Confirmed Minutes of the Strategy & Delivery Committee
Tuesday 11 May 2021 – 9:00am – 12:00pm
Via MS Teams

Chair:		
Michael Imperato	MI	Committee Chair
Members:		
Rhian Thomas	RT	Independent Member – Estates
Sara Moseley	SM	Committee Vice Chair & Independent Member – Third Sector
In attendance:		
Paul Burns	PB	Primary Care Commissioning
Emma Cooke	EC	Head Of Physiotherapy Services
Steve Curry	SC	Chief Operating Officer
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	MD	Director of People and Culture
Abigail Harris	AH	Executive Director of Strategic Planning
Fiona Jenkins	FJ	Executive Director of Therapies and Health Science
Fiona Kinghorn	FK	Executive Director of Public Health
Karen May	KM	Head of Medicines Management - PCIC
Catherine Philips	CP	Director of Finance
Ceri Phillips	CP	UHB Vice Chair
Jason Roberts	JR	Deputy Executive Nurse Director
David Thomas	DT	Director of Digital Health Intelligence
Keithley Wilkinson	KW	Equalities Manager
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		

Min Ref	Agenda Item	Action
S&D 21/05/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	
S&D 21/05/002	**Apologies for Absence** No Apologies for absence were received.	
S&D 21/05/003	**Declarations of Interest** The Independent Member – Third Sector (IM-TS) declared an interest as being part of the General Medical Council (GMC) in Wales The Executive Director of Therapies and Health Science (EDTHS) declared an interest as a Joint Executive Director of Cwm Taf Morgannwg UHB (CTMUHB).	

S&D 21/05/004	**Minutes of the Committee Meeting held on 9 March 2021** The minutes of the meeting held on 9 March 2021 were received and confirmed as a true and accurate record of the meeting. **The Committee Resolved that:** a) The Committee **APPROVED** the minutes of the meeting held on 9 March 2021 as a true and accurate record of the meeting.	
S&D 21/05/005	**Action Log following the Meeting held on 9 March 2021** The action log was received and the Committee noted that the majority of the actions had been completed or were on the agenda for discussion during the meeting, or were due for discussion at a future meeting. The CC confirmed the action relating to the Integrated Performance Report would be presented to the Public Board meeting in May 2021.	
S&D 21/05/006	**Chair's Action taken following the meeting held on 9th March 2021** The CC advised that he met with the Director of Digital Health Intelligence (DDHI) regarding the Strategy & Delivery Dashboard and had received a demonstration of the most updated iteration.	
S&D 21/05/007	**Draft Pharmaceutical Needs Assessment (PNA) report** The Draft Pharmaceutical Needs Assessment (PNA) report was received and the Executive Director of Public Health (EDPH) introduced the Head of Medicines Management – PCIC (HMM) & Paul Burns, Primary Care Commissioning (PB-PCC) who gave an update on the PNA process. The Committee noted: • The Welsh Government had changed the way in which applications from pharmacies, dispensing appliance contractors and dispensing doctors to provide pharmaceutical services are made and determined, by introducing pharmaceutical needs assessments (PNAs), • The NHS (Pharmaceutical Services) (Wales) Regulations 2020, which introduce the PNA in Wales, came into force on the 1 October 2020 and placed a statutory duty on each Health Board to publish its first PNA by the 1 October 2021. As a result, Cardiff & Vale UHB (CVUHB) had begun the process of developing its first PNA, • From the 1 October 2021, Health Boards would need to use the published PNA when determining applications from pharmacies, dispensing appliance contractors and dispensing doctors to provide pharmaceutical services under these regulations. She added that it was a significant change in the way applications to open new pharmacies were considered having a shift from a contractor driven, dispensing focused process to a system that could respond to the wider pharmaceutical needs of a population.	

