			✓
Other Project Risks			✓

Executive Summary Table 8: Risk Transfer

On completion of the project, the building will be owned by the Health Board and during the development of this FBC, appropriate arrangements have been agreed with all parties regarding the operational management of the facilities and Head of Terms regarding the lease arrangements are being agreed with Llan Healthcare GP Practice.

The Health Board intends to make payments to the externally appointed team in respect of products and services as follows:

- Charging will be completed under the 'Building for Wales' Framework terms and conditions.
- The contract will be managed by CVUHB under the NEC3 Option C Target Cost Contract.

2.5 Financial Case

2.5.1 Financial Expenditure

A summary of the capital costs and depreciation for the preferred option is as follows:

Capital Costs	£'000
Building/Engineering	13.868
Equipment costs	0.193
Total Capital Cost/ Cost Forms	**14.371**

Executive Summary Table 9: Capital Costs for the Preferred Option

	£'000
Impairment	8.787
Depreciation – Recurrent Building/Engineering	0.063
Depreciation - Accelerated	0.520
Depreciation – Equipment	0
Total Capital Charges/Depreciation	**9.370**

Executive Summary Table 10: Summary of Capital Charges and Depreciation.

The following is a summary of the total impact of impairment by year until the planned opening of thew new facility:

	2020/21 £'000	2021/22 £'000	2022/23 £'000	2023/24 £'000
DEL Impairment	0	0	0	0
AME Impairment	0	0	8.787	0
Total	**0**	**0**	**8.787**	**0**

Executive Summary Table 11: Summary of Total Impact of Impairment Year on Year

This FBC assumes all capital charges and depreciation will be funded by Welsh Government.

The detail of the community services to transfer into the new Wellbeing Hub includes services from a variety of settings. These have been worked through in detail through the information provided within the individual clinical service specifications and are included in the assessment of the current cost of services.

This cost assessment relates to those services currently delivered by Cardiff and Vale University Health Board and excludes services to be provided by the Local Authority, GPs, Public Health and the Third Sector.

	£'000
Current Service Costs (Health Board services only)	2,745
Total	**2,745**

Executive Summary Table 12: Current Service costs of Health Board Services

The following assumptions have been made in respect of the revenue case:

- Costs are based on 2020-21 rates and show full year costs;
- Revenue site costs (excluding capital charges and depreciation) are based on an assessment of the current architectural plans and based on m^2;
- Rental income received from Llan Healthcare GP Practice - current and revised - assumed to be cost neutral and excluded from the revenue assessment;
- No rental income is assumed from third sector organisations but will create revenue funding stream once plans are finalised.

Any reception cost cover has been excluded on the assumption that the reception cover from the existing Llanedeyrn Health Centre will transfer.

The following assessment also assumes the existing Public Sector Broadband Aggregation (PSBA) Circuit to Llanederyn Health Centre is available for the new build.

Full year costs:	Health Board current	Health Board increase	Total	Total increase in Revenue cost
	£'000	£'000	£'000	£'000
Cleaning	27	24	51	24
Estates	23	21	44	21
Waste	3	3	5	3
Security (incl TDSI & CCTV)	2	2	5	2
Energy Combined	23	20	43	20
Water	2	2	4	2
Rates	26	23	48	23
Total	**106**	**94**	**200**	**94**

Executive Summary Table 13: Summary of site based Revenue Costs: 2020-21

2.5.2 Overall Affordability & Balance Sheet Treatment

The anticipated capital spend, capital charges and depreciation profile for the extent of the project is as follows:

	2020/21 £'000	2021/22 £'000	2022/23 £'000	2023/24 £'000	2023/24 £'000
Capital (excl VAT)	2.510	7.480	1.050	0.020	0.005
Accelerated Depreciation	0.078	0.312	0.130	0	0
Depreciation	0	0	0.031	0.063	0.063
Total	**2.588**	**7.792**	**1.211**	**0.083**	**0.068**

Executive Summary Table 14: Impact on Income and Expenditure Account

All assets will be shown on the Health Board's balance sheet. The asset will be valued on completion and recorded on the balance sheet at that value. Subsequently it will be treated as per the Health Board's capital accounting policy.

The total capital requirement includes £263k (including VAT) regarding the construction of the hard surface multi use games area. It is assumed this funding will be passed to Cardiff Council as opposed to the Health Board as they will ultimately own this asset. The net cost of the construction of the play area (£224k) is included in the £7.480m capital spend figure for 20/21 above.

As highlighted above, it is assumed the impairment and recurrent charges for depreciation will be funded by Welsh Government. The net additional revenue costs and funding are summarised in the table below:

	£'000
WG Impairment funding	8.787
WG Depreciation funding	0.677
Service Costs (Health board only - assumes no change to service costs)	0
Other Revenue Costs to be managed by the Health Board	0.094

Executive Summary Table 15: Overall Affordability

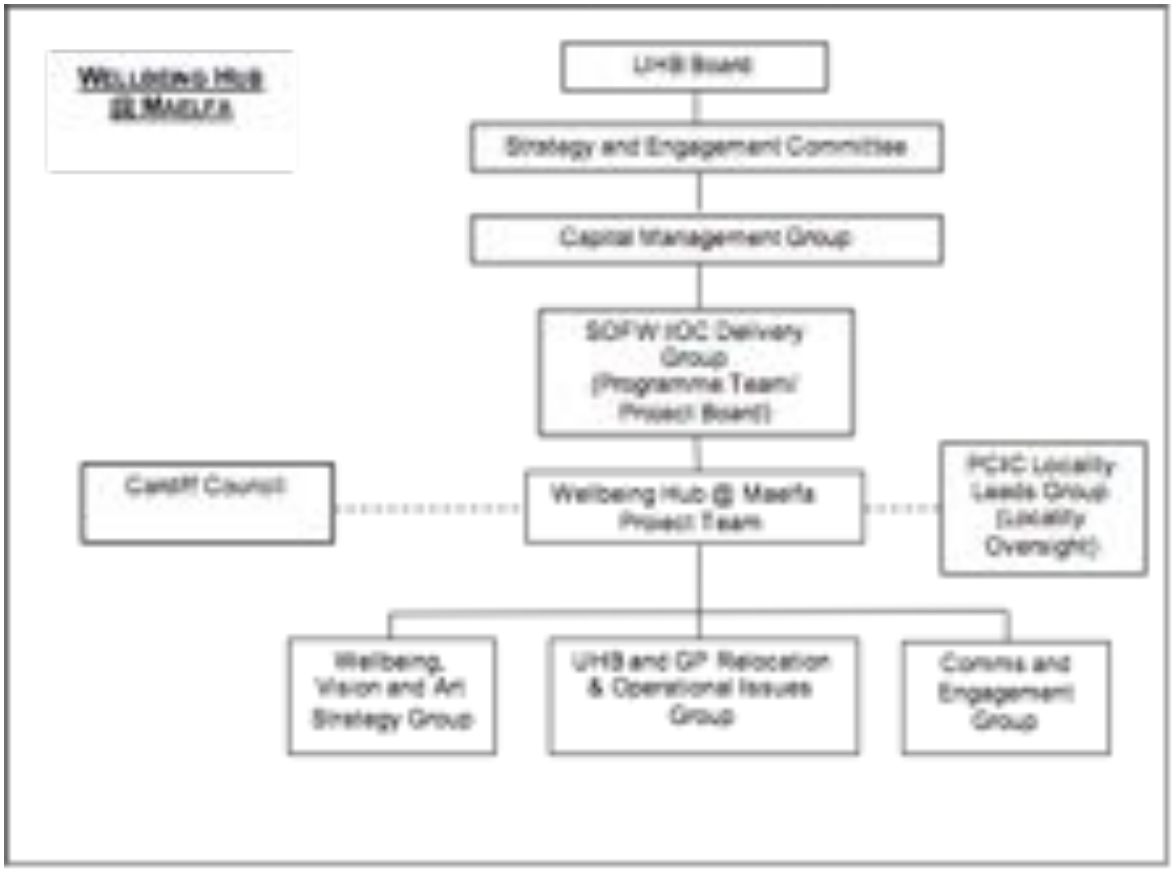
A review of costs has been provided by clinical and non-clinical managers through submission of detailed clinical service specifications and work to transform service delivery and release efficiency savings will be established wherever possible therefore a 3% transformational saving has been predicted based on the current assessed cost of Health Board services to be delivered from the Maelfa Wellbeing Hub.

2.6 Management Case

2.6.1 Project Management Arrangements

The project is an integral part of the Health Board's overarching Programme Business Case (PBC) which comprises a portfolio of projects for the delivery of the *'Shaping Our Future Wellbeing: In Our Community*' strategy. However, the Health Board recognises that individual robust project management arrangements for each project are vital to ensure the implementation of the project and that effective control is maintained over each capital scheme.

The reporting organisation and the reporting structure for the whole of the project is shown as follows:



Executive Summary Figure 1: Project Reporting Structure

The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
FBC submission to WG	July 2020
Approval of FBC	October 2020
Design completion and commence construction elements	November 2020
Phase 1 - Main site construction completion	February 2022
Facility operational	February 2022
Phase 2 - Demolition of existing Health Centre site and completion of works	August 2022

Executive Summary Table 16: Key Milestones

2.6.2 Benefits Realisation & Risk Management

A benefits realisation plan was developed during the OBC stage and has been further established to provide a framework for this aim and is overseen by the Project Board.

The final agreed plan describes the key objectives, benefits and measures, which will be used to evaluate the successful delivery of the project, it also shows who has the accountability for its realisation.

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 described. The outline service and strategic risk register has been further established throughout the development of this FBC for the preferred option and includes all risks identified to date. The risk register will be continuously updated during the life of the project, and counter measures identified and applied as required.

2.6.3 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. The finalised arrangements for post implementation review and project evaluation review have been established in accordance with best practice.

2.7 Recommendation

It is recommended that approval be given for the Cardiff and Vale University Health Board to develop the preferred option for a new build *Wellbeing Hub@Maelfa*. The project will enable Health Board to deliver wellbeing and healthcare services needed by the people in the communities of Pentwyn and Llanedeyrn as well as deliver the benefits of the Health Board's SOFW programme and strategy, in turn fully complying with the Welsh Government strategies such as *Wellbeing for Future Generations Act*, *Taking Wales Forward*, *Prosperity for All* and *A Healthier Wales*.

Report Title:	**Cardiff & Vale UHB's Digital Strategy**								
Meeting:	**Board**						**Meeting Date:**	**30th July 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Digital & Health Intelligence**								
Report Author (Title):	**Director of Digital & Health Intelligence**								

Background and current situation:

The development of a Digital strategy is key to supporting service transformation plans associated with embracing new and emerging digital technologies and adopting new ways of working. The strategy has been developed with significant input from the Chief Clinical Information Officer (CCIO), ensuring alignment with the UHB's clinical services plans.

The Digital strategy will form the basis of the UHB's IT and information plans for the next 5 years, informed by national strategy and developments as we all as local plans in supporting the UHB's strategy as described in "Shaping our Future Wellbeing".

Implementation of the work programme to support the Digital Strategy will be led primarily through the Digital directorate teams working closely with the UHB's Clinical Boards and their nominated clinical digital leads.

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

The Digital strategy commits the UHB to a direction of travel informed by clinical services and the UHB's own future plans. Delivery of the plans will require investment decisions to be made based on business cases that will describe the benefits to be derived from their implementation.

The Digital strategy is likely to continue to evolve and change as local and national initiatives become clearer and are implemented.

The Digital strategy was presented to the Digital & Health Intelligence Committee meeting on 9th July 2020 where it was ratified and recommended to be approved by the UHB Board at its next meeting.

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

The strategy's success will be dependent on adequate investment plans as well as an appetite to deliver transformed services, which will require cutural changes to the ways of working. This will include change management and new working practices in order to maximise the potential that digital solutions can offer.

Recommendation:

The Committee is asked to:

APPROVE the Digital Strategy for the UHB for 2020-2025.

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	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

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

Delivering Digital

Building a learning health and care system
A Five Year Strategy

Cardiff & Vale University Health Board

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

Digital Strategy for Cardiff & Vale UHB

- Section One — Overview
- Section Two — Achieving the Vision
  - 2.1 — Achieving the Vision: Stuff
  - 2.2 — Achieving the Vision: Staff
  - 2.3 — Achieving the Vision: Adaptive Change
- Section Three — Delivery

Overview

Our vision,

Our Principles

Introduction

This digital strategy is being produced to provide a clear roadmap for how digital technology will enable the transformation of clinical services described by the Cardiff & Vale University Health Board overarching strategy, 'Shaping Our Future Well-being'.

The ambition of the NHS in Wales has been set out in the Welsh government document a healthier Wales published in 2018, declaring the ambition for an integrated health and social care system which enables seamless care and the ability to promote health and well-being as close to home as possible. The document very clearly sets out the need for a modern digital infrastructure to enable this transformational change.

The strategy has been written after engagement with staff across the organisation, taking particular note of the attendees of the clinical information management and technology group, the clinical boards, the executive board and information available to us from patient feedback.
The strategy sets out a significant step change in the approach that Cardiff and Vale University health board will take towards a digital future for healthcare services.

Digital services should not be regarded as an end in themselves. The Parliamentary Review into Health and Social Care in Wales, informed by extensive public and service engagement, called for a transformation in the way we deliver services, and this has been accepted by the Welsh Government in the 'A Healthier Wales' strategy document. Both recognize that Digital services are a key enabler to transforming the way health and Care services are delivered in Wales, and in enabling patients to have greater involvement in managing their health and well-being.

CTRL-ALT-DEL

Digital as an enabler, not a blocker

Tolley, Laura
07/27/2020 11:09:35

Time to reset – Local driver

A staff engagement event (Amplify) in the summer of 2019 to review progress of Shaping Our Future Well-being at its halfway point of five years. A clear message at this event is that many people appreciated the great potential of digital technology to transform our services, but those same people felt that inability to deliver the technology itself and become a significant block to progress. A similar picture had emerged nationally, and in 2018 the Welsh audit office followed by the public accounts committee delivered to hard-hitting and critical reports into the failure of the health system in Wales to deliver at scale or that piece many of the elements set out in the national digital strategy, informed health and care.

Time to reset – National driver

In 2019 following those national reports, the Welsh government accepted the recommendations of an informatics architecture review, and also announced significant changes to the governance arrangements for the NHS Wales Informatics Service, and the relationship between and the Health Boards and Trusts responsible for delivering services. Importantly, Welsh Government has made available significant increase in funding levels specifically directed towards transformational change, with digital technology as its enabler.

The strategy described here is in line with the architecture review and maintains and updates the direction of travel set out in informed health care.

Our vision: A Learning Health and Care System

High Level Aims

- Digital First for patients and carers
- Digital First for staff.
- Seamless information sharing across professional and organisational boundaries.

Principles

- Co-production through user-centred design
- Digital as the enabler, not digital as a goal in itself
- Iterative, agile design
- Innovation aligned to startegy
- Democratise data, democratise knowledge

We are all used to using digital services in many areas of our life – banking, shopping, booking a table at a restaurant, leaving feedback about holiday accommodation etc. Health seems to be lagging compared to all other areas. This is a global phenomenon, and not unique to Wales. Health care is acknowledged by information technology experts to be especially complex, with information having to be shared over a large number of organisational boundaries, and tracking many different types of user-experiences through time. And yet it is possible to deliver and track those services digitally. The Baltic country of Estonia adopted a 'digital first' philosophy for its public services, including health, several years ago, and is held up as an international example of what can be achieved.

Closer to home, the UK Government Digital Services has revolutionised the way in which we can now use digital solutions to perform many functions which required extensive paperwork and trips to the post office or other government buildings – renewing a driving license or passport, completing a tax return or applying for state benefits for example.

We set out to adopt a similar 'digital first' philosophy for Cardiff and Vale University Health Board, enabling users and staff to use digital technology to access services.

A Learning Health and Care System

D2K	K2P	P2D
• By analysing the data we collect it turns into information and knowledge. We can only change and improve our system if we understand it.	• We must then use the understanding we gain to inform , improve and transform practice. This is the most important step, and the hardest to achieve.	• To collect our data, we will need to enable clinicians and patients to record their activities digitally without interfering with the processes of care. Data must be collected and used in 'real-time' to maximise its usefulness in operational as well as planning services

By collecting timely, accurate data, we will understand how our system works. We will be able to follow patients through care pathways, learning how we can make them more efficient, and ensuring their journeys are safe. The ability to collect and record patient outcomes means that we can compare ourselves to other organisations to ensure we are providing good quality outcomes.
By collecting patient reported outcomes we will see what works, and what doesn't work. This enables us to put Value Based Healthcare into practice.

In 5 years

Patients will have much more control over how and when they access services, and will be able to access more closer to home

Patients

- Patients will access their own health and care records, reports, and results.
- They will be able to see who else has accessed their information. They will be able to view appointments and re-schedule them via digital channels. They will be able to communicate securely with clinicians providing their care. They will have access to supporting health and care information designed tailored for their needs. They will have the power to share their information with anyone they wish to. They will be able to upload information from wearable devices, or care devices which are part of the 'Internet of Things'.

Clinicians

- Clinicians will access information about individual patients
- They will be able to communicate securely with other members of their clinical team, and in multi-disciplinary teams. They will be able to communicate securely with individual patients and will in many cases be supporting patient care in 'virtual' clinics using video communication technology familiar in other walks of life. securely and reliably via digital channels, which will include their own devices.

Local/National Data Resource

- The data collected will be used to build the foundation for a Learning Health and Care System
- Timely, high quality data on patient outcomes is used to enable the service to understand what works well, and what needs to be improved. Teams of trained data analysts will work closely with clinicians and service planners to derive knowledge from data. The focus will have moved further towards outcomes rather than the more traditional process measures.

Our promise

- Patients will be able to choose which information to share, and which they do not wish to share.
- Information will be visible across Wales, and across previous boundaries between primary and secondary care, health and social care, and public and third sector. Appropriate safeguards will ensure personal identifiable data is not shared where it should not be, or where patients have requested it should not be, but the default expectation will be that information will be shared to enable safe continuity of care seamlessly across the system.

Guiding Principles

A system built on data, delivered with care

Persistence and re-use of data

- Whenever digital information is collected, it will be stored in a form that enables it to be re-used by other appropriate applications. For example, if a patient has had an allergy recorded in a hospital clinic, that information will then be updated and re-used by another application used by a pharmacist, GP or other care provider. This will greatly enhance efficiency and safety.

Co-production through user-centered design

- The introduction of a digital process requires and understanding of what it means to the service users – both patients and clinicians. When introducing new digital solutions, patients and clinicians will therefore be involved in deciding what it should look like, where it fits in to their view of the service, and what benefits it might bring.

Digital as the enabler, not digital as a goal in itself

- Simply digitising a process seldom brings any benefits. It should instead provide an opportunity to review and change the care process, which will have been established around paper-based processes.

Iterative, agile design

- It is tempting to try and do everything at once, and to sponsor large-scale centrally controlled projects to achieve this. The so-called 'waterfall' approach does not generally work in digital health care. By the time the required governance and procurement cycles have been worked through, the digital landscape has often changed, and the solution acquired (and committed to) has been superseded. Instead, it is better to break projects down into smaller chunks using small, focused teams working in 'sprints' to achieve digital solutions which will be 'good enough' (although safe) rather than perfect initially, but which will then be changed in response to user-feedback in an iterative manner.

Innovation aligned to strategy

- CAV will continue to foster and encourage innovation, but will ensure that it is aligned with the digital strategy, and that any digital elements of innovation projects fit in with the digital architecture, and are capable of being scaled-up if they prove successful.

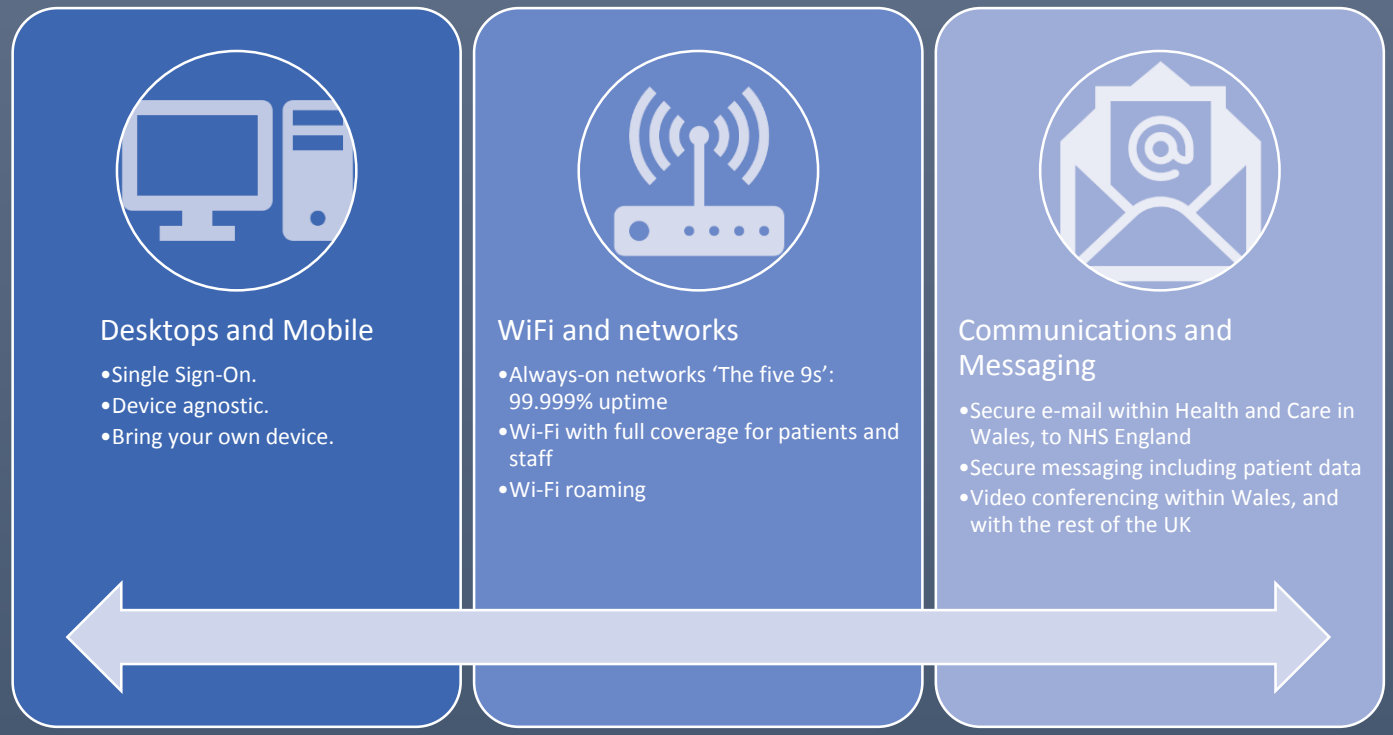
Democratise data, democratize knowledge

- The data collected by the organisation will produce large pools of 'big data' which is the foundation for the learning health system. With appropriate safeguards, this data will be made available to clinicians, managers and analysts across the organization. There are myriad ways of using, visualizing and interpreting data, and even in 5 years we will still only be beginning to understand how to do this. We need therefore to permit multiple stakeholders to innovate in making use of this data and turning it into knowledge. We will not constrain ourselves by assuming there is only one way of interpreting data – there are many mays to the truth!

Achieving the Vision

Stuff, Staff, Adaptive Change

Infrastructure



Without the basics, nothing else will be possible.

Before going further in this document, the importance of adequate infrastructure has to be highlighted. Without up to date devices, networks and wi-fi, any attempts to digitise the future will fail. We operate, and will always operate, in a resource limited environment. In those circumstances it is often tempting to cut costs in the less visible foundations of our services, and this has included technical equipment, associated staff and cybersecurity. This was recognised in the Welsh Audit Office review of Health Informatics in organisations across Wales in 2018. We recognise that failing to invest in and maintain infrastructure is ultimately counter-productive. It weakens the foundations of our digital system, and without these foundations no sustainable developments can take place. We will have to accept that much of the initial investment in our digital future will be used to address the under-investment of the past. Once that balance is restored, it can't be allowed to slip again.

Cybersecurity

Security Information and Event Management (SIEM)	- A software solution that aggregates and analyses activity from many different resources across our entire IT infrastructure
Nessus	- A remote security scanning tool
National Cyber Security Centre	- Access to CAV operating systems to monitor and provide support

Information Governance

This section provides a summary of the approach we wish to take to information governance.

Collecting health and care data on patients and service users requires then to trust our organisation to look after their data carefully, ensuring that only those who need to see the data access it, and that we safeguard it against inappropriate access or inappropriate sharing.

Legislation requiring us to do this in terms of common law duty of confidentiality and the general data protection regulation as well as the computer misuse act as an important safeguard for the public's trust. If we preach these rules we lose the trust of the public, and we will therefore not be able to use the information they share with us to benefit then and the system as a whole.

