PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 February 2022
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Hywel Dda UHB – Field Hospital Lessons Learned Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Field Hospital Triumvirate (COVID-19 Operations): • Gareth Rees, Acting General Manager • Meinir Jones, Clinical Lead (Field Hospitals) • Anna Llewellin, Interim Head of Nursing

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In August 2021, Hywel Dda University Health Board (HDUHB) received the *Field Hospital Decommissioning – Final Advisory Report* authored by NHS Wales Shared Services Partnership (NWSSP) Audit and Assurance Services Team. The recommended management action being:

Management should undertake a 'lessons learned' exercise with key individuals across the field hospital commissioning, operation and decommissioning phases in order to identify what went well and what could be done differently, not only for similar projects but potentially also in operation of acute hospital settings

The report appended to this SBAR provides feedback on the lessons learned exercise that took place on 8th November 2021, coupled with additional feedback gathered in the course of Field Hospital Design & Build/ Commissioning, Operationalising and Decommissioning phases.

The Audit & Risk Assurance Committee is asked to receive this report.

Cefndir / Background

Hywel Dda UHB's Field Hospitals (FH) design and build phase began in earnest on 20th March 2020. Preliminary discussions had taken place before this point with Local Authority colleagues, noting the scale and challenge in being able to provide suitable healthcare facilities for the projected surge in patients due to the COVID-19 pandemic.

By 24th April 2020, nine Field Hospital locations had been created in line with agreed specification, and equipped across the three counties covered by Hywel Dda. This provided a maximum physical bed capacity in excess of 900 beds.

Following the 'Design and Build' phase of Field Hospital development, the operational team leads took on the responsibility for driving the development of Field Hospital operations. The result being three Field Hospitals operationalised between June 2020 and July 2021, whilst the decommissioning of operationalised and un-operationalised FH sites took place between July 2021 and February 2022*.

Between June 2021 and August 2021, NWSSP Audit and Assurance Services Team reviewed and audited the FH Decommissioning process. Their report outlined a number of potential areas for improvement and a recommendation to carry out a lessons learned review.

The appended document outlines the outputs from the facilitated Lessons Learned workshop held on 8th November 2021, along with additional feedback/lessons learned feedback received from the three operationalised Field Hospital teams between September 2020 and July 2021.

***NOTE** – Decommissioning of final FH site: Ysbyty Enfys Selwyn Samuel is underway at the time of preparing this report.

Asesiad / Assessment

The Lessons Learned exercise(s) highlighted general themes that may be adapted to a similar emergency situation should it occur in the future. These included:

- Decisions made in any Commissioning phase are likely to have an impact on the Decommissioning phase. Therefore, wherever possible it is prudent to include those personnel that may be carrying out said decommissioning in decisions within commissioning. This may include a review of sites prior to commissioning/ condition surveys carried out, or a clear understanding of any contractual agreements put in place namely e.g. if leasing a site reviewing timescales allocated to decommissioning (and potential 'making good' at a site) and whether this is reasonable etc.

- Consistency of programme/ project support staff across commissioning, operationalising and decommissioning phases would allow for relationships and learning from one phase to the next to be transferred. This is of particular relevance in understanding decisions made in the commissioning phase when decommissioning a site/ location.

- A professional Multi-Disciplinary-Team (MDT) approach provides added value, not only in a clinical sense regarding delivery of clinical services but also in having distinct areas of experience and expertise to develop similar schemes. This including: project/ programme management, estates/ facilities, operational service leads (community & acute), finance, HR/ workforce, contract negotiation/ development/ legal. It may be that any future emergency planning procedure recommend expected key skill sets/ representation in any emergency response of this type, similarly highlighting any best practice available.

- The inherent value of basic due diligence needs to be properly understood even in moderated form. The decommissioning processes as they happened at key sites was hampered by the absence of any valid form of record of circumstances ahead of commissioning. Whilst it is noted that time to undertake these in a model manner was limited, with some effort future cost impacts and protracted discussions with landlords could have been mitigated or even avoided if condition records for the sites converted into field hospitals were compiled at the appropriate time.

Although the FH management team acknowledged all of the NWSSP improvement points, it was recognised that decisions made in the Design & Build/ Commissioning phase were made in unprecedented times with significant uncertainty around the potential scale and severity of the COVID-19 pandemic.

Therefore, although in hindsight, there may have been additional planning steps that could have been undertaken; the prudent approach for our population, in conjunction with our partners, was to ensure that facilities of sufficient capacity were in place should the pandemic have caused the worst-case scenario to be a reality.

What has also been made evident is that the partnership approach of working with Local Authorities, Welsh Ambulance Services NHS Trust (WAST), the wider public and third sector(s) along with the private sector was required to tackle this emergency – this joint working approach can only prove fruitful in any future partnership working initiatives.

Although there are some acknowledged improvements to the Field Hospital development, operations and decommissioning, the team felt the overwhelming evidence, as witnessed from the feedback in the appended report, was that the Field Hospital programme was a success and positive for those involved.

As a Health Board, we welcome the opportunity to embed the learning recorded from the lessons learned exercises that we have undertaken.

The learning from all phases is significant and where possible we will endeavour to utilise this learning to improve on similar processes in the future.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to receive this report for information.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Audit and Risk Assurance Committee (ARAC)
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	6.3 Listening and Learning from Feedback
Amcanion Strategol y BIP: UHB Strategic Objectives:	5. Safe sustainable, accessible and kind care
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A
Ansawdd / Gofal Claf: Quality / Patient Care:	N/A
Gweithlu: Workforce:	N/A
Risg: Risk:	N/A
Cyfreithiol: Legal:	N/A
Enw Da: Reputational:	N/A
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	N/A

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Hywel Dda UHB – Field Hospital Lessons Learned report

Response to NWSSP Audit and Assurance – Field Hospital Decommissioning: Final Advisory Report

December 2021

Contents

Rationale for report

In August 2021, Hywel Dda University Health Board (HDUHB) received the *Field Hospital Decommissioning – Final Advisory Report* authored by NWSSP Audit and Assurance Services Team. Within the report the recommended management action being:

Management should undertake a 'lessons learned' exercise with key individuals across the field hospital commissioning, operation and decommissioning phases in order to identify what went well and what could be done differently, not only for similar projects but potentially also in operation of acute hospital settings

This report provides feedback on the lessons learned exercise that took place on 8th November 2021, coupled with additional feedback gathered in the course of Field Hospital Design & Build/ Commissioning, Operationalising and Decommissioning phases.