	She highlighted that the assessment would be used to determine: • Additional contractor premises were required – pharmacies and appliance contractors, • Additional dispensing by doctors was required, • Existing contractors were adequately addressing pharmaceutical needs, • Where additional services were required from existing contractors The HMM advised that the following processes were followed: • CVUHB had set up a PNA Steering Group which would oversee the drafting of the PNA which was being supported by PCC CIC who were contracted in December 2020 to author the report, • The Chair of the Steering Group was the Head of Medicines Management Primary Care (HMMPC) and the members included representatives from Primary Care, Pharmacy, Public Health, the Local Medical Committee (LMC), Communications team, Finance, Planning, the Community Health Council (CHC), and Community Pharmacy Wales also had Pharmacy project management support, • Conducted a patient/public engagement survey, • Issued Community pharmacy questionnaires to 106 pharmacies, • Data collation and consideration at cluster level, which was draft edited and approved by the steering group, • Data examined to identify evidence regarding: o Current gaps that must be immediately met , o Future needs – gaps that would arise within the 5 year timescale of the PNA. The Committee noted that the following information was considered for each cluster: • Population demographics, • General health needs of the population, • Current provision of pharmaceutical services, • Access to pharmaceutical services, • Identification of other services that affect the need for pharmaceutical services, • Health needs that can be met by pharmaceutical services, • Developments planned in the cluster & progress, • Capacity of existing pharmacies to meet demand from planned developments. The Committee noted: • the findings of the PNA, • based on the information available at the time of developing the PNA no current or future gaps were identified in the provision of essential, advanced or enhanced services • the next steps which were to undergo a 60 day consultation from 12 May – 20 July 2021 and then review the responses and update the PNA. There are regulations as to who the PNA must be consulted with which will be published on their website, • The PNA would be reviewed by the steering group on the 23 August 2021, and be brought back to the S&D committee for sign	KM

	off on the 14 September 2021, before being published by the 21 October 2021. The Independent Member – Third Sector (IM-TS) queried what the potential was for the pharmacies to be used in terms of prevention and maintenance of health as part of CVUHB's strategic ambition. The HMM responded that the community pharmacy contract included a health promotion stream within it, and whilst this year had been more focused on dispensing predominantly due to COVID-19, there was a requirement within the core contract to undertake health promotion and offer health promotion advice including healthy eating, smoking cessation, alcohol, etc. She added that there could be up to 6 health promotions per year including National stop smoking day and Antibiotic awareness. The Independent Member – Estates (IM-E) queried what influence the Health Board had on the quality of the service provided. The HMM responded that as a Health Board they had the ability to monitor the pharmaceutical services over a 3 yearly monitoring cycle and that they also reviewed enhanced service data to identify and monitor delivery. She added that there were significant comments received in the patient questionnaires that were influenced by COVID-19 and advised that this needed to be taken into account, for example when people have to queue outside to maintain social distancing. The Executive Director of Strategic Planning (EDSP) queried the reference within the report which stated that Cardiff had the sixth largest percentage increase, she advised that Cardiff was the largest growing core city outside of London, and had the largest growing Local Authority area in terms of size, and queried if the reference was correct. She added that consideration should be given on how the population would be changing over time and how we could ensure that they are on the front foot to ensure that service provision was effective and that patients were still able to access them. The HMM stated that she would double check the information concerning the population figure. She added that the trajectory going forward was to improve and increase services and that Welsh Government had structured pharmacy contracts in Wales to support that, unlike in England. The Director of Corporate Governance (DCG) stated that due to the significance of this that it should be ratified by the Board in September 2021, following sign off by the Strategy & Delivery (S&D) Committee in September due to the statutory requirements. **The Committee Resolved that:** a) The Pharmaceutical Needs Assessment (PNA) Update report be noted, b) the proposed approach for Cardiff & Vale UHB (C&VUHB) to develop a process for developing its first PNA be endorsed, c) the need to take chair's action to include, and or act on, information contained within the report be considered.	KM