It is also important that data provided to us by clinicians is shared appropriately. Most patients think that we readily share information between clinicians, teams and other carers involved in providing services, and are often surprised if the discover this is not the case. In the past there has been a tendency to take a very restrictive approach when interpreting data protection legislation.

We need to take note of the general data protection regulation intention which is to enable information to be shared much more easily when it is appropriate to do so, but to give patients and carers the ability to control this without interfering with the processes of care. We are seeking to strengthen our information governance processes, and to ensure that important organisation level decisions about information sharing are taken in a proportionately taking into account both the clinical risks and their information governance risks, and involving legal and patient informed processes.

Digital Inclusion

Digital Inclusion is a social determinant of health

Like other inequalities, this means we need to ensure we take steps to address this imbalance so everyone in our community can take advantage of the digital future, and nobody is left disadvantaged
We will adopt the recommendations of the Gann report: 'Digital Inclusion in Health and Care in Wales'.

The Inverse Care Law applies to digital inclusion as it does to other aspects of healthcare. Sections of the population most in need of improved access to health care are also those less likely to be 'digitally included'.

85% of people in Wales use the internet – that means 15% do not.

Mainstream Digital Inclusion	Digital inclusion needs to move from the margins to the mainstream. The Gann report describes how local authorities have been more effective in digital inclusion than health care organisations. We will work with local authority partners to develop a more detailed and a more robust strategic approach to digital inclusion.
Use levers and Enablers	We will ensure that Wi-Fi is available freely across our health and care settings for patients and carers to use. We will invest in the Digital health literacy of our health and care staff to help ensure digital adoption by patients and service users., and frontline staff will be supported to become digital champions for their patients.
Scale Up Inclusion	We will sign up to the Digital Inclusion Charter. Without digital inclusion, the potential benefits of the patient channel work will not be realised. We need to learn from existing initiatives like Digital Communities Wales so we can ensure vulnerable people are not excluded from the benefits of digital.
Improve our knowledge	We will use the framework and tools available in the NHS Digital Inclusion Toolkit, and adopt any similar initiative that is developed in Wales. Even with digital skills and access to technology, people will not use digital health tools if they are not accessible and meaningful to them. Our promotion of user-centred design of all digital health products will include people who are less experienced digital users.

Internet use in Wales

People with a long-standing illness or disability	74%
Without disability	90%
Age 65-74	72%
Age 16 – 49	97%

Achieving the Vision
Stuff

How we will build the digital vision

The Digital Architecture:
understanding the lingo

Data repository
At the heart of any informatics or digital system is data stored on a computer hard drive, or where there is a lot of data, an array of hard drives (called a server).
Ories. The data held in these drives is usually organised in the form of a database or a collection of databases into which data can be added, removed, rearranged and analysed, either by programmes within the database or separate computer programmes.

Applications
The interface on the computer or mobile device which puts data into these databases or allows the data to be viewed are often called applications.
These applications are sometimes associated with programmes that manipulate the data in the ways described above, but increasingly such programming takes place ‘server side’ making the applications much simpler, and enabling easier ‘plug and play’ potential.
When used on mobile devices, these are usually referred to as ‘apps’.

Application Programme Interfaces (APIs)
These are, in effect, the connections or plugs which allow an application to interact with the data repositories and associated programmes.

Systems
Where a series of databases and applications exist for a particular ‘business domain’, for example pathology laboratories, the collection is referred to as a ‘system’. Each of these individual systems can either be acquired individually in a modular fashion, or as part of a large mega suite of many systems.

The Digital Architecture

Option One: the status quo

Once for Wales: modular ‘systems’

An enterprise architecture can be built up gradually, using the best available versions for particular business domains. The disadvantage of this ‘best of breed’ strategy is that the systems are often, in effect written in different languages, and in order to communicate with other systems, translation is required. In the digital world this is referred to as ‘interoperability’. This is complicated by the fact that many of the health organisations in Wales already had some modular systems of their own.

Cardiff and Vale have many dozens of information silos or information systems which have evolved over the years. In order to derive the full benefit of all this data, all of the systems which share information, but this would require very complex and labour-intensive translation. In fact, this requirement is so complex that experts question whether achieving interoperability for a health enterprise architecture in this way is even achievable.

This is broadly the approach that has been taken over the last few years in NHS Wales. This approach sought to either self-build or procure modular ‘systems’ to be implemented, usually as large national level projects rolled out across health boards in a staged fashion. These projects were centrally controlled and co-ordinated, but beset by delays, hampered by differing informatics architecture in different health boards and trusts, differing levels of digital maturity, and differing opinions as to the suitability and need for a given system in each organisation. Local organisations were unable to develop at their own pace, and to address their local priorities, but instead were constrained by a slower, less agile national approach. The Welsh Audit Office and Public Accounts Committee reviews of 2018 were critical of this way of working, and called for change. The architecture review commissioned by Welsh Government and published in 2019 calls for an end to this approach.

One positive benefit of the national level approach has been the ability to share information across health board boundaries, and is the envy of some of our neighbours.

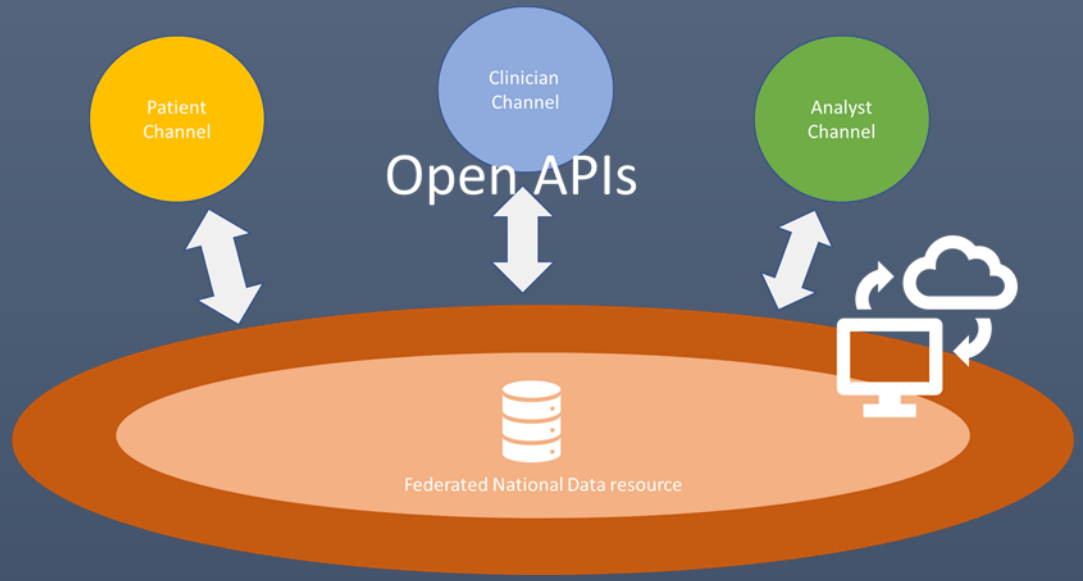
Option Two: Megasuite

Cerner, Epic, System C…

The second approach described is where a large provider has suite of systems written effectively in the same language and able to communicate with each other, providing digital part for several business domains, such as an electronic health record, electronic prescribing and decision support, and a laboratory system. The disadvantage of this approach is that such systems are very expensive, and even at best the provide less than 50% of the digital components for a typical healthcare organisation. Furthermore, these implementations, which are often called platforms, will generally only communicate with platforms created by the same provider. Thus if you are neighbouring health or care organisation uses a platform from a different provider you will not easily be able to share information, and it takes the service back to the interoperability problem. These can be considered closed platforms. This is an increasing problem for healthcare systems who have implemented mega suites.

This is the approach that has been taken over the past few years in NHS England where mega suite implementations using suppliers such as Cerner, Epic and Lorenzo have been implemented in the most digitally mature organisations (i.e. those with the infrastructure to support them), so called Global Digital Exemplar organisations and latterly, Fast Followers.

The Digital Architecture
Option three: Open Platform



Open, but not uncontrolled
Health data includes sensitive personally identifiable information. It is important to be clear that what is meant by 'open APIs' is that the configuration of these virtual plugs is made available only to developers of products who are trusted to hold such data by satisfying strict Information Governance requirements, and stringent Cyber-security standards. The APIs being 'Open' means that if they have achieved this status, they can design their solutions consistently with APIs made available to them, which increases the speed at which solutions can be developed.

What is an Open Platform?
The approach advocated by the architecture review is based upon the concept of an open platform. In this central collection of data is maintained according to a set of strict information and technical standards. This is particularly important because by ensuring that everything is recorded and described in the same way, and stored in the same format, the information can be retrieved and used reliably without the interoperability problems discussed above.

Mandated standards
The information platform can be imagined to be surrounded by a series of interfaces or virtual plugs the application program interfaces (APIs). These enable applications to contribute, view and analyse data in the way described above in applications integrated with other systems. However, the applications in this model are not specific to a particular system, but rather conform to the data and technical standards of the platform. This makes the process of introducing new applications when they emerge, and replacing old ones when they are superseded much easier.

Encourage innovation
By making the APIs open to trusted organisations and trusted suppliers, they can develop applications much more quickly and easily to the benefit of the service. This enables a flexible and agile approach for how our organisation and others in Wales collect, view and analyse patient information. The APIs can be designed to communicate with devices such as fitness trackers, heart rate monitors, medication pumps et cetera so that data can be provided in real-time without the need for staff for patients to input anything themselves. Much of the growth in the wider Digital Economy has occurred because suppliers have made their APIs 'open'.

The 'Single' Electronic Health and Care Record
The data collected on this platform can be used to inform individual patient care, as each element of data is identified as belonging to a unique patient, in this way you can see that the concept of a single electronic health record becomes difficult to visualise, because over time so much information and data could be gathered not just from individual interactions in clinic or hospital admissions in the way that traditional hospital wards are, but including information recorded on monitoring devices as described above. The single electronic health record actually becomes an enormous collection of data which can be visualised in a number of different ways according to the application suitable for the purpose at hand.

Clinician Channel

The ‘Electronic Health Record’

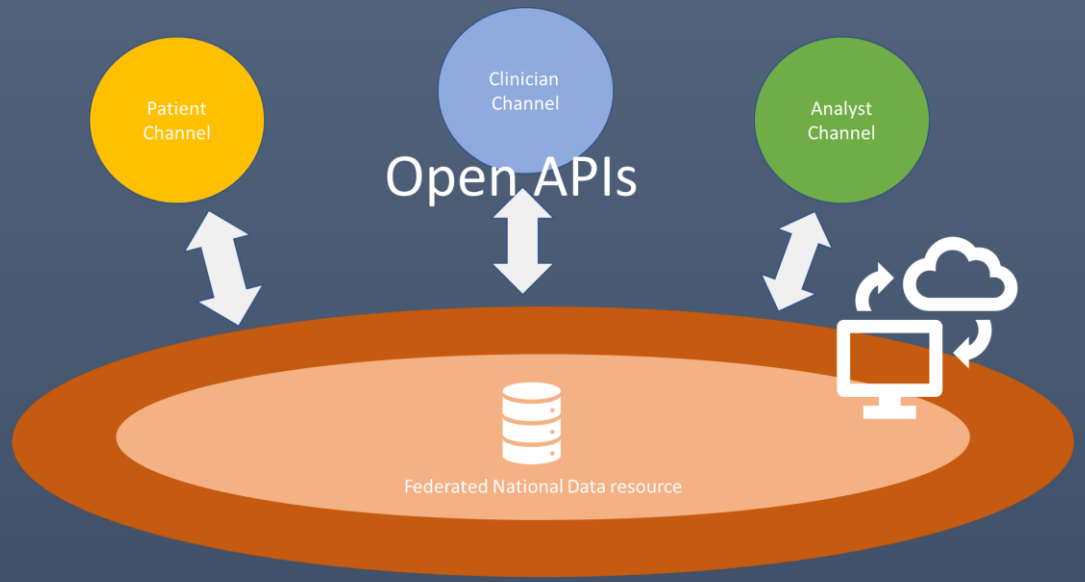
Applications used by clinicians to view results and reports, record clinical interactions and procedures, view images, prescribe medications, communicate with other clinicians.

Patient Channel

The ‘Personal Health Record’

Applications used by patients to book appointments, view results and reports, record outcomes, communicate with clinicians.

In effect, this creates a personal health and care record. Patients may upload information in symptom diaries, data from wearable health and fitness devices, and may choose to share some or all of this with clinicians providing their care.



Analyst Channel

Data to Knowledge

The applications which can intersact with data at various levels of aggregation from individual to population level which enable data to be turned into knowledge to understand, learn from and re-design the system.

Data Resource

Persistent and re-usable data

This is the pool of data held in accordance with strict information and technical standards so that it can be understood by and interact with applications via APIs . It is supported by an infrastructure that ensures its security.

It’s physical location. The resource will actually comprise several ‘local’ data resources created by Health Boards and Trusts together with some nationally hosted resources – a so-called federated model. Although physically disparate, they exist in a single ‘cloud’ architecture.

Bear in mind that these ‘Channels’ are a conceptual representation to help understand how things fit together. In reality, many applications will overlap in terms of the users.

Once for Wales?

Alignment to National Strategy

One of the reasons highlighted in the Welsh Audit Office report of 2018 as leading to a lack of pace and scale in digital implementation in the Welsh health service relates to numerous attempts to ensure our Once for Wales approach to large systems.

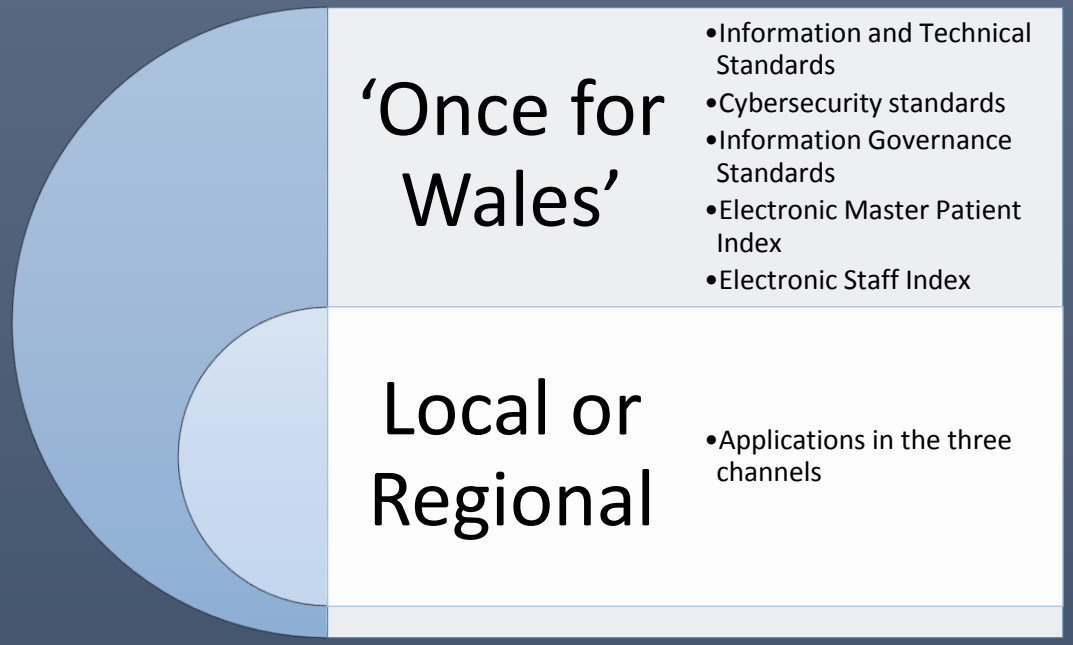
Lessons from abroad, lessons from home

It was clearly very attractive to think that for particular business domains one system across the country could be implemented very easily and with rapid agreement. This approach has been demonstrated in health systems across the world to be very difficult or impossible to achieve. The reality is that all organisations are at a different point in their digital journeys, and some have good systems for one business domain, and pure systems for another, but these won't necessarily correspond to those of the neighbours. The open platform approach requires that everyone agrees to provide information using the same standards and using the same technical organisation structure for the data, but leaves organisations free to source their own applications in a forum and at a time that suits them, and doesn't interfere with the operation of any other organisation.

Cultivate collaboration, mandate sparingly

Of course it may be the case that because applications become smaller and easier to design using open APIs, it may be easier to reach a national agreement to use a particular application for a particular business domain where there is a shared need and shared opinions, but importantly it need not be a mandatory requirement. Collaboration is probably more likely to occur as these applications, and the markets around them evolve in the next few years, but while that process is taking place it makes more sense to allow some flexibility at local and regional level.

Because of the importance that information in the platform is effectively written in the same language as explained previously, then it becomes very important that organisations agree to adhere to the information standards and the technical standards describing how that information is organised. It therefore means that once for Wales means the platform in the middle, but doesn't necessarily mean the applications around the outside.

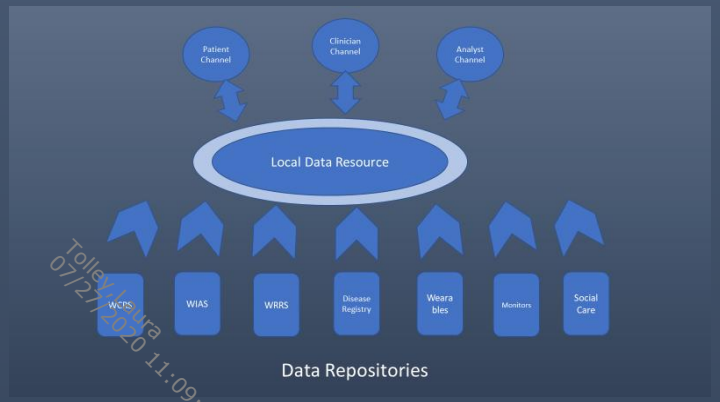


Working with our neighbours

Some of the elements required to build a Digital First approach may be more efficiently achieved by collaborating with our regional neighbours in Aneurin Bevan Health Board, Velindre NHS Trust and Cwm Taf University Health Board.

We will seek to build close working relationships around shared infrastructure, and seek to share learning with these organisations.

Local and National Data Resource



Building a Local Data Resource

Legacy data

In order to build a useful local data resource, which will in turn become part of the national data resource we need to make data we currently hold in individual data repositories available. This is not a simple matter of 'emptying' data into a new set of databases, unfortunately. The data needs to be 'translated' into a form that makes it available in a standardised format. This is called making the data 'interoperable'. This makes the data available to applications in the three channels referred to earlier.

The widely adopted standard for interoperability across health systems is called Fast Healthcare Interoperability Resource (FHIR) – pronounced 'fire'.

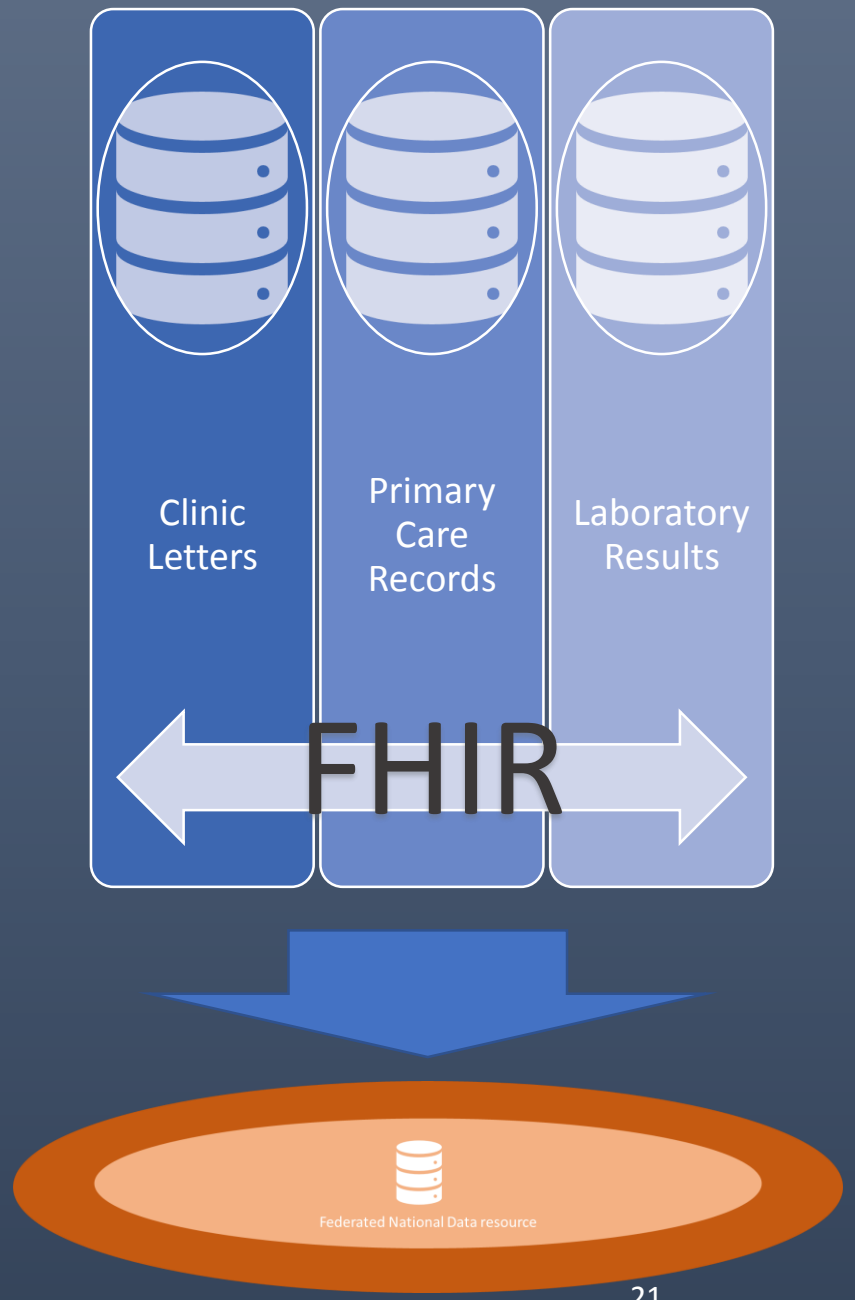
We will need to procure FHIR servers to store this data, and undertake work to convert legacy data into this format. This data varies from large stores of clinic letters, to smaller disease registers and bespoke team-specific databases.

New data

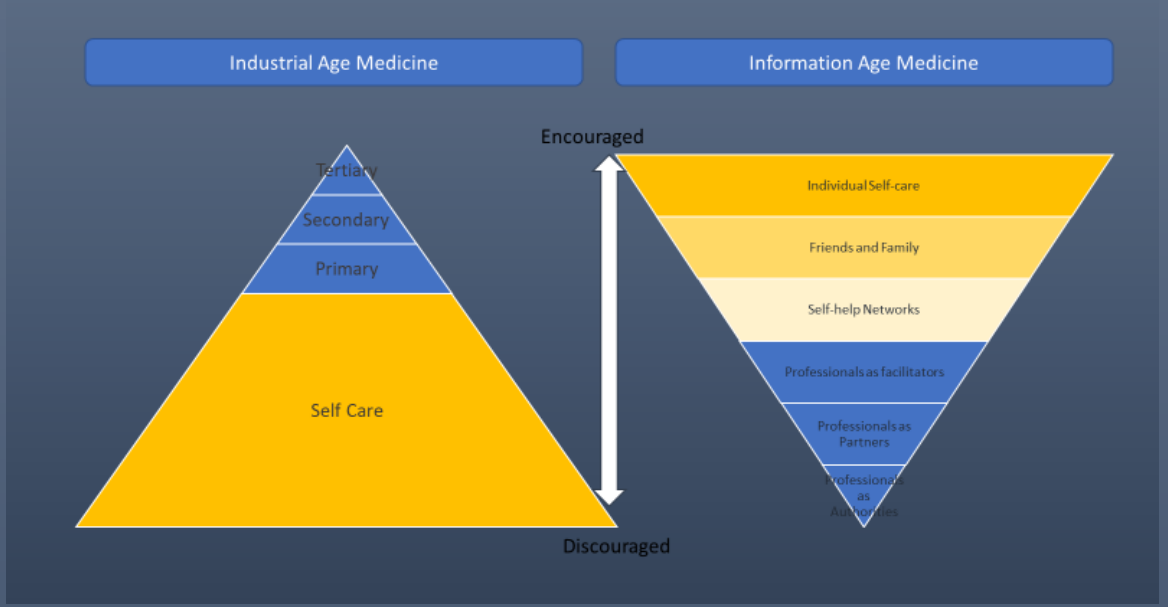
The disjointed silos of information we now seek to harmonise must be avoided in the future. Our strategy will be to avoid the creation of any information silos, and instead require that the data is FHIR compliant, and this will be essential for any third-party suppliers to comply with.

Open EHR

We will also look more favourably on products that use the Open Electronic Health Record structure. Using this approach, the data is effectively placed straight into the data resource without the need for translation.



