Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	31 March 2022
TEITL YR ADRODDIAD: TITLE OF REPORT:	Chief Executive's Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Steve Moore, Chief Executive
SWYDDOG ADRODD: REPORTING OFFICER:	Sian-Marie James, Assistant Director of Corporate Legal Services & Public Affairs

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to update the Board on relevant matters undertaken as Chief Executive of Hywel Dda University Health Board (the UHB) since the Board meeting held on 27th January 2022.

Cefndir / Background

This report provides the opportunity to present items to the Board to demonstrate areas of work that are being progressed and achievements that are being made, which may not be subject to prior consideration by a Committee of the Board, or may not be directly reported to the Board through Board reports.

Asesiad / Assessment

(1) Register of Sealings

The UHB's Common Seal has been applied to legal documents and a record of the sealing of these documents has been entered into the Register kept for this purpose. The entries at **Appendix A** have been signed by the Chair and Chief Executive or the Deputy Chief Executive (in the absence of the Chief Executive) on behalf of the Board (Section 8 of the UHB's Standing Orders refers).

(2) Consultations

The UHB receives consultation documents from a number of external organisations. It is important that the UHB considers the impact of the proposals contained within these consultations against its own strategic plans, and ensures that an appropriate corporate response is provided to highlight any issues which could potentially impact upon the organisation. A status report for Consultation Documents received and responded to is detailed at **Appendix B**, should any Board Member wish to contribute.

(3) Strategic and Operational Issues: local and regional

Quality and Safety Task and Finish Group – Change, Impact and Restoration
Members are advised that in February 2022, the UHB has established a Quality and Safety Task and Finish Group – Change, Impact and Resolution (T&F Group) that reports to the Executive Team. This T&F Group will facilitate the analysis and review the impact and consequences of changes made across the UHB in response to COVID-19.

This T&F Group is chaired by the Director of Nursing, Quality and Patient Experience and its membership includes the Board Secretary, an acute services clinician, together with officers from the Quality, Patient Experience, Transformation, primary Care and Community teams. The Terms of Reference are attached at **Appendix C** for information.

Home-based Bridging Care Service Evaluation
Members will be aware of the UHB's plan to introduce a pilot Home-based Enhanced Bridging Service to respond to the urgent pressures in the system; to be in place until 31st March 2022.

In response, two recruitment campaigns were held in October 2022 where 34.2 Whole Time Equivalent (wte) offers were made and 16.6 wte staff full on boarded. It was an achievement and testament to our staff that it only took 52 days between the Gold Planning Objective and the first recruit starting in post.

Each county established an Operational Delivery Group to recruit, induct and support the staff. Due to low numbers recruited and other operational pressures related to the third Covid wave, staff were deployed to support community staffing gaps in Ceredigion, the early opening of additional beds in Amman Valley Hospital in Carmarthenshire, and initially Sunderland Ward cover in Pembrokeshire. Home-based bridging care started in January 2022 in Pembrokeshire.

An evaluation of this scheme has been undertaken and the report will be finalised at the end of March 2022, with further financial and impact information. Key lessons and recommendations have been made following the initial recruitment and on-boarding process. A copy of the draft Evaluation Report is attached but is subject to updating in April 2022 (**Appendix D**)

The recruits in each county are now being offered substantive posts, either within the UHB or via a fast-track process with the local authority, depending on their individual preferences.

Building 14, St David's Park, Carmarthen
Formal approval is sought to complete the Lease on Building 14 located on the St David Park site; this is for a 10-year term with the option to terminate (break clause) on the fifth anniversary of the date of the Lease. This is a Local Authority owned building, leased by the UHB to support the occupation of centralised finance, procurement and audit teams. The UHB entered into an Agreement for Lease and occupied the building on the 22nd February 2019, the completion of the Lease being conditional on agreed works being undertaken by the Landlord. However, this Agreement for Lease was not submitted for the necessary Board approval for a Lease of this value at the time. The Local Authority has recently completed these works, and the UHB has now signed off these works allowing the UHB to complete.

On the basis that the Agreement for Lease and the works involved have been completed, formal approval is sought to complete on the Lease at a cost of an estimated £140,000 per annum over the 10-year term (to include rent, service charges, rates, utilities, cleaning, waste and maintenance). If Board approval is given (required for lease values over £500,000), the Lease will be signed under seal on 31st March 2021.

Unit 3, Dafen, Llanelli

The Board is also asked to note the Lease for Unit 3, Dafen, Llanelli to accommodate the Medical Record Scanning proposal previously supported by Board as part of the utilisation of recovery funding. This proposal is linked to a current Planning Objective to address a corporate risk. The costs for this lease are £90,000 plus VAT per annum for a term of 10 years, with a break clause at year 5.

Therapies Assistant Practitioner Diploma

On 28th February 2022, I am pleased to advise Members that 23 Band 4 Therapies Assistant Practitioners started a new and unique programme of study. Staff from podiatry, occupational therapy, dietetics and physiotherapy were enrolled onto the Therapies Assistant Practitioner Diploma run by the University of Wales Trinity Saint David (UWTSD). This new 18-month, Level 4 programme has been developed by professional staff in each of our Therapies professions and Learning and Development colleagues, working in partnership with UWTSD managers and academic staff.

Including modules in Developing Therapeutic Relationships, Study Skills, Research Skills to promote Health and Wellbeing, Therapy Assistant Practitioner Professional Skills and Clinical Decision Making, the programme will support both university and multi-professional Therapies Assistant Practitioners to increase their effectiveness in clinical practice and maximise their career opportunities through new routes into professional training.

This is the first course of its kind to run in Wales and we have worked with Therapies colleagues from across Wales to ensure the programme can eventually be delivered to Therapies Assistant Practitioners in other Health and Social Care organisations.

Llwynhendy Tuberculosis (TB) Outbreak Review

Members will recall that I provided you with the Terms of Reference for the Llwynhendy Tuberculosis (TB) Outbreak Review at previous Board meetings (30th September 2021 and 25th November 2021).

Members are advised that the review of the response to the TB outbreak in the Llwynhendy area jointly commissioned by Public Health Wales and the UHB will be delayed slightly. The report was due to be delivered around May 2022, and is now likely to be completed later in the year and presented to Board towards the end of 2022.

The delay is due to unforeseen issues in providing temporary contracts to the review panel, which meant they were unable to access information to carry out the review. Additionally, the rise in COVID-19 cases due to the Omicron variant restricted access to sites. The contractual issues have now been resolved, along with the reduction in COVID-19 cases, meaning that the panel's work is now underway.

The review is being chaired by Professor Mike Morgan, previously NHS England's National Clinical Director for Respiratory Disease. It will examine whether the response to the outbreak since 2010 overall, and at each stage, was conducted in accordance with best practice guidance in place at the time of each phase of the outbreak.

It will also review any reported cases of people identified over the course of the outbreak who have sadly died where the death certificate identified that TB contributed to, or caused, the death. Additionally, individuals who have developed active TB will also be reviewed to assess whether they have been managed appropriately.

Development of A Regional Collaboration for Health (ARCH) Mid and South West Wales Regional Centre of Excellence Cellular Pathology Laboratory, Regional Diagnostic Immunology Laboratory Facility and Regional Medical Microbiology facility
Swansea Bay University Health Board (in partnership with the UHB and Public Health Wales NHS Trust) is leading the project for a new build facility for Regional Pathology across both Health Boards.

In November 2020, WG approved a Strategic Outline Case (SOC), which had been approved by the Board in March 2019, supporting this development to progress to Outline Business Case (OBC) stage. Between February 2021 and January 2022, the South West Wales Regional Pathology Project Board, which includes representation from all three partner organisations, Swansea University and the NHS Wales Collaborative, evaluated a long list of potential locations within the region and agreed a shortlist of site locations within Morriston Hospital. The preferred option is a site adjacent to the existing Pathology Unit at Morriston Hospital. More detailed information about the option appraisal, which included possible sites in Carmarthenshire, is in the Swansea Bay UHB Board paper (**Appendix E**).

(4) National Issues

Joint Escalation and Intervention Arrangements
I am pleased to advise Members that on 3 March 2022, the Director General Health and Social Services/NHS Wales Chief Executive confirmed that she will be recommending to the Health Minister that the UHB's escalation status remains unchanged at "enhanced monitoring".

This follows a recent tripartite meeting with Welsh Government, Audit Wales and Healthcare Inspectorate Wales, where the UHB's good leadership was acknowledged. The group asked the UHB to consider the need to address its current financial position and financial strategy linked to future service and workforce plans, and to focus on urgent and emergency care and its continued workforce challenges.

The UHB is committed to reducing the delays our population is facing at times when trying to access our local Urgent and Emergency Care services, and has submitted its Improvement Plan to Welsh Government officials. The plan reflects the actions across the whole system and our plan to improve further our management processes to facilitate these improvements.

Integrated Medium Term Plan 2022/25
Members will be aware that it was our ambition to submit an approvable Integrated Medium Term Plan (IMTP) for the period 2022/25. This would be the first time our Health Board has been in a position to do this, largely due to the longstanding sustainability and financial challenges that exist in the NHS in West Wales, and would represent a bridge to the delivery of our strategy *A Healthier Mid and West Wales*.

The UHB has advised WG that it will not be in a position to submit a financially balanced IMTP by 31st March 2022, but we will be submitting a draft Three-Year Plan 2022/25, with a robust and detailed focus on 2022/23 actions, which we intend will set the foundations for an IMTP to be submitted in the summer.

COVID-19 Public Inquiry: Draft Terms of Reference
Members are advised that the draft Terms of Reference (ToR) for the UK COVID-19 Inquiry led by Baroness Hallett have been published for consultation; a copy is attached at **Appendix F**. The Health Board's Public Inquiry Readiness Governance Group has discussed the draft ToR and their initial thoughts and suggested additions are provided below:

The Terms of Reference should include a reference to the impact of:

- Immigration and asylum seekers on the health and care sector;
- Outbreaks of COVID-19 in universities on health services;
- Tourism on health services in rural areas; and
- An area with an older demographic, such as outbreaks in care homes restricting movement and inpatient demand.

In addition, it compared and contrasted the draft ToR against the areas considered to likely be included in the Public Inquiry and noted that the following were missing:

- Governance: decision making structures (Command structure) and risk assessment and monitoring processes, including clinical decision making;
- Effective partnership working: Local Authorities (Field Hospitals and Mass Vaccination Centres), Community Health Councils and Third Sector organisations
- Whistleblowing;
- Staff support and welfare;
- Data analysis: detection and response to different variants;
- Communication with stakeholders (politicians and CHC), staff and patients; and
- Forward planning: the use of data in capacity planning in the short to medium term (modelling) and in the medium to long term for planned care recovery.

There are four questions in the on-line consultation response: the first asking if there are any additional matters we wish to include; the second asking if we agree with the order of the evidence to be considered; the third, whether we consider there should be an end date for public hearings; and the fourth, how should the Public Inquiry be run.

The closing date for responses is 7th April 2022 and the UHB is proposing to submit the above suggested amendments in response.

Welsh Ambulance Services NHS Trust: Review of Service Rosters

The Welsh Ambulance Services NHS Trust (WAST) is undertaking a review of its emergency medical service rosters in response to its 2019 Demand and Capacity Review; this was led by Operational Research in Health (ORH) on behalf of the Emergency Ambulance Services Committee (EASC).

ORH identified that a review of the rosters would help to better align staffing with times and areas of peak demand; improving patient safety and optimising the use of resources. Both WAST and EASC are committed to improving service delivery, and of significance to the UHB, a rural impact assessment demonstrated that all three counties in the UHB should receive an increase in staff numbers to meet the roster requirements.