S&D 21/05/008	**Strategic Equality Plan – Action Plan** The Strategic Equality Plan – Action Plan report was received and the Equalities Manager (EM) stated that this was the first year of their action plan, and that the original plan was received and approved in September 2020 and it had been agreed that a more action orientated plan be developed for the future. The Committee noted: • Since the last report to the Committee the Equality Strategy & Welsh Language Standards Group (ESWLSG) had been established and had met on three occasions. The purpose of the ESWLSG was to advise, embed and assure the Strategy and Delivery Committee on the development and implementation of the UHB's Strategy Equality Plan - Caring about Inclusion 2020-2024 (SEP) and compliance with the Welsh Language Standards, and key enabling plans, • The agreed EDWLSG Terms of Reference of the group would be brought to the next S&D Committee for noting, • The first year action plan was developed to ensure the delivery of the SEP in the new healthcare landscape as a result of the COVID-19 pandemic and the disproportionate impact on those with protected characteristics and those who come from socio-economically deprived communities. The objectives had been reviewed and commitment reaffirmed that equality and human rights must take centre stage to the thinking and planning of the Health Board and inform our response to COVID-19, • The forthcoming year would be about sustainability and enhancement with its continuation of some actions as well as the identification of new actions as we move into a more inclusive and partnership approach for our SEP which initially began in April 2020 and would be ending in March 2024, • the new Socio-economic Duty came into force on the 31 March 2021 and some of the aspects of the legislation had been adopted within the first year plan, in particular how the Health Boardmust take into consideration all of their decisions to help reduce inequalities associated with Socio-disadvantage which was around poverty in regards to financially, accessibility, education, health, etc, • the original plan had been accepted and noted by the Equality & Human Rights Commission who were public sector enforcers who ensured the Health Board were adhering to legislation and to ensure that the plan was up to standard. The EDPH expressed her support for the equalities work and advised that she was pleased to see the range of actions within the plan and the work undertaken over the past year. She advised that the work undertaken for the Socio-Economic Duty had involved a lot of work on inequalities in health across the Health Board and within the partnership arena, and felt there was an opportunity to expand how they describe and take the inequalities work further as it was a key component of their strategy. The EDPH queried if the three actions from the "Black Lives Matter" task group were included in the action plan, and the EM confirmed that they were included in the plan and that he and Catherine Floyd – Public Health,	KW

	were members of Cardiff Council's Race Equality Task Force and were leading on the Health Work streams concerning the three actions. The UHB Vice Chair highlighted work undertaken by the Kings Fund concerning "The Road to Renewal" and "5 Priorities for Health & Social Care" which was a step change in inequalities and population in health. He advised that it suggested a movement away from recognising something needed to be done, to actually transforming the way things were done to secure reductions in inequalities. He stated that part of the agenda was to measure things appropriately to monitor the trajectory. He queried if a piece of work needed to be undertaken to get measures and metrics in place. The EM responded and advised that work was progressing to get measures and metrics in place. The EDPH added that that there were many areas of inequalities statements that require action to change the statistics, and that there was more work to be undertaken and there was much wide reaching and consideration needed to be given to how this work was reported. The Committee noted that work was being undertaken to consider additional reporting requirements and the findings would be brought back to a future meeting. **The Committee Resolved that:** a) the Strategic Equality Objectives - Delivery Plan Framework 2020-2022 report be noted, **b)** the first year Strategic Equality Plan (SEP) delivery framework Plan be approved.	KW
S&D 21/05/009	**Employment Policies for Approval** The employment policies report was received and the Director of People & Culture (DPC) advised that there were three policies for approval, two of which had been changed and one had been amended: **(a) Respect and Resolution Policy** The DPC advised that the Respect and Resolution Policy would come into force from the 1 June 2021 and would replace the existing the dignity at work policy. She advised that a lot of collaboration had gone into this piece of work on an all Wales basis in conjunction with the Trade Unions. The CC queried how staff would know about the new Respect and Resolution policy being implemented and the changes that had been made, and the DPC responded that numerous staff workshops had been held to create awareness of the new policy, and that hundreds of staff attended. She added that they were also issuing further communications through the HR Governance Team via emails and on the Electronic Staff Record (ESR). The Chief Operating Officer (COO) highlighted the difficulty of communicating out to a large organisation like CVUHB and wanted to point out the challenge for the DPC's team in doing this and that it was	

not just the policy itself but also how ourselves as leaders and managers build that into daily practice.