Patient Channel



Giving patients control

A famous diagram represented on this page shows Tom Ferguson's inverted triangles model when he forecast the likely effect of technological advances on patients' expectations of care.

This is entirely aligned to Prudent Health Care principles, and the strategy described in A Healthier Wales of enabling care closer to home, and providing support for patient's to maximise their well-being.

By allowing patients the ability to control their own journeys through healthcare, they benefit, and the whole system benefits. We can start to re-shape outpatient services such that patients are seen only when they need to be seen, and enabling interactions to take place remotely using video communication.

What will patients be able to do?

We want to allow patients to access test results without needing to come to clinic or to phone a service desk. We want them to be able to book and change appointments, record their outcomes (Patient Recorded Outcome Measures) and experiences (Patient Recorded Experience Measures).

They will be able to give access to carers or relatives, as they wish, and to be able to see who has access to their data.

There will be some information which it is inappropriate to share online, and where it may be harmful to see results without a face to face explanation, they can still be hidden, so the applications we use will need to allow some control of sharing from the clinician's as well as the patient's side.

National Patient Portal

We will collaborate with the national Patient Portal programme, which will provide a single secure portal which authenticates a patient's identity, and then allows access to various applications providing some of the functions mentioned. There will be more which evolve in future, and we will want to enable flexibility in enabling many applications to address functions which serve patient care as they become available.

But we don't have to wait until the portal is developed – we can go ahead and start to use some available applications in the meantime, using the principles described for the open platform approach.

Clinician Channel

Electronic Patient Record for Secondary Care
Community Care Record
Mental Health Care Record
Social Prescribing
Patient observations
Electronic prescribing

Viewing data

Clinicians must be able to see comprehensive information to inform the best care decisions for their patients. This will include information from their GP and community services, different secondary care settings, social care and third sector organisations. Many of our services are provided across a regional or National footprint, so the information must be visible across health board boundaries. 30% of our organisation work in the community, and it is vital that they can access this information via mobile devices. We know that increasingly our challenges relate to patients with multiple conditions, and in this group, care information is created in a large numbers of different settings.

Many patients would expect that we already allow information to flow seamlessly across these boundaries, and it is starting to. By putting our information onto one platform based on a Local and National Data Resource we can achieve this for everything.

We are already good at sharing clinical information, including laboratory results, clinical letters and reports and radiology images across health boards. We share images across primary care to secondary in Dermatology, and images of eye-conditions taken by local optometry services with secondary care ophthalmology services, but these are still pockets of digitally-enabled care rather than mainstream. We need to ensure that where such initiatives have proven successful, they will be scaled-up. This will be helped by improving our business change processes to ensure appropriate evaluation of project success, and also by describing scale up plans (and resource) in development cases.

Clinician Channel

The importance of coding

Making sure that information is recorded in a consistent way, and that each data item's meaning is interpreted correctly across applications, we need to fully implement the SNOMED-CT system. This stands for Systematised Nomenclature of Medical and Clinical Terms, and is the international standard, and has been formally adopted by the NHS in all Home Nations. Any systems we implement to act as data entry points to the Local and National Data Resource will need to have SNOMED-CT capabilities, and we will be working with local projects and with NWIS to enable this. Clinicians using the system will be able to pick from bespoke lists of commonly used terms to speed up data entry. The advantage of SNOMED-CT comes when data is aggregated, and clinicians want to understand features of patients with the same diagnosis, groups of diagnoses, particular procedures etc. It's hierarchical and conceptual nature will revolutionise how individual clinical team members can start to do their own exploration work for their patient groups, and it will greatly improve how the system can learn. For a better explanation of some of the detail see the NHS Digital website. For a simple animated explanation try this from NWIS

Entering data

Although we are getting better at sharing data across boundaries, that data is often not 'rich'. Much of our clinical information is held in the forms of clinical letters and discharge summaries. The information contained in these 'flat files' is not available to a computer to use – it needs to be read by a human being. All a computer can see is a document title, and some other coded information attached to it as 'metadata'. Our Patient Management System (PMS) records some information in a coded way where each item of data can be 'computed'. This is only a fraction of the clinically meaningful data we should be collecting, and in fact most of it is demographic content and a description of 'episodes' (admission, discharge, new clinic visit etc.). We Also know that even this small amount of data is not always correctly 'coded', and provided in a form that computers can do useful tasks with it, and we know that a lot of this coded information is incorrect. This, in turn makes information derived from it inaccurate or misleading.

We need to collect much richer data, we need it to be more accurate. We can do so by using a 'virtuous circle' effect of making data more visible. By improving the detail in information we 'code' (i.e. put into computable form), we will need to ensure it is entered in 'real-time, not as a bulk exercise from memory at a later time. This requires much more readily available devices to enter the data – but that also makes it easier to see pre-existing data. Because we will be using a platform around the national data resource, information which already exists (demographics, medicines, allergies, advanced care plans, problem lists), fields in data entry applications can be ready-populated making the update process more efficient. The process of real-time data entry will make the data more accurate.

Aggregated information will be available to clinical teams, and because this information is timely, any inaccuracies can be corrected quickly, and the data become useful. Much time currently is spent trying to derive information from data that we know is unreliable – over the period of this strategy, the quality of data will be driven up, its usefulness will be driven up, and the conversation will move away from disputing the data's accuracy, and onto converting what the data says into knowledge.

Clinician Channel

The electronic patient record (EPR)

For most of our clinical users in secondary care, a big gap in our digital capability is the ‘front end’ for putting this coded information into the LDR/CDR. We have some ability to put information in via either Welsh Clinical Portal and CAV portal, and some bespoke systems which input particular clinical-service information, often as part of a disease registry. In Mental Health and Community services we do have better functionality using PARIS, and we will evolve to contribute information collected in this way into a Welsh Community Care Information System (WCCIS).

Our strategy will be to develop a single entry portal where clinical information can be entered via any device from any location, but behind this portal the user will have the ability to access the information most important to them for a particular type of clinical interaction. This will involve a library of applications bespoke to particular user-requirements, but for the clinical user it will simply appear as one single interface, and will avoid the need to log in to multiple ‘systems’. This may or may not be Welsh Clinical Portal. The Architecture review requires that some work is done to ‘re-platform’ WCP to enable they type of arrangement just described, but it would also enable the use of another portal providing exactly the same functionality, giving us a choice as an organisation to adopt the interface our users prefer.

We are already starting to develop such a ‘front-end’ EPR for use in outpatients, currently called COM-2. It uses SNOMED-CT, and provides and retrieves data stored in the appropriate standards for the LDR/NDR.

Further into the future

This is a very rapidly evolving area. We know from health care systems that have had long-standing EPRs that the clinical users are not always in love with them. There is a feeling that the computer can start to come between the clinician and the patient. In the USA, hospitals have begun to employ teams of ‘medical scribes’ who record and enter information on behalf of clinicians who are better able to converse and make eye-contact with their patients rather than their computer screens. This is not a viable long term solution, but another emerging digital technology is. Natural Language Processing (NLP) is a use of machine learning/artificial intelligence algorithms which can ‘listen’ to a conversation and ‘understand’ what is being discussed, and what the outcomes are. If the current pace of evolution continues, then NLP may become our data entry assistants. We will continue to watch this space.

Analyst Channel

1. The learning health system
2. Outcomes over process
3. Analysts and data science working closely with clinicians
4. A ‘learning’ environment
5. Partnership with Universities and Industry

in this section talk about the fact that data is the most important way in which would be able to understand the services that we provide, whether being provided well whether the being provided in a timely fashion and whether the outcomes of good. The conversation here about how we make business systems visible to all clinicians across the organisation and there is a conversation about how we maximise the benefit of modern business informatics systems to generally automatic reports as well as self-service stuff

We also need to have a discussion in this section about the fact that telling the data into information is extremely important, but is quite difficult. That involves four relatively basic data good visualisation and an ability to have informed conversation with clinical users who actually unable to interpret what might be going on to explain some of the patterns described in the information.
Beyond this we need to make point that artificial intelligence requires data as its fuel and its only with this data resource that will be able to fully benefit from a high as it evolves.

WE NEED TO TALK ABOUT AI
This will be a short section emphasizing that AI is something to embrace, not fear.
Sometimes we are already using it because applications may be engineered using AI or Machine Learning.
The substrate for AI that we want to develop ourselves and with partners is good quality data held in a computable format. That is largely only available for images currently – we need to move to a world where it can be true of other clinical information recorded during care episodes.

Turning data into knowledge

Data doesn't turn into knowledge by magic. It is a process. It starts with good quality data, and requires people with different skill sets to visualise and explore patterns in the data. Features of interest may then be studied, and statistical learning techniques applied to this data to turn it into knowledge, and enable a deeper understanding of what happens to our patients, and of the services we offer. This requires clinicians working closely on a data to day basis with data analysts.

At it's most advanced level, the so-called 'statistical learning techniques' include machine learning, deep learning and artificial intelligence.

Currently we do visualisation, but then tend to jump straight to the end of the process, assuming we have understood the data and turned it into knowledge. For example, we look at historical activity data and extrapolate it to 'forecast' the future. This has utility, but is only scratching the surface of what we could do.

Quality 'real time' data	• An electronic health and care record • Structured data • Local and National Data Resource
Analytic capability and capacity	• Analysts • Clinicians to work with analysts • University partners • Industry partners

Achieving the Vision

Staff

Who will build the Digital Future?

Wachter principles

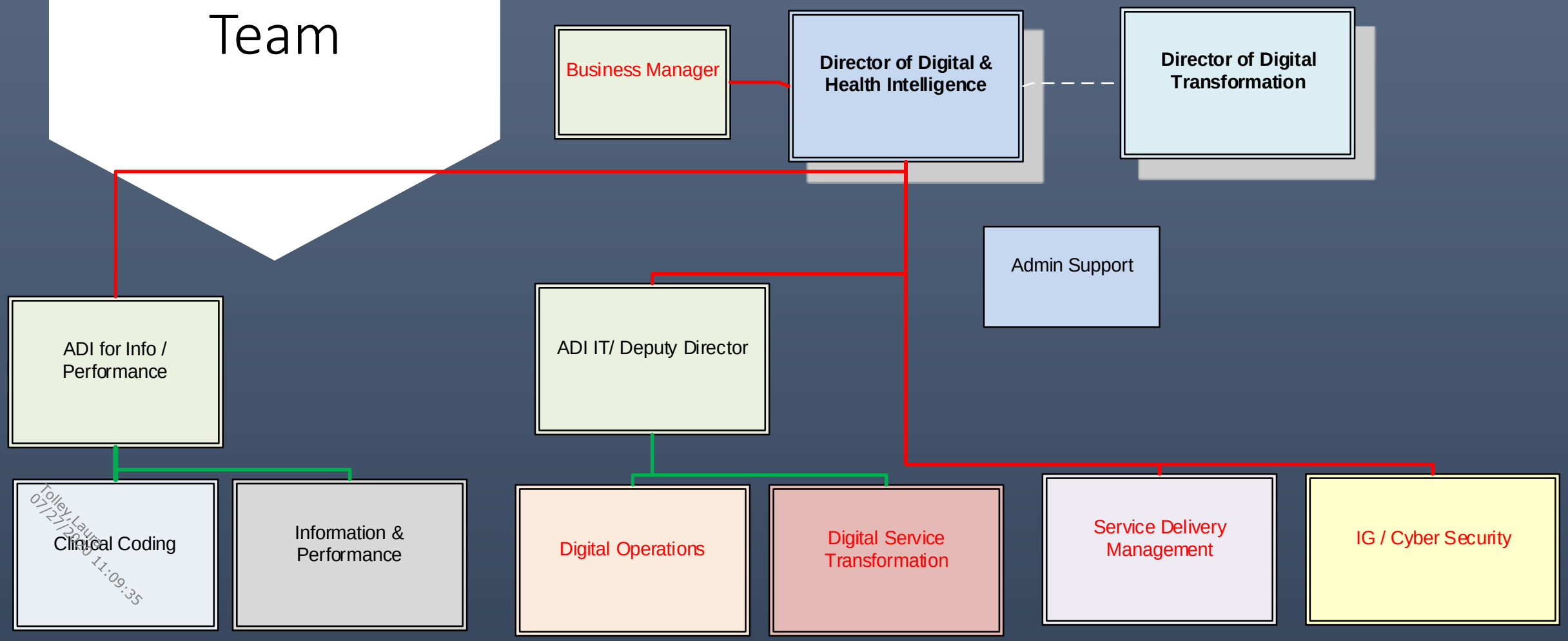
It's about the people, stupid

Dr Robert Wachter's seminal report into the failure of NPfIT in England established ten basic principles to learn from. We recognise that these lessons are not unique to England, but are generic, and apply to Health and Social Care digitalisation in Wales as elsewhere.

The overarching message from this report is the essential need for clinical engagement in the process of digital transformation.

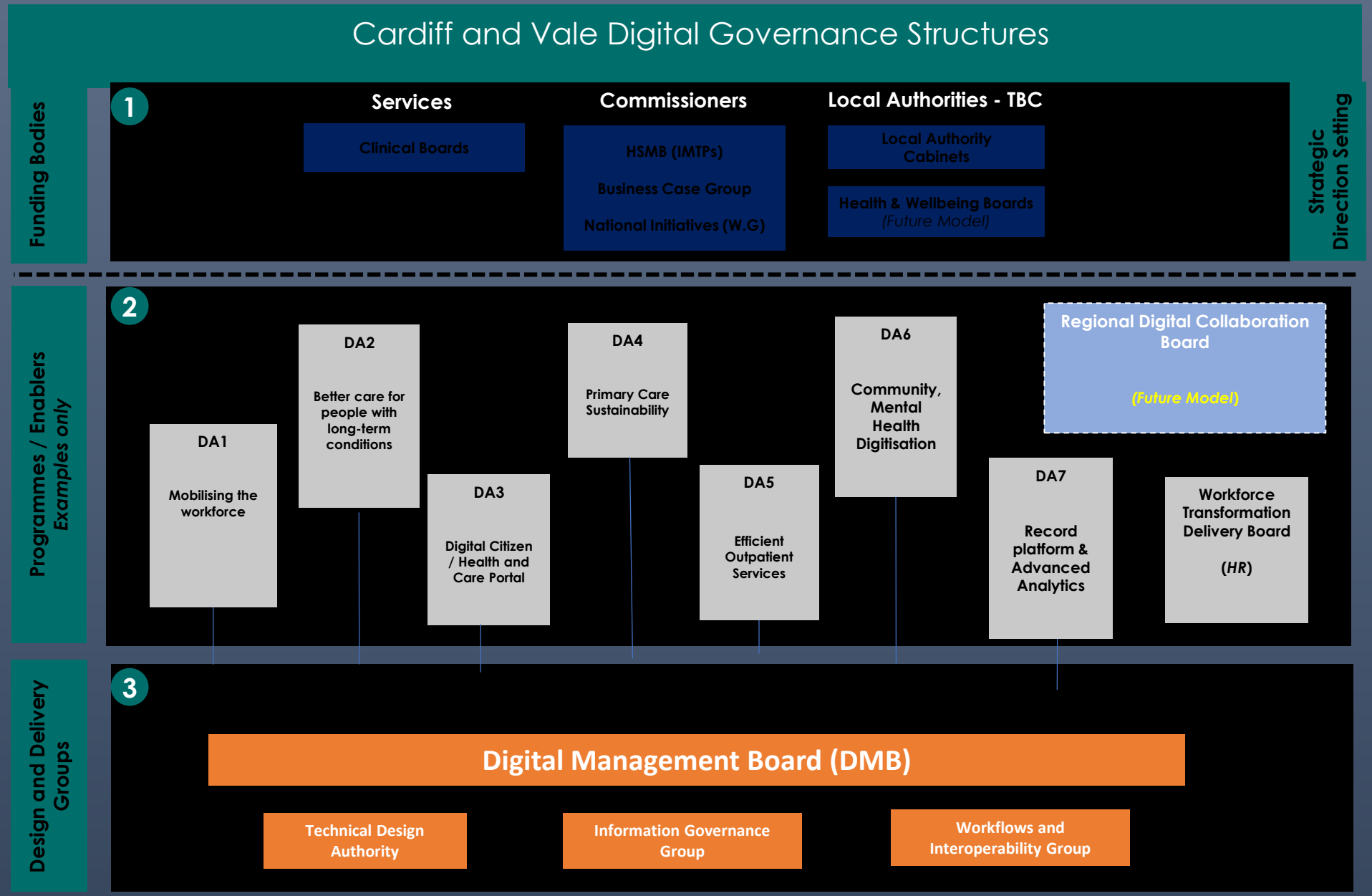
Digitise for the Correct Reasons.	• Don't digitise for the sake of it – digitise to re-imagine how things can be done
It is Better to Get Digitisation Right Than to Do it Quickly	• Balance the immediate operational drivers with the overall strategic aim.
Return on Investment from Digitisation Is Not Just Financial	• There is a productivity paradox. It will take time to bed-in, it will take to transform – be patient, and evaluate against more than the bottom line
Balance appropriately between local/ regional control and engagement versus centralisation.	• Standardise the central architecture, but allow organisations and teams to innovate and set their own pace and prioirities
Interoperability Should be Built in from the Start	• Today's solution is tomorrow's legacy. We know that our information systems need to speak the same language, so don't make life difficult for those who will inherit what we create.
While Privacy is Very Important, So Too is Data Sharing	• Information Governance Legislation (GDPR) has been introduced to encourage sharing of data safely and securely, not hinder it. Patients expect us to share their information to enable seamless, safe, efficient care.
Health IT Systems Must Embrace User-Centered Design	• Start from the patient's perspective, and involve patients in re-designing systems.
Going Live With a Health IT System is the Beginning, Not the End.	• This is probably the most common mistake, and the biggest contributor to failed digital implementations. Digital solutions only work when people understand them, can use them, and know what they can enable – and that involves time and effort.
A Successful Digital Strategy Must be Multifaceted, and Requires Workforce Development	• If we want our users to benefit from digital solutions, our staff have to be enabled to use them. If we want to build a Learning Health System, we need to train and retain staff to analyse and derive knowledge from the data we collect.
Health IT Entails Both Technical and Adaptive Change	• Health and care systems are complex. Technical fixes alone cannot solve their problems. Staff and users must be able to transform the way they interact with services to achieve the quadruple aim of health and care. Clinical engagement is the key.

The Digital Team



How the team is structured

Cardiff and Vale Digital Governance Structures



How digital is managed, co-ordinated and strategically aligned

Achieving the Vision

Adaptive Change

Using digital to transform the future

Tolley, Laura
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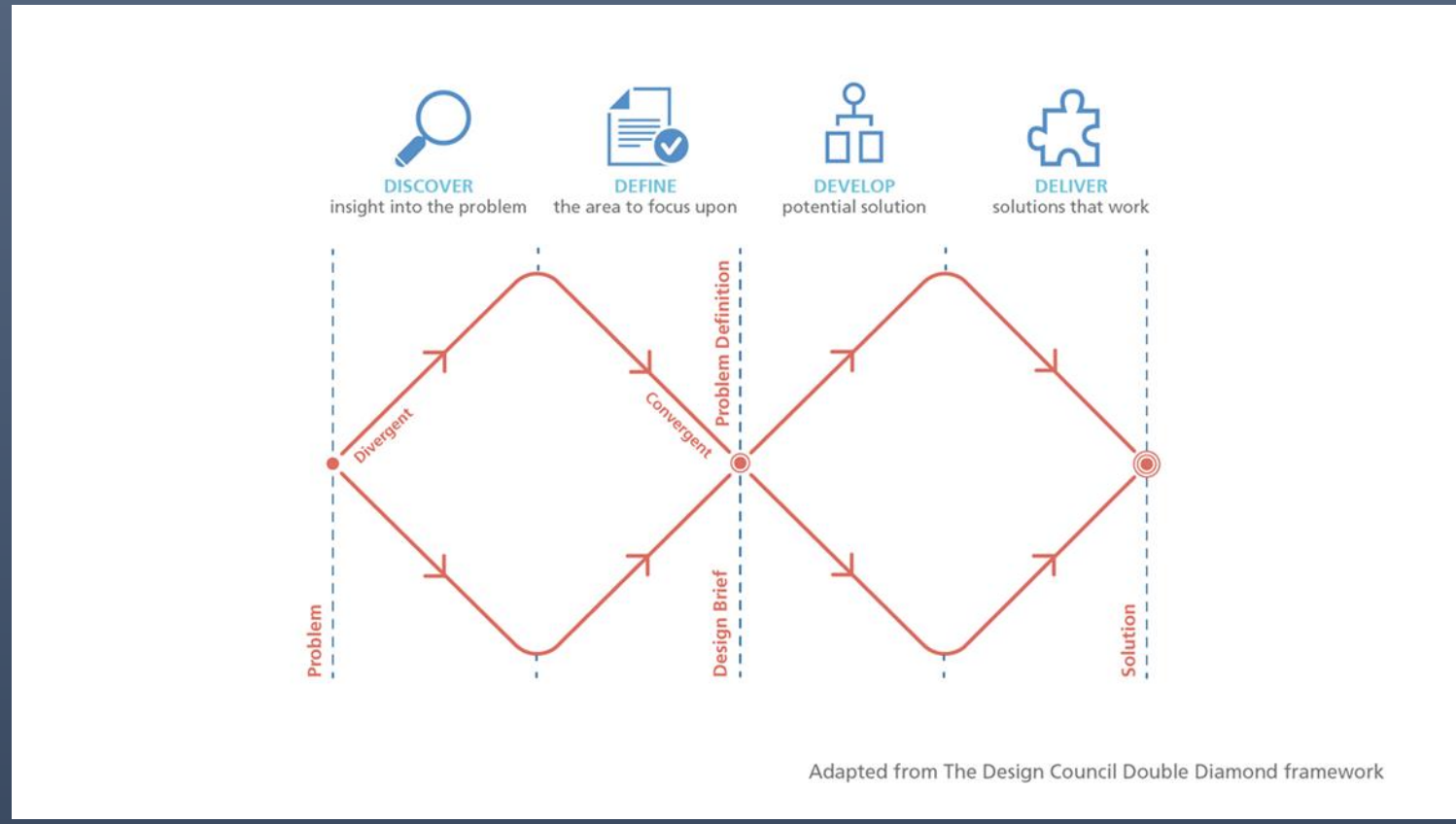
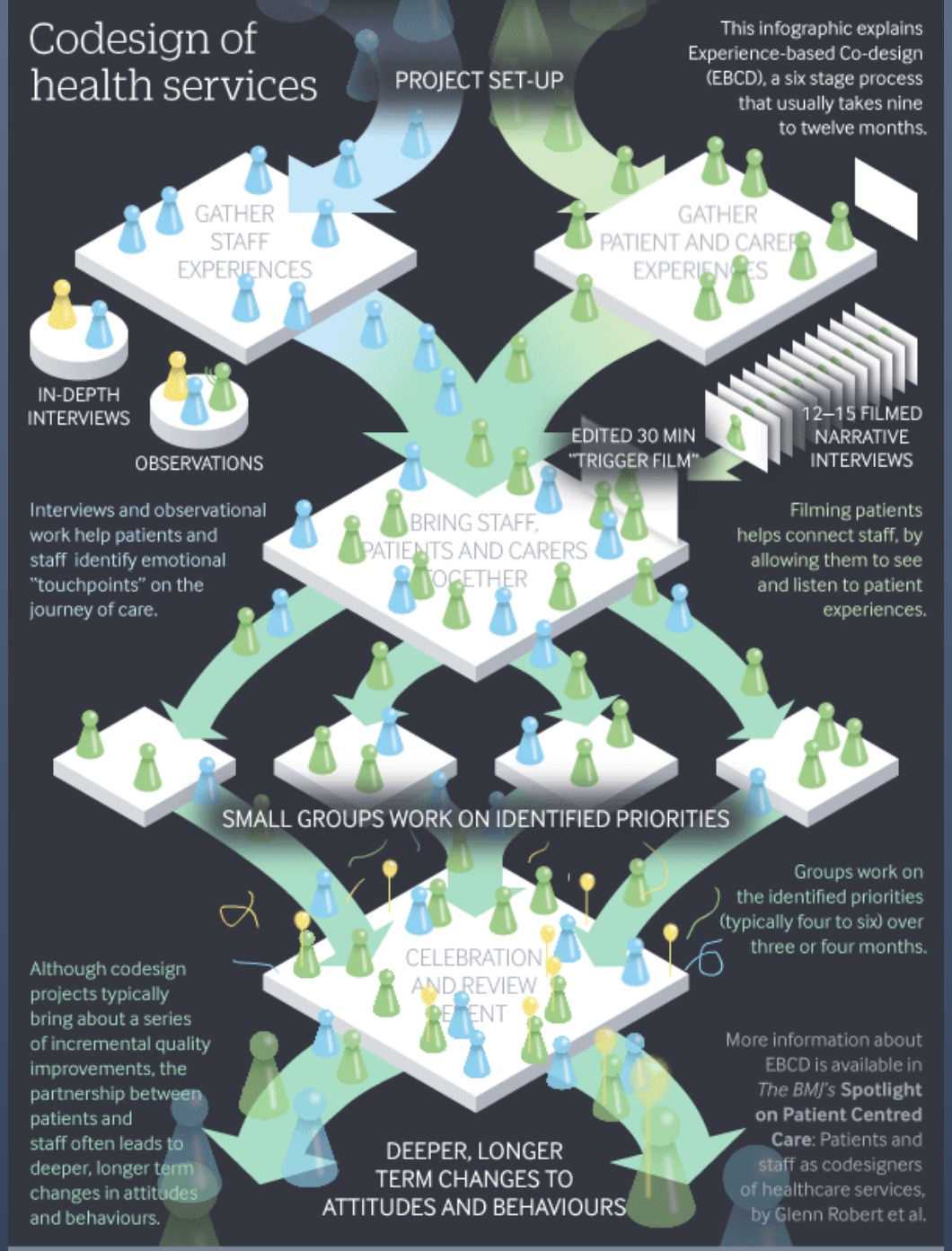
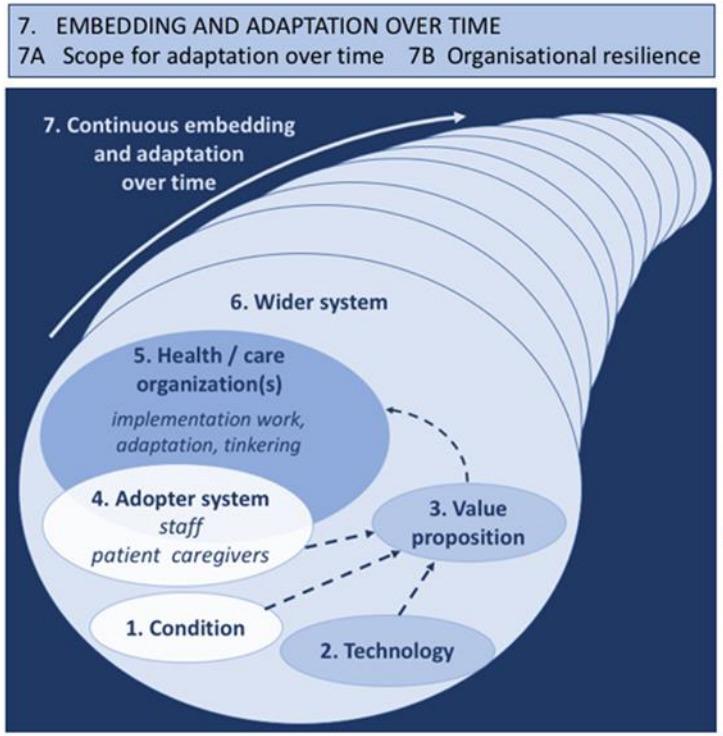
Design Principles