Argymhelliad / Recommendation

The Board is invited to:

- **Endorse** the Register of Sealings (**Appendix A**) since the previous report on 27th January 2022;
- **Note** the status report for Consultation Documents (**Appendix B**) received/responded to;
- **Note** the Terms of Reference for the Quality and Safety Task and Finish Group – Change, Impact and Restoration (**Appendix C**);
- **Note** the draft Evaluation Report on the Home-based Bridging Care Service (**Appendix D**);

- **Approve** the completion of the Lease for Building 14, St David's Park, Carmarthen for a term of 10 years (with a break clause on the fifth year) at a cost of an estimated £140,000 per annum over the term (to include rent, service charges, rates, utilities, cleaning, waste and maintenance);
- **Note** the Lease for Unit 3, Dafen, Llanelli to accommodate Medical Record Scanning for a term of 10 years (with a break clause on the fifth year) at a cost of £90,000 plus VAT per annum;
- **Note** the progress on the new build facility for Regional Pathology (Development of A Regional Collaboration for Health (ARCH) Mid and South West Wales Regional Centre of Excellence Cellular Pathology Laboratory, Regional Diagnostic Immunology Laboratory Facility and Regional Medical Microbiology facility) across both the UHB and Swansea Bay UHB (**Appendix E**)
- **Note** the draft Terms of Reference for the UK COVID-19 Inquiry (**Appendix F**) and the UHB's proposed suggested amendments.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s): Hyperlink to NHS Wales Health & Care Standards	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives: Hyperlink to HDdUHB Strategic Objectives	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners Develop a sustainable skilled workforce Support people to live active, happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Chief Executive's meetings (internal, external and NHS Wales wide), diary and correspondence
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Any issues are identified in the report.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Any issues are identified in the report.
Gweithlu: **Workforce:**	Any issues are identified in the report.
Risg: **Risk:**	This report provides evidence of current key issues at both a local and national level, which reflect national and local objectives and development of the partnership agenda at national, regional and local levels. Ensuing that the Board is sighted on key areas of its business, and on national strategic priorities and issues, is essential to assurance processes and related risks.
Cyfreithiol: **Legal:**	Any issues are identified in the report.
Enw Da: **Reputational:**	Any issues are identified in the report.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	• Has EqIA screening been undertaken? Not on the Report • Has a full EqIA been undertaken? Not on the Report

Appendix A - Register of Sealings from 14th January 2022 – 7th March 2022

Entry Number	Details	Date of Sealing
349	Deed of Novation Framework Agreement and Call Off Contract Relating to an Overarching Supported Living Services Contract between Pembrokeshire County Council, Hywel Dda University Local Health Board, The Royal National Institute for Deaf People and Achieve Together Ltd	17.02.2022
350	Agreement for Lease with Tenant's Fitting Out Works Relating to Unit 1 Honeyborough Industrial Estate, Neyland, Milford Haven SA73 1SE Between Hywel Dda University Local Health Board and Aspect Developments (Wales) Ltd	17.02.2022
351	Lease Relating to Premises Known as Unit 1 Honeyborough Industrial Estate, Neyland, Milford Haven SA73 1SE Between Hywel Dda University Local Health Board and Aspect Developments (Wales) Ltd	17.02.2022

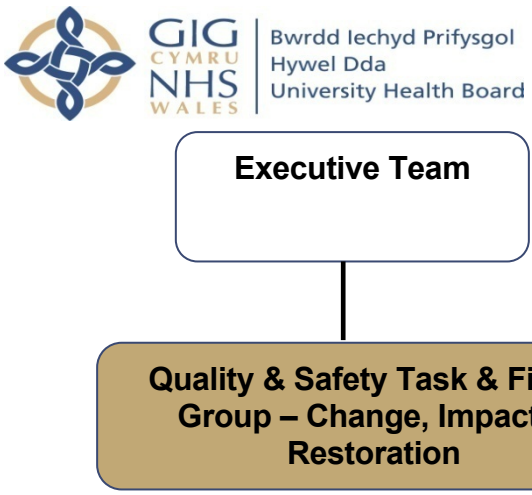
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Appendix B: Consultations Update Status Report up to 7th March 2022

Ref No	Name of Consultation (hyperlink included for online consultations)	Consulting Organisation	Consultation Lead	Received On	CLOSING DATE	Response Sent
474	Tobacco control strategy for Wales and delivery plan	Welsh Government	Bethan Lewis, Joanna Dainton - lead, Joanne McCarthy, Jan Batty	10.11.2021	31.03.2022	
475	Violence against women, domestic abuse and sexual violence (VAWDASV) National Strategy	Welsh Government	Mandy Rayani, Mandy Nichols-Davies, Rachel Munkley	14.12.2021	01.02.2022	25.01.2022
476	Disability Workforce reporting	UK Government	Lisa Gostling, Annmarie Thomas	04.01.2022	25.03.2022	
477	Obesity Surgery for Severe and Complex Obesity	Welsh Health Specialised Services Committee	Claire Jones, Dr Meryl James, Dr Akhila Mallipedhi, Zoe Paul-Gough	05.01.2022	09.02.2022	09.02.2022
478	Learning Disability Action Plan 2021-2026	Welsh Government	Andrew Carruthers, Liz Carroll, Melanie Evans	24.01.2022	28.02.2022	28.02.2022
479	Possible - Audit Wales proposed equality objectives for 2022-2026	Audit Wales	Lisa Gostling, Anna Bird, Helen Sullivan	01.02.2022	04.03.2022	22.02.2022

Appendix B: Consultations Update Status Report up to 7th March 2022

Ref No	Name of Consultation (hyperlink included for online consultations)	Consulting Organisation	Consultation Lead	Received On	CLOSING DATE	Response Sent
480	Mental health workforce plan for health and social care in Wales	Health, Education and Improvement Wales	Lisa Gostling, Tracy Walmsley	07.02.2022	28.03.2022	
481	Specialised and Non Specialised Paediatric Orthopaedics	Welsh Health Specialised Services Committee	Prof. Phil Kloer, Mark Henwood, Owain Ennis, Lydia Davies	24.01.2022	04.03.2022	02.03.2022



QUALITY & SAFETY TASK & FINISH GROUP – CHANGE, IMPACT & RESTORATION

TERMS OF REFERENCE

Version	Issued to:	Date	Comments
V1	Quality & Safety Task & Finish Group – Change, Impact & Restoration		
V2	Executive Team	09/02/22	Amend membership
V3	Executive Team		
V4			
V5			
V6			
V7			

QUALITY & SAFETY TASK & FINISH GROUP – CHANGE, IMPACT & RESTORATION

1. Constitution

1.1 The Quality & Safety Task & Finish Group – Change, Impact & Restoration has been established as a reporting group of the Executive Team and constituted from February 2022.

2. Membership

2.1 The core membership of the Quality & Safety Task & Finish Group – Change, Impact & Restoration will consist of the following:

Membership
Director of Nursing, Quality & Patient Experience (Chair) (Mandy Rayani)
Deputy Medical Director, Acute Services (Mark Henwood)
Assistant Director of Nursing – Acute Services (Sian Passey)
Head of Quality & Governance (Cathie Steele)
Head of Strategic Performance Improvement (Catherine Evans)
Assistant Director Legal Services & Patient Experience (Louise O'Connor)
COVID 19 Pandemic Response Support (Sonja Wright)
Board Secretary (Joanne Wilson)
Community Representative TBC
Primary Care Representative TBC
Performance Manager (Tracy Price)
Head of Transformation and Engagement Programme Office (Helen Morgan-Howard)
Head of Engagement – (Rebecca Griffiths)

2.2 Membership of the Quality & Safety Task & Finish Group will be reviewed initially on a 6 monthly basis.

3. Quorum and Attendance

3.1 A quorum shall consist of no less than a third and must include as a minimum either the Chair or their nominated deputy.

3.2 Should any officer member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair.

4. Purpose

4.1 The Quality & Safety Task & Finish Group – Change, Impact & Restoration has been established by the Chief Executive to facilitate the development of an informed analysis of the impact and consequences associated with the changes made within the Health Board in response to the COVID-19 pandemic.

5. Key Responsibilities

5.1 The Quality & Safety Task & Finish Group – Change, Impact & Restoration will:

5.1.1 Develop a matrix and report which clearly sets out the core elements associated with the operational changes made to provide a triangulated analysis. The report will be utilised to enable Independent Members to discharge their responsibility of scrutinising the Health Board response to the pandemic through a quality & safety lens.

5.1.2 Utilise the information relating to operational changes made throughout the pandemic to form the basis of the analysis. Focus will be given to the underpinning rationale for the changes made through the Command & Control structure (more latterly the Operational Planning & Delivery Programme) and the impact and consequences, where known, on the experience, harm and clinical outcomes for patients.

5.1.3 Identify any new metrics or approaches required to enable the consequences of the identified operational changes to be understood in the context of quality & safety (this includes patient and staff experience).

5.1.4 Engage with the CHC to ensure that the voice of the wider population served by the Health Board is considered when analysing the impact of changes made by the Health Board during the pandemic as well as informing future service arrangements.

5.2 The outcome of the analysis will be shared with the Command & Control structure (more latterly the Operational Planning & Delivery Programme) to inform decision-making about service restoration as the organisation emerges from the pandemic.

6. Agenda and Papers

6.1 The agenda for each meeting will be based around the Quality & Safety Task & Finish Group – Change, Impact & Restoration's work plan, matters arising from previous meetings, issues emerging throughout the year and requests from members. Following approval, the agenda and timetable for papers will be circulated to all members.

6.2 All papers must be approved through the Chair.

6.3 The agenda and papers for meetings will be distributed **five** days in advance of the meeting.

6.4 The minutes and action log will be circulated to members within **seven** days to check the accuracy.

7. Frequency of Meetings

7.1 The Quality & Safety Task & Finish Group – Change, Impact & Restoration will meet fortnightly and shall agree an annual schedule of meetings. Any additional meetings will be arranged as determined by the Chair of the Group.

7.2 The Chair of the Quality & Safety Task & Finish Group – Change, Impact & Restoration, in discussion with the Secretary shall determine the time and the place of meetings of the Group and procedures of such meetings.

8. Accountability, Responsibility and Authority

8.1 The Quality & Safety Task & Finish Group – Change, Impact & Restoration will be accountable to the Executive Team for its performance in exercising the functions set out in these terms of reference.

9. Reporting

9.1 The Quality & Safety Task & Finish Group – Change, Impact & Restoration, supported by the Secretary, shall:

9.1.1 Report formally, regularly and on a timely basis to the Executive Team on its activities;

9.1.2 Bring to the Executive Team's specific attention any significant matters under consideration by the Quality & Safety Task & Finish Group – Change, Impact & Restoration.

10. Secretarial Support

10.1 The Quality & Safety Task & Finish Group – Change, Impact & Restoration Secretary shall be determined by the Chair.

11. Review Date

11.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis for approval by the Executive Team.

Home Based Bridging Care Project Evaluation

DRAFT :

Contents

Introduction & Project Initiation

On 10th September 2021 the project initiation meeting for the Home-based Enhanced Bridging Scheme was held. The Health Board Gold Command agreed the following Planning Objective on 8th September:

With recruitment processes starting during week commencing 13th September, the HB's existing Bridging Service will be immediately extended such that it can provide transitional support to all patients awaiting domiciliary care up to the point when an appropriate package of care becomes available or the 31st March 2022 (whichever is sooner).

An exit strategy from this arrangement for each individual receiving bridging support will need to be agreed prior to the commencement of that support recognising and planning for the fact that, whilst local authorities would seek prompt transfer from any temporary provision for each individual receiving bridging support, there is a risk that this would not be possible.

The proposed model will aim to enhance existing integrated arrangements in each County area and its impact will be closely monitored from inception so that decisions can be made on refinement / cessation as appropriate. The expectation is that there are no/minimal delays for patients deemed ready to leave across all HB services.

Arrangements will be designed to prevent negative wider system impact e.g. by avoiding recruitment directly from the existing health and domiciliary care capacity within the region and have a comprehensive risk register to support this.

It is not anticipated that the implementation of this service extension includes the opening of Field Hospital capacity as part of the solution which would require Gold Command Group consideration before enacting. The above does not entail setting aside the usual assessment process to establish eligibility and undertaking timely reviews of packages for those in receipt of domiciliary care.

This report seeks to share the learning and outcomes from the project to date, in order to inform future discussion and decision making.

Scope/Definition

In order to ensure consistency of terms across the region the following definition was agreed as:

Bridging care provides additional capacity to bolster the provision of home care and support in the short to medium term where other forms of social care are not available within a timescale that is deemed reasonable relative to the risk in the system. It enhances the community Support Worker workforce which will integrate and enhance social care provision in partnership with Local Authorities.

Care may be provided :

- for those individuals at home to prevent or reduce the risk of an urgent admission to hospital / residential care
- for those individuals in an acute or community hospital bed who require care to enable their discharge home
- for those individuals in an Interim care bed to support transfer home

Dependent on the specific local drivers of demand and need, Bridging Care can be provided in the following ways:

- Providing additional capacity to home-based care to increase social care availability
- Providing additional capacity for home based care where a long term care provider has advised they can currently only provide a proportion of the total care package
- Providing the care at home for an individual / patient where long term care provider has agreed to provide care however unable to start until a date in the future.

- Providing additional capacity to support safe staffing in step down beds in community

Furthermore, it is proposed that due to the significant risk in accessing onwards packages of long term care and therefore blocking the bridging care services, the following definition for **Interim Long Term Care** could be considered as part of the scope of this proposal :

Interim Long Term Care can be provided by the community Support Worker workforce deployed through the Local Authority registered home care service on a short-medium term basis in order to increase the total capacity of home based social care. This workforce would need to be registered with Social Care Wales which will be supported during a joint induction process. This workforce could also provide assessed Continuing Health Care and other health related packages to release capacity into social care system and Fast Track packages.