(b) Special Leave Policy

The DPC advised that the Special Leave Policy had been reviewed and a number of changes introduced including:

- The introduction of an underlying principle that managers should 'know their staff' and be familiar with any issues or particular needs they may have. The manager, in knowing their staff, had the ability to apply discretion to the application of the policy,
- Individual, social, cultural, religious and geographical circumstances should be considered when granting special leave for bereavement purposes,
- A section on staff experiencing domestic abuse had been added – managers should be flexible and treat each instance sensitively and individually,
- Definitions, including that of a dependant and a carer, had been updated,
- The section on Public Duties had been strengthened to make it clear that individuals who had been allowed paid time off for public duties must refrain from claiming or accepting a fee or allowance for undertaking that duty,
- The section on time off and pay during jury service had been widened to include attending court as a witness,
- Support and reasonable time off would be provided to an employee who was the partner of someone receiving fertility treatment,
- The provisions in respect of the death of a child, which previously applied to staff employed on AFC terms and conditions only, had now been widened to include medical and dental staff.

(c) Recruitment and Retention Protocol

The Recruitment and Retention Protocol had been reviewed by the Welsh Partnership Forum (WPF) and a small number of amendments were made as follows:

- Further information was provided on what makes the payment robust enough to resist an equal pay challenge,
- If an extension was sought the review process needed to be initiated 12 months before the expiry date of the RRP,
- Reference was included to the public sector equality duty.

The Committee Resolved that:

a) the Respect and Resolution Policy be approved and adopted by CVUHB with effect from 1 June 2021,
b) the Dignity at Work Process and NHS Wales Grievance Policy be rescinded with effect from 1 June 2021,
c) the revised Special Leave Policy be approved for adoption by the CVUHB,
d) the revised Recruitment and Retention Payment (RRP) Protocol be approved for adoption by the CVUHB.

S&D 21/05/010	**No Smoking and Smoke Free Environment Policy** The No Smoking and Smoke Free Environment Policy was received and the DCG and CC confirmed that as the policy document had been brought to the committee the EDPH would send the policy out to the CC so that a chairs action could be taken to approve. The EDPH advised that the Public Board meeting in March 2021 had received a report on the smoking regulations and that the policy had since been updated and an Equality Health Impact Assessment had been completed and articulated the requirements under the regulations. The Committee noted that the following amendments had been made to the Policy: • Reference to the legislative requirements relating to the Smoke-Free (Wales) Regulations 2021, • Reference to the use of e-cigarettes inside specific, risk assessed areas for in-patients with mental health conditions, • Smoking Cessation Service provider name changes and updated information (including the implementation of the Level 2 Enhanced Smoking Cessation Service for Community Pharmacies, introduced June 2020), • Data updates where available, • Evidence updates where available. The EDPH highlighted that CVUHB had a comprehensive smoking cessation policy in place since 2011 and that they had a track record on having an approach to tackling smoking on hospital premises. She added there had been a revision of the original policy and not a complete re-write. The Committee noted that: • the policy included a Policy Statement including aims which were to protect Employees, Contractors, Visitors, Patients, and Service users to UHB sites from exposure from second hand smoke in line with legislation and to actively promote Health & Well-being, • smoking and tackling smoking played into being an inequality gap and that one of their tasks was to reduce smoking prevalence in their most disadvantaged communities and with populations that were more vulnerable and at risk. • The Management Executive Team had already considered the updated policy and an emphasis was placed on the importance of showing leadership right across all other leadership responsibilities to encourage and push the requirements within the policy. • the Equality Impact Assessment had not identified any negative impacts, however there were a few areas where they had compiled an action plan that they would take action on, to enable people with learning disabilities to have appropriate access and additional work to ensure they have the right materials and communication tools for people with visual impairments.	