Evaluation



7. EMBEDDING AND ADAPTATION OVER TIME
7A Scope for adaptation over time 7B Organisational resilience

6. WIDER SYSTEM
6A Political / policy
6B Regulatory / legal
6C Professional
6D Socio-cultural

5. ORGANISATION
5A Capacity to innovate (leadership etc)
5B Readiness for this technology / change
5C Nature of adoption / funding decision
5D Extent of change needed to routines
5E Work needed to implement change

4. ADOPTERS
4A Staff (role, identity)
4B Patient (simple v complex input)
4C Carers (available, nature of input)

1. CONDITION
1A Nature of condition or illness
1B Comorbidities, socio-cultural influences

2. TECHNOLOGY
2A Material features
2B Type of data generated
2C Knowledge needed to use
2D Technology supply model

3. VALUE PROPOSITION
3A Supply-side value (to developer)
3B Demand-side value (to patient)

Report Title:	**Temporary Amendments to Standing Orders, Reservation and Delegation of Powers.**						
Meeting:	Board				**Meeting Date:**	30th July 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Director of Corporate Governance**						

Background and current situation:

Cardiff and Vale University Health Board is responsible for reviewing and ensuring that it's Model Standing Orders remain up to date and that any developments are taken into account. Cardiff and Vale's Standing Orders are informed by Model Standing Orders issued using Welsh Ministers power of direction and in accordance with the National Health Service (Wales) Act 2006.

The Cardiff and Vale University Health Board Standing Orders were last approved by the Board in November 2019 in line with Model Standing Orders issued by Welsh Government under Welsh Health Circular 2019/027 issued in September 2019.

In March 2020, in response to the COVID-19 pandemic the Welsh Government agreed to delay the date by which NHS bodies were required to hold their Annual General Meetings from before the end of July to before the 30 November 2020.

On 5 July 2020, in response to the suspension of recruitment to public appointments in Wales, the ***National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020*** came into force. The purpose of these Regulations is to dis-apply the maximum tenure of office contained in the specified regulations for NHS board/committee non-officer members for a time limited period.

Cardiff and Vale University Health Board received Welsh Health Circular 2020/111 on 9th July outlining the amendments required to the Health Boards Standing Orders. This also included amendments required to the Joint Health Committees of (Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC) which as joint Committees of the Cardiff and Vale Health Board are incorporated within our Standing Orders.

The appendices attached show the changes (in red) required to Cardiff and Vale University Health Board including the changes required to the Joint Committees (EASC and WHSSC) Standing Orders which form part of the Standing Orders for Cardiff and Vale University Health Board.

The changes required to the Standing Orders need to be approved by the Board no later than 31st July 2020 as directed by the Welsh Government circular.

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

The Standing Orders for WHSSC were approved by Chairs Action and confirmation received via letter from Professor Vivian Harpwood, Chair of WHSSC on 16th July 2020. Within the letter the Chair of WHSSC also confirmed that the matter would be reported to their next Joint Committee for ratification.

The Standing Orders of EASC were approved at their Committee Meeting on Tuesday 14th July 2020.

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

The are no specific risk in undertaken these changes as they are required by Welsh Health Circular across Wales.

Recommendation:

That the Board:

1. **Approve** the changes as set out in Appendix 1 to Cardiff and Vale University Health Board Standing Orders.
2. **Approve** the changes as set out in Appendix 2 to the Standing Orders for the Welsh Health Specialised Services Committee to be incorporated into the Standing Orders of Cardiff and Vale University Health Board as a Joint Committee of the Board.
3. **Approve** the changes as set out in Appendix 3 to the Standing Orders for the Emergency Ambulance Services Committee to be incorporated into the Standing Orders of Cardiff and Vale University Health Board as a Joint Committee of the Board.
4. **Note** that the temporary arrangements will cease to have effect on the 31st March 2021.

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.*

Appendix 1

Temporary Amendments to the Model Standing Orders

Reservation and Delegation of Powers

For Local Health Boards – July 2020

The following amendments, shown in *red* are required to the Model Standing Orders issued in September 2019 with immediate effect. They will cease to have effect on the 31 March 2021 or, where an appointment(s) has been made under the ***National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020*** or, to the tenure of a Chair or Vice-Chair of the Stakeholder Reference Group or Health Professionals' Forum, at the end of that term, whichever is the later.

Page 17 – **1.3 Tenure of Board members**

1.3.1 Independent Members and Associate Members appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years*, with the exception of those appointed or re-appointed in accordance with Regulation 2 of the* ***National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020****. These members will hold office in accordance with the terms of their appointment or re-appointment.* Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.3.2 Any Associate Member appointed by the Board will be for a period of up to one year. An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years*, with the exception of those appointed or re-appointed in accordance with Regulation 2 of the* ***National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020****. These members will hold office in accordance with the terms of their appointment or re-appointment.* Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member.

The following amendment, shown in *red* is required to the Model Standing Orders issued in September 2019 with immediate effect. They will cease to have effect on the 31 March 2021

Page 34 – *Annual General Meeting (AGM)*

7.2.5 The LHB must hold an AGM in public no later than *30 November 2020*.

The following amendments, shown in *red* are required to the Model Standing Orders issued in September 2019 with immediate effect. (Note – reference to the additional term being limited to one year has been removed.) They will cease to have effect on the 31 March 2021 or where an appointment(s) has been made in accordance with the amendment, at the end of that term, whichever is the later.

Page 72 and 73 - **Schedule 5.1 – Stakeholder Reference Group, Terms of Reference and Operating Arrangements**

1.4 Appointment and terms of office

1.4.6 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional *term(s).* That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Chair has ended.

1.4.8 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for additional *term(s),* in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

Page 79 - **Schedule 5.2 – Health Professionals' Forum, Terms of Reference and Operating Arrangements**

1.5 Appointment and terms of office

1.5.3 The Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Chair for an additional *term(s).* That individual may remain in office for the remainder of their term as a member of the HPF after their term of appointment as Chair has ended.

1.5.5 The Vice Chair's term of office shall be for a period of up to two (2) years, with the ability to stand as Vice Chair for additional *term(s)*, in line with that individual's term of office as a member of the SRG. That individual may remain in office for the remainder of their term as a member of the SRG after their term of appointment as Vice Chair has ended.

Appendix 2

Schedule 4.1 – MODEL STANDING ORDERS FOR THE WELSH HEALTH SPECIALISED SERVICES COMMITTEE

The following amendments, shown in *red* are required to the Model Standing Orders issued in September 2019 with immediate effect. They will cease to have effect on the 31 March 2021 or where an appointment(s) has been made under the ***National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020*** at the end of that term, whichever is the later.

Page 16 – **1.4 Appointment and tenure of Joint Committee members**

1.4.1 The *Chair,* appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years, *with the exception of those appointed or re-appointed in accordance with Regulation 4 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These members will hold office in accordance with the terms of their appointment or re-appointment.* Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.2 The ***Vice Chair*** and two other ***Independent Members*** shall be appointed by the Joint Committee from existing Independent Members of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than 4 years, in line with that individual's term of office on any LHB Board, *with the exception of those appointed or re-appointed in accordance with Regulation 4 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These members will hold office in accordance with the terms of their appointment or re-appointment.* Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

Appendix 3

Schedule 4.2 – MODEL STANDING ORDERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

The following amendments, shown in *red* are required to the Model Standing Orders issued in September 2019 with immediate effect. They will cease to have effect on the 31 March 2021 or where an appointment(s) has been made under the ***National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020*** at the end of that term, whichever is the later.

Page 15 – **1.4 Appointment and tenure of Joint Committee members**

1.4.1 The ***Chair,*** appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years, *with the exception of those appointed or re-appointed in accordance with Regulation 6 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These members will hold office in accordance with the terms of their appointment or re-appointment.* Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.2 The ***Vice-Chair*** shall be appointed by the Joint Committee from amongst the Chief Executives or their nominated representatives of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than four years, *with the exception of those appointed or re-appointed in accordance with Regulation 6 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. These members will hold office in accordance with the terms of their appointment or re-appointment.* Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

Confirmed Minutes of the Public Audit & Assurance Committee
Held on Tuesday, 21st April 2020
Executive Meeting Room, 2nd Floor, Woodland House

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
Dawn Ward	DW	Independent Member – Trade Union
In Attendance:		
Bob Chadwick	BC	Executive Director of Finance *(via Skype)*
Nicola Foreman	NF	Director of Corporate Governance
Mike Jones	MJ	Wales Audit Office *(via Skype)*
Mike Usher	MU	Sector Lead – Health & Central Government *(via Skype)*
Ian Virgil	IV	Head of Internal Audit
Secretariat		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		
Martin Driscoll	MD	Deputy Chief Executive Officer / Executive Director of Workforce & Organisational Development
Craig Greenstock	CG	Countefraud Manager
Stuart Walker	SW	Executive Medical Director

AAC 20/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 20/04/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/04/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/04/004	**Minutes of the Committee Meeting held on 3rd March 2020** The Committee reviewed the minutes of the meetings held on 3rd March 2020. **Resolved that:** (a) the minutes of the meeting held on 3rd March 2020 be	

	approved as a true and accurate record.	
AAC 20/04/005	**Action Log following the Committee Meeting held on 3rd March 2020** The Committee reviewed the action log and noted the following updates: **AC 20/03/008** – It was confirmed an internal audit would be carried out at an appropriate time agreed with the Executive Medical Director (EMD) **AC 19/05/007** – It was confirmed that Performance Reporting Data Quality –RTT had moved to the 2020-21 plan. **Resolved that:** (a) the Committee noted the action log and the verbal updates provided.	
AAC 20/04/006	**Chairs Action taken since the last Committee Meeting held on 18th February 2020** There had been no Chairs Action taken. The CC advised the Committee that a weekly Board Governance meeting had been arranged with the Chair and Vice Chair and minutes from that meeting would be shared with all Independent Members as appropriate. The Director of Corporate Governance (DCG) confirmed that all questions raised were recorded to keep an audit trail.	
AAC 20/04/007	**Internal Audit Progress and Tracking Report** The Head of Internal Audit (HIA) introduced the report and explained the current pandemic had a significant impact to complete work outlined in the work plan, however, the audit reports that were in draft were anticipated to be completed. The HIA further explained that the Committee usually discussed audits that had been fully completed, however, given the current circumstances, asked if the Committee could view the audit reports in draft during the May for information, and the final report would be brought to a future meeting when possible. After Committee discussion, the CC confirmed he was comfortable with proposed approach. The HIA confirmed the following audit reports were included in the report for information: • CD&T Laboratory Turnarounds – Substantial • UHB Core Financial Systems - Substantial • Risk Management – Reasonable The DCG confirmed the UHB was pleased with the report and in particular, the substantial reports.	**IV**

	The HIA confirmed that work was being undertaken to complete the audit plan and subsequently deliver the Head of Internal Audit Opinion. The Committee were advised that seven reports were unable to be undertaken due to COVID-19. The HIA advised the Committee that enough audits had taken place to provide sufficient coverage across the eight domains to complete the Head of Internal Audit Opinion, which would be a reasonable assurance rating. The Independent Member – ICT (IM-ICT) queried why the Health Care Standards had not been completed. In response, the HIA confirmed it was due to adjustments to the annual plan, which meant the timing had changed. The HIA commented that the draft audit plan for 2020-21 had been shared with the DCG and other appropriate Executive Directors for approval, and it was agreed that the audits that had not been completed would be reviewed on a risk based approach before including them on the plan. The CC explained he was pleased to hear that the outstanding audits would take a risk based approach and thanked the HIA for all the work undertaken over the past year. **Resolved that:** (a) the Committee considered the Internal Audit Progress and Tracking Report; (b) the Committee approved the proposed changes outlined within the report.	
AAC 20/04/008	**Declarations of Interests, Gifts and Hospitality Tracking Report** The DCG introduced the report and advised the Committee that the back log of forms had been added to the register, so the report was fully up to date which was positive. The DCG added that due to the current pandemic, all communications regarding declarations of interest had stopped, however the team were still monitoring declarations that were being received, and to date, nothing had been received that raised concern. The Independent Member – Trade Union (IM-TU) congratulated the team for the excellent progress made within Standards of Behaviour and asked how the Committee would be sighted on any Declarations of Interest taken on board at Ysbyty Calon Y Ddraig. In response, the DCG confirmed she would discuss with the Executive Director of Workforce & Organisational Development and a report would be brought back at a future meeting. The IM-ICT asked where individuals are known to the Health Board to have interests, would there be any proactive steps to ensure people declare. In response, the DCG encouraged members to inform the Corporate Governance team of any known interests and this would be followed up accordingly.	**NF**

	Resolved that: (a) the Committee noted the ongoing work in Standards of Behaviour and the progress made to date; (b) the Committee noted the Declarations of Interest Register.	
AAC 20/04/009	**Regulatory Compliance Tracking Report** The DCG introduced the report and confirmed that all trackers were up to date until COVID-19 and advised the Committee that there were no visits ongoing currently, there were planned visits for June / July, however it was anticipated these would not take place. The CC asked if there were appropriate visits and sign off for Ysbyty Calon Y Ddriag. In response, the DCG confirmed that a report outlining all visits would be produced at a future meeting to provide the Committee with assurance. **Resolved that:** (a) the Committee noted the continuing development within the Regulatory Compliance Tracking Report.	**NF**
AAC 20/04/010	**Internal Audit Tracking Report** The DCG introduced the report and confirmed activity had slowed due to COVID-19, however the number of recommendations had been reduced which was positive. The DCG advised the Committee that the UHB Chair had queried what action would be taken for significantly overdue recommendations. In response, the DCG confirmed that after COVID-19 it was expected these would be picked up and escalated as appropriate. The HIA added that the Internal Audit team would review the recommendations to ensure they were still relevant and had not been superseded. The IM-ICT asked that work be undertaken with the Director of Digital & Health Intelligence to ensure that responses received are transparent and more detailed. In response, the DCG confirmed with the new capacity, it was hoped this area would be improved significantly. **Resolved that:** (a) the Committee noted the Internal Audit Tracking Report.	**NF**
AAC 20/04/011	**Wales Audit Office Tracking Report** The DCG explained that work was still being undertaken in this area, however, it had slowed due to COVID-19. The DCG confirmed there had been a decrease from 90 outstanding recommendations to 48 which were over a course of three years.	

	Resolved that: (a) the Committee noted the Wales Audit Office Tracking Report.	
AAC 20/04/012	**Review the Risk Management System** The DCG advised the Committee that significant progress had been made within Risk Management and there was now a strategy and agreed risk appetite, along with systems in place to manage risks. The DCG explained that consistent scoring was the next phase of work to be undertaken, however this had been paused due to COVID-19. The DCG further explained that there was an expectation that risk registers would be maintained, however scoring would not be reviewed. The DCG advised that for COVID-19, a risk management register had been put in place and risk registers for the four hubs had been developed, the risk registers would be presented at the Board Governance Group and at the Board Meeting at the end of May 2020. Within the six key risks, one had been slightly amended from 'planning recovery' to 'risks to Cardiff & Vale IMTP'. **Resolved that:** (a) the Committee reviewed and noted the Risk Management System.	
AAC 20/04/013	**Annual Internal Audit Plan** The HIA advised the Committee that unfortunately, the Full Audit Plan and Charter was not included in the papers, therefore it would be circulated after the meeting. The HIA explained the audit plan had been produced following discussions with all Executives, UHB Chair and Chief Executive Officer. The HIA further explained that the Committee were being asked to approve the annual plan, but with the acknowledgement that it would need further adjustment and amendment to reflect the emerging risks coming from COVID-19. The HIA added that work was being undertaken with shared services to access potential additional support through agencies to catch up with work required after COVID-19. The IM-ICT requested an update be provided at the next Committee meeting, detailing any changes made to the plan. In response, the HIA confirmed he would update the Committee as part of the progress report. **IV** **Resolved that:** Subject to the caveats discussed;	

	(a) the Committee approved the Annual Internal Audit Plan.	
AAC 20/04/014	**Internal Audit Reports** • CD&T Laboratory Turnarounds — Substantial • UHB Core Financial Systems — Substantial • Risk Management — Reasonable **Resolved that:** (a) the Committee noted the Internal Audit Reports and Ratings.	
AAC 20/04/015	**Annual Audit Plan – Impact of COVID-19** The Sector Lead – Health & Central Government (SL-HCG) advised the Committee that all audit work had been suspended for the time being due to COVID-19, however work was being undertaken to capture learning from the pandemic on an All Wales Level. Wales Audit Office confirmed that in terms of accounts, the timetable had been altered to 22nd May – 30th June and the performance report had also been delayed to 31st August which allowed key staff to focus on current challenges. It was also explained that an Audit Committee and Board Meeting would be required either on 26th or 29th June to reflect the time table change. Wales Audit Office also explained that FRS 16 –Leases, Change in Accounting Standards had been deferred for one year, into 2021-22 which was very helpful as that would be a significant amount of work for all Health Boards. The IM-TU asked when the UHB would be sighted on the piece of work in relation to Learning from COVID-19. In response, the SL-HCG advised this was an evolving piece of work and would be shared on an All Wales Level when appropriate. **Resolved that:** (a) the Committee noted the Annual Audit Plan – Impact of COVID-19.	**MU**
AAC 20/04/016	**Items to bring to the attention of the Board/Committees.** There were no items to be brought the attention of the Board/Committees.	
AAC 20/04/017	**Review of the Meeting** The CC facilitated a review of the meeting. Members confirmed that given the current circumstances, all aspects of the meeting worked well and ran smoothly.	

AAC 20/04/019	**Date & Time of next Meeting** *(to be confirmed)* Tuesday, 19 May 2020 9.00am – 12:30pm Coed y Bwl Room, Ground Floor, Woodland House	

CONFIRMED MINUTES OF THE PUBLIC AUDIT AND ASSURANCE COMMITTEE HELD ON THURSDAY, 28 MAY 2020 NANT FAWR 1, WOODLAND HOUSE

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth (via Skype)	EB	Independent Member – ICT
Dawn Ward (via Skype)	DW	Independent Member – Trade Union
In Attendance:		
Nicola Foreman (via Skype)	NF	Director of Corporate Governance
Chris Lewis (via Skype)	CL	Deputy Finance Director
Helen Lawrence (via Skype)	HL	Head of Financial Accounting and Services
Ian Virgil	IV	Head of Internal Audit
Rhodri Davies (via Skype)	RD	Wales Audit Office
Secretariat		
Sian Rowlands	SR	Head of Corporate Governance
Apologies:		
Bob Chadwick	BC	Executive Director of Finance
Craig Greenstock	CG	Counter Fraud Manager
Mark Jones	MJ	Wales Audit Office
Mike Usher	MU	Sector Lead – Health & Central Government
Anne Began	AB	Wales Audit Office

AAC 20/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 20/05/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/05/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/05/004	**Minutes of the Committee Meeting held on 21 April 2020** The Committee reviewed the minutes of the meetings held on 21 April 2020. **Resolved that:** (a) the minutes of the meeting held on 21 April 2020 be approved as a true and accurate record.	

AAC 20/05/005	**Action Log following the Committee Meeting held on 21 April 2020** The Committee reviewed the Action Log and noted the following updates: **AC: 20/03/008 and AAC: 20/04/005** – It was confirmed that Consultant job planning had moved forward and had been considered in detail a few meetings prior. The Head of Internal Audit would be providing an update at the February meeting. **AC 19/12/012** – The WAO Effectiveness of Clinical Audit Report would be kept as outstanding as its status had been affected by COVID-19. The Director of Corporate Governance would speak with WAO about plans to progress post COVID-19. **AAC 20/04/008** – It was confirmed that the aim would be to bring a report detailing Declarations of Interest in relation to Ysbyty Calon Y Drraig to the July meeting but it might be September. The Committee was advised that a record was being kept of Declarations of Interest relating to Ysbyty Calon Y Drraig. **AAC 20/04/009** – Likewise the Regulatory Compliance Tracking Report would resume July / September subject to being able to return to normal business. **AAC 20/04/013** – The Head of Internal Audit confirmed that he would provide a verbal update regarding the Annual Internal Audit Plan to the Committee today. **AAC 20/04/015** – The Committee would await confirmation from MU and the WAO team regarding the All Wales learning from the pandemic. **Resolved that:** (a) the Committee noted the Action Log and the verbal updates provided.	**NF**
AAC 20/05/006	**Internal Audit Progress and Tracking Reports** The Head of Internal Audit advised the Committee that the usual progress report was presented and that the Internal Audit plan tied in with the Annual Report to be discussed in the later Workshop. The Head of Internal Audit talked the Committee through the report, highlighting that it provided detail of progress with the delivery plan since the last meeting. Section 2 of the report showed eight audits had been completed since the last meeting and all received positive assurance reports. The Committee was advised that two audits were submitted to the Committee today in draft format as finalisation of the reports had not been possible due to COVID-19.	