Staffing Requirement

To understand the scale of the issue an initial scoping exercise was undertaken to inform the challenge facing home based care. The baseline position on 10th September 2021 was :

County	Current Dom Care Waiting List	People waiting at home	People waiting in hospital	People waiting in an interim bed	People already bridged through health or reablement teams
Carmarthenshire	111	61	31	3	16
Ceredigion	72	25	6	1	40
Pembrokeshire	104	64	18	22	20

In order to care for the whole brokerage waiting list it was assessed that there would be a need for **175WTE** home based care support workers in the system.

- Carmarthenshire – maximum 65WTE
- Ceredigion – maximum 45WTE
- Pembrokeshire – maximum 65WTE

Additional Support Staffing – in order to effectively train, manage and support this workforce it was also identified that there needed to be c.4-5 additional clinical staff per County – this would be further considered and assessed throughout the pilot.

Management Staff – it was also suggested that to effectively run the service sufficient management and administration/co-ordination would be required in the basis of c. 3WTE per County.

Workforce Assumptions – on the basis of seeking an additional 175WTE the following workforce assumptions were made:

- 50% down time contingency to support travel, training, peer support & supervision
- 1HCSW band 2 based on 37.5 hours pw for 42 weeks of the year – factoring in sickness and annual leave
- Agenda for change enhancements applied
- 1 B5 RN to provide supervision and clinical governance / oversight for caseload for every 45WTE HCSW – core hours

- 1 B4 Assistant Practitioner to provide direct caseload and team support including reviewing and rightsizing packages and some therapy support / trusted assessor function for every 15WTE HCSW – core hours
- Administrative / management support to be confirmed
- Two initial costing models were presented to the group. The first model, which was based on 700 hours of care was recorded as costing £995,423.94 with the second, based on a 1700 hours of care, costing £1,920,847.88.

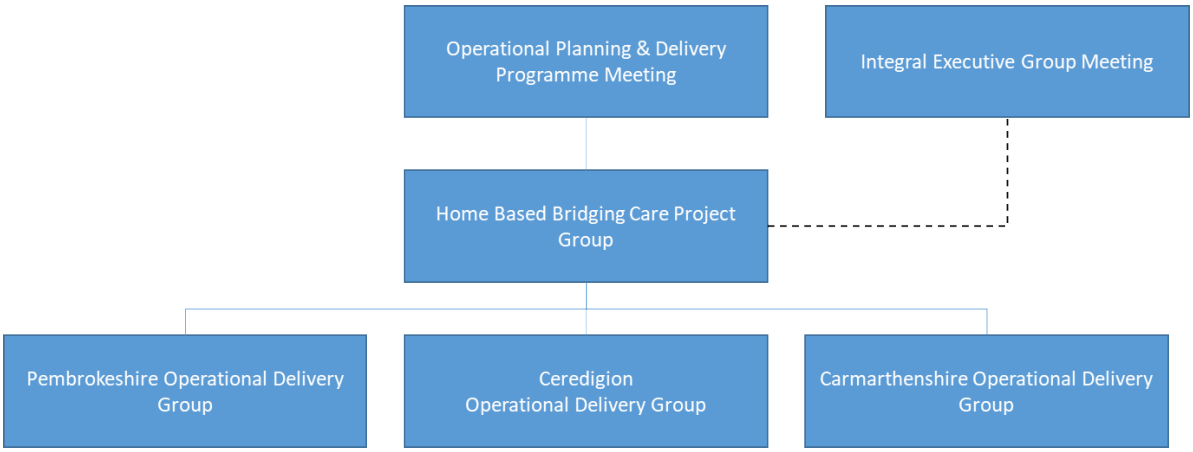
The initial breakdown was then revised and resulted in a reduction in the WTE from 175 WTE to 60 WTE. The break down by county was noted as:

The full costing breakdowns of the models/methodology are noted in **Appendix 1**. The initial breakdown was based on an WTE of 175 which then was revised to **60 WTE** to focus on those people who would need care to either support a transfer home from hospital or to avoid a hospital admission.

Project Reporting Structure

In order to deliver on this key project, four new groups were created reporting at a Health Board and Regional Partnership Board level:

- Home-based Bridging Care Project Group
- Pembrokeshire Operational Delivery Group
- Carmarthenshire Operational Delivery Group
- Ceredigion Operational Delivery Group



The Home-based Bridging Care Project Group provided the regional co-ordination and alignment. Meetings were held fortnightly and key priorities included:

- Co-ordination of the project plan
- Development of a single job description and recruitment plan
- Assessing and managing the risks
- Providing co-ordinated reporting and seeking approval for further developments
- Impact Assessment

The three County specific Operational Delivery Groups (ODGs) were tasked with the following actions and submitted fortnightly highlight reports:

- To agree the scope of the bridging care model using the definition and principles locally

- Identify what team this additional recruitment will enhance, rather than the development of a new separate team
- Develop the local workforce model including the need for the additional roles
- Interviewing and locally inducting recruits
- Reporting on outcomes
- Operationally delivering the model
- Submit an updated report using a template to the Home Based Bridging Care Project Group meeting
- An Action log was created for the ODGs to track progress (As found in Appendix 2)

Lesson Learnt

Project management support
Due to the rapid pace at which this project needed to be mobilized, the implementation of project management structures should have been considered at the start and appropriate resources made available until the end of the project.

Membership

Home based bridging Care Project Group

- Senior Responsible Officer (SROs): County Director - Pembrokeshire
- Project Management/Support: Senior Project Manager, Transformation Programme Office (TPO), Project Manager, (TPO)
- Carmarthenshire Operational Delivery Group members
- Pembrokeshire Operational Delivery Group members
- Ceredigion Operational Delivery Group members
- Finance representative
- Workforce representatives
- Professional nursing representative
- Corporate risk representative
- Finance business partner

Carmarthenshire ODG	Ceredigion ODG	Pembrokeshire ODG
Chair - County Director General Manager GGH General Manager PPH Head of Recruitment Head of Nursing LA Head of Adult Social Care LA Head of Commissioning Human Resources, Workforce and Organisational Development representative Head of Workforce Development and Education Assistant Head of Workforce Head of Nursing Head of Integrated (Older Adult) Services	**Chair - County Director** Assistant Head of Workforce General Manager BGH Head of Nursing Head of Recruitment Head of Workforce Development and Education Human Resources, Workforce and Organisational Development representative LA Head of Adult Social Care LA Head of Commissioning Senior Workforce Manager	**Co-Chair - General Manager Pembrokeshire** **Co-Chair - LA Head of Adult Social Care** Assistant Head of Workforce Clinical Lead Nurse Urgent & Intermediate Care Finance Business Partner Head of Financial Planning Head of Recruitment Human Resources, Workforce and Organisational Development representative Intermediate Care Services Manager LA Head of Commissioning

Head of Homes & Safer Communities Senior Workforce Manager		PA County Director & General Manager Senior Workforce Manager

Lessons Learnt

Registered Nurse (RN) representation

There were limited clinical/registered nurses on the Project Group and in the ODGs at the start of the program. To mitigate this, further scoping of the stakeholder groups and the membership of those would need to be considered and a regular review of the membership of each group.

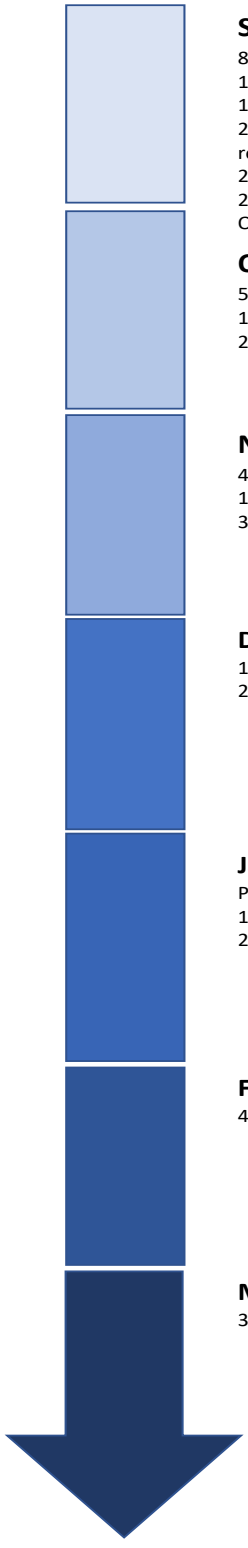
SharePoint and Documentation

Within this project, the use of SharePoint was primarily for document storage and to help facilitate version controls. Links to documents were circulated when they needed to be updated which included the action log and the template for recording the baseline metrics. However, it was noted that the files were not being updated and statistics for the site show that its over all usage was very limited. In addition to this, non-NHS members were difficult to add to the group to ensure data sharing.

Integrated Impact Assessment

Due to the rapid response needed, it was not until later into the project that it was identified that an Integrated Impact Assessment was required. Ideally, any form of assessment should be undertaken as early as possible to help incorporate and mitigate any issues which may arise.

Timeline



September 2021

8th September 2021 – Gold / Executive Team Ask
10th September – First Scoping Meeting held
13th September 2021 – Scope and Project Aims Presented to Project Group
27th September 2021 – Revised criteria to go to Health/Rescoping of Need leading to a reduction in WTE expectations
27th September 2021 - Teams channel set up
27th September – Job description approved
ODG memberships agreed and set up

October 2021

5th October 2021 - Performance Metrics presented to project group
1st October 2021 – 10th October 2021 –Adverts issued for HCSW
20th October 2021 – 31st October 2021 – Adverts issued for HSCW for second time

Nove mber 2021

4th November 2021 – first four staff recruited begin induction
15th November 2021 – Requested for ODGs to review Membership
30th November 2021 –base line data collection agreed

December 2021

1st December 2021 to 13 th December 2021 - Baselining metrics data expected
20th December 2021 to 3 rd January 2022 - Baseline metrics data expected

January 2022

Project Evaluation begins
13th January – 24th January 2022 - Staff Evaluation circulated for completion
24th January 2022 – Lessons learned from ODGs around recruitment collected

February 2022

4th February – Gold consideration of HCSW contract extension to end June 2022.

March 2022

31st March 2022 - Phase 1 comes to an end

Project Evaluation Measures

Originally it was intended to undertake a full evaluation using the following measures :

Process Measures Bridging Service

- No. on active caseload
- Rationale for bridging e.g. D2RA assessment, Reablement, LTPOC, CHC, fast track
- WTE Employed staff & staff mix
- Care package at commencement of service – No. hours, No. carers, No. calls
- Care package upon handover of the patient - No. hours, No. carers, No. calls
- Average length of stay - days

System Outcome Measures

- No. ED lodgers at 8.30am
- No. surge beds at 8.30am
- No. patients in hospital bed, medically optimised on D2RA Pathway 2 & no. days
- No. patients in hospital bed, ready to leave waiting POC / Reablement & no. days
- No. people & total hours waiting on LTPOC brokerage list – in community & hospital

Balancing Measure

- No. patients readmitted within 28 days of discharge
- Reduced interest in domiciliary care adverts
- No. of applications received for HCSW who are working within social care sector (either independent or Local Authority

However, given the small number of staff recruited and the deployment of many of the staff to different services the evaluation measures were significantly refined as reflected in the next section.

Lesson Learnt

Performance indicators- evaluation of project
To evaluate the impact of the project, 20 performance indicators were proposed to the project group and feedback requested. Limited feedback or comment was received so they were taken as agreed although due to the reduced scale of the project were not achievable. Operational groups need to be more engaged in the discussion on evaluation to ensure understanding of purpose and responsibilities.

Results and Analysis

Project Evaluation

A template was created in the MS Teams channel for ease of data collection and recording. Completion of baseline data proved challenging due to the size of recruited staff in each County and operational demands reducing the time available for data collection and reporting.

Ceredigion ODG:

- Ceredigion does not have a Bridging services as such so will not be implementing [performance indicator data collection / reporting]
- These staff will be incorporated into existing community structures and would not be a new, separate team that requires additional monitoring outside of existing processes.
- A brief narrative update on what these staff have been doing can be provided but this will be consistent with the wider team.

Carmarthenshire ODG:

- Data has been collected re the existing Bridging (and our IC MDT) since beginning of October. This can be used as a baseline and will monitor improvements against this from the date when the new resource comes online.
- Additional metrics can be included.

Pembrokeshire ODG:

- Baseline information is available for the existing bridging service and metrics can be reviewed against that position.