Field Hospital background and context

Our response to the global COVID-19 pandemic – development of Field Hospitals

Design and Build/ Commissioning

Hywel Dda UHB's Field Hospitals (FH) design and build phase began in earnest on 20th March 2020. Preliminary discussions had taken place before this point with Local Authority colleagues noting the scale and challenge in being able to provide suitable healthcare facilities for the projected surge in patients due to the COVID 19 pandemic. The Design and Build 'kick off' discussion on 20th March 2020 noted the magnitude of the challenge – namely to create in excess of 1000 beds, effectively doubling the Health Board's current bed capacity. This number was based on the data modelling for the projected 'reasonable worst case' of COVID-19 patients at the peak of the pandemic.

As part of the discussion, there was an allocation of work streams to lead officers to drive activity. Although following a formal project and programme management approach it was noted that all involved would need to work at pace and vigour, across professional and organisational boundaries along with flexibility to achieve the goal.

During the FH Design and Build Phase there were significant challenges but there was an overall 'hand in glove' approach to working together with all professions involved in the process such as nursing, therapies, infection prevention & control, estates, procurement, human resources, information technology, medicine, clinical engineering, pharmacy and finance along with programme and project management. The collaboration with local

authority partners namely, Carmarthenshire, Pembrokeshire and Ceredigion County Council enabled the joint delivery of these facilities in rapid time.

The end-result of this intense period of true partnership working concluded with a handover from the project team to operational colleagues on 24th April 2020. In 5 weeks, nine Field Hospital locations were created in line with agreed specification, and equipped across the three counties covered by Hywel Dda. This provided a maximum bed capacity of 975 beds and included:

- Ysbyty Enfys Scarlets (Barn - 259 beds)
- Ysbyty Enfys Scarlets (Stadium - 80 beds)
- Ysbyty Enfys Selwyn Samuel (143 beds)
- Ysbyty Enfys Llanelli (121 beds)
- Ysbyty Enfys Caerfyrddin (93 beds)
- Ysbyty Enfys Carreg Las (128 beds)
- Ysbyty Enfys Aberystwyth (Plascrug Leisure Centre - 52 beds)
- Ysbyty Enfys Aberystwyth (Penweddig School - 51 beds)
- Ysbyty Enfys Aberteifi (48 beds)

Operationalisation

Following the 'Design and Build' phase of Field Hospital development the operational team leads took on the responsibility for driving the development of Field Hospital operations - on review agreed a maximum 915 beds available (following some spaces requiring reutilisation for other purposes and adherence to fire safety management protocols). This number subject to being able to source sufficient staffing. Initial review of sites raised initial questions namely:

- What is the expectation of acute sites on FH sites?
- Will piped oxygen provision be available at FH sites?
- What will be the model of care? – at handover to operational leads undetermined – early thinking noted this would primarily be for those patients who required discharge planning or who were waiting on care and support being available

It was also recognised that the use of field hospital capacity provided a means of easing system pressures at the acute hospital sites, by creating additional system wide surge capacity for patient care.

A COVID 19 Operational Triumvirate was put in place to drive forward Field Hospital operational phase. This Triumvirate having the overall Field Hospital operational management responsibility put in place site management structures, and overall systems and processes. The Triumvirate consisted of:

- A General Manager (COVID-19 Operations)
- A Head of Nursing (COVID-19 Operations)
- A Clinical Lead (Field Hospitals)

Initial challenges related to staffing each of the sites. These included:

- Staffing ratios
- Rota challenges
- Staff ownership and investment
- Medical rota – model amendments e.g. GP, ANP
- Staff continuity throughout
- Staffing local management teams - values

Although staffing challenges existed this presented opportunities for alternative ways of working to be explored namely:

- A strengthening of MDT working
- Reviewing processes and practices
- Enhancing staff skills e.g. extended roles
- Extended team
- Digital working
- Shared vision and common purpose

Further site specific (estate) challenges also existed during operationalisation:

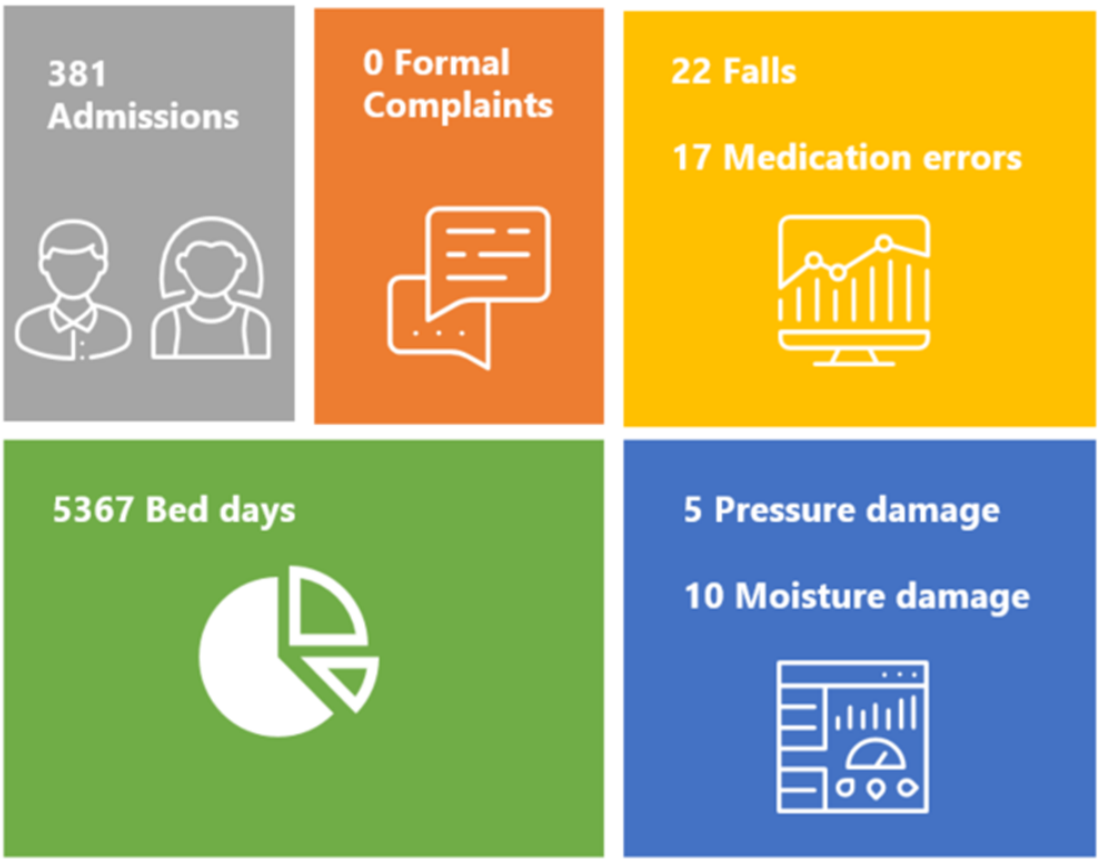
- Water safety challenges
- Heating/ cooling challenges
- Infestation/ pest control
- Infection control
- Social distancing
- Catering challenges
- HIW recommendations
- Adverse weather
- Responsiveness of minimum support requirements
- Care after death process
- Adapting policies and procedures
- Fire safety issues
- Share site challenges
- Staffing

These initial queries, concerns and challenges were overcome during operationalisation, when three sites became operational making a positive contribution. These were

- Ysbyty Enfys Caerfryddin
- Ysbyty Enfys Carreg Las
- Ysbyty Enfys Selwyn Samuel

Key operational statistics:

Statistics across the three operationalised sites included 381 Admissions resulting in 5367 Bed days and 0 (zero) Formal Complaints. A summary of operational statistics:



Ysbyty Enfys Caerfyrddin	
Operational period:	June to September 2020
Patients treated	32
Length of Stay	Average LoS 14.5 days
Status	Mothballed (building/ engineering materials stored on site – build works required to become operational again)

Ysbyty Enfys Carreg Las	
Operational period:	December 2020 – April 2021
Patients treated	86
Length of Stay	Average LoS 11.7 days
Status	Decommissioned

Ysbyty Enfys Selwyn Samuel	
Operational period:	November 2020 – July 2021
Patients treated	263
Length of Stay	Average LoS 14.54 days
Status	Hibernation (equipment in situ on site should site need to become operational)

Quality and Governance
Development of appropriate Field Hospital quality and governance procedures took place to support:

- Patient Panel
- Patient criteria
- Documentation
- Discharge planning
- HIW review (and endorsement)
- Meeting structure and team building

At the outset of the field hospital campaign, a robust process to support the identification of patients for transfer to the Field Hospitals was established, to not only assure robust clinical governance / patient safety, but also to support an approach and culture where decision-making was owned and progressed by MDT consensus.

This process consisted of a 'Daily Panel' with representation from field hospital and acute hospital teams incorporating the Consultant Physician, Senior Nurses, Physiotherapists, Occupational Therapists, Dieticians, Social Workers, Discharge Liaison Nurse and Management Support colleagues.

Associated with the patient panel was Patient Criteria – this being an evolving process based upon the current COVID-19 position at that time. To support the panel and criteria was associated documentation namely:

- MDT completion of revised documentation
- Documentation and record keeping information board.
- Risk assessment information board.
- Audit processes

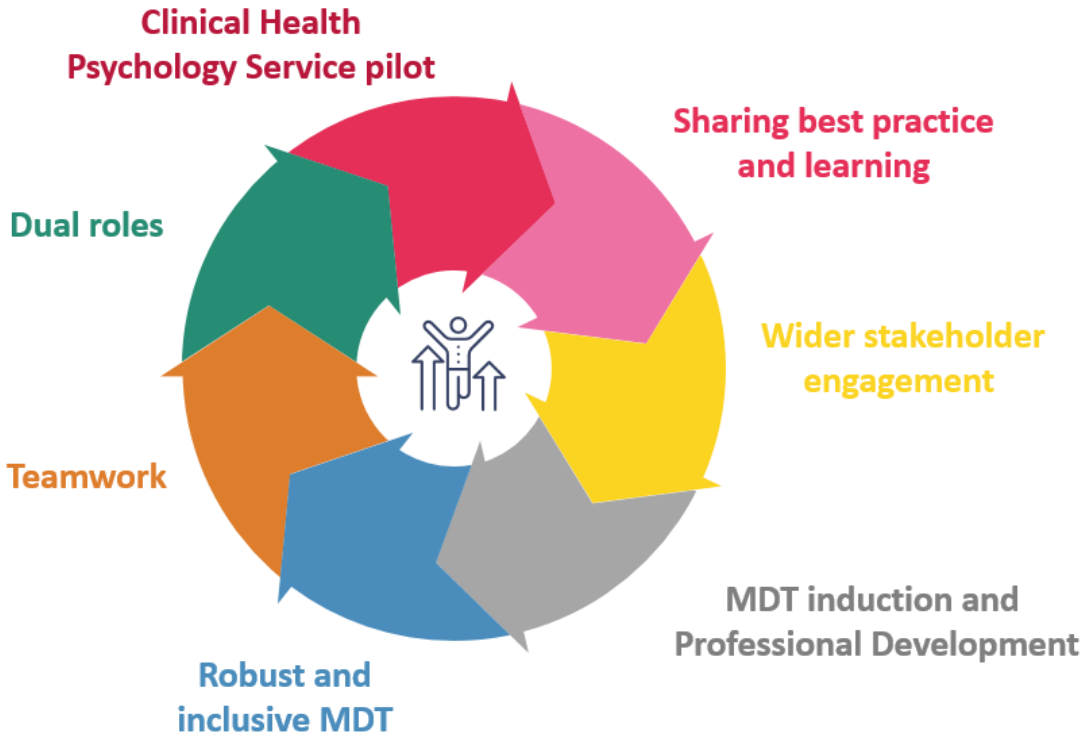
For discharge planning, Daily Safety Huddles and a weekly discharge pathway meeting with members of the MDT took place, whilst ongoing communication channels was vital across teams including:

- Scrutiny Meetings, Risk Management, Datix reporting, Audits Care metrics, Patient outcome measurements, Senior Nurse Audits, ICP audits.
- Daily touch point meetings

Finally, in support of the approach taken, HIW formally endorsed the staffing ratios and facilities.