	The Committee agreed to receive the reports in draft as it would not be reasonable for departments to have to agree actions at this time. The Head of Internal Audit would revisit with managers and bring a confirmed action plan to a future meeting for completeness. The Independent Member – ICT commented that the approach of giving sight of the draft report and bearing with managers was appropriate and that she supported it. The Independent Member – Trade Union agreed that it was a sensible and sensitive approach. The CC concluded that it was good to see that the last update for the year was positive and one of reasonable assurance and recognised the hard work of Internal Audit and of managers in responding. The Head of Internal Audit explained that section 3 of the report fed into the annual opinion provided. Internal Audit were able to produce 39 completed reports which gave enough coverage across the domains to provide an annual audit opinion. Appendix C and D provided the Committee with information on key performance indicators; all were green save for those relating to the time taken for managers to respond to reports. The Committee was advised that this has been impacted by COVID-19 but progress was being made in this area. The Committee was advised that in terms of the 2020-21 plan, there had been a discussion with the Executive Director of Finance and Director of Corporate Governance regarding looking at the general governance arrangements and financial governance around COVID-19. As there was also a detailed KPMG audit currently being conducted around this, a brief would be pulled together to avoid duplication of work. The Director of Corporate Governance added that it was important to get the scope of the Internal Audit governance review right and that it would be sensible to wait for the outcome of the KPMG report which had looked at the whole governance structure to avoid duplication. In addition, WAO also were intending to review governance. The CC asked whether there was a date agreed for the KPMG report and it was confirmed that there was not currently but that an outcome meeting was being arranged and that a date would no doubt be provided then which could be fed back to the CC. The Deputy Finance Director added that the KPMG audit had been commissioned by Welsh Government and was due to include in around a fortnight. The audit was concentrating on financial due diligence, governance and contracting with a focus around the Dragon's Heart Hospital. The Independent Member – ICT asked whether we had received Terms of Reference for the KPMG audit.	**IV** **NF**

	The Deputy Finance Director responded that the Terms of Reference had been requested but not released to us. The CC confirmed that he had received a presentation regarding the audit that he would share. The Independent Member – Trade Union commented that she was pleased to hear that we would be looking back at this period and auditing it. The CC queried the normal number of internal audits in a given year. The Head of Internal Audit responded that between 40-50 for the plan but the intention was to reduce the number and increase the scope to provide more detail. Audits not done this year would feed into next year's plan but this would be considered on a risk basis as to whether these audits were still appropriate. **Resolved that:** (a) the Committee considered the Internal Audit Progress Report and the findings and conclusions from the finalised and draft individual audit reports.	**CC**
AAC 20/05/007	**Report of the Losses and Special Payments Panel** The Deputy Finance Director advised the Committee that the Losses and Special Payments Panel met twice a year and brought its recommendations to the Committee for approval as per the Scheme of Delegation. The Panel met on 13 May 2020 and considered the period for the second part of the year. The Assessment section of the report made a number of recommendations. The Committee was advised that losses were included in the financial accounts for final sign off. The Deputy Finance Director advised the Committee that there was a big number for Clinical Negligence which related not to cost but the size of the loss. The large figure for ex-gratia payments was highlighted and the £250k relating to stock right off across areas, the Committee was advised that this figure was £461k the preceding year so was not out of synch with past years. The CC raised a query about the wheelchair losses after the flood. The Deputy Finance Director advised that as the connected losses were so large, this was not within the delegated authority of the Health Board to approve and therefore it had gone to Welsh Government who had approved the losses so this would come to a future Committee for noting as it related to the new financial year. The Independent Member – Trade Union was happy to approve the write offs but asked whether going forward, in the spirit of protecting public	

	money, there was anything more that could be done regarding stock control. The Deputy Finance Director responded that as Chair of the losses and special payments panel, it was within his remit to make further enquiries regarding items as necessary. In keeping with this, he had made a special request for detail regarding stock write offs but there was nothing that stood out as a serious breach of control. The aim going forward was to obtain better trend analysis. The Independent Member – ICT commented that it was unclear how much of the debt write off had been referred to a collection agency and what percentage of this became a write off. The Deputy Finance Director agreed to provide this information before the next Audit Committee meeting. Putting the figure into context, he advised that the amount was extremely small in comparison to the income received. The Independent Member – ICT commented that there was no knowing whether we were better or worse in comparison with others so information regarding this would be helpful. The Deputy Finance Director explained that the details of clinical negligence go through another Committee of the Board. **Resolved that:** (a) the Committee approved the write offs outlined in the Assessment Section of the report.	**CL**
AAC 20/05/008	**Internal Audit Reports** The Committee received the Internal Audit reports provided. The Independent Member – Trade Union commented that tremendous progress had been made around reassessment but that it was a little alarming to observe a slight downward trend of audits happening in some of the clinical areas and it was important to consider how to better motivate and engage staff and reinforce the importance of audit. The CC added that we should as a Committee be congratulating areas on positive assurance findings. The Head of Internal Audit confirmed that the team meets with Health Board staff and pushes the importance of audit in these meetings. The CC added that we also now had the Internal Audit Tracker in place which was good progress and he was reassured by the reports done and actions being taken. The Head of Internal Audit confirmed that he would be reviewing the reports and would pull into an overall report for Committee.	**CC** **IV**

	Resolved that: (a) the Committee noted the Internal Audit reports.	
AAC 20/05/009	**Good Governance During COVID-19** The Director of Corporate Governance confirmed that the report was for information only as it had already received Board approval but as the Committee had not formally seen the arrangements it was being brought for noting. The report described the framework put in place initially (the structure resembled Gold Command), and where the Health Board were with Committees that had been cancelled. The Committee was advised that the Health Board were now starting to revert to business as usual and the Chair had asked Committees to look at their terms of references so that we do not fully revert to as we were before. The document would also be attached as part of the Chair's report to the Board to be ratified. The Independent Member – Trade Union queried the timescales for reverting back to business as usual. The Director of Corporate Governance explained that the structure was constantly under review. The Operational meeting was still convening daily, and taking lessons from what worked well, this was likely to continue. There was talk to now stand down the Strategic Group and revert to the normal Management Executive meeting. The UHB had kept to the Scheme of Delegation and SFIs so reverting back would not be an issue. **Resolved that:** (a) the Committee noted the report setting out the Governance Structure and arrangements during COVID-19 (b) the Committee noted arrangements to the Board and Committees set out at paragraph 2.7 and appendix 2 (c) the Committee noted the changes to Standing Orders set out in Appendix 3 of the report.	
AAC 20/05/010	**Review of the Meeting** The CC facilitated a review of the meeting. Members confirmed that given the current circumstances, all aspects of the meeting worked well and ran smoothly.	
AAC 20/05/011	**Date and Time of Next Meeting** **Special Audit Committee** Monday, 29 June 2020 10:00 am Executive Meeting Room, 2nd floor, Woodland House	

Confirmed Minutes of the Public Audit and Assurance Committee
Held on Monday 29th June 2020 10:00am – 11:00am
Executive Meeting Room / Via Skype

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth (via Skype)	EB	Independent Member – ICT
Dawn Ward (via Skype)	DW	Independent Member – Trade Union
In Attendance:		
Bob Chadwick	BC	Executive Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Craig Greenstock	CG	Counter Fraud Manager
Mark Jones	MJ	Audit Wales
Chris Lewis	CL	Deputy Finance Director
Helen Lawrence (via Skype)	HL	Head of Financial Accounting and Services
Ian Virgil (via Skype)	IV	Head of Internal Audit
Rhodri Davies (via Skype)	RD	Audit Wales
Secretariat		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		

AAC 20/06/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 20/06/002	**Apologies for Absence** Apologies for absence were noted.	
AAC 20/06/003	**Declarations of Interest** There were no declarations of interest.	
AAC 20/06/004	**A Report on the Annual Accounts of the UHB 2019-20** The Deputy Director of Finance (DFD) introduced the report and confirmed the Annual Accounts also formed part of the Accountability Report. The DFD reminded the Committee that the report had previously been reviewed and scrutinised at the meeting held on 28th May 2020. Adjustments to the report were outlined on page 2, however these did not change the impact of the report on the financial position of the UHB.	

AAC 20/06/005	**Audit Wales ISA 260 Report** Audit Wales (AW) introduced the report and confirmed that the accounts were materially true, fair and prepared with the exception of stock, this was due to AW being unable to attend the stock take for 2019-20 due to COVID-19, therefore, this would not report negatively for the Health Board. AW advised the Committee of two emphasis of matter which were explained as: • Valuation of Land – The Health Board carried out 7 valuations during 2019-20, 4 of which were conducted during COVID-19. AW confirmed it was an emphasis of matter due to the unreliability around valuations due to market uncertainty. • Pension Regulations – This affected all Health bodies with the exception of HEIW. AW confirmed the narrative around this had been agreed with Audit Wales and Welsh Government. AW advised the Committee that the Auditor General intended to certify on the 2nd July 2020 and Welsh Government were expected to lay the accounts on the 3rd July 2020 which would include a press release. AW expressed thanks to the UHB Finance team, Corporate Governance team and all staff involved with the audit, advised it had been a difficult year to deal with the reports virtually but all stakeholders worked very well together to achieve this.	
AAC 20/06/006	**The Head of Internal Audit Annual Report for 2019-20** The Head of Internal Audit (HIA) introduced the report and confirmed that the Audit Annual Report for 2019-20 had been reviewed and scrutinised during the meeting held on 28th May 2020 and no changes had been made. The DCG confirmed that the Audit Annual Report for 2019-20 had also been presented to Management Executive and was also reflected through the Annual Governance Statement.	
AAC 20/06/007 Tolley, Laura 07/27/2020 11:09:35	**The Counter Fraud Annual Report for 2019-20** The Counter Fraud Manager (CFM) introduced the report and confirmed the following: • The appointment of a Band 4 team member to assist with awareness training going forward;	

	• 59 new investigations and 11 cases brought forward from 2018-19; • Collaborative working was being undertaken with HR colleagues to address identified policy weaknesses; • Self-assessment had been completed, signed off by the Executive Director of Finance (EDF) and submitted within the set deadline to the NHS Counter Fraud Authority on 31st March 2020; • All areas are rated green against areas set by NHS Counter Fraud Authority, this was positive, however it was important to note a challenging year ahead; • Total cost of running a Counter Fraud department for the UHB totalled £91,000.00, however, the UHB had recovered £27,000.00 in costs. The CC commented it was very positive to see all areas reporting green and thanked the Counter Fraud department for all work undertaken and achieved during 2019-20 and noted the difficulty heading into 2020-21.	
AAC 20/06/008	**To receive and consider the following for 2019-20:** **a. The Letter of Representation included within the ISA 260 report** AW introduced the report and confirmed this was a standard letter used, however there was a specific section within the letter which highlights corrections, this letter would require Board, CEO and Chair approval. The Independent Member – Trade Union (IM-TU) queried if there would be consequences over the estimated stock levels and valuations. In response, the DFD confirmed from a UHB perspective he was confident these were correct, therefore there was no cause for concern. The Independent Member – ICT (IM-ICT) asked in relation to the treatment of pool budget, the UHB had corrected 2019-20 accounts, but had not corrected previous year's accounts. In response, the DFD advised confirmation from Welsh Government had been received which explained that previous changes did not need to be made. **b. The response to the audit enquiries to those charged with governance and management** The DFD confirmed this was endorsed at the meeting on the 28th May 2020, in addition to being endorsed by the Chair, CEO and DCG. **c. The Annual Accountability Report including the Financial Statements** The DCG confirmed that the Annual Accountability Report had been reviewed and scrutinised at the meeting held on 28th May 2020. Audit	

	Wales and Welsh Government comments had been included in the final document. Part 1, related to the performance report was to be developed and presented at the Annual General Meeting on 27th August 2020.	
AAC 20/06/009	**Resolved that:** The Audit and Assurance Committee:- (a) noted the reported financial performance contained within the Annual Accounts and that the UHB has breached its statutory financial duties in respect of revenue expenditure. (b) noted the changes made to the Draft Annual Accounts; (c) reviewed the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management and the Annual Accountability Report which includes the Annual Accounts and financial statements; (d) recommended to the Board that it agrees and endorses the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the audit enquiries to those charged with governance and management; (e) recommended to the Board approval of the Annual Accountability Report for 2018-19 including the Annual Accounts and financial statements.	
AAC 20/06/010	**Items to bring to the attention of the Board / Committees** The Committee agreed the following items would be taken to the Board: (a) Audit Wales ISA 260 Report; (b) The Head of Internal Audit Annual Report for 2019-20; (c) The Letter of Representation included within the ISA 260 report; (d) The response to the audit enquiries to those charged with governance and management; (e) The Annual Accountability Report including the Financial Statements;	**NF**
AAC 20/06/011	**Review of the Meeting** The CC thanked all involved in developing the reports and documents presented at the meeting. The IM-TU thanked the CC and Committee members for informed and transparent reporting.	
AAC 20/06/012	**Date and Time of Next Meeting** Tuesday 7th July 2020 9.00am – 12:00pm Via Skype	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE HELD ON 29th APRIL 2020 NANT FAWR 1 MEETING ROOM/SKYPE, WOODLAND HOUSE

Present:

John Union	JU	Chair, Independent Member – Finance
Charles Janczewski	CJ	Interim Board Chair
Dr Rhian Thomas	RT	Independent Member - Capital & Estates
Abigail Harris	AH	Executive Director of Strategic Planning
Andrew Gough	AG	Assistant Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Len Richards	LR	Chief Executive
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director
Steve Curry	SC	Chief Operating Officer

In Attendance:

Ian Virgil	IV	Head of Internal Audit

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Martin Driscoll	MD	Executive Director of Workforce and Organisational Development

FC 20/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 20/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 20/003	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 20/004	**MINUTES OF THE FINANCE COMMITEE MEETING HELD ON 26th FEBRUARY 2020** The minutes of the meeting held on 26th February 2020 were reviewed for accuracy. There was one amendment noted that the wrong year	

	was on the meeting date. It was agreed that this be amended and the minutes were then agreed as a true and accurate record. **Resolved – that**: The minutes of the meeting held on 26th February 2020 were approved by the Finance Committee as an accurate record.	
FC 20/005	**ACTION LOG FOLLOWING THE LAST MEETING** There was one action to note on the action log and this is now recorded as complete. **Resolved – that**: The Finance Committee **noted** that there were no outstanding actions.	
FC 20/006	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 20/007	**FINANCE PERFORMANCE REPORT 2019/20** The Deputy Director of Finance presented the UHB's Finance Report for the year ended 31st March 2020. The UHB's provisional year end revenue outturn is a surplus of £0.058m which is broadly in line with the break-even position previously forecast. The UHB is also reporting that it stayed within its Capital Resource limit and achieved its creditor payment compliance target. The Finance Committee was asked to note that these are all provisional at this stage as the accounts will be subject to external audit scrutiny, though the reported year end position is not expected to materially change. It was highlighted however despite achieving a surplus in 2019/20 the UHB still breached its statutory break even duty by £36.667m over the three year period. The key issues to note were: • That the UHB's financial position improved again in March in line with the profiled plan to reach a break even position; • Plans were flexed in March to respond to the additional operational demands arising as result of the COVID 19 virus and an additional £1m revenue funding was secured from Welsh Government to cover the increase in net costs; • At the beginning of 2019/20 the UHB had a brought forward underlying recurrent deficit of £36.3m. This has now reduced to £11.5m, albeit £7.5m higher than planned; • This reflected a satisfactory outcome to what has been a very challenging financial year.	

	The Interim Board Chair (CJ) commented that this was a significant achievement given where the Health Board has come from. An in year break even position and reducing the underlying deficit from £36.3m to £11.5m was not just down to the Finance Team but all involved in managing budgets across the UHB. The Chief Executive (LR) reiterated that this was a significant achievement and that the only disappointment was that some of the savings made were non recurrent thus leaving the carry forward underlying deficit higher than was planned. The Deputy Director of Finance continued to present the year end position, noting that the UHB had a number of income gains in the month with a year end overachievement on income of £2.0m. Pay budgets also held up in the month and ended the year £3.9m underspent. Non pay budgets however continued to deteriorate in the month resulting in a year end overspend of £5.9m. Taken together Delegated budget holders broadly hit their risk adjusted forecast position and the final position on the savings programme and underlying deficit were as expected and previously reported. The cash balance at the end of the year was £1.4m and the final year end performance against the PSPP target was 95.8%. The provisional year end performance against the CRL was an £0.088m underspend. As part of this Welsh Government were carrying forward circa £1m funding due to scheme slippage caused by COVID 19 and the UHB managed to secure an additional £1.6m funding at the year end for COVID 19 related capital costs. The Finance Committee Chair (JU) asked if the actual year end position was in line with the plans to break even that were previously presented to the Finance Committee. The Deputy Director of Finance commented that the overall position against the profiled plan was shown in Appendix 6 of the report and that the identified risks and opportunities were broadly as planned. The Finance Committee Chair (JU) asked if there was any changes to the Welsh Risk Pool charges. It was confirmed that there were not and that that these were fixed by Welsh Government after month 10. The Independent Member - Capital and Estates (RT) asked if the delivery of an in year break even position was due to forecasting or in driving a better financial position. The Deputy Director of Finance confirmed it was both. The forecast position showed the financial improvements needed and the UHB then tried to minimize expenditure and to take all financial opportunities available in order to deliver a break even position. The Chief Executive noted how difficult the last six months had been in order to achieve this. The Finance Committee Chair (JU) also noted that the Finance Committee had supported actions taken in January to reduce discretionary expenditure in order to support this. **Resolved - that:**	

	The Finance Committee **noted** the provisional draft year end revenue surplus of £0.058m against the planned breakeven position. The Finance Committee **noted** that the UHB achieved its creditor payment compliance. The Finance Committee **noted** that the year end capital position was expenditure of £58.071m against a CRL of £58.159m.	
FC 20/008	**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 The extreme risks on the Dragon's Heart Hospital (DHH) were also noted as being: **Fin01/20 DHH** – Financial Plan impact of DHH. **Fin02/20 DHH** – Cost exceeding forecast ranges due to unforeseen factors. **Fin03/20 DHH** – Damage and alteration to the stadium driving reinstatement costs above current projected provision. It was noted that KPMG has been appointed by Welsh Government to support and review the commissioning of the DHH. The Interim Board Chair (CJ) informed the Finance Committee that their report needed to be considered by the Board and not the Finance Committee as it mainly concerned governance. The Director of Finance noted that whilst the UHB had requested to discuss the draft report with KPMG when it is completed, they may not be in a position to do this before finalisation. Also, whilst the recording of decisions made in respect of the DHH appeared to be in a reasonable state, it is likely that not everything is included given the pace at which the DHH was developed. The UHB had been open and honest in sharing information on the DHH with Welsh Government and would do the same with KPMG. They also have the experience of reviewing the Excel Centre in London which was also developed at pace. The Director of Finance requested that a risk be added to the DHH register relating to the fact that in many instances there is only a letter of intent in place as opposed to a formal contract.	Assistant Director of Finance (AG)

	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 20/009	**MONTH 12 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 20/010	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD / OTHER COMMITTEES** There were no items to bring to the attention of the Board or other Committees.	
FC 20/011	**DATE OF THE NEXT MEETING OF THE FINANCE COMMITTEE** The next meeting will take place at 2.00 pm, Wednesday 27th May, Woodland House (meeting room to be confirmed).	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE
HELD ON 27th MAY 2020
CEFN MABLY MEETING ROOM/SKYPE , WOODLAND HOUSE

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
Charles Janczewski	CJ	Interim Board Chair
John Union	JU	Independent Member - Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Andrew Gough	AG	Assistant Director of Finance
Chris Lewis	CL	Deputy 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
Steve Curry	SC	Chief Operating Officer

In Attendance:

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Abigail Harris	AH	Executive Director of Strategic Planning

FC 20/026	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 20/027	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 20/028	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 20/029	**MINUTES OF THE COMMITTEE MEETING HELD ON 29TH APRIL 2020** The minutes of the meeting held on 29th April 2020 were reviewed for accuracy and were agreed as a true and accurate record.	

	Resolved – that: The minutes of the meeting held on 29th April 2020 were approved by the Committee as an accurate record.	
FC 20/030	**ACTION LOG FOLLOWING THE LAST MEETING** **FC 20/008– FINANCE RISK REGISTER -** Additional Risk to be added to the Dragon's Heart Hospital (DHH) Risk Register relating to the fact that in many instances there is only a letter of intent in place as opposed to a formal contract. It was confirmed **that a** risk had been added to DHH Risk Register included in May 2020 papers where a letter of intent is in place as opposed to a formal contract. **Action complete**. **Resolved – that**: The Finance Committee **received** the Action Log.	
FC 20/031	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 20/032	**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 The Finance Committee was asked to note that the COVID-19 financial plan risk (FIN10/20) was shown at appendix 2 as a sub-set to the main risk register. It was noted that the mitigation of risks was in part dependent on decisions taken by Welsh Government to support and review plans in place to manage the impact of COVID -19 on UHB services. Picking up on this theme the Director of Finance indicated that the Risk Register would be subject to substantive review as the circumstances around risks changed. The Finance Committee Chair (RT) asked if further detail could be provided on specific actions to mitigate some of the current risks and	Assistant Director Of Finance

	the Assistant Director of Finance agreed that further detail would be provided to future Committee meetings where actions had been taken. **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 20/033	**ITEMS TO BEING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 20/034	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday** 24th June**; 2.00pm;** Cefn Mably Meeting Room, Ground Floor, HQ, Woodland House	

Confirmed Minutes of the Quality, Safety & Experience Committee
Held on Tuesday, 14th April 2020
Executive Meeting Room, 2nd Floor, Woodland House

Chair		
Dawn Ward	DW	Independent Member – Trade Union
Present:		
Susan Elsmore	SE	Committee Chair and Independent Member – Local Government *(via Skype)*
Michael Imperato	MI	Independent Member – Legal *(via Skype)*
In Attendance:		
Stephen Allen	SA	Chief Officer – Community Health Council *(via Skype)*
Mike Bond	MB	Director of Operations
Carol Evans	CE	Assistant Director of Patient Safety and Quality *(via Skype)*
Nicola Foreman	NF	Director of Corporate Governance *(via Skype)*
Angela Hughes	AH	Assistant Director of Patient Experience *(via Skype)*
Ruth Walker	RW	Executive Nurse Director *(via Skype)*
Secretariat		
Laura Tolley	LT	Corporate Governance Officer
Apologies:		
Robert Chadwick	RC	Executive Director of Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Kinghorn	FK	Executive Director of Public Health
Stuart Walker	SW	Executive Medical Director

QSE 20/04/001	**Welcome & Introductions** The Committee Chair and Independent Member – Local Authority (CC/IM-LA) welcomed everyone to the meeting and advised members that on this occasion, due to technology issues, Independent Member – Trade Union (IM-TU) would Chair the meeting.	**ACTION**
QSE 20/04/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 20/04/003	**Declarations of Interest** The IM-TU invited Committee members to declare any interests in relation to items on the agenda. The following declarations of interest were received and noted:	

	• CC / IM-LA declared an interest as Chair of the Regional Partnership Board.	
QSE 20/04/004	**Minutes of the Committee Meeting held on 18th February 2020** The Committee reviewed the minutes of the meetings held on 18th February 2020. **Resolved that:** (a) the minutes of the meeting held on 18th February 2020 be approved as a true and accurate record.	
QSE 20/04/005	**Action Log following the Committee Meeting held on 18th February 2020** The Committee reviewed the action log and noted the following updates: **QSE 20/08/008** – it was agreed that the Medicine Clinical Board Assurance Report would be brought to a future meeting, once the ongoing pandemic had eased. **QSE 20/02/015** – The Executive Nurse Director (END) advised the Committee that all routine HIW inspections had ceased and at present, there were no areas of concern. It was agreed that HIW reports would be brought to the Committee in September 2020. **QSE 20/02/017** – The Director of Corporate Governance (DCG) confirmed the Committee Annual Work Plan and Terms of Reference would be brought to the Committee in September 2020. **QSE 19/12/016** – it was agreed that an update on Health Eating Standards for Hospital Restaurant and Retail Outlets would be brought to the next Committee meeting. **QSE 19/12/019** – the Chief Officer – Community Health Council (CO-CHC) advised the Committee that a paper would be brought in December 2020 which would inform the Committee relating to their visits to Primary Care Contractors. **QSE 19/09/016** – it was agreed that the Centralisation of Endoscopy Decontamination would be included as an agenda item at a future meeting. **QSE 19/09/008** – it was confirmed that the Children's Charter would be included on the Committee Work Plan. **QSE 19/06/020** – the END advised the Committee that Maternity was a constant area of focus for the UHB, however, this action had been superseded by the HIW All Wales Review of Maternity Services. The END explained that Phase 2 of the HIW Review was very robust and looked at, in detail, areas around Governance. Initial verbal feedback from the report	**CH** **RW** **NF** **FK** **SA** **FK** **NF**

	was very positive which the team were very pleased about. The Committee agreed to close this action. **Resolved that:** (a) the Committee noted the action log and the verbal updates provided.	
QSE 20/04/006	**Chair's Action taken since the last Committee Meeting held on 18th February 2020** There had been no Chair's Action taken.	
QSE 20/04/007	**PCIC – Patient Story** Due to the ongoing and changing developments regarding COVID-19 the PCIC Clinical Board will bring their Patient Story and Assurance Report to a future meeting.	
QSE 20/04/008	**Mortality Review – Learning from Deaths** The Assistant Director of Patient Safety & Quality (AD-PSQ) introduced the paper and it was taken as read by the Committee. The AD-PSQ explained that Level 1 Compliance had been an area of improvement over the past 12 months. It was noted that in Critical Care, compliance had improved from 66% to 100% in January 2020, and overall the Health Board was at 80% compliance. The AD-PSQ informed the Committee that discussions on an All Wales Level had taken place to confirm if Level 1 should be continued during the ongoing pandemic, and it had been agreed that the Qualified Death Certifier form, combined with the Public Health form would be accepted as a Level 1 review, this combined form approach would specifically be carried out when dealing with the death of COVID-19 patients. The CC/IM-LA queried who would be attendees of the UHB Mortality Group which was chaired by the Executive Medical Director (EMD). In response, the AD-PSQ explained the Terms of Reference were currently being developed, and would be shared with the Committee for information at a future meeting. The Independent Member – Legal (IM-L) asked if the process of appointment for Medical Examiners has been postponed due to the ongoing pandemic. The AD-PSQ explained that central appointments were in place, however, further enquiries would be made on how recruitment into assisting posts would be achieved. The IM-TU asked if the UHB had flow and follow through for morgue capacity. In response, the END advised that the UHB had mortuary capacity, as of 13.04.2020, the mortuaries were full, therefore, the UHB had moved into extra capacity arrangements, this was due to the weekend and undertakers not available to collect bodies.	**CE**

	The END also confirmed that the Assistant Director of Patient Experience (AD-PE) had refreshed communication to staff across the UHB around End of Life, in particular in the following areas: 1. Sensitively have conversations with patients around DNAR/CAR on arrival to hospital 2. How to help families remain in contact with loved ones who are critically ill The END advised the Committee of two services that had been set up: (a) Helpline for the Public on patients (b) Bereavement Helpline – The team were contacting all patients who are bereaved, paying particular attention to COVID-19 patients. The AD-PE confirmed that both helplines had been very well received and the team were now looking at receiving messages from relatives, along with virtual visiting, both these areas would be discussed at the Operational Group. The CO-CHC asked what safeguards were in place to ensure that patients understand what is being asked on admission to hospital in terms of DNAR/CAR. The END confirmed that staff at senior levels would hold these conversations, they would ensure that the patient has appropriate capacity to answer and the process is reviewed on an ongoing basis. The END added whilst using technology for families to be involved in these conversations virtually would be supported, the END confirmed using technology can be very difficult, particularly in Critical Care due to PPE. The AD-PE added that the UHB were encouraging GPs and Primary Care to have DNAR/CAR conversations with patients, prior to admission to hospital to assist with the process. The IM-TU asked if the team would put together a package to support religious rituals around death. In response, the AD-PE confirmed that the UHB were still continuing to carry out rituals within 24 hours, especially for Muslim and Jewish patients and that the communities were being very appreciative and understanding of the current situation and difficulties faced. **Resolved that:** (a) the Committee noted the Mortality Review – Learning from Deaths	
QSE 20/04/009 Tolley,Laura 07/27/2020 11:09:35	**Ophthalmology waiting times and the management of Patient risk** The Director of Operations (DO) gave an overview of the report and confirmed that work had been undertaken to develop a sustainable and positive plan. The Ophthalmology team had developed and tested a virtual service which was successful. The DO advised previously, 4000 patients were outstanding that required care, however this had significantly improved and had moved down to circa 300-400 patients.	