	The EDPH added that when the regulations had been discussed with the Board it was suggested that this formed a component part alongside support and highlighted that Welsh Government expected the public to be widely compliant with the new legislation. As such, local arrangements for enforcement would depend on adherence by both the public, patients and staff. She added that there were enforcement arrangements in place with Local Authorities as they had a duty to support Health Boards with enforcement. **The Committee Resolved that:** a) the No Smoking and Smoke Free Environment Policy was noted and endorsed, b) the No Smoking and Smoke Free Environment Policy be published in full in accordance with the UHB Publication Scheme, c) That Chairs action be taken to formally approve No Smoking and Smoke Free Environment Policy, as the revised policy document had not been included in the papers for the Committee.	
S&D 21/05/011	**Recovery Planning Update – Presentation** The Recovery Planning Update – Presentation was received and the COO gave an update on the planned care recovery. The COO advised that it had been a difficult year and that there were a number of recovery challenges with the continued uncertainty both in terms of the impact of the mass vaccination programme, the potential of a third wave, the significant supressed demand, and a fatigued team from facing COVID-19 challenges. The COO gave an overview on the recovery planning approach and the Committee noted the Recovery Planning Cycle and Scenario modelling which was informed by: 1. Infection, Prevention & Control (IP&C) conditions, 2. A requirement to put capacity into the system, and 3. Access to skilled personnel All of these were assumed under the context of the uncertainty of a third wave. The COO explained the scale of the challenge they faced and presented modelling to demonstrate the peak of the waiting list backlogs that were likely to be seen, where they might peak, where they levelled off, and what would happen to them. He advised they would apply assumptions to the modelling process to forecast where the backlogs may appear. The Committee noted the level of activity lost from March 2020 to February 2021, in which more than 22,000 procedures had not been undertaken. He stated this was expressed in different ways showing the top 10 volume specialties on how capacity was lost. The COO stated that when planning at a modelling level they had needed to put some assumptions in related to the scenarios and had included a best, central, and worst case scenario. He added it will be dependent on	

	the IP&C restrictions being removed and the degree to which lost activity will return:
	• **Best Case** – 30 weeks to return to normal levels,
	• **Central** – 60 weeks to return to normal levels,
	• **Worst Case** – 90 weeks to return to normal levels
	
	The COO stated that their assessment would be:
	1. A full 'recovery' from the pandemic was likely to take 5-10 years and would require sustained and significant additional capacity,
	2. Additional capacity alone would not be enough and the NHS would need to fundamentally review the services it provided and the way in which they were provided,
	3. Both additional capacity and pathway redesign would take time and therefore there would be a need to support patients, manage expectations and enhance the services which were alternatives to treatment.
	
	The COO added that he was providing a level of modelling that was informing their planning to date and would continue to do so culturally and sustainably as they wanted to get into specialty level planning. This would help them orientate themselves into the 'Clinically Validate, Prioritise, & Design' element of the Recovery Planning Cycle which would give them different levels of planning.
	
	The COO advised that they needed to ensure that there was proper capacity and capability to make this work and that each of the cells (i.e. Workforce, IP&C, Capacity & Estates, etc.) would have Programme Management Support, Improvement Support, and Data Support. From that they would have learned from the COVID-19 response in terms of corporate cells that function to support Clinical Boards.
	
	The Committee noted the current position:
	• Maintenance of essential services through the first and second COVID-19 peaks,
	• The development of Protected Elective Surgical Units (PESU),
	• Independent Sector capacity,
	• An ambition to return to elective activity to:
	  ○ 70% of pre-COVID-19 levels in Q1,
	  ○ 80% of pre-COVID-19 levels in Q2,
	• An Outpatient transformation programme
	
	The COO presented graphs which demonstrated re-establishing activity in 3 areas:
	• Outpatients – returned to 81% of activity in February 2021
	  ○ Outpatient activity was slightly different as not all activity recovered was good activity as they wanted to do things differently and not just recover.
	• Inpatient / Day Case – Achieved 70% in November 2020 before having to suspend in January 2021 but was now up to 66% in February which was on target for the 70% that they aimed for by Q1,	

- Radiology – was now at 100% of pre-COVID-19 activity and had remained at a strong and improving position since September being at 96%.

The Committee noted that:

- that there had not been a significant waiting list increase since January 2020 – March 2021, however assurance should not be taken from this as it was part of the cycle of recovery activity coming back which hadn't grown significantly, and would change as other activity started to pick up,
- the 26-week position was starting to rise and had been since September 2020 – March 2021, however this was anticipated, and there was an assumption that as people got referred back into the system the under 26 week group would increase and in proportion the over 36 weeks group should reduce,
- they were starting to make some progress in Diagnostics showing the number of 8-week waits highlighting that they had made some significant gains in this area and that sustaining this would be an issue however there were signs that they could make rapid progress in some areas.

The COO advised that next steps would be a huge challenge, and that a start had been made on some major schemes including:

- Endoscopy was being worked through,
- Green Zones were being expanded and had been a success in terms of outcomes and volumes,
- Continuing to use the Independent Sector,
- Continuing to use Mobile MRI Scanners – which affected the 8 week diagnostic position,
- Using Mobile Day Surgery Units – the rate limiter would be staff,
- Using traditional methods of waiting list initiatives which were not sustainable.