A meeting was held on 13th January by the Project team to review and agree a more pragmatic and proportionate approach to evaluation. The following was agreed :

- Recruitment process, learning and outcomes including overall headcount increase across sector
- Staff feedback on the recruitment process, on boarding, role and future ambitions
- ODG Feedback on the process, learning, utilisation of additional staff and impact
- Patient stories
- Local Authority feedback on workforce and impact
- System impact on changes identified
- Cost of the care compared to alternative system costs

Patient Experience

It was proposed that Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) needed to be collected as part of the evaluation of the home based bridging care team project (Phase 1). The International Consortium for Health Outcomes Measurement (ICHOM) "Standard Set for Older Person" PROM tool as initially considered and discussions held with the Value Based Health Care (VBHC) Team. It was not possible to use DrDr system and the same questionnaire as used for the NHS Benchmarking Intermediate Care Project was considered but also discarded due to logistical challenges in collecting the data. It was then agreed to use the Most Significant Change method of evaluation.

Lessons Learnt

Patient Reported Outcome Measures (PROMs)- Evaluation of project

It became apparently early that capturing the patient story would be important. It was noted that some of the traditional methods of PROM and PREM collection would not be suitable for this scheme due to the wait for electronic systems to be set up. Finding alternative ways of capturing patient feedback is needed early into a project recognising the timescale and scope of the project.

Most Significant Change
ODG support is needed to undertake patient feedback, this takes specific focus and effort which may be challenging at times of operational pressure and therefore project support needs to be considered.

Recruitment

During the initial scoping of the project, it was noted a requirement of 175 WTE Band 2 HCSW along with additional supervisory, administrative and management staff would be needed. The WTE requirement for Band 2 WTE was reduced to 60 WTE following a reassessment of those people with a healthcare need to enable them to either avoid an imminent hospital admission or support transfer home following admission.

The HCSW Band 2 Job description was approved on the 27th September 2021 with the first recruitment advertising campaign running between the 1st October 2022 and 10th October 2021. This was followed up with a second campaign between the 20th October 2021 and 31st October 2021. In addition to the HDUHB and NHS Jobs website, this was also advertised on Facebook and Twitter.

A summary of the social media statistics are as follows:

FACEBOOK		TWITTER	
Reach	79732	Retweet	54
Comments	145	Like	25
Share	511	Comments	3
Likes	147	TOTAL	82
TOTAL	80535	GRAND TOTAL	80617

The recruitment figures as at end January 2022 were as follows:

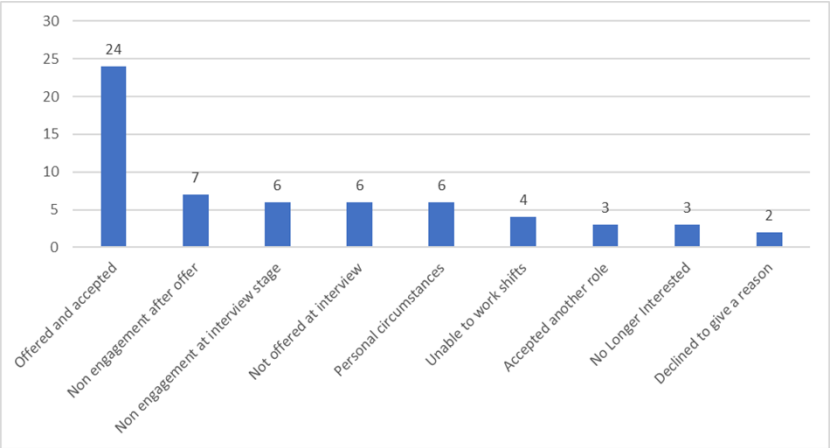
	Carmarthen		Ceredigion		Pembrokshire		TOTAL	
	HC	WTE	HC	WTE	HC	WTE	HC	WTE
Target wte to be appointed		30.00		10.00		20.00		60.00
Total applicants	32		4		29		65	
Applicants interviewed	28		4		27		59	
Applicants offered	22	15.60	3	2.20	24	16.40	49	34.20
Applicants withdrawn/rejected	10	7.20	1	0.60	14	9.80	25	17.60
Applicants moving forward	12	8.40	2	1.60	10	6.60	24	16.60
Applicant pending pre-employment checks (PECs)	0	0.00	0	0.00	0	0.00	0	0.00
Applicants completed pre-employment checks (PECs)	12	8.40	2	1.60	10	6.60	24	16.60
Average time from offerconditional to pre-employment checks (PECs) completed	30.0 days		13.5 days		30.8 days		29.0 days	

At the end of January 2022, 16.60 WTE had been recruited against a target of 60 WTE with all bar one person having commenced in post. There was a significantly high withdrawal rate when compared to other similar fast-track Covid recruitment:

Homebased Care HCSW	**51%**
COVID 5 Immunisers	18%
COVID 6 Bank HCSW	20%
COVID 7 Hotel Services	32%

Of 61 applicants only 24 completed the induction process. Non-engagement or not appropriate for the role accounted for 59% of the withdrawals.

A review of the job description and advert noted that there was no mention of shifts or rotas.



Advertisement Campaigns

Adverts for the HCSW were issued twice due to low levels of recruitment resulting from the first campaign. The second campaign yielded fewer appropriate recruits meaning that 20 people were employed from the first campaign and only 4 from the second.

Time Scales

- Between advert closing and an interview being set up was generally 2 days for the first advert and between 3 to 5 days for the second advert.
- 1 – 3 days between interview and a conditional offer
- 21 - 81 days between conditional offer being made and a start date on ESR being recorded. 1 staff is pending a start date.
- 25% start dates were recorded within 30 days of conditional offer
- 52 days between the initial Gold Planning Objective and the first recruit starting in post

		Oct-21				Nov-21					Dec-21				Jan-22				
	27/09/2021	04/10/2021	11/10/2021	18/10/2021	25/10/2021	01/11/2021	08/11/2021	15/11/2021	22/11/2021	29/11/2021	06/12/2021	13/12/2021	20/12/2021	27/12/2021	03/01/2022	10/01/2022	17/01/2022	24/01/2022	31/01/2022
Carmarthenshire	Closed 10th Oct		11			4	2						4		1				
Ceredigion			2				1	1											
Pembrokeshire			3	3					3		1				2				
Carmarthenshire				Closed 31st Oct			1								1				
Ceredigion																			
Pembrokeshire						2					1							1	

Advert
Date offered
Date commenced

Additional Support Staffing & Management Staff

To date, no staff other than the HCSWs were agreed to be recruited due to the low numbers. The clinical, administrative and managerial support for these new staff is currently being supported from within existing teams.

Lessons Learnt
Attrition rate of recruited / appointed HCSWs

As part of the recruitment, it was noted that a large percentage (50%+) of the staff either withdrew their applications, left the post once trained or did not engage once successful in their application. In Pembrokeshire, it was particularly noted that shift work was not mentioned in the job description or in the job advert. This may have potentially helped with retain some of the staff. The approach to recruitment needs to be carefully considered to enable candidates to fully consider and commit to the process earlier on.

Time Scales
Looking at the start dates of the members of staff, it has taken between 52 (start date of w/c 01/11/2021) and 133 days (start date of w/c 24/01/2022) since the initial Executive ask for these members of staff to begin in work. This does not factor in the induction phase, which would add another 5 days and the period of in work training, especially for those with no prior experience. These roles therefore may be less suitable for short term or fixed term projects.

Supervision and Support
Although additional staff were not appointed, partially due to the timeframe and also the small numbers of HCSWs recruited, there was a considerable burden of time needed from existing staff to undertake the recruitment, local induction, training and support. Any future scheme needs to carefully consider the support needed for new staff who have not worked in care before.

Employed staff feedback

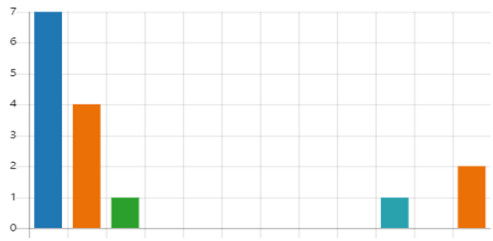
Given the very particular challenges felt across the system in employing this cohort of staff, it was felt that seeking their feedback on the process to inform future action was essential. In consultation with the Culture and Workforce Experience Team, it was agreed to administer a questionnaire via Microsoft Forms which could be completed anonymously. The questions would seek to cover:

- Feedback about the application / recruitment process
- Concerns about starting work in the Health Board
- Feedback about first few weeks in post
- Future aspirations / career goals

In October 2021 the Project Group and ODGs agreed the content of the questionnaire. Both English and Welsh versions were transferred to Forms and then responsible managers for the new staff were asked to distribute the link to the form for completion. This was carried out between the 13th and 24th January 2022. A copy of the questionnaire is located in Appendix 6.

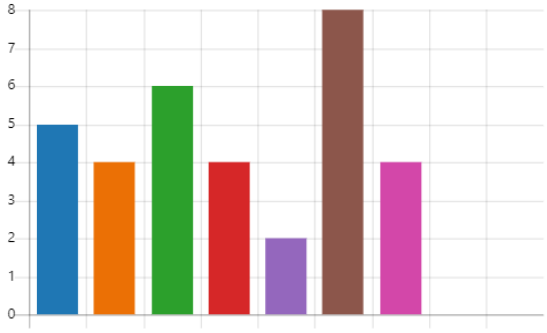
Out of a potential 18 staff employed at the time of distribution, 12 responses were received (67%).

Q1. How did you hear about the vacancy you applied for? Please tick all that apply.



The Hywel Dda website and NHS Jobs were the main sources of information about the roles. Under Other, it was noted that staff had received telephone calls from Hywel Dda Members of staff informing them about the post.

Q2. What motivated you to consider applying for a job in care? Please only choose the top three that were most important to you.



Rewarding and Varied work with Long Term prospects were the most attractive incentives for applying for the roles.

It is worth noting that "Don't Know" was not selected as an option.

Q3. Did anything put you off considering applying for the job and / or were you worried about anything? For example, image of the sector, needed support to apply, lack of understanding about what the work would be about.

The responses were varied but in general the response was recorded as "No" or "Nothing" (6 out of 12). However, the below responses raised concerns around the post itself and some elements of their employment.

- Lack of information on the job role itself, where I would actually be working or who with. Lack of information on training and start dates. Being told to not give notice on then current job until a start date had been given to me but then requesting a reference from my then current job without my permission. I then had to give my notice without a start date for new job so very stressed about when I would be starting and having such a gap between wages etc.
- Just the amount of paperwork for an application
- No nothing put me off applying for the job, or was I worried about anything as I had spoken to employee's from the sector to which I had plenty of help and advice.
- Although I knew I had some transferrable skills from 26 years in my previous job (primary teaching) I was concerned that this was a very different job and that I had a lot to learn.
- Short contract
- The pay is low for what the job demands of you.

Q4. When you applied for the job, what did you think a job in care might involve? Please provide details.

Within the responses, there was a high level understanding around the care element of role and providing support to patients. A few of these were noted as:

- To assist and support all patients to the best quality of care making them a number one priority and to there own care needs.
- Care is to look after those who need support for many reasons and to care for those individuals to highest standards of the health board
- Personal care Understanding Helping others Support

- Making sure that the patients are looked after with care.

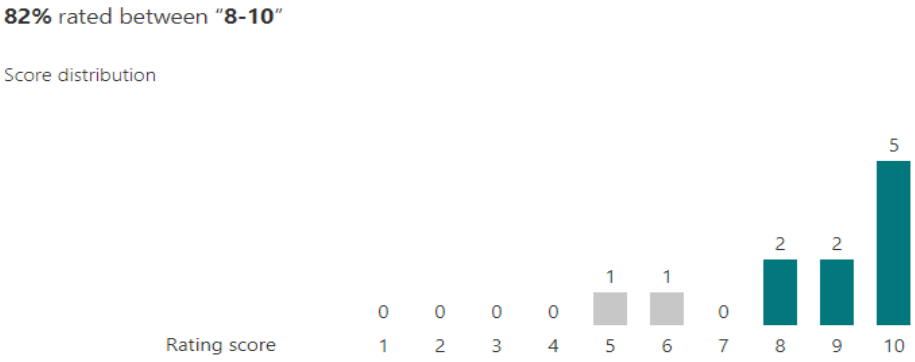
The ability to provide care was a strong theme present within the replies. It would be fair to conclude that that the majority of the applicants understood the day to day nature of the role and its' hands on caring nature.

Q5. When you applied for the job, what did you think the skills and personal qualities you would need to do the job would be?
Caring was featured in a number of the responses as highlight below:

- Punctual, caring, kind, good worker, patience, team work
- Caring Passionate Loyalty Patience Hard working Fun Making sure all patients are a number one priority

Only one of the responses referenced the need for a formal qualification with the rest having a strong focus on the need to care, provide support and have good communication skills.