	The DO advised this significant progress had been made prior to COVID-19, and since the start of the pandemic, the team had managed to maintain some virtual work with colleagues, however demand had increased therefore conversations were being held with Welsh Government to explore how to move this area forward. Patients were still being treated at the Llanishen site, with a patient risk management plan in place. The DO explained that the pandemic emphasised the need to enhance technology across the UHB. The DO explained there was a concern that patients were not attending clinics, therefore, there was a potential for a backlog of patients when the pandemic ends. The DO commended Clinicians who had worked very hard to maintain services for non COVID-19 patients. The IM-TU recognised the technology failing on an All Wales level and explained there was not sufficient digital infrastructure to support the Health Boards during the pandemic. The IM-TU added that the Ophthalmology model provided the Committee with assurance that all risks were being managed. The CC/IM-LA requested Committee gratitude to be passed onto colleagues. **Resolved that:** (a) the Committee noted the Ophthalmology Waiting Times and the management of Patient risk update	
QSE 20/04/010	**Exception Reports – Key Issues** The END introduced the report and confirmed that the focus was on management of COVID-19 patients and patients who are waiting for care. The END advised the Committee of All Wales concerns around PPE and informed the Committee of the loss of two colleagues. The Committee sent condolences to the families and staff across the UHB. The END advised the Committee that it was agreed between the END and EMD, that in the event of a colleague dying form COVID-19, an assessment would be undertaken to identify where they were working at the time. **Resolved that:** (a) the Committee noted the Exception Reports – Key Issues	
QSE 20/04/011 Tolley, Laura 07/27/2020 11:09:35	**Annual Quality Statement** The AD-PSQ informed the Committee that due to the ongoing pandemic, and current pressure on services, the Annual Quality Statement would be brought to the next Committee meeting **Resolved that:**	**CE**

	(a) the Committee agreed that the Annual Quality Statement would be brought to the next Committee meeting for approval	
QSE 20/04/012	**Items for Noting & Information** The following item was presented for noting: • UHB self-assessment and improvement plan against the Cwm Taf HIW/WAO governance review The CC/IM-LA confirmed the Committee supported the UHB to do whatever was required to increase capacity in this area to ensure colleagues are able to carry out their duties safely. The IM-TU added that it had been noted that the UHB improvement plan had been very lean for some time and congratulated the team for what has been achieved. The END explained that the self-assessment had been presented to Management Executive, but requested it be taken to Board level. The END added that it was very important to keep corporate oversight over Quality & Safety whilst the pandemic is ongoing. **Resolved that:** (a) the Committee noted the UHB self -assessment and improvement plan against the Cwm Taf HIW/WAO governance review and the verbal updates provided. (b) the Self-Assessment Outcomes be presented to the Board	**NF**
QSE 20/04/013	**Any Other Business** The AD-PSQ advised the Committee that the National Clinical Audit Plan had been stood down by Welsh Government, however, the team would keep in touch with the Clinical Audit Teams to ensure that data is still inputted, although it is not a priority. The AD-PSQ advised that due to the pandemic there would be a 6 month gap in the data when it is over. The IC-TU acknowledged the work that had been undertaken to date in this area, and confirmed the Committee were assured by the robust systems in place that this would be handled appropriately.	
QSE 20/04/014	**Items to bring to the attention of the Board/Committees.** It was agreed that the following items would be taken to the Board: (a) Ongoing work around complaints and concerns (b) Self-Assessment outcomes against the Cwm Taf HIW/WAS Governance Review	**NF**
QSE 20/04/015	**Review of the Meeting**	

	The IM-TU facilitated a review of the meeting. Members confirmed that: • Good robust conversations had taken place • Acknowledgement of technology issues and the ongoing work to address these • The need for the UHB to start thinking about non COVID-19 patients awaiting routine appointments/operations • Expressed thanks to all teams across the UHB for the ongoing work undertaken.	
QSE 20/04/016	**Date & Time of next Meeting** Tuesday 16th June 2020 9.00am – 12:30pm Coed y Bwl Room, Ground Floor, Woodland House	

Minutes from the Local Partnership Forum meeting held on 12 February 2020 at 11am in Coed y Bwl, Woodland House

Present	
Mike Jones	Chair of Staff Representatives/UNISON (co-Chair)
Martin Driscoll	Exec Director of Workforce and OD (co-Chair)
Ceri Dolan	RCN
Rhian Wright	RCN
Nicola Foreman	Director of Corporate Governance
Chris Lewis	Deputy Director of Finance
Andrew Crook	Head of Workforce Governance
Rachel Gidman	Assistant Director of OD
Caroline Bird	Deputy COO
Fiona Kinghorn	Exec Director of Public Health
Pauline Williams	RCN
Dawn Ward	Independent Member – Trade Union
Peter Hewin	BAOT/UNISON
Steve Gaucci	UNISON
Ruth Walker	Exec Director of Nursing
In Attendance	
Keithley Wilkinson	Equality Manager
Nicola Bevan	Head of Employee Health and Wellbeing
Michelle Fowler	Volunteer Services Manager
Helen Palmer	Workforce Governance Advisor (observing)
Apologies	
Stuart Walker	Medical Director
Fiona Jenkins	Exec Director of Therapies and Health Sciences
Len Richards	CEO
Lianne Morse	Head of HR Operations
Julie Cassley	Deputy Director of WOD
Stuart Egan	UNISON
Mathew Thomas	UNISON
Fiona Salter	RCN
Janice Aspinal	RCN
Bob Chadwick	Exec Director of Finance
Peter Welsh	Hospital Manager, UHL and Barry
Secretariat	
Rachel Pressley	Workforce Governance Manager

LPF 20/001 Welcome and Introductions

Mr Jones welcomed everyone to the meeting and introductions were made.

LPF 20/002 Apologies for Absence

Apologies for absence were noted.

LPF 20/003 Declarations of Interest

There were no declarations of interest in respect of agenda items.

LPF 20/004 Minutes of Previous Meeting

The minutes of the meeting held on the 4th of December were noted and approved subject to the following amendment:

- Page 2, Clinical Services Plan: the minutes referred to 'Prosperity for All', but Mr Hewin had actually been asking for the timescale for the Rehabilitation Strategy.

In reference to the Move More, Eat Well Strategy, Mr Jones stated that there were notices appearing in canteen area asking staff to not use that area without purchasing food. Mr Driscoll stated that he would follow this up with Mr Lewis and gave assurances once more that these notices would be removed.
Action: Mr Driscoll

(Ms Brandon entered the meeting)

LPF 20/005 Action Log

The Local Partnership Forum noted the action log.

LPF 20/006 Volunteers Framework

Ms Fowler was in attendance to present the Volunteers Framework 2020-23. She advised that this was the 4th iteration of framework. Ms Fowler noted:

- The good working relationship that she had with staff side, and the high levels of trust that had been built up over the years, especially around considering new volunteer roles.
- There is good governance around volunteering, including recruitment checks and training and bespoke safeguarding training has been developed.
- Important work has taken place to engage with younger people and the community. In addition mental health volunteering were recently been taken on by the Volunteer Services team.

Mrs Walker stated that the framework ensures safety of patients and volunteers and that it was important it was used consistently across the UHB.

Mrs Gidman stated that there was an overlap between this work and the work taking place around inclusion and the Apprentice Academy and suggested that it would be good to align them.

Mrs Kinghorn welcomed the efforts to engage more with the community. She stated that there was a need to build stronger links between health and the community, and suggested that existing links with community groups could be built on to draw volunteers from these areas. Mrs Walker

suggested that it would be useful to add a list to the framework of the areas that we currently work in to see where gaps existed and where there could be greater alignment.

Mr Hewin stated that as an Occupational Therapist he saw the value of volunteering and agreed that there was a long-standing relationship and scrutiny with staff side. He was glad that mental health volunteering has been brought into the team. He stated that he was happy to endorse the framework though he was concerned about the phrase peer support as this was also used to recruit staff with lived in experience. Ms Fowler agreed that this role title could be changed.

Miss Ward also endorsed the work, describing it as valuable and saying that it could be transformational. She said that staff side could see the social and ethical benefits of volunteering and if anything she felt that the framework could be bolder because of the good trusting relationship between them. There were a few small points she would like to make about the framework but she suggested that these could be picked up outside of the meeting.

The Local Partnership Forum supported the Volunteers Framework subject to the agreed change around peer support. The Framework would now be taken to the Quality Safety and Experience Committee for final sign off.

LPF 20/007 Local Partnership Forum Work Plan

Mr Driscoll presented the work plan proposed for 2020/21 and asked the Forum if anything had been missed.

Mr Hewin stated that the Forum was particularly interested in the implications for staff in terms of service change etc and that he would expect this kind of thing to be discussed on a meeting by meeting basis. Mr Driscoll reminded him that the work plan was an annual document and that these types of discussions could not be scheduled in advance, however if there were proposed changes to the workforce it would be brought here for discussion as, for example, had happened when the future of Sam Davies Ward was under consideration. However, he emphasised that these conversations needed to take place at a local level first. Mr Hewin wondered whether there should be a mechanism for escalation from the Workforce Partnership Group or from Clinical Board Local Partnership Forums. Dr Pressley reminded him that this was a live document which could be changed in response to issues and that items would be scheduled as needed. Mr Driscoll agreed, but reiterated that local discussions were key - the Local Partnership Forum meets for two hours, six times a year so if there is a need for detailed escalation it may be that a separate meeting would have to be scheduled.

Ms Ward questioned whether or not the workplan reflected the issues that were discussed by staff side when they meet and whether it allowed staff side to share the issues raised with them constructively and collectively. She suggested that perhaps it was timely to have another time out or away day to manage and share the intelligence that the staff representatives received from members. Mr Driscoll referred to the workshops that happened after the last staff survey and stated that this would happen again after the next survey to enable conversations with staff about key issues. He agreed that maybe it was time for the Forum to have another time out and agreed to arrange this with Mr Jones.
Action: Mr Driscoll/Mr Jones

LPF 20/008 Strategic Equality Plan – Themes and Objectives

Mr Wilkinson was in attendance to discuss the draft Strategic Equality Plan and Objectives 2020-24. He explained that the objectives included in the paper were those for all public bodies. The consultation process for the UHB plan had now finished and local objectives would be developed using this feedback. The strategic equality plan would be published by 31 March and the final version would be shared with the Forum.

Mr Wilkinson advised that from the 1st of April 2020 a new socio-economic duty would come into force and that it was necessary to be mindful of this.

Miss Ward acknowledged that the timing of this meeting was not quite right as the final draft was not ready to be shared and suggested that they could meet outside the meeting. She said that it would be good to see more data and noted that there was some difficult reading in the material they were directed to. With regards to socio- economic and ethical direction of the organisation, she wanted to see what we could potentially and realistically achieve. She acknowledged that it was a big piece of work to draw all of this together but she felt that the workforce plan should be based on the projections of this plan.

Mr Hewin said that the values throughout the plan were fundamental to trade unionism but that there was a need to ensure that it flowed through all of the organisation.

Mr Wilkinson noted that that the themes which had emerged from the consultation resonated with some of the conversation already held at this meeting, particularly in relation to reaching out to the community.

(Mr Wilkinson left the meeting)

LPF 20/009 Patient Safety Quality and Experience Report

Mrs Walker presented highlights of the Patient Safety, Quality and Experience Report to the Forum:

- With regards to ophthalmology she advised that a detailed paper was going to the Quality Safety and Experience committee and that the UHB was in communication with the families affected. She advised that a considerable number of lessons have been learnt.
- There was good news around falls and fractures.
- The assessment unit remains an area for concern though there have been improvement, especially for surgical patients

Mrs Williams noted that adolescent mental health patients were regularly included in the report and asked if the UHB was acting on this. Mrs Walker explained that although it was part of the pathway for under 18s to sometimes be treated in adult wards it had to be reported as a serious incident even though measures such as having additional staff on duty were in place.

(Mrs Walker left the meeting)

Mrs Kinghorn provided an update on coronavirus. She reminded the forum that IP&C practices are essential for any infectious disease and that handwashing is key. As of 10 February there had been 43,000 cases internationally 99% of which were in China, and there were eight confirmed cases in the UK (none of which were in Wales). Public Health Wales was working closely with Public Health England and modelling was being used to develop plans if it was necessary to scale up the response.

Mrs Bevan asked for guidance from an Occupational Health and staff perspective. It was agreed that this would be picked up outside the meeting with the Public Health team.

Ms Brandon advised that the communication team were working closely with Public Health Wales and that separate guidance would be issued for staff and the public.

LPF 20/010 Chief Executive Update

Mr Driscoll advised that we have now had sight of the month 10 financial report. Steps have been taken over the last couple of months and they were cautiously optimistic that the UHB would meet its plan by the end of the year. This was important to maintain the good relationship which had been built with Welsh Government. He thanked the Clinical Boards and staff for responding to the request to reduce spending and asked for this to continue.

Conversations were starting to take place with Welsh Government around the finance necessary for a core team to develop the Clinical Services Plan. He said there was a lot of work which needed to take place before we could really start to develop workforce plans etc.

LPF 20/011 Performance Update

The Local Partnership Form received a presentation from Ms Bird on performance in the context of winter and unscheduled care. She advised that this was really a stock take position as we are still in the middle of winter. It was important to note that the starting point going into winter this year had been difficult as the situation had not really improved during summer and this impacts on the resilience of staff.

She noted that every year winter is different. A number of unscheduled care initiatives such as 'keep me home', 'right place, right time', 'every day counts' and 'get me home' had been used this year. However it was a challenge every year in terms of the workforce, with recruitment needed to enable the additional schemes.

The data showed that activity had increased and performance had gone down, however, Ms Bird emphasised that we were doing comparatively well compared with the rest of the UK.

Ms Bird noted that each year at the end of the winter period there is a debrief and she asked staff representatives to be involved this year. A further update would be provided to Local Partnership Forum again in October and would include the debrief lessons and plans for next year. She emphasised that there was a real need to make sure that staff are supported formally and informally, and thanked staff for all the work that they are doing, but noted that the real aim was for resilience within the system through new ways of working etc.

LPF 20/012 Tackling Stress in the Workplace

Mrs Bevan was in attendance to present a paper on tackling stress in the workplace. She noted that it involved was a tiered approach, looking not just at individuals and building their resilience but rather:

- Primary/preventative – prevention within the UHB
- Secondary/proactive – building individuals ability to cope
- Tertiary/reactive – recovery support for individuals

Examples of the various tiers were noted.

Miss Ward said that she was disappointed to only see that only 3 Clinical Boards were included in the report. She suggested that the message at the top might be right, but it was not getting through all levels of the organisation. She also suggested that more data would be useful (including how many people were accessing services) and she would like to see more of the preventative agenda included. She stated that the organisation is trying to be transformational and demand was not matched by the resilience of individuals and departments. Mrs Bevan agreed that more data would be useful and advised that they were working on this. She also advised that what was not included was the work going on around nurse retention, and the strategic and leadership work taking place.

Mr Driscoll noted that there was excellent work taking place, but agreed that it was now necessary to add the physical metrics to the narrative in future reports.

(Mrs Williams and Mrs Bevan left the meeting)

LPF 20/013 Workforce and OD Key Performance Indicators

Mr Driscoll advised that sickness was climbing and that we need to ensure we are doing all we can in this area. He indicated that we now have clarity on the unsocial hour's payments, which will not be paid for the first six weeks of sickness but then will be paid after that. Mr Crook would contact NHS employers to follow up communications around this.
Action: Mr Crook

In terms of recruitment, there had been event the previous week which was well supported with over 120 expressions of interest. The UHB had also recruited nine Consultants in the last couple of weeks.

A #CAVYourSay newsletter had been developed to share the work that taken place since the last Staff Survey. The 'A Day in the Life...' initiative was being implemented to enable departments to invite an Executive to spend time with them. 16 departments had responded to the call for invitations and the visits would take place over the next three months or so.

There have been lots of difficulties in getting the right location for the showcase but we now have a likely building which is near to Woodland house and it will be launched in the late spring.

LPF 20/014 Finance Report

The Local Partnership Forum received the report for the period ending 31 December 2019.

Mr Lewis reminded the forum that we had pledged to reach a balanced position by the end of the year. Month nine had been particularly good, though part of that had been seasonal, and this trend had continued through January. However, Mr Lewis emphasised the need to maintain financial discipline over the next couple of months, because while the financial position was improving and the risks were lowering, the margins remained narrow.

LPF 20/015 Items to be brought to the attention of the Board.

There were no items to be specifically brought to the attention of the Board.

LPF 20/016 Any Other Business

There was no other business for consideration by the Forum.

LPF 20/017 Future Meeting Arrangements

The next meeting would take place on Thursday 16th April 2020 at 10 am in room Nant Fawr 1, Woodland House (with a staff representative pre-meeting at 9 am)

Minutes of an extraordinary Local Partnership Forum meeting held on 21 May 2020 at 10am, remotely and in Cwm George, Woodland House

Present	
Martin Driscoll	Exec Director of Workforce and OD (co-Chair)
Mike Jones	Chair of Staff Representatives/UNISON (co-Chair)
Lorna McCourt	UNISON
Julie Cassley	Deputy Director of WOD
Jo Brandon	Director of Communication and Engagement
Stave Gaucci	UNISON
Nicola Foreman	Director of Corporate Governance
Peter Hewin	BAOT/UNISON
Dawn Ward	Independent Member – Trade Union
Andrew Crook	Head of Workforce Governance
Julia Davies	UNISON
Abigail Harris	Exec Director of Strategy and Planning
Ruth Walker	Exec Director of Nursing
Fiona Salter	RCN
Ceri Dolan	RCN
Zoe Morgan	CSP
Chris Lewis	Deputy Director of Finance
Mat Thomas	UNISON
Peter Welsh	General Manager UHL and Barry
Apologies	
Stuart Walker	Medical Director
Fiona Jenkins	Exec Director of Therapies and Health Sciences
Len Richards	CEO
Lianne Morse	Head of HR Operations
Stuart Egan	UNISON
Bob Chadwick	Exec Director of Finance
Pauline Williams	RCN
Rachel Gidman	Assistant Director of OD
Joe Monks	UNISON
Rhian Wright	RCN
Secretariat	
Rachel Pressley	Workforce Governance Manager

LPF 20/018 WELCOME AND INTRODUCTIONS

Mr Driscoll welcomed everyone to this extraordinary meeting of the Local Partnership Forum which had been convened to discuss issues relating to COVID-19. He thanked the Forum for being supportive by allowing the organisation to move so fast in workforce matters over the last few weeks. He stated that the workforce's response to COVID had been phenomenal and that the leadership shown by LPF along with the capacity, capability and desire of our staff had made everything that had happened over the last few weeks possible.

LPF 20/019 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

LPF 20/020 DECLARATIONS OF INTEREST

There were no declarations of interest in respect of agenda items.

LPF 20/021 Review of the last few weeks

Mr Driscoll summarised the work that had taken place over the last few weeks in response to COVID-19. In particular he referred to the building of the Dragon's Heart Hospital (DHH) in just 5 weeks. He noted that DHH had not been needed on the scale that had been expected, which was good news, and there were currently 23 patients. The next lockdown announcement would be in two weeks time and the levels of infection were relatively low, but there was no vaccine. The future of DHH would need to be reviewed in this context.

Mr Jones emphasised that full engagement with the Trade Unions was needed and that partnership working needed to get back on track. Mrs Harris agreed. She reminded the Forum that the Executive team had overlaid the CB structure with new operating arrangements and she felt that some things had fallen between the two. Mr Hewin noted that the Joint Partnership Forum had published some partnership principles the previous week and suggested that this might be a good starting point. He would forward these to Dr Pressley so that they could be shared with the Forum
Action Mr Hewin

Mrs Harris advised that Welsh Government had issued a planning framework for transitioning back to business as usual. A quarter 1 plan had been produced and submitted to WG and would be shared with the Forum.
Action: Dr Pressley
The plan included:

- Maintaining activity for essential treatment (e.g. cardiac, cancer)
- Working with Primary Care to develop an alternative model to deal with the non-emergencies which have traditionally presented at EU
- A complex operational plan including 'green' zones which were as covid free as possible

Other transformational opportunities had also been achieved in very short time including digital GP appointments. Mrs Harris explained that there would be some changes which we would not want to keep, but others would need to be embedded and aligned with SOFW.

With regards to partnership working, Mr Driscoll stated that mature relationships had meant that we had been able to do what needed to be done to care for our patients. Mr Jones said that there have been some good practices but there were concerns in some areas, hence the interest in becoming more involved.

Miss Salter congratulated the organisation on what had been achieved, but said that as a senior staff representative it did not feel like partnership working had taken place. She believed that a huge opportunity had been missed and the staff representatives had not has the information they needed

to support members. She emphasised the need for staff representatives to be involved from the outset for future peaks.

Mr Driscoll advised that on reflection he felt that a weekly online-call would have been helpful. The decision to not have one was not intentional and we could learn from this for next time. He appreciated the feedback and knew that it was well meant.

LPF 20/022 SHIELDING OUR WORKFORCE

Mr Driscoll advised that approximately 650 people are currently not attending work because they are 'shielding'. Some of these have received a CMO letter and others are shielding on the advice of their GP/Consultant or with local agreement with their line manager. A group is being established under the leadership of Julie Cassley to determine who these people are, why they are shielding and what we can do to support them. He asked for staff representative volunteers to join this group.
Action: Mr Jones

Mr Jones indicated that to support this piece of work and other matters it was important that they met more regularly as a staff side. Dr Pressley was asked to support him with co-ordinating this. Mr Driscoll stated that he was happy to join them whenever they felt this would be beneficial.
Action: Dr Pressley

It was noted that the group would seek to balance health and wellbeing with ensuring there was a productive role for the individuals, but it was also about engaging with them and ensuring they did not feel excluded.

Mr Hewin stated that the Trade Unions would be able to help more if they had a clearer understanding of the structures we are working in now and whether their roles as Clinical Board lead reps remained the right ones. Mr Driscoll advised against altering the staff representative structure. Although the Hubs had overlain the formal structure during COVID, the Clinical Board structure remains in place and continues to be the pathway for consultation and discussion.