He added their long term plans would be Risk Orientated, Data Driven, Clinically Led, through a programme delivered approach, looking through a number of lenses.

The CC queried what the difference of the new approach would be in comparison with the old approach used 3 years ago, the COO responded that the differences were the scale and the priority as they used to manage people by wait time whereas now they needed to shift to risk.

The Independent Member Capital & Estates (IM-CE) queried the viability of a long term dependency on the independent sector and that as the workforce was identified as a rate limiting factor, assuming there was an injection of cash into the system which would create public perception on how quickly recovery could happen, she also queried how they would deal with that.

The COO responded that long term dependence on the independent sector was not what they should be planning for and that one of the things they were doing through their annual plan bids was to be clear that short

	term planning would not get them out of this and that strong bids for recurrent funding should be made to be able to invest and grow their own core services to ensure they could recover in a sustainable way. The COO advised that in relation to workforce CVUHB were planning ahead and were actively recruiting staff as it was anticipated there would be a need to grow capacity staff, and that there will be significant competition for skills and a lag to growing those skills locally. The CC queried what advice was being sought from Welsh Government on what should be done to manage the workforce, and the COO stated that there was active discussion and a keenness to get a scale of planning at granular level from the clinicians on the front line as the Clinicians were informing this and the risk would be appropriate in terms of that need. He added that the Clinicians were also involved on national committees and were keeping Welsh Government sighted on the discussions to provide an informed view. **The Committee Resolved that:** a) the Recovery Planning Presentation be noted.	
S&D 21/05/012	**Shaping Our Future Wellbeing Strategy (SOFW) Update** **a) Flash Update** The flash update presentation on "Accelerating delivery of our strategy - our road to recovery and renewal" was received and the EDSP shared a presentation to illustrate how they had regrouped some of their work concerning the strategic programmes. The EDSP reminded the Committee that the overarching vision was about the health inequalities in the population and that they were striving to equalise the inequalities seen which would have likely deteriorated throughout the pandemic. The Committee noted that the strategy was delivering joined up care based on home first; avoiding harm, waste and variation; empowering people; and delivering the outcomes that matter to them. The strategic objectives set out in their strategy were: • Reduce health inequalities – reduce the 12 year life expectancy gap, and improve the healthy years lived gap of 22 years, • Deliver outcomes that matter to people, • All take responsibility for improving our health and wellbeing. The Committee noted the 4 design principles: • Empower The Person, • Home First, • Outcomes That Matter To People, • Avoid Harm, Waste And Variation. The EDSP advised that they were keen to ensure they were able to shift the power balance and show they had greater equity in relation to people who use the services.	

	The EDSP reminded the committee in November 2020 there was a mid-year review of the strategy which was informed by all of the learning from the response to the pandemic. The Committee noted: • the emerging strategic programmes of the UHB were Strategic Programmes, Operational Programmes, and Enabling Programmes, • work was being undertaken on the measures, metrics, and indicators of how they would know they are delivering on the principles and outcomes that they wanted to achieve for the population, • they were developing a live interactive outcomes framework by applying the learning taken from Canterbury Hospital, • the Annual plan focussed on the four COVID-19 harms, remaining COVID-19 ready, COVID-19 recovery (staff wellbeing, planned care, MH demand, long COVID-19 rehabilitation, emergency care and planning for the winter), moving beyond COVID to transforming services in line with Shaping our future wellbeing (SOFWB) strategy, Zero carbon, Dragon's Heart Institute, Spread and scale intensive learning academy and Working in collaboration, • a strategic programme meeting was held each fortnight where the individual programmes were discussed. The purpose of this was to make sure as a collective group of directors they had responsibility across all programmes, also to hold Senior Responsible Officers (SRO's) to account that they are on course to deliver. **b) Deep Dive – (Rehabilitation Model Implementation)** The deep dive presentation on the Rehabilitation Model Implementation was received and the Head Of Physiotherapy Services (HPS) advised that the rehabilitation model was launched in 2020 and was being used to try and map where and when they should be implementing rehabilitation services and that they were aligned to the model. The Committee noted that there are 5 tiers within the model: **<u>Specialised Rehab</u>** • Critical Care / Rookwood facility, • MDT rehabilitation, **<u>Non Specialised rehab</u>** • Supported rehabilitation – non specialised rehabilitation, • Primary Care support – delivered in a primary care setting in peoples home or GP's, • My Health and Well Being – centred on enabling and empowering the population to use their community assets to support their health and wellbeing. The Committee noted: • a programme was being developed that would look at how they would deliver rehabilitation against their model,	