Q6. On a scale from 1 to10, where 1 is not satisfied at all and 10 is extremely satisfied, how satisfied are you with your job?



Q7. What do you enjoy most about your job? Please provide details.
Most of the responses in this section were focused on patients and providing care to them. Patient and care was mentioned multiple times across most of the responses. There were strong themes around care giving and providing support for people recorded.

Q8. What do you enjoy least about your job? Please provide details.

5 of the responses were noted as "Nothing" or similar. However, a number of the comments raised issues around uncertainty in the day to day role such as:

- "Never knowing where we will be"
- "Lack of communication. Not hearing of my manager to see how I am getting on. Feel I have no support at times. Not being told when I am working next but other staff having to send me a rota as they have a copy of the rota"

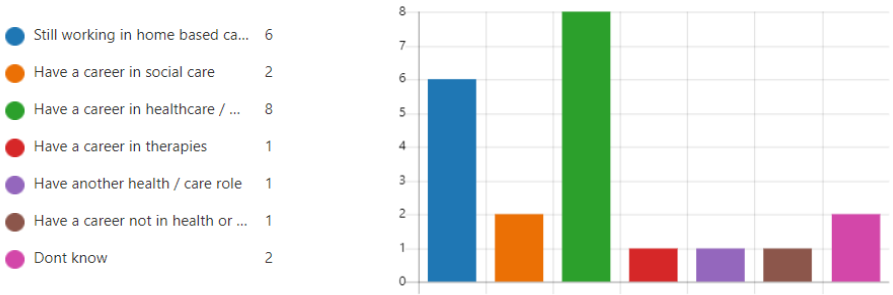
Other themes are some of the interactions with patients i.e. not being prepared to deal with stressful situations with families and patients, when a patient dies etc. An example would be:

- "The stress of going to such a sensitive and highly emotional setting aka the home of a patient and their family"

Q9. On a scale from 1 to 10, where 1 is do not agree at all and 10 is agree in full, to what extent do you agree with the following statement? I work in a supportive team.

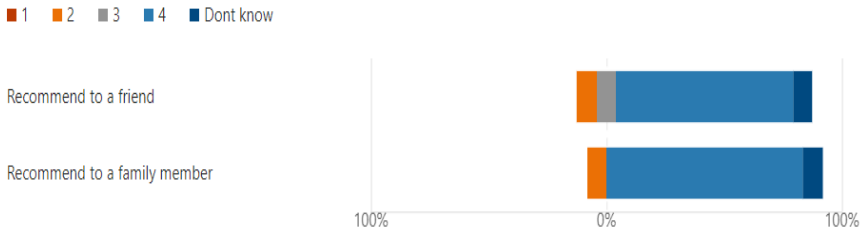
The majority of the responses agreed that they are supported within their role by the team. However, it was noted in the previous question that there were areas where management support could be reviewed.

Q10. In 2 years' time, where would you like to be working? Please select as many as you like.



Three of the responses selected "Have a career in healthcare / nursing" only and two highlighted "Don't know". However, Still Working in home based care was a strong contender as well as Working In Healthcare.

Q11. On a scale of 1 to 4, where 1 means not at all and 4 means definitely, how likely would you be to recommend working in care to a friend or family member?



From the responses, only one selected "Don't know" for Friends and Family with 83% selecting definitely for both friend and family. The lowest score given was 2 for both Friend and Family (8%). No one selected the "Not At All" option.

Q12. Please use this space to make any other comments about the application process for your role or the role itself. There was only a 50% response rate to this final question. Some of the specific additional comments were:


Some of the new starters who started at the same time as me have had previous care role experiences and so I felt as though I had much more to learn compared to others which did concern me at first. However, the more shifts I do the more confident I am becoming.
Application was straight forward. Checks took the longest maybe look at shortening the time for these.
Happy with everything, hopefully will be a permanent contract at the end
If I was 10 years younger I would definitely have wanted to gain experience in this role first and then apply to train as a nurse. However, at this point in my life I do not wish to do this and am very happy in this role.
I was a little overwhelmed and unsure of everything at first as there is a lot of new information to take in when starting a new job with a different organisation.
I tried for 15 different jobs in health care with the NHS before this one. I do think that it is too hard to get into the NHS, I had been trying for months with no joy.
I don't have any regrets about taking this role, I love it and wanting to learn and do lots of training and go into nursing, which i hope I will get the chance with the right support.
I never thought about going in to care but am so glad that I did, my only regret is not doing it years ago
The colleagues I have been working with have all been amazing. They have been so supportive, patiently answered my constant questions, modelled good practise and made me feel welcome

Lessons Learnt

Staff feedback questionnaire- evaluation of project
Collecting staff feedback was an important evaluation criteria however collecting and analysing the data presented challenges. Clarifying roles and responsibilities at the outset of the project would have reduced delay and duplication. The survey itself was well responded to with the majority of staff satisfied within the role. The majority of staff wished to continue their role within Healthcare and still within their post in Home Based Care.

Recruitment Process
Short-term contracts were noted as a concern to applicants and a potential reason for low numbers recruited to. Any future scheme needs to carefully balance the risk of recruiting substantively.

The fast track interview process meant that a lot of time was spent by operationally teams trying to get hold of applicants who did not respond. It was also noted that a face to face discussion gave a better opportunity for potential candidates to have a discussion about the post and for interviewers to get an opportunity to really assess the motivation, values and intent of the applicants.

Induction
Delays were reported in new staff attending training, sometimes due to the need to balance existing employment commitments, which has delayed their commencement of post.

Team leaders and staff advised that attending the Health Board induction day was valuable as they were able to reassure the new staff that they would be supported during their fixed term contract.

Providing training to new starters in an inpatient setting e.g. a community hospital ward, provided a valuable and supportive function for the candidates who were able to learn skills in a more supportive environment. Formally including this in any future induction would be beneficial.

On boarding and training large numbers of staff at one time presents challenges for existing teams who are operationally stretched. Where recruitment is seeking to bring new, inexperienced people to the role, the need for strong local induction, training and support is essential and needs careful planning.

Fixed Term Contracts
The short-term nature of the posts means that a significant proportion of their time employed has been in training and inducting them. If the posts do come to an end in March, there will be limited return on investment with the posts.

Staff Utilisation

During the Project Group meeting held on the 17th January 2022, it was requested each of the ODG's complete a template highlighting where the new members of staff were being utilised, where the impact of these staff was being felt and what lessons had been learnt as part of the recruitment process.

	Current deployment	Impact of deployment
Carmarthenshire **7.7WTE** **11 people**	Inducting at Amman Valley Hospital.	5 HCSWs had been appointed through TRAC for AVH and still going through the recruitment process. The bridging HCSWs have therefore contributed to the earlier opening of the extra beds at AVH.
Ceredigion **2.8WTE** **4 people**	Embedded into the ART/CRT service and are working as part of the team to provide care to patients. This involves providing personal care to palliative patients working with other nurses from Marie Curie and Art/DN teams as needed. They also work as part of the team in leg clubs supporting the patients, taking down dressings, washing legs and preparing for assessment and re-dressing by a qualified nurse	These staff have been utilised to support the existing community nursing service to enable the continuation of care for patients at a time of challenged workforce availability.
Pembrokeshire **5.6WTE** **9 people**	Providing bridging care as part of the Care At Home Team.	Maintaining current runs with CAHT due to staff absences and on 31.01.2022 enabled a further early run to commence.

Local Authority Evaluation

One of the most discussed risks during the initiation of the project, was the potential destabilisation of the independent sector and Local Authority sector. This due to preferential NHS terms and conditions and potentially the perceived benefit or status of the NHS brand.

With the main aim to substantially increase the whole home base care workforce, rather than move existing staff between organisations, tracking the impact of the recruitment was an important evaluation factor.

As a local authority, has there been any negative impacts on the care sector and its staffing as a result of the recruitment to the Bridging Care Project?

Carmarthenshire – Due to the relatively low numbers recruited, we don't think the project has had an impact on destabilising the social care workforce. However, if the numbers had been more significant there would have been a real risk that existing carers in the sector or those considering a career in care would have been attracted by the perceived enhanced terms and conditions and some peoples view of the NHS brand. This could have had a negative impact on an already very compromised workforce. Thankfully due to the low numbers recruited, this has not been the case, but we would be very concerned surrounding any future approach by the Health Board to recruit such a workforce at any scale when the care sector is so compromised.

Ceredigion – In Ceredigion we have 3 members of staff recruited as part of the bridging service which equated to 2.2 wte in hours. Only 2 members who have commenced employment with us and the third lady is due to start in 2 weeks' time. They are working as part of the ART/CRT team providing nursing support for patients in their own homes. They are overseen by qualified nurses who will delegate patients to be seen according to skill set and needs. They have undertaken the induction programme run by the Health Board and are now undertaking shadow shifts with the team and this will continue until they have settled into their new roles. The

biggest impact was to everyone involved in the ODGs and the campaign as a whole – there was a large amount of resource went into organising what has been a pointless exercise from a Ceredigion perspective.

Pembrokeshire - Not at this time

As a local authority, has there been any positive impacts on the care sector and its staffing as a result of the recruitment to the Bridging Care Project?

Carmarthenshire – Due to the low numbers recruited, we have seen no positive impact on the care sector or its staffing. In fact, to date, our understanding is that the project has not delivered any bridging care in Carmarthenshire. Our feeling was that there was a lack of understanding regarding how a care service is run, the critical mass required and the expertise to support and mange runs in the homecare sector. The initiative has however been positive in that the HCSWs recruited have been utilised to help open the additional 8 beds in Amman Valley Hospital earlier than planned which has had a positive impact on the Carmarthenshire system. This was not however the original purpose for these workers.

Ceredigion - No

Pembrokeshire - Not yet, but hopeful that fixed term HDUHB posts will translate permanent social care posts and are working with the local team on this.

Are there any recruitment campaigns for domestic care taking place within your locality at present?

Carmarthenshire – We have an ongoing Carmarthenshire County Council campaign to recruit new home care workers. Over the time period of the recruitment to the NHS posts there have been in the region of 40 staff recruited to our in-house service. Alongside this we are supporting the external sector to recruit and retain their workforce and improve terms and conditions.

Ceredigion - All Ceredigion's Domiciliary care is commissioned. We have been consistently supporting the sector with their recruitment programmes including advertising posts on the council website.

Pembrokeshire – Yes, large recruitment campaign see attached https://inpembrokeshirewecare.co.uk/ also includes video, press, radio, online media, UCAS final year social work students email, roadshows in Feb and even some signs for the sides of busses in the next few weeks.

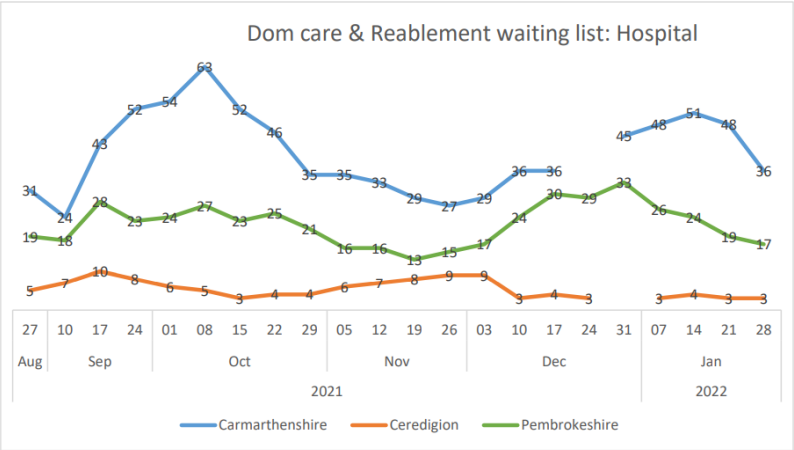
Lessons Learnt

Impact of the project on social care workforce
It was generally agreed that there was no negative impact on the social care workforce however this may be due to the scale of the recruitment. It was also viewed as not significantly benefitting the social care waits for patients.

System Impact

Domiciliary Care Waiting List Impact

The main purpose of this scheme was to reduce the number of people waiting Domiciliary Care in Hospital by increasing the workforce. The baseline numbers given in the first section deteriorated significantly whilst implementation of the scheme was ongoing.



In October, Carmarthenshire in particular saw a significant increase in the number of people waiting.

During this same period it is important to note that Interim beds have been increasingly used to support the delays :

	Interim Beds 10th September 2021	Interim Beds 28th January 2022	Highest number & week
Carmarthenshire	3	26	31 – 14.1.22
Ceredigion	12	17	21 – 17.12.21
Pembrokeshire	24	22	30 – 26.11.21

The reablement waiting list has been generally stable however there was a stepped increase for all three Counties at the end of October. On average there has been a 30% increase in the total waiting list. This may be because it is also challenging to discharge people into long term packages too thereby reducing flow through the schemes. There was a significant number of packages handed back to local authorities through this period which would have presented challenge and resulted in reduced capacity for hospital discharges:

- Carmarthenshire – 55 packages handed back throughout September and October. During this time the number of people waiting in hospital increased by 39 indicating that some hospital flow continued although as a slower rather than previously, potentially supported by the increase in interim bed use.