The approach provided across all operationalised Field Hospital sites was one of a 'Team around the Patient'

Team around the patient



Specific wrap-around support included:

- **Clinical Health Psychology Service pilot*:** Support from other teams in the Health Board. Specifically provided staff training and direct consultant support for patients identified as having anxiety and/ or depression.
- **Dual roles:** Porters and Hotel Services staff dual roles and would assist with patient care e.g. mobility under the delegation of the RN.
- **Teamwork:** Support from other teams in the Health Board. Clinical and non-clinical- Estates, clinical psychologists, dieticians,
- **Robust and inclusive MDT:** MDT engagement, clear identity, one purpose and vision – excellent patient care

- **Sharing best practice and learning:** Frequent meetings to review learning to improve patient experience. Daily catch ups
- **Wider stakeholder engagement:** Health Board, County and Town Councils, third party organisations (Scarlets, Bluestone, Just Wales), volunteers, military, Contractors (Lloyd & Gravell, Lorne Stewart) Welsh Government, patients, families, Fire service, funeral directors.
- **MDT induction and Professional Development:** A training needs analysis was undertaken and staff trained in extended roles such as point of care testing, bladder scanning and ECG recording

***NOTE** – Pilot carried out in Ysbyty Enfys Selwyn Samuel only.

See Annex 1: 'Leadership across Field Hospitals in response to the Pandemic in Rural West Wales' for further information on Field Hospital operationalisation phase.

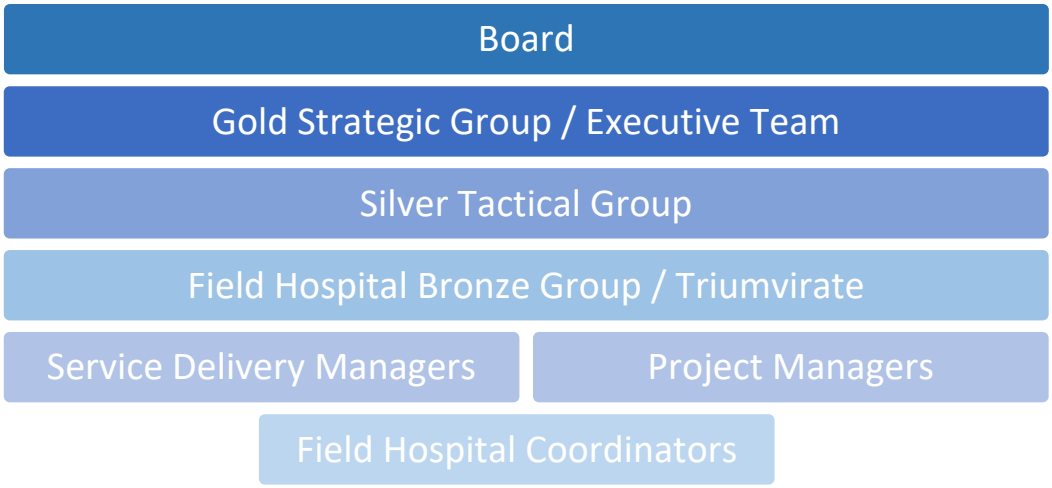
Decommissioning

The decision to decommission varied by site. The following lists a number of the associated variations experienced across the counties:

- No formal notice was served in relation to Penweddig School as site was returned at the expiry of the Licence to Occupy in July 2020.
- Carmarthenshire County Council served notice on the Health Board relating to Llanelli Leisure Centre and Carmarthen Leisure Centre during August 2020.
- No formal notice was served relating to Parc y Scarlets Stadium due to renegotiations of the second Underlease concerning the Barn area only, commencing in September 2020.
- The Health Board served notice on Local Authorities relating to Parc y Scarlets Barn, Bluestone and Plascrug during March 2021.

Where notice was served by the Health Board, decisions were considered and approved via governance structure set out within this document and evidenced as such within meeting papers and minutes.

Decommissioning Monitoring and Reporting:
The Governance structure demonstrated scrutiny of decommissioning activities at all Levels:



A comprehensive selection of documentation including agendas, action logs, risk register, meeting notes and minutes were used as part of the following monitoring and reporting activities:

- Gold Strategic Group managed, and approved key decisions relating to field hospital decommissioning and delegated associated tasks to the Silver Tactical Group. Ratification at Public Board Meetings was sought of any decisions made.
- Bi-weekly Silver Tactical Group meetings oversaw the operational response to the decommissioning programme, including consideration of issues and escalations from Bronze Groups and endorsement of key decisions.
- Weekly Field Hospital Bronze Group / Triumvirate meetings coordinated the decommissioning programme across all sites with appropriate membership of key stakeholders including Deputy Director of Operations as SRO, Acting General Manager and Chair, Clinical and Nursing Leads for Field Hospitals, Service Delivery Managers, Project Managers and Field Hospital Coordinators.
- Weekly Programme Group meetings (across Health Board and Local Authority colleagues) maintained pace and progress of decommissioning tasks critical to achieving key dates.