Miss Ward noted that there were opportunities for new and improved ways of working and she welcomed the regular staff side meetings. With regards to staff who are shielding, she suggested that it was necessary to determine the level of tolerance for health and safety and risk. She believed that a shared view or position would help when dealing with staff.

LPF 20/023 REMOTE WORKING AND SOCIAL DISTANCING

Mr Driscoll presented the paper developed by Nicola Robinson, Head of Workforce and OD, on achieving greater homeworking. He explained that this paper set out the initial considerations and that a task and finish group would be established to determine how to do this. He noted that homeworking had gone from an occasional and informal arrangement to being undertaken by a significant proportion of our workforce very quickly. This was seen as a real win-win opportunity, but there are technical and IT issues to be resolved. He asked for staff representative volunteers to join this group.
Action: Mr Jones

Mr Hewin stated that the ability to facilitate social distancing is key, and this work is fundamental to achieving staff safety and the ability to work. However, hot desking is not social distancing. He reminded the Forum that an All-Wales risk assessment was due to be published the following week.

Mrs Cassley reminded the group that Microsoft 365 would be rolled out across the UHB and this would be a huge enabler. Mr Jones pointed out that quite a few staff representatives, including senior reps, were not IT enabled. Mr Driscoll asked Dr Pressley to support Mr Jones in sorting this out.
Action: Dr Pressley

Mr Hewin also noted that homeworking is only a part of social distancing and that consideration needed to be given to staff in work as well. Mr Driscoll agreed and noted that the real challenge was getting people to change their behaviours. Ms Brandon reminded the Forum that there had been a huge communications programme around this and hand washing etc. She said that there was going to be a move towards enabling colleagues to challenge each other constructively, but noted that close working proximity in ward areas and clinics meant that some people were not making the transition to social distancing when outside the work areas. She welcomed any ideas the Forum may have on how to continue to promote this in new ways. Mr Thomas stated that the social distancing message needs to come from the top. He reported that he had seen Consultants and surgeons sitting a table together and felt that this was not leading by example. Miss Ward suggested that principles and case examples of when social distancing can and cannot be reduced (eg when wearing PPE) might be helpful.

LPF 20/24 PPE

Miss Salter advised the Forum that she was a member of the PPE Group. She believed the situation was healthy and that she was reassured about the procurement department's ability to obtain PPE.

She advised that a new mask had had to be used recently and that there was a high failure rate at the fit test. However, there was a process in place so that individuals who failed were re-tested on a different model until they passed the fit test. If they ran out of options the individual would be re-deployed but she advised that this had only happened in very small numbers. In areas where they could not be redeployed e.g. theatres, a reusable respiratory mask was used.

Miss Salter re-iterated that the work undertaken was commendable and that she felt very re-assured. She asked Forum members to let her know if they were aware of any issues around specific areas.

LPF 20/025 ITEMS FOR THE ATTENTION OF THE BOARD

The Board should be made aware that the Forum had met and that there would be a weekly staff side meeting which Mr Driscoll would attend if the staff side felt that this was beneficial.

LPF 20/026 FUTURE MEETING ARRANGEMENTS

The next meeting is scheduled to take place remotely on Thursday 18 June (time to be confirmed).

Report Title:	**Local Partnership Forum Report**								
Meeting:	UHB Board						**Meeting Date:**	July 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 18 June 2020.

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

Dr Sherard Le Maitre, Clinical Director for Urgent Primary Care, was present to discuss plans for transforming urgent care. The dividends around this model were recognized and it was noted that it is strategically aligned to A Healthier Wales and SOFW, but there were questions around how to get the message out and how to staff it. There were also concerns about the potential pressures this would place on other parts of the service.

A task and finish group had been established to look at staff who are shielding following the last meeting. The group had explored how many staff were shielding and whether this was due to a CMO (or GP/specialist) letter, a family member or with agreement with their line manager. The main principles of the group were ensuring meaningful work was available and the wellbeing of the member of staff. Guidance was being developed for managers to help them support their staff.

A second task and finish group had been established to consider remote working. This was considered one of the dividends of COVID, though it was acknowledged that it was not suitable for all jobs. A draft statement had been drawn up and issued to the Forum for their views. It was noted that this work had links with the Sustainability Action Plan which is the UHBs response to the climate emergency.

The Executive Director of Strategy and Planning shared the UHBs recovery plan with the Forum. She advised that the organisation was taking a planned approach to coming out of COVID - we had come through the immediate emergency response and were now in the 'living with COVID' phase. The UHB would want to keep some of the changes introduced because of COVID, but if altering them from temporary to permanent arrangements it was necessary to consult with staff and stakeholders and capture their feedback.

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

CONFIRMED MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON WEDNESDAY 29 JANUARY 2020, NANT FAWR 1, WOODLAND HOUSE

Present:	
Richard Thomas	Care and Repair Cardiff and the Vale (Chair)
Sam Austin	Llamau
Sarah Capstick	Cardiff Third Sector Council
Liz Fussell	UHB Volunteer
Iona Gordon	Cardiff Council
Tricia Griffiths	Carer
Zoe King	Diverse Cymru
Dean Loader	South Wales Fire and Rescue
Paula Martyn	Independent Care Sector
Linda Pritchard	Glamorgan Voluntary Services
Geoffrey Simpson	One Voice Wales
In Attendance:	
Federica Faggian	Consultant Microbiologist, Public Health Wales (items 20/01-20/06)
Aaron Fowler	Head of Corporate Governance, UHB
Abigail Harris	Executive Director of Strategic Planning, UHB
Ann Jones	Patient Safety & Quality Assurance Manager, UHB (item 20/09)
Vicky LeGrys	Programme Director, Major Trauma Centre, UHB (item 20/08)
Anne Wei	Strategic Partnership and Planning Manager, UHB
Harriet Whitaker	Antimicrobial Pharmacist (items 20/01-20/06)
Keithley Wilkinson	Equality Manager, UHB
Apologies:	
Duncan Azzopardi	Cardiff University
Mark Cadman	WAST
Shayne Hembrow	Wales and West Housing Association
Steve Murray	South Wales Police
Rachel Nugent-Finn	Vale of Glamorgan Council
Secretariat:	Gareth Lloyd, UHB

SRG 20/01 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and Tricia Griffiths was introduced as the new member providing a carers' perspective.

SRG 20/02 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not members of the SRG, apologies had been received from Nikki Foreman, Angela Hughes and Wendy Orrey.

SRG 20/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 20/04 MINUTES AND MATTERS ARISING FROM STAKEHOLDER REFERENCE GROUP MEETING HELD ON 27 NOVEMBER 2019

The SRG **RECEIVED** and **APPROVED** the minutes of the SRG meeting held on 27 November 2019 subject to amending the spelling of Sarah Capstick's name in the list of those present.

Draft Sustainable Travel Plan
Anne Wei provided an update from Colin McMillan. The Sustainable Transport and Travel Group had met earlier that month and received a presentation on the initial draft Travel Plan. Although well received, the Group had expressed concerns that the staff survey response had been low and that no patient/visitor survey had been undertaken. The transport consultants had therefore been asked to undertake further survey work. The comments made by the SRG had been noted by the Group as well as its offer to assist with any further engagement exercise.

Draft Cardiff and Vale of Glamorgan Move More, Eat Well Plan 2020-2023
Anne Wei reported that the Plan was being finalised and would be launched in March 2020 following sign off by the Public Services Boards. Welsh Government had allocated £7m for prevention to Health Boards via the Regional Partnership Boards with £881k being provided to Cardiff and Vale. Plans for how this would be spent were aligned to delivery of the Move More, Eat Well partnership plan.

SRG 20/05 FEEDBACK FROM BOARD

The SRG **RECEIVED** and **NOTED** the agenda and draft minutes of the Board meeting held on 28 November 2019.

SRG 20/06 ANTI-MICROBIAL STEWARDSHIP

The SRG **RECEIVED** a presentation from Federica Faggian on initiatives to change prescribing practice to prevent the development of resistance to antibiotics.

The SRG was informed that antibiotics are drugs used to treat bacteria. Certain bacteria are inherently resistant to particular antibiotics. Some bacteria undergo genetic modifications which may be random or occur through the acquisition of genetic material from other bacteria. These processes can lead to antimicrobial resistance. Antimicrobial resistance is increasing at a faster rate than antibiotic development and in the relatively near future it may not be possible to treat even simple infections with antibiotics. The consequence is that the risks of infection associated with surgery may render elective surgery such as organ transplants prohibitively dangerous and emergency surgery such as Caesarean sections could become life threatening. It is estimated that there may be 10 million deaths per year attributable to antimicrobial resistance by 2050 which would be more than from cancer.

The National Institute for Health and Care Excellence describes antimicrobial stewardship as 'an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness.' The UHB has an Antimicrobial Management Group that has managed to influence antibiotic use through the years but is struggling to maintain an appropriate level of activity because of resource constraints. The SRG was informed of the different strategies that have been used including the removal of some antibiotics from guidelines, the creation of an antimicrobial App to store antimicrobial guidelines for primary and secondary care, collection of data through audits and usage surveys and public engagement events. Clinical pathways are also being developed to ensure there is consistency in the way illnesses and conditions are treated.

The SRG was then asked for its views on ways to engage with the public and other stakeholders to support this work. The SRG made a number of observations.

- Patients often present to their GPs and expect to leave with a prescription. Federica Faggian explained that delayed prescriptions are one possible tool. Patients could be issued with a prescription but be told how their symptoms were likely to progress and advised to only obtain their medication if their conditions deteriorate.
- Prescribers need to be empowered with the confidence not to prescribe.
- There is a pressure to go to GPs for 'sick notes' to authenticate absences from work or school.
- The SRG could help with getting messages out to the public via third sector and other networks.

- Increasing awareness of the issues and the need for behavioural change could be promoted through training of front line staff e.g. school nurses, district nurses and staff from partner organisations
- Everyone has the responsibility for promoting the antimicrobial stewardship messages but it would be particularly helpful if social influencers were to become involved.

SRG members were encouraged to advise Federica Faggian should they think of any further suggestions after the meeting.

Action: All

SRG 20/07 DRAFT CLINICAL SERVICES PLAN

The SRG **RECEIVED** a presentation from Abigail Harris on the draft Clinical Services Plan (CSP) that was currently being tested internally within the UHB. The UHB was working with the Consultation Institute on the development of a comprehensive external engagement programme but this was an opportunity to keep the SRG updated on progress and seek its early views.

The SRG was reminded of the background to the Plan and informed of the key proposals over the next ten years. Arguably the biggest proposed change would be that all Medical admissions would go to UHW with UHL becoming the centre of excellence for planned surgery. The CSP should articulate clearly the fact that the changes are proposed on the basis of anticipated improved clinical outcomes.

The SRG was asked for its views on the draft plan and the 'Plan on a Page' and made the following observations.

- The UHB should pre-empt criticism and the potential reasons people may give for opposing the proposals and consider how it would respond.
- Access and parking to UHL is likely to be a big issue. Abigail Harris explained that it had been acknowledged that the current Park and Ride service to UHL would have to be improved. There might also be an opportunity to look at increasing voluntary transport provision. She suggested it may be a trade off with people having to accept travelling further but with a much reduced chance of their procedures being cancelled.
- The public transport infrastructure needs to be improved and working with both local authorities to provide a more co-ordinated plan for sustainable travel across the region was important.
- The development of the UHB's sustainable travel plan is an opportunity to get the views from stakeholders including patients and carers, on

barriers to using more sustainable travel options and to promote messages about alternative ways to access services.

- The CSP will have to be more public facing once the external engagement commences e.g. it should use storytelling and examples to illustrate simple, tangible benefits to 'Wyn'. Abigail Harris indicated that consideration was being given to describing how 'Wyn' would travel through different clinical pathways.
- The 'plan on a page' is too focussed on buildings.
- There is a lot of information to digest and it may be better to find ways to bite-size key messages.
- It may be difficult to convince people of the benefits of the provision of GP beds as in the past health providers have closed similar facilities citing patient safety. Abigail Harris explained that this would be a different type of GP bed providing urgent treatment rather than rehabilitation.
- The focus on enabling patients to remain in their own homes for as long as possible is welcomed but there will inevitably be some people who will require admission to a residential home. Is the UHB working with care homes to ensure patients receive the care they need whist they are there and that their changing needs can be met without having to move? Abigail Harris confirmed that there was a desire to work with residential homes but their registrations would have to change to enable them to be more flexible in the nature of care that they can provide.

SRG 20/08 MAJOR TRAUMA CENTRE

The SRG **RECEIVED** a presentation from Vicky LeGrys on the roll-out of the Major Trauma Network and the establishment of the Major Trauma Centre at UHW.

The SRG was informed that the South, Mid and West region of Wales was currently the last area of the UK to have a formal Major Trauma Network but that the South Wales Major Trauma Network would go live in April 2020. The SRG was reminded of the patient benefits of establishing a Network and why UHW had been chosen as the location of the Major Trauma Centre (MTC).

The UHB had recruited approximately 200 additional staff (70% of the additional staff required) only 6% of whom have come from other Health Boards. The UHB was continuing to work with the other Health Boards on developing the patient pathways a key component of which would be the repatriation of patients back to their home Health Board area once they no longer need to be treated in the MTC. Patients referred to the MTC would be admitted via the current Emergency Unit (EU). An additional resuscitation bay was being created and a replacement CT scanner being commissioned.

The SRG was asked what it thought the public and other stakeholders would be most interested in to inform the UHB's communication plan as it nears the launch of the Network.

The SRG made several observations.

- An update was requested on the provision of accommodation at UHW for relatives. Vicky LeGrys explained that there was limited physical space on the UHW site and it would not be possible to provide specific overnight accommodation for relatives. There are already facilities for relatives of patients in Critical Care and the UHB was working with patients and their families to see how to improve facilities on the new Polytrauma ward. The UHB has worked with other Major Trauma Centres to see how they address this need. A key worker has also been appointed who will be able to liaise with patients and their families to help support them with their accommodation requirements.
- It might be difficult to explain what constitutes Major Trauma to the general public and how the service will differ from what people expect to be available already. Vicky LeGrys explained that the Major Trauma Network was producing a Communications plan and list of frequently asked questions that would address issues such as the type of patient that would be sent straight to UHW and why.
- Communications should focus on the improved patient outcomes and compliance with the 98 standards for a MTC.

SRG 20/09 ANNUAL QUALITY STATEMENT

The SRG **RECEIVED** a presentation from Ann Jones on the development of the UHB's Annual Quality Statement (AQS) 2019/20. The AQS would be published on 29 May 2020 in English and Welsh alongside the Annual Report and Annual Accounts. It was likely to be the last time that a physical AQS would be published in this way as a new NHS Quality Bill was being published which would introduce different requirements.

The SRG was then asked to consider these specific questions.

- Are there any specific items you feel should be included in this year's AQS?
- Was there the correct balance of words, photographs and infographs in last year's AQS?
- Was there a good balance of what went well and what did not go so well.
- Is it written in an open way?
- Does the SRG have any other comments?

The SRG asked several questions and made a number of observations.

- The AQS was visually impressive
- The AQS was too focussed on Cardiff with insufficient information on initiatives in the Vale of Glamorgan. It was agreed examples relevant to the Vale should be sent to Ann Jones

Action: Linda Pritchard

- How is evidence obtained? The SRG was informed that validated data is obtained from Clinical Boards and Corporate teams. Information is also obtained through direct conversations with staff and patients.
- Are third sector commissioned services included? The SRG was informed that this year's document would have a special focus on community mental health services and that third sector services were very much part of this
- 'Show Me Where' resource might be useful for volunteers, perhaps in an adapted format. Ann Jones agreed to discuss with Angela Hughes.

]

Action: Ann Jones

SRG members agreed to email Ann Jones any further comments.

Action: All

SRG 20/10 UPDATING SRG TERMS OF REFERNCE

Anne Wei informed the SRG that Health Boards had been issued with revised Model Standing Orders by Welsh Government. The new Standing Orders confirm that SRG members must not serve more than five years consecutively. This means that Liz Fussell and Richard Thomas would both be attending their final SRG meeting in March. The process of recruiting new members and a selecting a new Chair would begin immediately. It was agreed that an interim Chair would be appointed on the basis that new members might wish to be considered for the role of Chair.

Two other changes are that SRG agendas will henceforth also be published in Welsh and SRG members will have to confirm their eligibility to continue as members in writing on an annual basis. A simple form has been produced for this purpose.

SRG 20/11 NEXT MEETING OF SRG

9.30am-12pm, 24 March 2020, Nant Fawr 1, Woodland House.

Report Title:	**Update on COVID-19 care home engagement and support in Cardiff and Vale of Glamorgan**								
Meeting:	Cardiff & Vale UHB Board					**Meeting Date:**	30/07/2020		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	Executive Director of Public Health								
Report Author (Title):	Consultant in Public Health Medicine								

Background and current situation:

Enclosed settings such as care homes, residential schools and prisons pose particular risks for the causes and transmission of infection. This is due to the nature of the physical environments and the vulnerability of those living within them. As a Health Board, with the statutory responsibility for the health of the population, we take our responsibilities to people living in closed settings very seriously.

The most effective way to prevent illness and death in the current pandemic within closed settings is to prevent the virus that causes COVID-19 entering. The evidence suggests that there are six areas for action:

- Hand hygiene
- Environmental decontamination
- Staff rotation
- Visitors restricted to only emergency/critical cases
- Testing
- Resident and Staff Wellbeing

In Cardiff and the Vale of Glamorgan, a strong multi-agency approach is being employed to support each of these evidence-based practices. The agencies involved have included Cardiff and Vale University Health Board (C&VUHB); Local Authorities (Commissioning, Safeguarding, Education) and Shared Regulatory Services; Health and Safety; HMP Cardiff; Public Health Wales (PHW) closed setting cell/regional health protection and local public health teams; Care Inspectorate Wales; cluster GPs and service providers.

Care homes[1] provide for particularly vulnerable groups, because of the resident's age, co-morbidities, and the fact that they are dependent on care. This purpose of this paper is to highlight the proactive work done to meet the challenge of protecting the circa 3,000 people living in care homes in Cardiff and Vale, engaging with service providers and supporting them through this first months of the COVID-19 pandemic.

Throughout this period, Welsh Government issued guidance with respect to care homes testing and management, and a listing of these can be found in the Appendix.

[1] 'Care homes' here follows the Care Inspectorate Wales definition i.e, pertaining to adults or children, for nursing/personal care and for physical, mental health and learning disability needs.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:
Despite community prevalence, half of CIW registered care homes in Cardiff and Vale area have not reported COVID-19 cases to date. This figure demonstrates the immense amount of hard work by partner agencies together with the staff and families of residents in the settings themselves. The particular achievements of C&VUHB noted can be grouped as:

1. Multi-agency working
2. Flexible testing
3. Hospital to Care Home Discharge Risk Assessment

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

1. **Multi-agency working**

Each local authority took oversight of the COVID-19 pandemic care home work, including proactive prevention advice, support during outbreak/incidents and management of safeguarding/governance issues. Membership of the oversight groups includes Local Authority (Commissioning, Safeguarding) and Shared Regulatory Services; C&VUHB; Public Health Wales closed setting cell/regional health protection and local public health teams; Care Inspectorate Wales; Health and Safety. Available support grew across the time period, as detailed below.

Phase One: Support to the first care homes with COVID-19 cases (late February –mid March 2020)
Testing of symptomatic individuals in Cardiff and Vale was available from 17 February 2020 and Cardiff and Vale of Glamorgan started to see COVID-19 cases confirmed in care home settings by mid-March 2020. Support from the nurse assessor team was present from the start, e.g. identifying Aerosol Generating Procedure care needs in the community/care homes and ensuring provision of Personal Protective Equipment for these, assessing staffing levels and staff well-being, and giving Infection, Prevention and Control (IPC) advice.

Our UHB Director of Public Health liaised with our two Directors of Social Services and our regional CCDC over advice for care homes and domiciliary care. The core of this advice was that care homes and domiciliary care needed to follow the flu plan advice, as applied each winter. This advice, delivered by PHW in conjunction with Shared Regulatory Services Environmental Health Officers, covered IPC, environmental decontamination, staff rotation, visitors restricted to only emergency/critical cases, testing to establish the first confirmed cases in a single setting. The prioritised testing of symptomatic keyworkers, which expanded to include social care staff/care home staff, commenced in early March 2020.

Phase Two: Engagement with wider care homes and managing the peak (mid- March - end of May 2020)

PHW established the enclosed setting cell in mid-March 2020 as infection rate in residents and staff began to rise.

Locally, as an enhancement to existing arrangements to supplement the support given to homes and settings by PHW ‘closed settings’ cell, a protocol of daily, then, as the

situation became more stable, twice weekly, telephone calls to homes and settings were carried out in both local authorities. Guidance and protocols for staff in local and national closed settings were developed. In addition, Nurse Assessors from the UHB Locality Teams worked together with these teams for targeted extra support to homes, when needed.

The overall support offered from the combined Local Authority, Shared Regulatory Services and Health Board resource in this period included:

- Daily calls to check on Provision of Personal Protective Equipment (PPE) supplies and cases
- Training on specific enhanced PPE, including FIT testing of care home staff
- Bi-weekly calls for Infection, Prevention and Control (IPC) advice
- Written information
- Visits by nurse assessors, to monitor and discuss staffing challenges and identify staff for testing for COVID 19, where appropriate
- Offers of on-site training advice
- Participation in Supporting Closed Settings with the Management of an Outbreak of COVID-19 teleconference calls
- Testing for care home residents and staff as per Welsh Government Policy at the time, and supported by the Ministry of Defence (MOD) team since 15 May 2020
- Briefings on key messages and changes around aspects such as end of life care, advanced care planning and medicines management during the pandemic
- Webinars delivered by microbiology aimed at care home managers, where IPC issues were discussed and useful resources are flagged
- GPs and wider primary care workforce supporting individual homes
- Promotion of on-line death verification training for appropriate care home staff

It is important that there was a co-ordinated response when a closed setting experienced cases of COVID-19 given the number of agencies that appropriately interface with care homes. Multi-agency Support meetings with individual providers, including C&VUHB representation, covered the following issues:

- PPE
- Workforce position
- Access to testing
- Medication
- Support from district nursing and GPs
- Access to testing for staff and residents
- How we can best work together to support the safeguarding and protection of residents and well-being of staff

The initial meeting agreed a management plan and points of contact for the home during the

period of the outbreak.

Phase Three: Incorporation of Test, Trace and Protect (June 2020 onwards) and enhanced Regional Health Protection Support

Since the advent of Test, Trace and Protect implementation, and the closing down of the PHW 'enclosed cell', we have moved to a regional (Cardiff and Vale of Glamorgan) approach to care homes incident management. This means that whilst the initial report of a case or outbreak will go to PHW (with initial advice), the subsequent management of the care home will be passed to a regional multi-agency approach, including involvement by the Test, Trace and Protect team.

2. Flexible Testing

Over the period, five testing routes have opened to individuals outside of hospital, for RT-PCR testing. The first three routes are coordinated by C&VUHB, and tests are analysed in NHS Wales laboratories, and data are therefore available.

i. **The Community Testing Units** (CTUs): drive-through facilities based on the Whitchurch Hospital site and the Therapy Centre, Splott. These serve Health Board, Welsh Ambulance Service and Velindre NHS Trust staff who are symptomatic, and their symptomatic household contacts (Cardiff & Vale of Glamorgan resident) with 7,996 tests carried out as of 30th June 2020. In some circumstances, staff without access to a car will be visited in their own homes to be tested.

ii. **The Population Testing Unit** in Cardiff City Stadium. This service facilitates 240 tests/day and is a drive-through facility for other (non-health) key workers (including care home staff). Originally run by Public Health Wales, since 10th June 2020 this was run by the UHB. Since 10th June 2020, up to and including tests on 30th June 2020, we have tested 2176 people via this pathway - averaging 109 daily.

iii. **Our CTU teams** also visit Cardiff and Vale care homes to test. Up to 30th June 2020, 7,326 tests had been carried out by our CTU in such closed settings, resulting in positive results for 183 staff or residents.

iv. **Care home portal**: since Monday 15th June 2020, all asymptomatic care home staff have been offered a weekly test for a four week period. These involve the use of self-administered swabs. All symptomatic care home staff are still being offered tests via the UHB testing service.

v. Via the **nhs.uk/ask-for-a-coronavirus-test portal** for symptomatic individuals (staff or members of the public).

Overall within the first three services above, 15,132 tests have been carried out in Cardiff residents (15% positive) and 6,198 tests have been carried out in Vale of Glamorgan residents (12% positive), in the period up to 30 June 2020[2].

'Whole Home' Testing

Our ongoing 'whole home' testing programme, including symptomatic and asymptomatic staff

[2] Public Health Wales: Confirmed case data (NHS Wales laboratories only) daily surveillance dashboard

and residents of care homes with new and ongoing outbreaks of possible or confirmed COVID-19 remains a priority.