- Ceredigion – fewer packages handed back since September, a total of 8. 4 of these were handed back in one week in November which may account for the rise in waiters that month which was subsequently recovered in mid-December as the number of interim beds in use increased.

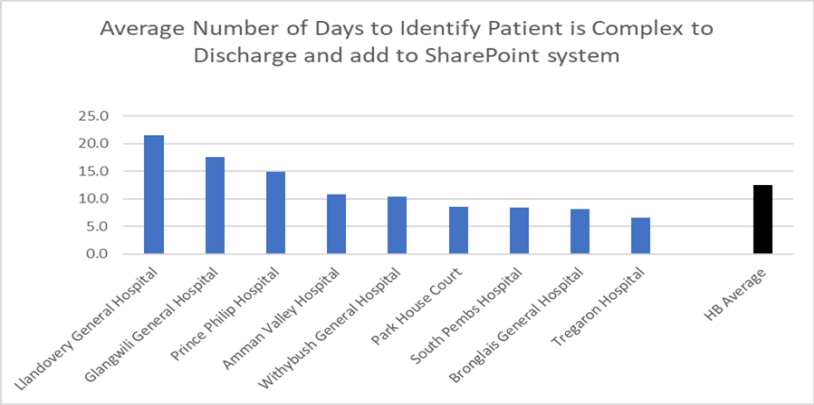
- Pembrokeshire : there was a run of 9 weeks starting mid October where 42 packages were returned, resulting in the rising trend of hospital waiters from the end of November.

Lessons Learnt

Domiciliary Care Waits
The size of the recruitment and the number of competing factors makes it difficult to assess whether any impact has been demonstrated. The recruits are also not deployed into bridging care roles, with the recent exception of Pembrokeshire, and therefore it is too soon to assess any potential impact.

Discharge Delay Impact
An analysis of the SharePoint Complex to Discharge system was undertaken for those people either discharged between June 2021 and end January 2022 and those currently an inpatient.

Total discharges from the list average 322 per month across all sites, this has been relatively static with December (341) seeing the largest number of discharges and January (304) the fewest. However, the process of managing discharges and the number of lost days is key to analyse.



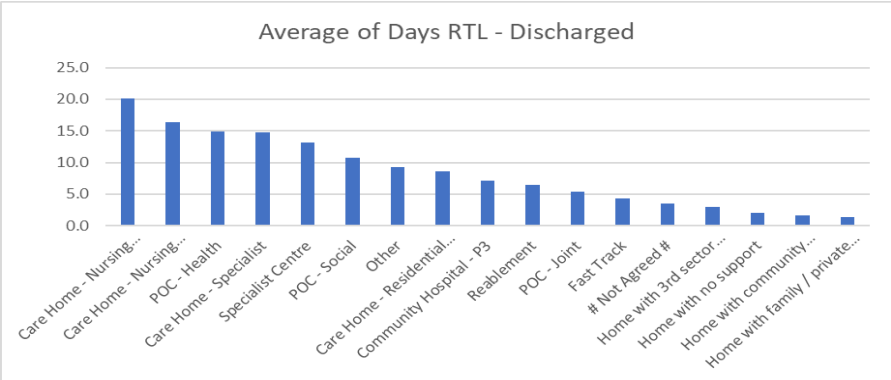
For the Health Board, it takes an average of **12.5 days** following admission for a patient to be identified as Complex to Discharge and to be added to the SharePoint list. There is significant variation in this with 22% of people being identified and added within the first 3 days and 15% taking more than 21 days (sample of 2616 patients).

It then takes an average of **26.6 days** from admission to the date medically optimised. There may be some changes between Medically optimised and not during this period which is not captured. In Community Hospitals where the expected Length of Stay is longer to aid recovery and rehabilitation at 37.2 days and in the Acute Hospitals this reduces to 24.6 days.

The average number of days between Medically Optimised and Ready to Leave date is **5.8 days**. This is the average time period for all final assessments to be undertaken. This figure however is skewed by Ceredigion who do not routinely use both these dates. There is also some missing data and therefore where there is only one date, it has been assumed that RTL and MO happened on the same date. Where there is no MO and RTL date it is assumed this was the same date as discharge. The data quality means that this is not a comparable and reliable figure.

The average number of "lost days" between the date RTL and discharged is **7 days** across the HB with some considerable variation between sites and the range is significant from 0 to 117 days. 50% of the sample (2330 patients) were discharged the same day as ready to leave however 12% saw a delay of 3 weeks or more. Those waiting longer than 3 weeks accounted for 11,837 bed days, or 67% of the total lost days. There were 10 people who waited over 100 days to be discharged accounting for 1285 lost bed days. This may be affected by the data quality and inconsistent approach to entering the dates. Further analysis has been undertaken on these lost days – across pathways and time.

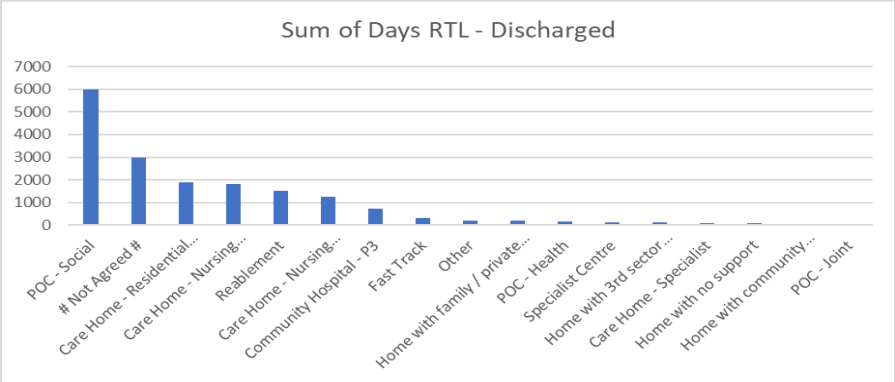
Between June 2021 and January 2022 the most common Discharge Pathway added was for a Package of Social Care and Reablement. This accounted for 48% of those people where a pathway was added (sample of 1603 patients). Similarly Discharge to Recover and Assess Pathway 2 (assessment at home) was the most common Pathway accounting for 50% (sample of 2054 patients). Although the D2RA Pathway is more often completed it is important to note that there is still a tendency to assess in acute because of the wider capacity constraints in home based care, it also does not indicate where the patient ended up being discharged to.



When considering the Days lost based on Discharge Pathway, the longest average days lost is for those people waiting a Nursing or Specialist Home, or those waiting on a Health Package of Care.

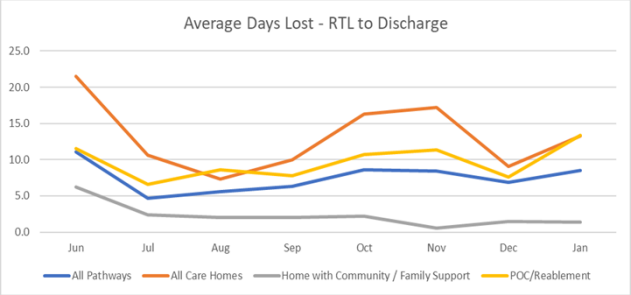
However, because of the total number of people waiting, the total days lost is far higher for

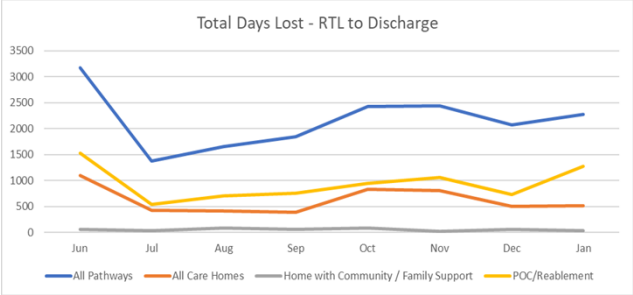
those waiting a Social Package of Care.



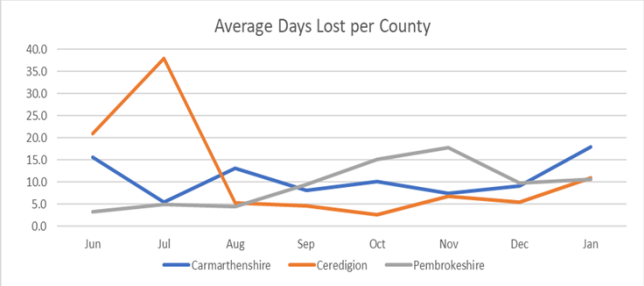
It also needs to be noted that flow into Care Homes has changed considerably and with Care Home accepting more people into Interim Placements, who may be less complex, those with higher needs are waiting longer whilst a Care Home is found willing to accept the individual patient.

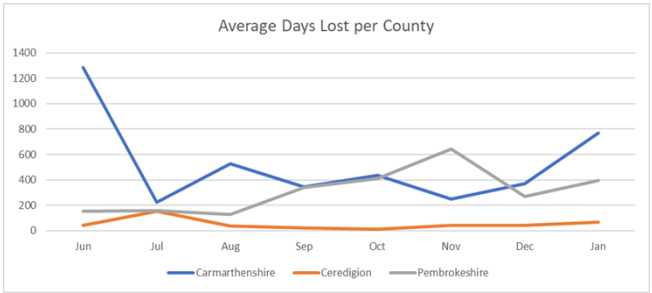
Looking over time at the changes, both in the average days lost and the total days lost, it would be premature to draw conclusions, particularly due to the embyonic nature of the pilot, the other conflating factos and the variable distribution of the bridging care model. The December and January factor needs to be considered as combining these two demonstrates a far flatter line and limited change.





A comparison of days lost across Counties was also undertaken. This did demonstrate initial signs of a reduction in the average and total number of days lost in Pembrokeshire following the on boarding of the additional recruits into the bridging service in December / January. An additional run was established at the start of February and no data is as yet available to determin the impact of this.





This system analysis provides useful baseline data and some context however it does not consider the whole system changes and is also premature in being able to support any conclusions.

Lessons Learnt

Identification of Complex to Discharge Person
More needs to be done to ensure that those people who are complex to discharge are identified within their first 3 days of admission.

Medical Optimisation
Data suggests that for those people who stay beyond 3 days, their lengths of stay can be very protracted, therefore systems need to consider how to support people back home within 3 days wherever safe and

appropriate to do so. This will reduce the number of packages lost and reduce the risks associated with deconditioning and other hospital acquired infection or harm.

Use of SharePoint
There is inconsistent approaches to data recording. For example Ceredigion do not routinely use both Medical Optimisation and Ready to Leave date, thereby skewing the figures reported and reducing understanding of how long the assessment period takes. More work is needed to increase the standardised use of the system.

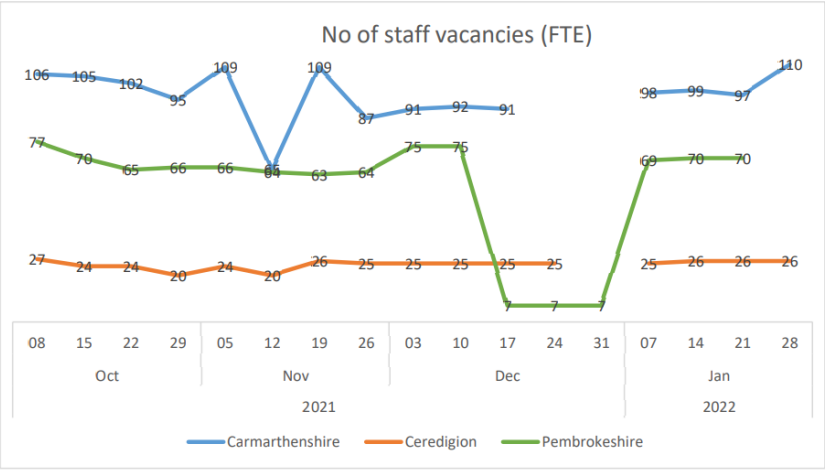
Homebased Care Need
Half of those people identified as complex require some level of home based care or assessment, thereby requiring timely support to get home. This figure is potentially under-reported and further "Home First" training, as well as SharePoint training, is required to be more confident in figures reported. However there remains a significant demand for this type of care.

Days Lost
People waiting for Homebased Care are not the only cohort who experience long waits for discharge. Consideration needs to also be given to the care home capacity and pathways which might have been considerably constrained due to the covid restrictions.