- Task and Finish Groups established for each site to monitor and feedback to Field Hospital Bronze Group with progress and issues with appropriate membership of key stakeholders including Service Delivery Managers, Field Hospital Coordinators, Project Managers, and representatives from Local Authorities.
- Weekly Flash Reports presented to the Field Hospital Bronze Group, which formed the basis of monitoring decommissioning activities and included comprehensive updates on key information including summary of actions to date, RAG ratings for upcoming tasks and any matters of concern for the Group to consider.
- Frequent 1:1 meetings between Field Hospital Site Leads, including Project Managers and Service Delivery Managers, and the Deputy Director of Operations.
- Daily touch-point meetings between Clinical and Nursing Leads, Project Managers, Service Delivery Managers and Field Hospital Support Coordinators.
- Financial reporting by the Finance Committee to the Board on the costs associated with field hospitals, including a schedule of costs associated with Parc Y Scarlets and Bluestone in April 2021.

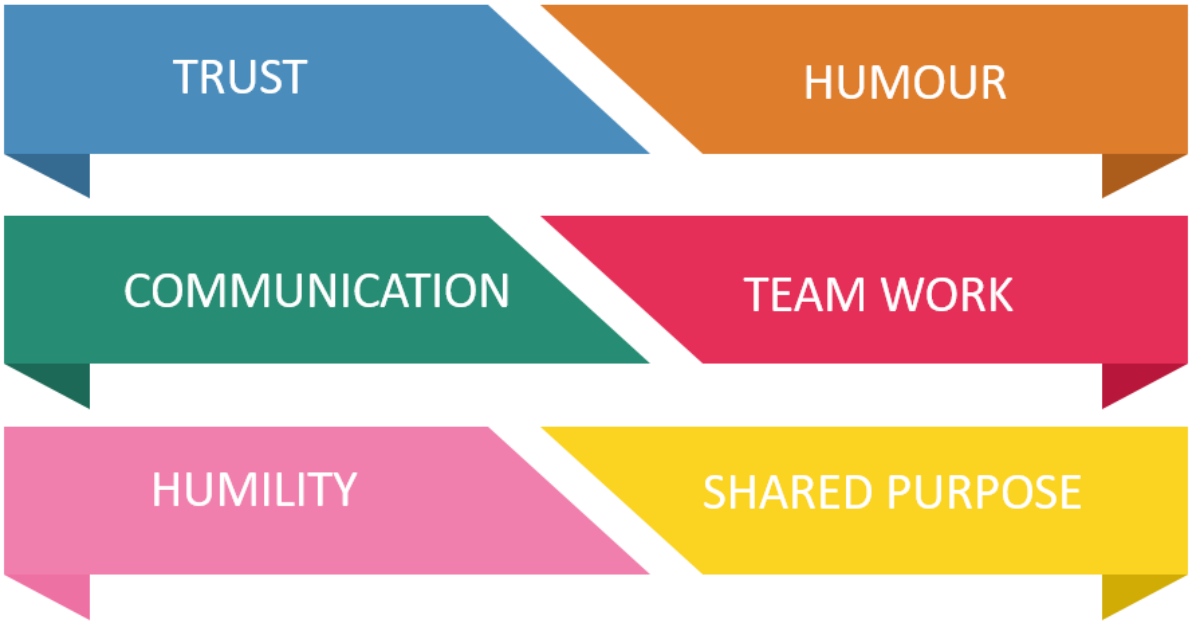
As of December 2021 the status of field hospital sites are:

Field Hospital	Status
Ysbyty Enfys Caerfyrddin	Partly decommissioned/ mothballed in 2020/21 (building/ engineering materials stored on site)
Ysbyty Enfys Llanelli	Decommissioned in 2020/21
Ysbyty Enfys Scarlets (Stadium and Barn)	Decommissioned in 2020/21
Ysbyty Enfys Aberystwyth (Penweddig School and Plascrug)	Decommissioned in 2021/22
Ysbyty Enfys Carreg Las	Decommissioned in 2021/22
Ysbyty Enfys Aberteifi	Decommissioned in 2021/22 – Retained as Test, Trace & Protect and Mass Vaccination facility for a period before being returned to the Local Authority (as a major capital scheme is in the adjacent school).
Ysbyty Enfys Selwyn Samuel	Hibernated - Retained as surge facility in the event of a third wave of COVID-19

Feedback from Lessons Learned exercise(s)

Lessons learned session(s) with operational team members:

Feedback/ lessons learned sessions carried out between September 2020 - July 2021 and the three (3) Field Hospital operational teams noting key themes as vital to a successful operational phase:



It was noted that having the right culture, which promotes open and honest communication with all team members within the immediate and wider system and adapting to need, allowed for what is considered a successful outcome. This along with trust and allowing all colleagues to become leaders by taking on key roles, responsibilities and decision-making.

Trust, transparent communication, humility and a lightening of mood through humour were noted as key in delivering a successful programme and delivery of excellent care for patients in temporary hospitals.

The stated lessons learned including:

- **Leadership** at all levels creates a learning environment and reduced hierarchical emphasis
- Transparent **communication**
- **Empowerment** to solve problems
- Accountability on staff, given tools, **confidence** and support to take measured risks
- **Learning** without compromising patient care
- A humorous and human **compassionate** approach to leadership across all sites and professional levels
- **Culture** of prioritising staff wellbeing and built confidence
- **Flexible** approach to adapt to the rapidly changing pressures in the system
- A **Team** approach to all of the above

Feedback highlighted that the impact of operating Field Hospitals has not only been on the unscheduled care system but has also influenced the wider health and care system. Allowing and encouraging all colleagues to feel a part of one team with the same-shared goal i.e. the team around the patient was seen as vital to providing safe and quality care provision.

Direct quotes from team members in support of the approach included:

Quotes from staff feedback session :

- "I feel appreciated, it feels like a family."
- "Feels like a community, we are shown respect."
- "Brilliant atmosphere, leadership and comradery – we are so lucky."
- "I've enjoyed learning and adapting in my role here."
- "Everyone has been in integrated roles and all mucking in."
- "There is a need for something like this in the community, the set up with pharmacy, Drs, RN's all works so well, we are missing a trick."
- "I never thought I'd be in a job like this, we are more resilient than we think."
- "I've come out of my comfort zone and we should all be proud of the end result."
- "It's not about the building, it's about the people."
- "I now know I want to become a nurse."