As of 30th June, of the 151 care homes in Cardiff and the Vale of Glamorgan registered with Care Inspectorate Wales, 82.8% or 125 'whole' homes have been tested - noting all large homes (21) have been completed. Of the remaining 26 homes, 1 has a test arranged, 7 have declined to be tested (but we are having ongoing conversations about individual consent and power of attorney), 12 have agreed but are yet to submit data (8 adult and 4 children's settings) and six are currently closed.

The UHB remains prepared and ready to provide 'whole care home' testing at all outstanding establishments when the data required is made available. The approach to whole home testing is agreed at a national level, with the most recent letter outlining the future policy direction issued by the CMO on 5th June 2020.

Timeliness of results
Comparing timeliness of test results returns for CTUs across Health Boards, Cardiff and Vale UHB has the highest percentage of tests returned within one day (71%, Wales average 41%) and two days (92%, Wales average 76%)[3].

3. Hospital to Care Home Discharge Risk Assessment

In partnership, the UHB and both local authorities have agreed to a discharge risk assessment protocol, to ensure consistent steps taken across Cardiff and the Vale of Glamorgan. Practical delivery of policy aims of the acute and community sectors, has been a very complex task. This joint tool was agreed at the Strategic Leadership Group on 1st July 2020, and is being seen as a model of good practice by other regions.

Overall Risk Implications
The extra resource given to achieving good multi-agency working and flexible testing has incurred extra costs and been made possible by the use of UHB staff redeployment. A balance will need to be achieved in order to continue to support this way of working and at the same time manage the recovery of the other UHB services.

<u>In summary: particular examples of good practice in C&VUHB area:</u>

Testing:
- Agreed protocol regarding **capacity/consent** for individuals – meaning that some residents were not swabbed, despite perception of pressure from the care home sector around the April peak
- Agreed protocol not to test at the '**end of life'**, in conjunction with care provider and family
- **On-site training** of care home staff to swab residents/buddying system for mutual support
- **Flexibility** – significant numbers of care workers do not have access to a car to access the drive-in facility, and the Cardiff City Stadium PTU could not accommodate individuals under 16 years of age (staff household members). The C&V UHB responded, often

[3] Public Health Wales 28.6.20, from Welsh Government internal briefing

resulting in staff returning to work sooner
- Giving of **positive results** – these were actually talked through with staff, not just via a text – to ensure maximum use of the teachable moment

Wider support

- **Bespoke IPC support**, often in settings where relationships already existed, this wrapped around the swabbing provision and extended into the 28 waiting period to ending of the home incident
- Palliative care supplementary training, anticipating potential shortages of syringe drivers
- Prescribing team support with Standard Operating Procedure for re-purposing of medications, anticipating potential shortages of end-of-life medication
- Strong links meant **good communications** with Local Authority, further building rapport within a challenging policy environment
- Awareness of, and prompt action around, any **safeguarding issues (non-COVID-19)**
- Promotion of revised Direct Enhanced Service for care homes within GP clusters

Recommendation:

The Board is asked to:

- NOTE the progress made to date, and examples of good practice engaging and supporting the care home sector
- ACKNOWLEDGE the positive response of teams at all levels within the relevant organisations, strengthening relationships ahead of potential further waves
- SUPPORT continued efforts to progress required action in this arena, particularly in personal care/residential care homes without in-house nursing expertise

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	

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

Equality and Health Impact Assessment Completed:	Not Applicable

Tolley Laura
07/27/2020 11:09:35

APPENDIX: TIMELINES FOR CARE HOME GUIDANCE FROM WELSH GOVERNMENT

Date	Policy/Guidance Issued
9 April 2020	Welsh Government letter to Care Homes setting out the support available and including the need to notify PHW and including Version 1 of the Public Health Wales guidance
22 April 2020	Welsh Government letter. Updated discharge policy guidance on the testing of patients prior to discharge from hospital or transfer from a care home or new admissions to Care Homes from the community. Patients to have a negative test result prior to returning to a Care Home.
24 April 2020	Welsh Government letter. Diagnostic testing now to be offered by Health Boards to all possible (symptomatic) cases of Covid-19 in care homes.
7 May 2020	Welsh Government letter and published guidance document instructing Health Boards that where a confirmed case of COVID 19 is identified in a previously unaffected care home, all residents and staff will be tested by mobile testing units For care home outbreaks or incidents that have begun prior to May testing will be offered to new symptomatic residents and staff The offer of testing will also be available for the largest care homes (those with more than 50 beds) that are at greater risk of experiencing an outbreak because of their size. Clarity that Health Boards are responsible for swabbing and providing results to care homes and PHW
13 May 2020	Letter instructing Health Board to offer testing for COVID-19 to all asymptomatic and symptomatic residents and staff in care homes (who have not previously tested positive) that have an on-going outbreak, which commenced before 2 May 2020.
20 May 2020	Letter and guidance from Welsh Government to Health Boards, Local Authorities and Care Homes outlining opportunity to undertake rapid testing for care homes registered for 50 or more beds over the next two weeks. The testing of staff and residents in smaller care homes who do not have a Covid-19 infection will be delivered by one of two routes, either directly by the health board or by the new social care portal for self-testing kits mentioned above which goes live shortly Issue of Welsh Government *Interim Care Home Testing Guidance* to aid health boards, care home providers for adults and children local authorities and others interpret and implement the extended testing policy for care homes in Wales.
15 June 2020	Social care portal for staff – weekly for 4 weeks. Announced 27 May 2020, started 15 June 2020, Cardiff & Vale first access Friday 19 June 2020 onwards.
15 July 2020	COVID-19 Testing Strategy announced – including continuation of weekly care home staff testing and targeting homes with a new case, plus surveillance sample for antibody testing. UHB preparing programme to surveillance sample for antibody testing.

Report Title:	**Audit and Assurance Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**28.05.2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair, Audit & Assurance Committee**								
Report Author (Title):	**Head of Corporate Governance**								

SITUATION

To provide the Board with a summary of key issues discussed at the Audit and Assurance Committee held on 28 May 2020.

Internal Audit Progress and Tracking Report

The Committee were advised that eight audits had been completed since the last meeting, all receiving positive assurance reports.

The Committee agreed to receive two audits in draft format due to COVID-19.

The Head of Internal Audit advised that Internal Audit were able to produce 39 completed reports which gave enough coverage across the domains to provide an annual audit opinion of Reasonable assurance.

The Committee were advised that the 2020-21 plan would include an audit looking at the general governance arrangements and financial governance around COVID-19. The intention was also to reduce the number and increase the scope of audits to provide more detail.

Report of the Losses and Special Payments Panel

The Committee received the Losses and Special Payments Panel report and approved the write offs outlined. The Committee were advised that the losses detailed were included in the financial accounts for final sign off.

Internal Audit Reports

The Committee were pleased to receive the following Internal Audit reports:

- UHW Neonatal Development Project — Substantial assurance
- Service Improvement Programme Team — Substantial assurance
- Rookwood Re-location Project — Reasonable assurance
- Surgery Clinical Board – Enhanced Supervision — Reasonable assurance
- Infection Prevention & Control — Reasonable assurance
- Management of Health Board Policies — Reasonable assurance

- Pre-Employment Checks (Draft) Reasonable assurance
- Strategic Planning / IMTP (Draft) Reasonable assurance

The Committee were pleased that the Internal Audit Tracker was in place.

Good Governance During COVID-19

The Committee noted the report setting out the Governance Structure and arrangements during COVID-19 including changes to the Standing Orders.

The Committee were advised that the document would also be attached as part of the Chair's report to the Board to be ratified.

The Committee were informed that the UHB had kept to the Scheme of Delegation and SFIs during this time.

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		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Audit & Assurance Committee – Chair's Report**									
Meeting:	**Board Meeting**							**Meeting Date:**	**30.07.2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**	
Lead Executive:	**Chair, Audit & Assurance Committee**									
Report Author (Title):	**Corporate Governance Officer**									

SITUATION

To provide the Board with a summary of key issues discussed at the Audit & Assurance Committee held on 29th June 2020.

A Report on the Annual Accounts of the UHB 2019-20

The Committee were assured that the report on the Annual Accounts of the UHB 2019-20 had been reviewed and appropriately scrutinised at the meeting held on 28th May 2020.

Audit Wales ISA 260 Report

The Committee were advised by Audit Wales that the accounts were materially true, fair and prepared with the exception of stock, this was due to Audit Wales being unable to attend the stock take for 2019-20 due to COVID-19, therefore, this would not report negatively for the Health Board.

The Committee were informed of two emphasis of matter which were explained as:

- Valuation of Land – The Health Board carried out 7 valuations during 2019-20, 4 of which were conducted during COVID-19. AW confirmed it was an emphasis of matter due to the unreliability around valuations due to market uncertainty.

- Pension Regulations – This affected all Health bodies with the exception of HEIW. AW confirmed the narrative around this had been agreed with Audit Wales and Welsh Government.

The Head of Internal Audit Annual Report for 2019-20

The Committee were assured that the report had been reviewed and appropriately scrutinised at the meeting held on 28th May 2020, in addition to being presented at Management Executive and being reflected through the Annual Governance Statement.

The Committee were pleased to note the 'Reasonable Assurance' rating for the UHB.

The Counter Fraud Annual Report for 2019-20

The Committee were pleased to note all areas reported 'Green', however noted due to the impact of COVID-19, 2020-21 would be a more challenging year.

To receive and consider the following for 2019-20:

The Committee received and considered the following for 2019-20:

a. **The Letter of Representation included within the ISA 260 report**
b. **The response to the audit enquiries to those charged with governance and management**
c. **The Annual Accountability Report including the Financial Statements**

Resolved that

During this meeting, the Committee:

(a) noted the reported financial performance contained within the Annual Accounts and that the UHB has breached its statutory financial duties in respect of revenue expenditure.
(b) noted the changes made to the Draft Annual Accounts;
(c) reviewed the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation, the response to the audit enquiries to those charged with governance and management and the Annual Accountability Report which includes the Annual Accounts and financial statements;
(d) recommended to the Board that it agrees and endorses the ISA 260 Report, the Head of Internal Audit Annual Report, the Letter of Representation and the response to the audit enquiries to those charged with governance and management;
(e) recommended to the Board approval of the Annual Accountability Report for 2018-19 including the Annual Accounts and financial statements;

and the Committee agreed the following items would be taken to the Board for approval:

(a) Audit Wales ISA 260 Report;
(b) The Head of Internal Audit Annual Report for 2019-20;
(c) The Letter of Representation included within the ISA 260 report;
(d) The response to the audit enquiries to those charged with governance and management;
(e) The Annual Accountability Report including the Financial Statements;

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

Report Title:	**Audit & Assurance Committee – Chair's Report**									
Meeting:	**Board Meeting**							**Meeting Date:**	**30.07.2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**			**X**
Lead Executive:	**Chair, Audit & Assurance Committee**									
Report Author (Title):	**Corporate Governance Officer**									

SITUATION

To provide the Board with a summary of key issues discussed at the Audit & Assurance Committee held on 7th July 2020.

Internal Audit Progress and Tracking Reports

The Committee reviewed the adjustments made to the plan due to the impact of COVID-19 and were advised of two areas removed from the Audit plan:

- 1 audit removed from Public Health;
- 1 audit removed from IT, the strategy and implementation of IT systems was proposed to be moved to the 2021-22 plan due to the pressure from COVID-19 on the department.

The Committee considered the Internal Audit Progress Report and approved the proposed amendments to the Internal Audit Plan for 2020-21.

Audit Wales Update

The Committee were pleased to hear that Audit Wales were working very closely with Internal Audit and Corporate Governance discuss progress on the structured assessment, governance, internal audit and KPMG work and were encouraged to hear that Audit Wales and Internal Audit work was aligned and advice would be taken on board from KPMG when made available.

The Committee were informed that the governance review of WHSSC was reinstated and expect a draft report to be circulated once completed.

Declarations of Interests, Gifts, Hospitality & Sponsorship Tracking Report

The Committee were pleased to note that communication around declarations would be reinstated and Corporate Governance continued to see improvement and development in this area.

The Committee received assurance that donations received during COVID-19 were being monitored and the Charitable Funds Committee had received a comprehensive list of all donations to ensure appropriate governance.

Regulatory Compliance Tracking Report

The Committee were informed that where management responses had been received against recommendations, Internal Audit were conducting spot checks to ensure the correct actions were being followed. The Committee agreed that a re-assessment of recommendations would be undertaken that would include new target dates for teams to work towards.

Internal Audit Tracking Report

The Committee noted the tracking report which is now in place for tracking audit recommendations made by Internal Audit and noted progress would be seen over the coming months in the number of recommendations which are completed / closed.

Audit Wales Tracking Report

The Committee were informed that all external visits had ceased due to COVID-19, however a letter was received on 6th July 2020 from HIW which set out how they plan to conduct visits going forward. These would be tiered as:

Tier 1 – Completely offsite
Tier 2 – Combination of offsite and limited on site
Tier 3 – Onsite inspections

The Committee were advised a commencement date had not been confirmed, however it was anticipated by the September the UHB may see this activity coming back.

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

Report Title:	**FINANCE COMMITTEE KEY ISSUES REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	30th July 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Robert Chadwick, Executive 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 27th May 2020.

Assessment and Risk Implications

Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 4 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.
- Management of budget pressures.
- Delivery of the 3.5% CIP (£29m)
- COVID-19 impact on financial plan

In addition, there were three extreme risks on the Dragon's Heart Hospital (DHH) sub set risk register and these were noted as being:

- Damage and alteration to the stadium driving reinstatement costs above the current projected provision.
- COVID-19 financial plan impact - Dragons Heart Hospital(DHH)

- Costs exceeding forecast ranges due to unforeseen technical and/or market forces factors.

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

Report Title:	**FINANCE COMMITTEE KEY ISSUES REPORT**								
Meeting:	Board Meeting						**Meeting Date:**	30th July 2020	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Robert Chadwick, Executive 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 24th June 2020.

Assessment and Risk Implications

Risk Register

The 2020/21 Finance Risk register was presented to the Committee.

It was highlighted that 4 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.
- Management of budget pressures.
- Delivery of the 3.5% CIP (£29m)
- COVID-19 impact on financial plan

In addition, there was one extreme risk on the Dragon's Heart Hospital (DHH) sub set risk register and this was noted as being:

- Damage and alteration to the stadium driving reinstatement costs above the current projected provision.

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

Report Title:	**Strategy & Delivery Committee – Chairs Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**30th July 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 14th July 2020.

Report outlining deferred agenda items due to COVID-19 pandemic

The Committee received a helpful report outlining agenda items that had been deferred due to COVID-19.

Ensuring that service provision, quality, finance and workforce elements are aligned and integrated – Dragons Heart Hospital

The Committee received a detailed presentation from the Director of Transformation & Informatics which highlighted the exceptional scale and speed of work undertaken to develop Dragons Heart Hospital, with all involved pulling together to serve the population.

The Committee were pleased to hear that there had been shared learning across NHS England & Wales and joint up learning would be continued going forward.

Update on Home First – PCIC

The Committee were provided with an update on Home First – PCIC and were informed that future funding options were being explored to ensure the service was sustained through 2020-21.

Service Delivery Plan 2020-21 - Quarter 2 Update

The Committee received an informative Quarter 2 Update and were advised that the plan included a strong focus on track, track and protect. The Committee were encouraged to hear of some improvements to services during COVID-19, in particular R&D Preparedness and Pharmacy Set Up times and were pleased to note that Executive colleagues would be looking at how these improvements could be sustained going forward.

The Committee were advised that the UHB Health & Wellbeing group addressed the immediate

need during COVID-19 and were now looking at plans to support the workforce in the coming months, and the All Wales Group had looked at how the UHB could protect BAME colleagues during COVID-19 as much as possible and were assured that Management Executive would be discussing how the UHB could improve inclusion and diversity within the organisation.

Research & Development

The Committee were very pleased to hear the UHB were UK Level Leaders in Research during the COVID-19 Pandemic, there was an exceptional research based performance which was recognised at 10 Downing Street, and were encouraged to hear that strong relationships had been developed between Medical Directors, Clinical Board Directors, Research & Development teams and Cardiff University.

The Committee were also advised that significant progress had been made with the Joint Research Office within Cardiff University which was anticipated to open in October 2020.

Tertiary Services Update including Presentation

A detailed and informative presentation was received in relation to Tertiary Services, and the Committee were pleased to see this was aligned with Shaping our Future Wellbeing Strategy.

The Committee were pleased to hear that Executive support had been received throughout the development of Tertiary Services, acknowledged the ongoing work in this area and requested that an update on the progress in this area be brought at a future meeting.

Primary Care Out of Hours Peer Review – Action Plan

During this meeting, the Committee reviewed the Primary Care Out of Hours Peer review – Action Plan and were encouraged to note the significant progress made within the CAV247 Out of Hours Service.

Key Organisational Performance Indicators

The Committee noted the Key Performance Indicators and acknowledged that the UHB were in a very good position prior to COVID-19, therefore noted the ongoing challenges this presented. The Committee were informed that throughout COVID-19 all work was clinically led, based on clinical priorisation.

The Committee were encouraged to hear the UHB would ensure that services would be re-introduced to patients in a safe way when possible.

Board Assurance Framework Update – Workforce

The Committee were presented with the Board Assurance Framework Update on Workforce and were encouraged to note that the report would be broadened to include wellbeing and inequality going forward.

Reserve Forces - Training and Mobilisation Policy for NHS Wales

During this meeting, the Committee adopted the Reserve Forces - Training and Mobilisation Policy for NHS Wales.

Any Other Business

The Committee were informed that going forward Michael Imperato would be the Chair of theStrategy & Delivery 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:	Yes / No / Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

presentation from the Assistant Director of Finance which clearly demonstrated how quality, finance and workforce elements were aligned through the work of the Business Case Approval Group.

Report Title:	**Quality, Safety & Experience Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**30/07/2020**	
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 16th June 2020.

PCIC Clinical Board Assurance Report

The Committee were assured that the daily operations meeting discussed any quality, safety & experience issues and these were raised to the PCIC bi-monthly meeting.

The Committee were informed of four significant risks that scored highly within the report;

- COVID-19 – To address this, an additional COVID-19 Risk Register had been developed;
- LDP Growth;
- Complex packages of care; and
- Primary Care and Community estate development

An identified risk not included within the report was:

- GMS Sustainability.

This had not been included within the report as work had been completed to address the risk therefore, the pressures on the service had not been evident.

The Committee were pleased to hear of the leading work in Wales that was being undertaken, especially within Ophthalmology and it was noted that PCIC were leading the way, delivering the UHB Strategy in relation to delivering care closer to home.

COVID-19 Related Incident Reporting – Themes and Actions

The Committee were informed that a COVID-19 category had been added to the DATIX reporting system and noted that a larger piece of work would be conducted, led by Welsh Risk Pool which would investigate all incidents reported to look at potential harm caused to non COVID-19 patients during the pandemic, the Committee expect to receive a report on this at a

future meeting.

The Committee noted further significant work was required in relation to social distancing amongst staff across the UHB.

COVID-19 Patient Experience Response

The Committee were pleased to note that;

- 480 tablets had been managed and set up, with the assistance of the IT department, which helped to enable family contact and virtual visiting;
- Bereavement helpline had been launched which had received 280 calls to date;
- 'Chatterline' launched which was run by volunteers for patients and carers who are lonely;
- Repatriating of property for the bereaved, this included a condolence card, developed by C7 but amended and used across the UHB;
- Chaplaincy service, a day of prayer was held and was very successful achieving over 20,000.00 hits on social media.

COVID-19 Assurance on Reporting of Deaths

The Committee were very encouraged to note the UHB provided excellent assurance in reporting COVID-19 deaths in all areas, with a very low number of missed cases.

Annual Quality Statement

The Committee reviewed the draft Annual Quality Statement and were advised this would be presented in final draft at the next meeting in August.

End of Year Position on Quality Indicators

The Committee were pleased to note that although the UHB were in an ongoing pandemic, a number of indicators had reduced which was very positive and significant progress had been made in all areas.

The Committee were advised that Pressure Damage required further work, therefore it would be a focus for 2020-21 and that a workshop would be held to agree other areas of focus for 2020-21.

Concerns and Claims Report

The Committee were informed that there had been a 10% increase which was positive as the UHB encouraged people to raise concerns. The Committee were advised the number of concerns closed had increased by 15% and were pleased to note performance was above Welsh Government targets at 82%.

Items for Noting & Information

During this meeting, the Committee noted the following:

- Revised Guidance/Regulations Issued in Response to the COVID-19 Pandemic

Any Other Business

The Committee agreed that Dr Raj Krishnan – Assistant Medical Director for Quality & Safety be added to the Committee membership going forward.

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

Report Title:	**Stakeholder Reference Group Report**								
Meeting:	**UHB Board**						**Meeting Date:**	**30th July 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Abigail Harris**								
Report Author	**Richard Thomas, 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 29 January 2020.

REPORT

BACKGROUND

This is a report provided to the Board by the Chair of the UHB SRG.

ASSESSMENT

The SRG considered the following.

Draft Sustainable Travel Plan

The SRG was informed that the Sustainable Transport and Travel Group had received a presentation on the initial draft Travel Plan. Although well received, the Group had expressed concerns that the staff survey response had been low and that no patient/visitor survey had been undertaken. The comments made by the SRG and its offer to assist with any further engagement exercise had been noted.

Draft Cardiff and Vale of Glamorgan Move More, Eat Well Plan 2020-2023

The SRG was informed that the Plan was being finalised and would be launched in March 2020 following sign off by the Public Services Boards.

Antimicrobial Stewardship

The SRG received a presentation from Federica Faggian on initiatives to change prescribing practice to prevent the development of resistance to antibiotics. The SRG was informed about antibiotics and the processes that can lead to antimicrobial resistance which is increasing at a faster rate than antibiotic development. In the relatively near future it may not be possible to treat even simple infections with antibiotics. It was estimated that there may be 10 million deaths per year attributable to antimicrobial resistance by 2050 which would be more than from cancer. Antimicrobial stewardship is a system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. The UHB has an Antimicrobial Management Group that has managed to influence antibiotic use and the SRG was informed of the different strategies that had been used. The SRG was asked for its views on ways to engage with the public and other stakeholders to support this work. It suggested that prescribers need to be empowered with the confidence not to prescribe. Increasing awareness of the issues and the need for behavioural change could be promoted through training of front line UHB staff and staff from partner organisations. The SRG could help with getting messages out to the public via third sector and other networks. Everyone has the responsibility for promoting antimicrobial stewardship messages but it would be helpful if social influencers became involved.

Draft Clinical Services Plan

The SRG received a presentation from Abigail Harris on the draft Clinical Services Plan (CSP) that was currently being tested internally within the UHB. The UHB was working with the Consultation Institute on the development of a comprehensive external engagement programme but this was an opportunity to keep the SRG updated on progress and seek its early views. The SRG suggested that the UHB should pre-empt potential reasons that people may give for opposing the proposals and consider how it would

respond. Access to and parking at UHL is likely to be a big issue and it would be important to work with both local authorities to provide a more co-ordinated plan for sustainable travel across the region. The CSP will have to be more public facing once the external engagement commences e.g. it should use story-telling and examples to illustrate simple, tangible benefits to 'Wyn'. The 'plan on a page' is too focussed on buildings. Key messages should be 'bite-sized'. Convincing people of the benefits of the provision of GP beds might be difficult as in the past health providers have closed similar facilities citing patient safety. The UHB should work with care homes to ensure patients receive the care they need whist they are there noting that residential care home registrations would have to change to enable them to be more flexible in the nature of care that they can provide.

Major Trauma Centre (MTC)
The SRG received a presentation from Vicky LeGrys on the roll-out of the Major Trauma Network (MTN) and establishment of the MTC at UHW. The SRG was asked what it thought the public and other stakeholders would be most interested in to inform the UHB's communication plan as it nears the launch of the MTN. The SRG highlighted the need to provide accommodation at UHW for relatives. It suggested that it might be difficult to explain what constitutes Major Trauma to the general public and how the service would differ from what people expect to be available already. Communications should focus on the improved patient outcomes and compliance with the 98 standards for a MTC.

Annual Quality Statement
The SRG received a presentation from Ann Jones on the development of the UHB's Annual Quality Statement (AQS) 2019/20 and was asked for its views on the style and content. The SRG suggested that the AQS was visually impressive but too focussed on Cardiff with insufficient information on initiatives in the Vale of Glamorgan.

SRG Terms of Reference
The SRG was informed that the new Standing Orders confirm that SRG members must not serve more than five years consecutively. Liz Fussell and Richard Thomas would therefore be attending their final SRG meetings in March. The process of recruiting new members and a selecting a new Chair would begin immediately. An interim Chair would be appointed on the basis that new members may wish to be considered for the role of Chair. Two other changes are that SRG agendas will henceforth be published in English and Welsh and SRG members will have to confirm their eligibility to continue as members in writing on an annual basis.

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								