Those waiting for a social package of care accounted for the largest amount of days lost, indicating a need for whole system development of this important workforce.

It is premature to conclude whether the increased bridging capacity in Pembrokeshire has supported a sustained reduction in days lost, further analysis would be required at end of March.

Workforce Impact
Workforce changes in the sector have been difficult to capture as a whole however, the independent sector and local authority provider services have submitted this data weekly since start October. Please note that Pembrokeshire data for 17-31st December is likely to be due to fewer provider returns (this is also the reason for the Carmarthenshire 12th November result).



This would seem to suggest that the recruitment and onboarding, which largely took place at the end November, did not significantly contribute to the workforce challenges facing the sector.

It is also difficult to see the impact of the recruitment undertaken by Carmarthenshire and Pembrokeshire Local Authorities at this point and a longer time period is required.

Lesson Learnt

Change to the Homebased Care Workforce
It is premature to see any change in the total workforce. There is no discernible negative or positive impact from the Health Board's recruitment campaign, nor from the Local Authorities. Further assessment over time is required.

Impact of a Homebased Bridging Service

It has not been possible to demonstrate direct impact of this recruitment into the system due to the numbers recruited being so low. Pembrokeshire is the only County to have deployed the staff specifically into a bridging service and this because there was an existing team already supporting this function.

In June 2021 an assessment of the team needed to support bridging and deliver assessment at home in Pembrokeshire was agreed within the Health Board. The total cost of the workforce below was £998k which is funded through the Integrated Care Fund, Transformation Fund and Urgent Primary Care Fund.

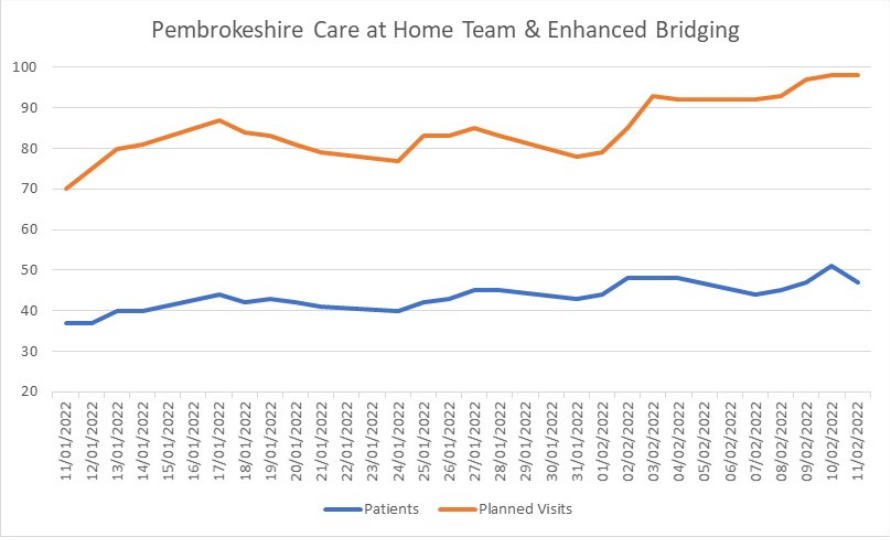
- 4.25WTE RNs – deployed through the Acute Response Team
- 2.75WTE Associate Practitioners – deployed through the Acute Response & Care at Home Team
- 15.74WTE Band 3 HCSW – deployed through the Care at Home Team
- 12.75WTE Band 2 HCSW (grow our own) – deployed through the Care at Home Team

This team works collaboratively to manage assessments and care, utilising capacity as best as possible, and complements additional core funded staff. In addition to bridging care they also offer care for fast track palliative and end of life patients, as well as some people requiring long term packages of care. The data below relates only to the bridging care service offered over a 10 week baseline period September to November 2021.

- 52 new referrals – average of 5 per week
- 46 related to facilitated discharges and 6 for admissions avoided.
- Only 10 patients were able to be discharged during the 10 weeks and 8 of these were to reablement or a long term package of social care, capacity for long term provision being the main reason for lack of discharge.
- The active caseload grew from 8 to a maximum of 19 people.
- The average amount of time on the caseload rose from 4.5 days at the start to 31.1 days at the end of the period, those days would otherwise have been spent in a hospital setting.

The current enhanced bridging scheme pilot has in Pembrokeshire enabled this existing team to grow and increase the care offered.

The graph is indicative of the current activity supported by the team and demonstrates a growth in both patients cared for at home and visits provided over the last 5 weeks.



Over this period an average of 44 people were cared for at home each day with 2 visits each. The number of people on the caseload has grown by 20% over this period. This has saved the same number of beds in an acute hospital and has reduced the risk of harm associated with lengthy hospital stays.

In 2018-19 both Carmarthenshire and Pembrokeshire operated a bridging service utilising Winter funding.

Key findings from Carmarthenshire:

- The bridging service reduced the time for a package to start from 16 days to 5 days saving a total of 536 bed days – average of 13.7 days per person.
- 21 of the 39 patients saw a reduction in their package in term of hours, visits or number of staff.
- It took an average of 13 days to move patients onto a long term provider from the start of the bridging service.
- 39 people received care through the pilot.
- Funding of £138,852 was made available to support the 12 weeks of the scheme.

Key findings from Pembrokeshire:

- It took an average of less than 1 day for the brigand service to commence with 92% of packages commencing within 48 hours saving a total of 943 bed days – average of 13.4 days per person.
- 70 people received care through the pilot.
- Funding of £55,998 was made available to support the 17 weeks of the scheme.

Lessons Learnt

Impact of additional staffing
It is premature to draw any conclusions from the introduction of additional staff into the established team in Pembrokeshire however, early indications suggest that it has supported growth of the caseload and activity.

Previous analysis would suggest that there is positive impact and bed day savings from bridging care scheme but further work is needed to assess the varying levels of impact between independent, local authority and health board delivered services.

Cost of the Pilot & Comparative Costs

Further work will be required at the end of March to assess the full cost and potential impact / benefit of the project. This will be based on :

The total cost of the workforce – pay and non-pay costs.
The benefit of the impact for each County :

- Carmarthenshire – the positive impact of opening Amman Valley Hospital prematurely against the surge / acute bed cost.

- Ceredigion – this number of staff are very small and therefore the only comparator could be bank or agency staff for the teams supported.

- Pembrokeshire – the delivered bridging care versus the cost of a hospital bed.

Comparison of the costs of running the bridging service in Pembrokeshire versus the cost of the Local Authority care and reablement team would be a positive comparator.

Project Outcomes

Deliverable	Status	Update

Develop a home based care team to deliver accessible care for those waiting on Local Authority waiting lists	Partially met	It wasn't possible to recruit to the full WTE numbers meaning the service was unable to deliver this full need.
For this team to cover all three Counties within Hywel Dda University Health Board (HDUHB)	Partially met	All three Counties provide some bridging as part of core services, only in Pembrokeshire did this recruit support specific additional capacity. In the other counties stability and additional bedded capacity was provided.
Team to initially be in place until March 2022	Met	All members of staff taken on as part of this recruitment are expected to be in post until March 2022.
Approach to be prudent & proportionate – but rapid and balanced in terms of risk	Partially met	Prudence and risk reduction possibly had the impact of reducing the HB recruitment but may have supported the stabilisation risk across the whole sector.

Conclusions

Due to the low levels of recruitment achieved it is difficult to assess the impact of the workforce on delays experienced by people waiting to go home, with care, from hospital. Early indications suggest that where deployed to deliver this service, positive impact has been achieved and capacity grown however it would need a longer assessment over time to draw conclusions.

It is important to note that those staff not deployed into bridging care, have supported a constrained and challenged workforce to remain more stable and have supported the opening of alternative capacity sooner than otherwise possible in Amman Valley Hospital.

Further comparison between different models of home based care would be needed to understand the relative benefits of each different model.

Significant lessons have been learnt, particularly around recruitment, on boarding and how we work in partnership to address this challenge.

Positive feedback from those appointed and commenced in post do indicate an opportunity not to lose these staff from the sector and therefore the workforce as a whole has increased through this pilot.

For the future it is important that this learning be shared and considered prior to making decisions about further schemes. The following recommendations are proposed :

- The challenge of homebased care capacity is predominantly one of workforce. Partnership work to solve the recruitment, training and retention is necessary and this can be co-ordinated through the Regional Workforce Group.

- Long term development of teams and services is essential to support recruitment and schemes which carefully select candidates and provide a significant level of induction, training and support are key, for example the apprenticeship programme.

- Quick recruitment and short term schemes are unlikely to yield significant benefit due to the time taken to on board and train staff new to the sector.

- Project management and analyst support is required for future pilots to enable sufficient data and evaluation to be undertaken.

Meeting Date	**31st March 2022**	**Agenda Item**	**3.6**
Report Title	Development of A Regional Collaboration for Health (ARCH) Mid and South West Wales Regional Centre of Excellence Cellular Pathology Laboratory, Regional Diagnostic Immunology Laboratory Facility and Regional Medical Microbiology facility		
Report Author	Heather Edwards, Business Planning Manager, Capital Planning (SBUHB)		
Report Sponsor	Christine Morrell – Director Therapies & Health Science (SBUHB) – Senior Responsible Owner (SRO) and Siân Harrop-Griffiths - Director of Strategy (SBUHB)		
Presented by	Christine Morrell – Director Therapies & Health Science (SBUHB) – SRO		
Freedom of Information	Open		
Purpose of the Report	This paper briefs Swansea Bay University Health Board (SBUHB) and its project partners, Hywel Dda University Health Board (HDUHB) and Public Health Wales NHS Trust (PHW) on progress to date shortlisting the preferred location for the A Regional Collaboration for Health (ARCH) Regional Pathology new build facility.		
Key Issues	In November 2020 a Strategic Outline Case (SOC) supporting this development was approved by Welsh Government to progress to Outline Business Case (OBC) stage. Between February 2021 and January 2022 the South West Wales Regional Pathology Project Board, which includes representation from all three partner organisations, plus others including Swansea University and the NHS Wales Collaborative, evaluated a long list of potential locations within the region and agreed a shortlist of site locations within Morriston Hospital. Once draw-down of OBC stage resources from Welsh Government is agreed Project Board will select a Supply Chain Partner from Welsh Government's Building for Wales Framework to support development of the OBC (final site selection will be informed by evaluation of participating architects tests for fit proposals).		
Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**

(please choose one only)	☐	☒	☐	☐
Recommendations	**Members are asked to:** • **NOTE** progress to date on this scheme, and that the Project Board has agreed that the new build should be on the Morriston Hospital site; • **AGREE** the proposed location of the new build will be at Morriston Hospital; • **AGREE** Director of Strategy and SRO will continue to request Welsh Government funding release and the development of the OBC.			

South West Wales Regional Pathology Unit new build location option appraisal process to date

1. INTRODUCTION

Nationally, NHS Pathology services face a number of challenges. Within the Mid and South West Wales' region, Hywel Dda University Health Board (HDUHB), Swansea Bay University Health Board (SBUHB) and Public Health Wales NHS Trust (PHW) are struggling to manage workforce and sustainability pressures, to maintain quality and safety issues and to meet clinically driven targets.

2. BACKGROUND

Between 2014 and 2015 the Cellular Pathology Project Group (CPPG) undertook a non-financial appraisal exercise to support the creation a two-site solution for the future delivery of Cellular Pathology services' in South Wales. The CPPG confirmed one site was required in Cardiff and one in Swansea.