See Annex 1: 'Leadership across Field Hospitals in response to the Pandemic in Rural West Wales' for further information on Field Hospital operationalisation phase.

Lessons learned facilitated session – 8th November 2021 (NWWSP Final Advisory Report response)

A facilitated 'lessons learned' session took place on 8th November 2021. This being a recommended management action from the Advisory Report carried out by NWWSP Audit and Assurance colleagues. The specific recommendation being to:

'…..undertake a 'lessons learned' exercise with key individuals across the field hospital commissioning, operation and decommissioning phases in order to identify what went well and what could be done differently, not only for similar projects but potentially also in the operation of acute hospital settings.'

The structure of said session was to review the: (1) Commissioning/ Design & Build; (2) Operationalisation; (3) Decommissioning phases. It was impossible to limit scope to the audit review title of decommissioning as invariably decisions taken in particular at the commissioning phase influenced decisions at the decommissioning phase.

Key questions answered during the semi-structured session for each phase included:

- Did we achieve the original expectations?

- Do we think we achieved the project goals?
- What went well?
    - What made these happen this way?
- What could have gone better?
- What were the key obstacles we faced that could have been avoided?

Attendance at the session included representation from key personnel/ departments that worked across the three phases specifically from:

- Estates and facilities
- COVID-19/ FH Triumvirate
- Project Management Office/ Transformation Programme Office
- Field Hospital site specific Management Team members

See Appendix 1 for named personnel in attendance. The summarised feedback from the session included:

(1) Design & Build/ Commissioning phase	
Question	**Summary of responses**
Did we achieve the expectations?	The general feeling was that expectations were met although recognition that those expectations were 'fluid' from the outset of the design & build/ commissioning phase. Modelling on bed requirement drove what was expected – that modelling starting at a requirement for 500 beds which then rose to 1000 beds, before some discussion regarding 1200 bed requirement before finally settling at 1000 beds needed. Additionally there was fluidity in the medical model at said field hospital sites, driving the design and build of said sites. Original thinking was the model would be similar to field hospitals in the traditional sense i.e. military camp beds, limited nurse provision etc. This then changed in line with the realisation the likely cohort of patients would be elderly and therefore need more care and assistance – this in turn influenced the equipment requirements for FH sites.
Do we think we achieved the project goals?	Yes – in that a significant number of sites/ beds were made available to potentially operationalise should the need be there.

	As already noted the expectations were fluid due to the time constraints on delivery, associated modelling flexing and un-finalised final medical model in which to work towards. However, in the extreme situation that colleagues found themselves, it was felt the project goals were achieved.
What went well? ○ What made these happen this way?	It was an incredible achievement that 9 FH locations were available for use with associated equipment on sites within 5 weeks. The ability of multiple teams across Hywel Dda to mobilise behind a single goal along with the drive and commitment of all involved within the process made this a success. The fear of the unknown and concern regarding the worst-case scenario that the region may be facing drove the commitment to develop field hospitals in order to be able to care for the population. This could not have happened without the significant partnership working that was part of the process. This included close working with Carmarthenshire, Pembrokeshire and Ceredigion County Councils regarding site selection along with utilisation of construction contractors off their existing frameworks – work in this area was very much in partnership in order to achieve the development of FH sites within the extraordinarily tight timescales.
What could have gone better?	The speed in which the development took place did not allow much time to reflect, and work through what would be normal planning and review steps within less pressurised and time sensitive times. Specifically normal site condition surveys of locations was not carried out leaving the organisation open to significant risk of incurring possible 'making good' costs that otherwise could have been avoided. Additionally the process was heavily reliant on the good will of staff to drive the process forward sometimes with

	little or no respite. This pressure potentially having longer-term negative impact on staff wellbeing. The process could also have benefitted from clear emergency planning guidelines in place re; design of wards or community facilities. This was felt not to be in place so in some cases the process 'felt harder than what it could have been'. Noted however, (during lessons learned discussion) that some guidelines are likely to be in place (re ward design etc.) but were not accessed by the project staff largely due to the time pressures already highlighted.
What were the key obstacles we faced that could have been avoided?	Avoidable obstacles included lack of clear emergency plans in the case of a pandemic – although the event being unprecedented it is noted that guidelines/ framework would have been a useful reference point.

(2) Operationalisation phase	
Question	**Summary of responses**
Did we achieve the expectations?	There was a strong feeling that expectations were met – although acknowledgement as within the design & build/ commissioning phase expectations were fluid regarding likely number of Field Hospital sites that would open (either due to demand or ability to staff said Field Hospital sites). That said the expectations of providing a safe and quality care environment (in the sites that did open) were achieved.
Do we think we achieved the project goals?	Residing feeling that the project goals were met - Feedback received as part of operational lessons learned sessions highlighted positive experiences for patients and staff alike.
What went well? ○ What made these happen this way?	Overcoming the various staffing and estate challenges to provide an environment, systems, processes that provided safe and high quality patient care.

	This was achieved by a highly supportive culture in place where all involved were empowered to make decisions and provide the best possible care they could.
What could have gone better?	Various staffing and estate challenges presented during the operationalisation phase. If operational staff had been more closely involved in the design and build/ commissioning phase this may have mitigated the risk of the final facilities and procured equipment indeed being 'fit for purpose'. Examples included FH equipment procured not being suitable for the final facility that was created e.g. commodes. Although it needs to noted that the eventual operational team were not identified until much later. Similarly having consistent programme support resource (across phases 1 & 2) may have positively influenced as would have brought with them knowledge re; rationale for decisions made within phase 1.
What were the key obstacles we faced that could have been avoided?	There was inconsistency in programme support resource with officers involved in the design & build/ commissioning phase being allocated to other areas of work when commencing the operationalisation phase. This had an impact regarding building up site knowledge that may have been mitigated, if there was indeed consistency in support teams.