	• as it was 8 weeks of support they decided to focus on areas that were least developed within their tier one and two areas and felt that they needed to be developing more co-produced behavioural changed programmes focusing on prevention, self-management, for people with chronic conditions living within the community, • the 8 week programme will include fortnightly 60-minute catch-ups with the programme lead, workshops with more than 60 individuals attending, 60-minute meetings with stakeholders from across the organisation and Kick-Off meetings with the key stakeholders, • key topics identified for discussion include Stakeholder engagement, Communication and IT & Digital Capabilities, • the short term aim which was to start developing a Living Well Programme for long-term conditions in partnership with the Recovery College and their long term aspiration which was a long-term condition rehabilitation service in the community to support people to live well, • an initial 90-day implementation plan has been designed and CVUHB are developing an 18 month implementation plan The HPS outlined the Governance and reporting structures and felt the work would be better aligned in the Shaping Our Future Clinical Services (SOFCS) strategy. The CC asked that a brief update on this item be brought back to the committee later in the year. **The Committee Resolved that:** a) The Flash update Presentation be noted. b) The Deep Dive presentation on the Rehabilitation Model Implementation be noted.	
S&D 21/05/013	**Strategy & Delivery Dashboard Demonstration Update – Verbal** The verbal update on the Strategy & Delivery Dashboard Demonstration was received and the CC advised that he had met with the Director of Director of Digital Health Intelligence (DDHI) and received an update / demonstration on the Dashboard. He stated that he was impressed with the proposal, and that it provided a simpler easy to use dashboard, which highlights key targets and performance. The CC stated that he had discussed having the dashboard presented at a Board development session with the UHB Chair to ensure that IM's were sighted on this. Once this had been done the CC could sign it off for completion. The DDHI advised that the dashboard was published and validated data and that were looking to expand the number of indicators, as it currently only focussed on the 38 indicators mapped to the S&D Committee. He added the plan is to have a "Biz Dashboard" set up for each IM to show them the data in a useful way. **The Committee Resolved that:**	DT

	a) The verbal update on the Strategy & Delivery Dashboard Demonstration was noted.	
S&D 21/05/014	**People and Culture** The People and Culture update was received and the DPC advised that her title has now changed to People and Culture and wanted to encapsulate that in a People and Culture plan going forward. The Committee noted that the team were working on: • developing a wellbeing plan for the next 12 months, • A VBA Campaign – which would be very important when referring to statistics and was a foundation that they needed to drive forward on. The DPC advised that a presentation will be brought a future meeting providing an update, • Project Search – in relation to diversifying the workforce and were working in collaboration with the Local Authority and Project Search concerning individuals coming into the Health Board with learning disabilities, • a procurement tender for a virtual showcase to help spear a social movement and to encourage staff to be on board with the strategy. This will link in with SOFCS and engage with the population in a creative way, • Discussion with the CEO of Health Education improvement Wales (HEIW) regarding higher level apprenticeships. **The Committee Resolved that:** a) The verbal People and Culture update be noted.	RG
S&D 21/05/015	**Performance Reports** **(a)Organisation Key Performance Indicators** The **Organisation Key Performance Indicators** update was received and the COO advised that he wanted to recognise the good work being undertaken in the Diagnostics & Therapies department as they had reached almost zero 8-week waits for diagnostics last year. He stated that it then increased to 10,000 as a result of COVID-19 but they had reduced to 4,500 in March 2021. The COO highlighted two areas of concern: • **Stroke** – 4 hour access was very poor and this was directly related to COVID-19 as the stroke reception unit is very small where patients go to receive optimal care. The front door pathways state that if any of the patients are suspected to have COVID-19 symptoms they had to go to a different place, • **Mental Health 28 Day Assessment** – this continued to be a concern and they were seeing some real improvements for the trajectory for Children and Adolescent Mental Health Services (CAHMS). There is a slight improvement in Mental Health highlighting that the previous months referrals were 1,400 but that were not at 900. The COO stated that he and the mental health	

team had gone through a recovery plan and were seeing some recovery up to 20% for May 2021, but it was dependent on recruitment which had a lag to benefit. They were working on what could be done in the short term whilst the recruitment was ongoing.