(3) Decommissioning phase	
Question	**Summary of responses**
Did we achieve the expectations?	All sites were decommissioned (or mothballed), in line with contract termination/ end of contract agreements – therefore it was felt that expectations were met.
Do we think we achieved the project goals?	The goal of the decommissioning phase was to decommission sites in line with contractual agreements/

	timelines – to this end, there was an overall feeling that the goal was met.
What went well? ○ What made these happen this way?	The decommissioning of sites met the expectations. Specifically all sites were decommissioned in line with agreed timescales (with site owners) and associated 'making good' works carried out. To support the process a structured project management approach was followed, with associated site-specific plans, coupled with the commitment and drive of all personnel involved. Additionally decommissioning involved a partnership approach working in conjunction with site owners and third party delivery and equipment storage agents to carry out all works within tight timescales. This approach was of paramount importance to complete the decommissioning within timescales allowed.
What could have gone better?	There was limited realisation of the contract agreements in place regarding the timescales to decommission. This is noted as likely due to the inconsistency in programme support resource across the 3 phases i.e. no 'cradle to grave' support put in place. Therefore a recognition that consistent support across all phases may have eased the burden re; the decommissioning phase.
What were the key obstacles we faced that could have been avoided?	There was inconsistency in programme support resource with officers involved in the initial decommissioning of sites being allocated to other areas of work when the latter elements of decommissioning were carried out. Although a handover/ description of decommissioning works was carried out, the process may have been made more straightforward if a consistent supporting resource was provided. Additionally agreements regarding contract decommissioning periods (agreed within phase 1 – design & build/ commissioning) could have involved those that were likely to be carrying out said decommissioning, as they could have highlighted how challenging agreed

	timelines were likely to be, or flag the level of resource needed so that said timelines did not present such challenges.

Summary of Lessons Learnt/ recommendations:

The Lessons Learnt exercise highlighted general themes that may be adapted to a similar emergency situation, should it occur in the future. These include:

- Decisions made in any Commissioning phase are likely to have an impact on the Decommissioning phase. Therefore, wherever possible it is prudent to include those personnel that may be carrying out said decommissioning in decisions within commissioning. This may include a review of sites prior to commissioning/ condition surveys carried out, or a clear understanding of any contractual agreements put in place namely e.g. if leasing a site reviewing timescales allocated to decommissioning (and potential 'making good' at a site) and whether this is reasonable etc.

- Consistency of programme/ project support staff across Commissioning, Operationalising and Decommissioning phases would allow for relationships and learning from one phase to the next to be transferred. This is of particular relevance in understanding decisions made in the commissioning phase when decommissioning a site/ location.

- A professional Multi-Disciplinary-Team (MDT) approach provides added value, not only in a clinical sense regarding delivery of clinical services but also in having distinct areas of experience and expertise to develop similar schemes. This including: project/ programme management, estates/ facilities, operational service leads (community & acute), finance, HR/ workforce, contract negotiation/ development/ legal. It may be that any future emergency planning procedure recommend expected key skill sets/ representation in any emergency response of this type, similarly highlighting any best practice available.

- The value of due diligence needs to be properly understood if even in moderated form. The decommissioning processes as they have happened at key sites was hampered by the absence of any form of due diligence undertaken ahead of the set up phase. Whilst it is noted that time was not available to undertake these in a model manner, with some effort future cost impacts and protracted discussions with landlords could have been mitigated or even avoided if condition records for the sites converted into field hospitals were compiled at the appropriate time.

Concluding comments

The NWSSP Field Hospital Decommissioning Final Advisory Report noted the below key findings as areas for improvement:

HDUHB areas for improvement:

- Absence of an overarching decommissioning plan/strategy, although task-based decommissioning plans were developed for each site.
- Whilst we found that an operational structure is in place for the decommissioning team this structure is not documented, and roles and responsibilities lack clarity. The SRO / Acting General Manager was heavily involved in the operational arrangements, potentially highlighting the need for additional capacity for operational oversight and co-ordination of the field hospital sites as a whole.
- Inconsistent and insufficient resources allocated to decommissioning phases, with no arrangements for formal handover, resulting in a lack of clarity around responsibilities for key elements such as non-medical equipment and Workforce.
- Poor control over the recording of non-medical equipment during the commissioning phase resulted in a lack of traceability and uncertainty over the completeness of equipment schedules at the point of decommissioning.
- The urgency at the commissioning stage meant that site surveys were not undertaken during design and build phase to agree the condition of sites prior to occupation by the Health Board, resulting in disputes arising as part of the reinstatement process.

The FH management acknowledge all of the NWSSP improvement points, as witnessed by the feedback within the Lessons Learned feedback session (8th November 2021). We agree that the completion of site condition surveys prior to build phase beginning, and consistent and sufficient resources to manage all phases of the programme being of significant importance should an emergency-situation similar to the pandemic occur in the future.

It should however be recognised that decisions made in the Design & Build/ Commissioning phase were made in unprecedented times with significant uncertainty around the potential scale and severity of the COVID-19 pandemic.

Therefore, although in hindsight, there may have been additional planning steps that could have been undertaken; the prudent approach for our population, in conjunction with our partners was to ensure that facilities of sufficient capacity were in place should the pandemic have caused the worst-case scenario to be a reality.

What has also been made evident is that the partnership approach of working with Local Authorities, Welsh Ambulance Services NHS Trust (WAST), the wider public and third sector(s) along with the private sector was required to tackle this emergency – this joint working approach can only prove fruitful in any future partnership working initiatives.

Although there are some acknowledged improvements to the Field Hospital development, operations and decommissioning, the team feel the overwhelming evidence, as witnessed from the feedback in this report, that the Field Hospital programme was a success and positive for those involved.

A case in point being the development of a ‘team around the patient’, which may otherwise not have been possible had said colleagues not received the experience of working within Field Hospitals.

As a Health Board, we welcome the opportunity to embed the learning recorded from the lessons learned exercises that we have undertaken.

The learning from all phases is significant and where possible we will endeavour to utilise this learning to improve on similar processes in the future.

Appendices

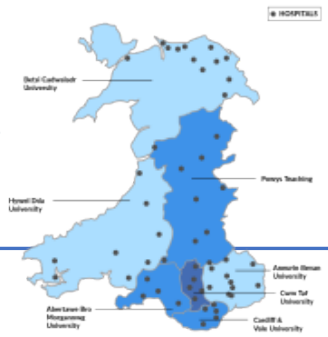
Appendix 1: 8th November 2021 Lessons Learned facilitated session attendees:

Name	Role (in Field Hospital set up/ operations)
Gareth Rees	Acting General Manager (COVID 19 operations)
Anna Llewellin	Interim Head of Nursing (COVID 19 Operations)
Lee Elwell ***(Session facilitator)***	Principal Project Manager – Project & Programme Management (Phases 1, 2, 3)
Joanna Jones	General Manager - Ysbyty Enfys Selwyn Samuel
David Hawkings	General Manager/ Senior Nurse Manager - Ysbyty Enfys Carreg Las
Sarah Williams	Senior Nurse Manager - Ysbyty Enfys Selwyn Samuel
Paul Williams	Head of Property Performance – Estates and facilities Lead (Phases 1, 2, 3)
Yvette Pellegrotti	Project & Programme Management (Phases 1, 2, 3)
Andrew Hopkins	Project & Programme Management (Phases 1, 2, 3)
Kate Tennant	Equipment storage & distribution lead / Operational & Decommissioning Project Management (Phases 2 & 3)

Leadership across Field Hospitals in Response to the Pandemic in Rural West Wales

Dr Meinir E Jones AMD Transformation & Clinical Lead Field Hospitals & Anna Llewellin Head of Nursing COVID-19 Operations

A total of 9 field hospital sites offering 915 beds across the counties of Pembrokeshire, Ceredigion and Carmarthenshire were designed and constructed in collaboration with Local Authority and Hywel Dda University Health Board within 6 weeks to respond andmeetthe predicted Covid-19 case demand. This was to support a rural population of over 380,000 covering a ¼ of land mass of Wales. Three of the 9 sites became operational, admitting a total of 381 patients. The use of field hospital capacity provided a means of easing pressures on the acute hospital sites by creating additional surge capacity for patient who no longer required acute site intervention. These were primarily those patients who required discharge planning or who were waiting on care and support being available in the community setting.



Issue - The establishment of a field hospital raised several logistical and managerial challenges :

- **Timeline** – responding to pandemic in flexible and urgent manner
- **Facilities** – access to beds and facilities to meet patient and staff needs
- **Staffing & clinical support** – appropriate, flexible and expert workforce and support from departments within the NHS such as IT and clinical engineering given the workforce shortages due to sickness and demand
- **Treatment** – Access to treatments including oxygen provision & appropriate POCT to support clinical decision making and reduce unnecessary transfers back to the acute setting
- **Patients** – providing compassionate End of life care and coordinating, supporting and facilitating visits for families. Complexities of cohorting COVID & Non Covid patients
- **Environment** –Leadership and culture to support and adapt to change.

Assessment

This was a huge challenge in addition to existing pressures of the pandemic. To address these we led daily regular touch point meetings to discuss to ensure involvement of the relevant individuals and teams within the organisations:

- Transparency
- Building confidence and trust
- Keeping everyone informed

Real world continuous analysis was conducted, adopting staff feedback and patient experience and outcome measures. Analysis and interpretation were done on a regular basis to allow adaptation in response.

Intervention

This rapid paced implementation, review and adaption of a new system during a pandemic required key leadership and management skills, particularly:

- Trust
- Autonomy
- Transparent communication
- Positive working Culture – positivity, humour,
- Shared purpose
- Staff feeling valued, having a voice
- Enabling and empowering staff to step up into new roles through upskilling

Strategy for improvement

To ensure efficiency and effectiveness, we adopted an iterative process with rapid learning cycles flexible to adapt to shifting goal posts including changes to venues, supplies, government regulations (including Social distancing) and ability to manage infection control. Allowing staff and patients to have a voice in the care pathway was key.

Measurement of improvement

A mixed methods approach was adopted to understand the systems and managerial learning, focusing on patient outcome data and feedback, staff pathways and responses. Rich data was reviewed to streamline services and pathways and weekly meetings were held to review and raise risks, actions and share learning. Escalating issues as required

Impact

- We were able to create surge capacity to support the wider system and alleviate pressure.
- Feedback from patients was positive with ability to support visiting due to enhanced Infection control (4m social distancing & side rooms)
- Cross partnership working- (Military, third party organisations etc.) and collaborative working approach increased efficiency and flexibility
- Problems encountered included system engagement, environmental considerations & workforce.

Lessons learnt

- Leadership at all levels creates learning environment and reduced hierarchy
- Transparent communication
- Autonomy to solve problems.
- Accountability on staff, given tools, confidence and support to take positive risks.
- Learning without compromising patient care
- Humour and human such as a compassionate approach to leadership across all sites and professional levels.
- Culture of prioritising staff wellbeing and built confidence.
- Flexible approach to adapt to the pressures in the system.

Messages for others

Having the right culture, which promotes open and honest communication with all team members within the immediate and wider system and adapting to need, allowed for a successful delivery. Along with trust and allowing individuals to become leaders at all levels taking on roles and responsibilities. **TRUST, TRANSPARENT COMMUNICATION, HUMILITY** and **HUMOUR** were key in delivering a successful programme and delivery of excellent care for patients in temporary hospitals. The impact has not only been on the Health Board system but has also impacted on the wider system. Allowing and encouraging everyone to feel a part of one team with the same shared goal of being the team around the patient

Trust | Transparent Communication | Humility | Humour

Stakeholders: Health Board, County and Town Councils, third party organisations (Scarlets, Bluestone, Just Wales), volunteers, military, Contractors (Lloyd & Gravell', Lorne Stewart) Welsh Government, patients, families, Fire service, funeral directors.