The IM-TS queried what was being offered in lieu of an assessment and if there was a watchful waiting support for individuals rather, than them having to wait in distress. The COO advised he would happy to arrange a meeting with the CC, IM-TS and the UHB Vice Chair to provide greater detail. He added that with other services Mental Health protected the higher acuity essential services and therefore they had taken a risk based approach to this, however this is not acceptable but is understandable, as the figures demonstrated that their staff have been affected in the same way as Physical Health staff.

The CC queried the impact of CAV 24/7 and how it was being assessed. The COO advised that it was being measured in the same way as before and was still constituting one third of activity in the emergency department (ED). He added that a new scheme was proposed which extended access to surgical direct referrals which rather than book people into ED would also book them into a direct urgent surgery slot going forward. The Committee noted that if the surgical teams were keen on this there was potential to replicate this. They would be going from an unplanned event to a semi-planned event so at the end point of the event it will not default to the ED anymore but instead to cardiology, surgery, psychiatry, etc.

(b)Workforce Key Performance Indicators (KPI's)

The Workforce Key Performance Indicators (KPI's) report was received and the DPC gave a summary of performance against the KPI's presented within the report.

The Committee noted that the total monthly pay bill had doubled and that the DPC she was working with the finance teams to discuss the central monies received from Welsh Government for this purpose.

The DPC advised that there was an additional £17 Million bonus for NHS staff plus the accrual of £10 Million and that they had to give the estimation for annual leave carryover and study leave for junior doctors.

The Committee noted that of the 1,600 voluntary resignation monitored from the period 2019-2020 there had been only an 8% return of exit questionnaire feedback, and the DPC felt that more work was required in this area through discussion with managers and managers training. She advised that people were generally leaving to transfer to other NHS organisations in the same profession.

The DPC advised that they had analysed the number of staff leaving and that 11% of the 130 staff had retired, and some comments of concern were identified stating staff were not feeling valued or managers were not behaving in the correct way.

	The DPC advised that the sickness absence rates correlated with the first wave in April 2020, which saw the biggest spike of over 8% sickness which was similar to December 2020 when the second wave occurred. The Committee noted that the sickness rates were decreasing, however they were not yet below the target set for NHS Wales. **The Committee Resolved that:** a) The year to date position against key Organisational Performance Indicators for 2020-21 but in the context of current operating framework principles be noted, b) the Workforce & OD Key Performance Indicators Dashboard report be noted.	
S&D 21/05/016	**Board Assurance Framework** The Board Assurance Framework (BAF) report was received and the DCG outlined the risks that would be presented to the Public Board meeting in May 2021 for discussion. The DCG also detailed which risks were aligned to the S&D Committee and proposed to bring two risks to each committee going forward, rather than one in an effort to maintain the momentum and risk discussions going. The Committee noted that in addition to the nine risks detailed, the DCG would work with the EDPH to integrate the risk concerning inequalities into the BAF, and that this will be taken to the Board meeting on the 29 July 2021. **The Committee Resolved that:** a) the Board Assurance Framework (BAF) and the risks which will be presented to the Strategy & Delivery Committee once the full BAF has been agreed at the Board meeting on the 27 May 2021.	NF
S&D 21/05/017	**Induction Support For New Committee Members – Verbal** The verbal update on the Induction Support for New Committee Members was not received as there was no need for the matter to be discussed further.	
S&D 21/05/018	**Review of the Meeting** The CC asked if attendees were satisfied with the business discussions and format of the meeting, and all Committee members confirmed it was a positive meeting with an appropriate level of Independent Member challenge and scrutiny.	
S&D 21/05/019	**Date & Time of next Meeting** The CC thanked everyone for their attendance and contribution to the meeting, and confirmed that the next meeting would be held on Tuesday 13 July 2021 at 09:00am Via MS Teams	