In March 2019, the Strategic Outline Case (SOC) (£77m) to support the development of A Regional Collaboration for Health (ARCH) Mid and South West Wales Regional Centre of Excellence Cellular Pathology Laboratory, Regional Diagnostic Immunology Laboratory Facility and local SBUHB Regional Medical Microbiology facility was submitted to Welsh Government for approval. The SOC had been endorsed by Project Board and all three partner organisations. It identified Morriston Hospital as the location for the new regional build. During the 18-month scrutiny of the SOC Welsh Government questioned *whether the service needed to be wholly or partially located on an acute site and, queried, what other location options other than Morriston Hospital had been considered?*

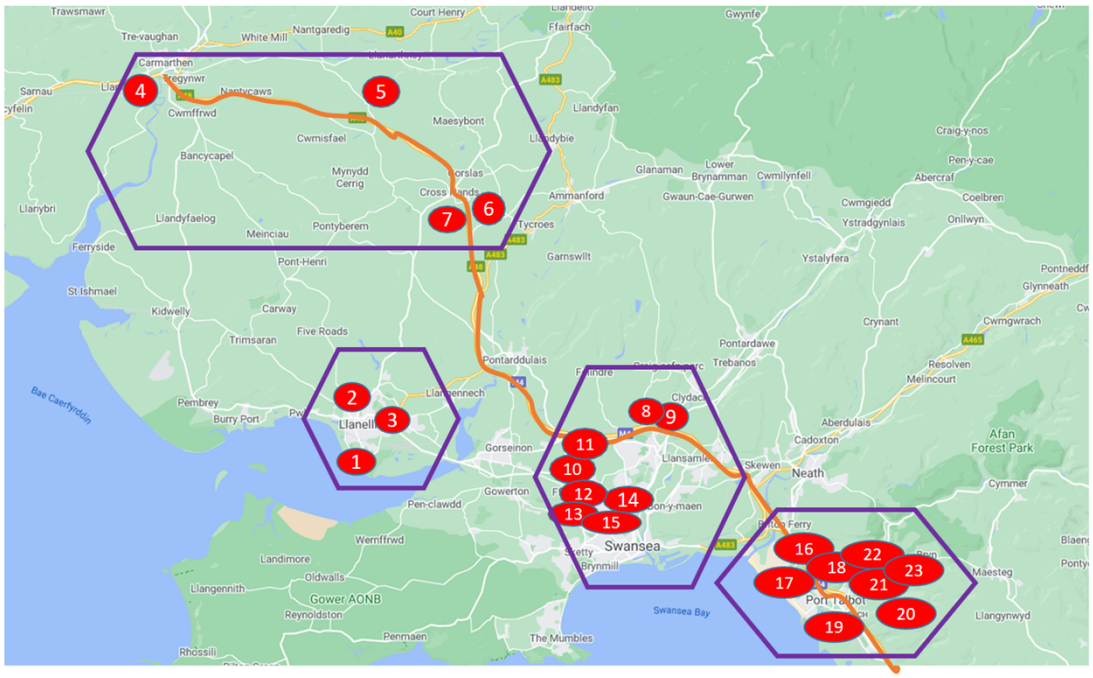
In October 2020, at an Infrastructure Investment Board meeting with Welsh Government's Capital & Estates leads, project partners discussed these concerns and agreed to review the choice of preferred location prior to the appointment of the Welsh Government Building for Wales' Framework Supply Chain Partner (SCP) and Design Team and progression of the Outline Business Case (OBC).

In November 2020 the SOC was approved by Welsh Government and in February 2021 the Project Board re-formed and refreshed its membership to support production of a robust OBC, and commenced the identification and evaluation of a range of potential locations across the region with the aim of identifying a preferred location for the new co-located facility.

3. CURRENT LOCATION OPTION APPRAISAL PROCESS

In March 2021 NHS Wales Shared Services Partnership - Specialist Estates Services (NWSSP-SES) were commissioned by Project Board to identify a range of potential locations. NWSSP-SES were tasked with identifying locations sited along the M4 corridor between the Carmarthen area and east Swansea with between 1-2 hectares

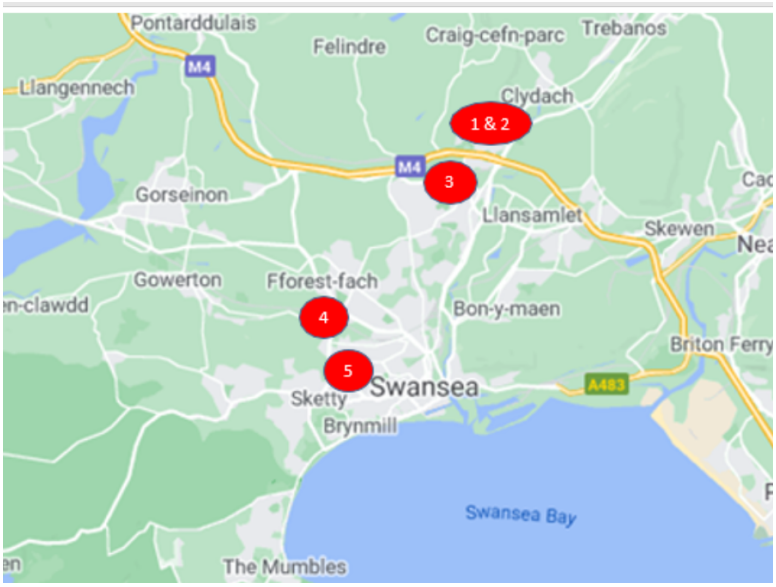
of developable space. A longlist of 22 potential locations were identified - please see map below (for further details please see **Appendix A**):



The Project Board agreed the following non-financial criteria for evaluating the long list locations:

- Does it support development of a 'one site' model for the future configuration of Mid & South Wales' Cellular Pathology service and car parking (200 spaces)?
- Does it support sustainable recruitment and retention of staff?
- Does it support acute/trauma/cancer services appropriately & supports partnership working with University and regional and South West UK clinical services?
- Is it equitably sited for local population, provides ease of access to/from the M4 corridor, allowing timely transportation of samples?
- Does it have developable space?
- Does it minimise travel time for visiting consultants/services?
- What is the planning risk?
- What is the infrastructure risk (e.g. electrical supply)?
- Ease of acquisition (i.e. site is owned by NHS or minimal acquisition timescales)?
- Other criteria: Planning permissions & planning conditions?; Capital implications?; Programme implications?

In April 2021 Project Board members completed a high-level SWOT analysis of the long list discounting locations which did not satisfy the above criteria and agreed a shortlist of five potential locations. This workshop was well attended and included representation from both Health Boards, the Service Director for Morriston Hospital Delivery Unit, Swansea University, representatives from The Pathology Collaboration and NWSSP-SES. Post the workshop, we engaged with Public Health Wales, which was fully supportive of the outcome. It was independently facilitated by the Chief Executive Officer Life Sciences Hub Wales. The following 5 shortlisted locations were agreed (please see map below):



1. Morriston Hospital - adjacent to the existing Pathology Unit
2. Morriston Hospital - land to the north of Mynydd Gelli Wastad Road
3. Parc Felindre, Llangyfelach, Swansea
4. Plots sited at J44 & J45 M4, Swansea
5. Singleton Hospital (west of Sketty Park)

In May 2021, the Project Board evaluated the shortlist options using a SWOT approach. Singleton Hospital was discounted due to its location providing poor access for specimens from across the region and not supporting recruitment and retention. Plots at J44 & J45 M4 were discounted due to its potential flood plain risk, being a congested site, and being less accessible for staff travelling from the west of the region. The following 3 options were taken forward for detailed evaluation:

- Morriston Hospital - adjacent to the existing Pathology Unit
- Morriston Hospital - land to the north of Mynydd Gelli Wastad Road (ARCH land Plots D1 & D2)
- Parc Felindre, Llangyfelach, Swansea

In October 2021, following test for fit exercises informed by Stride Treglown Architects, Project Board discounted the Parc Felindre, Llangyfelach, Swansea site (this site did not provide optimum clinical adjacencies). Noting that a potentially suitable developable space was available in Morriston Hospital's latest Master Plan (i.e. a large demolitions area in the centre of the main site), Project Board agreed this site should be considered in the final short list for consideration.

Project Board noted the following planning risks:

Location Option	Pros	Cons
Adjacent to the existing Pathology Unit	Provides co-location with the existing Pathology Block, which will continue to host Laboratory Sciences and will host regional Diagnostic Immunology services	Site is limited in size making this a tight fit for the 5,080 m2 new build plus on site car parking for 200 vehicles. Does not provide adjacency with the existing Pathology Block. Higher planning risk (development is linked to delivery of the new access road from the M4).
Mynydd Gelli Wastad Road (ARCH land Plot D1)	Green field site.	Higher planning risk as above.

		Does not provide adjacency with the existing Pathology Block.
Mynydd Gelli Wastad Road (ARCH land Plot D2)	Green field site.	As above.
Demolitions area within the centre of the main site	Less planning risk than the above options – local planners are receptive to a development if we can demonstrate reduced travel impact on site under wider service plans (a Traffic Impact Assessment is currently underway). Ease of access for construction traffic with less disruption to site services.	Does not provide adjacency with the existing Pathology Block.

In December 2021 Project Board undertook further test for fit evaluations and agreed the following two shortlisted sites:

Location Option
Adjacent to the existing Pathology Unit - ***Preferred***
Demolitions area within the centre of the main site

4. NEXT STEPS

Once draw-down of OBC stage resources from Welsh Government is agreed Project Board will select a Supply Chain Partner from Welsh Government's Building for Wales Framework to support development of the OBC (final site selection will be informed by evaluation of participating architects tests for fit proposals).

5. RECOMMENDATIONS

Members are asked to:

- **NOTE** progress to date on this scheme, and that the Project Board has agreed that the new build should be on the Morriston Hospital site;

- **AGREE** the proposed location of the new build will be at Morriston Hospital;

- **AGREE** Director of Strategy and SRO will continue to request Welsh Government funding release and the development of the OBC.

Appendix A Long List

1. Dyfatty Industrial Park, Burry Port, Llanelli, Carmarthenshire, SA16 0FB Plot
2. Plot C7 Llanelli Gate, Dafen Industrial Park, Llanelli, Carmarthenshire
3. Plot C1 Dafen Industrial Estate, Llanelli, Carmarthenshire, SA14 8QG
4. Llysowen Road, Travellers Rest, Nantycaws, Carmarthenshire, SA31 3RS
5. National Botanic Garden of Wales, Llanarthne, Carmarthenshire, SA32 8HN
6. Dragongate, Crosshands, Llanelli, Carmarthenshire, SA14 6RB
7. Cross Hands East Strategic Employment Sites, Cross Hands, Carmarthenshire, SA14 6RE
8. Morriston Hospital – adjacent to the existing Pathology Unit **– shortlisted**
9. Morriston Hospital - land to the north of Mynydd Gelli Wastad Road **- shortlisted**
10. Plots J&V, Swansea West Industrial Estate, Bruce Road, Felinfach, SA5 4HS
11. Parc Felindre, Llangyfelach, Swansea, SA5 7LU**- shortlisted**
12. Aneurin Way, Gower Road, Sketty, SA2
13. Plots sited at J44 & J45 M4, Swansea, SA7 0AH**- shortlisted**
14. Plots C1&C2 Olympus Court, Millstream Way, Swansea, SA7 0AQ
15. Singleton Hospital (west of Sketty Park) **- shortlisted**
16. Plot C3 Fford Amazon - East side of Swansea - Fabian Way SA1 8QX
17. Ffordd Amazon, Fabian Way, Swansea, SA1 8QX
18. Plots SV04 & SV05 Fabian Way, Swansea, SA1 8QT
19. Plot C1 Baglan Industrial Park, Neath Port Talbot
20. Margam Wharf, Port Talbot SA13 1RB
21. Land at Kenfig Industrial Estate, Neath Port Talbot
22. Baglan Energy Park, SA12 7DJ, Neath Port Talbot

UK COVID-19 INQUIRY
DRAFT TERMS OF REFERENCE – MARCH 2022

The inquiry will examine, consider and report on preparations and the response to the pandemic in England, Wales, Scotland and Northern Ireland, up to and including the inquiry's formal setting-up date. In doing so, it will consider reserved and devolved matters across the United Kingdom, as necessary, but will seek to minimise duplication of investigation, evidence gathering and reporting with any other public inquiry established by the devolved administrations.

The aims of the inquiry are to:

1. **Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account. Including:**

- In relation to central, devolved and local public health decision-making and its consequences:
    - preparedness and resilience;
    - how decisions were made, communicated and implemented;
    - intergovernmental decision-making;
    - the availability and use of data and evidence;
    - legislative and regulatory control;
    - shielding and the protection of the clinically vulnerable;
    - the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings;
    - testing and contact tracing, and isolation;
    - restrictions on attendance at places of education;
    - the closure and reopening of the hospitality, retail, sport and leisure sectors, and cultural institutions;
    - housing and homelessness;
    - prisons and other places of detention;
    - the justice system;
    - immigration and asylum;
    - travel and borders; and
    - the safeguarding of public funds and management of financial risk.

- The response of the health and care sector across the UK, including:
    - preparedness, initial capacity and the ability to increase capacity, and resilience;
    - the management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of *'Do not attempt cardiopulmonary resuscitation'* (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels;
    - the management of the pandemic in care homes and other care settings, including infection prevention and control, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, and changes to inspections;

    - the procurement and distribution of key equipment and supplies, including PPE and ventilators;
    - the development and delivery of therapeutics and vaccines;
    - the consequences of the pandemic on provision for non-COVID related conditions and needs; and
    - provision for those experiencing long-COVID.

- The economic response to the pandemic and its impact, including government interventions by way of:
    - support for businesses and jobs, including the Coronavirus Job Retention Scheme, the Self-Employment Income Support Scheme, loans schemes, business rates relief and grants;
    - additional funding for relevant public services; and
    - benefits and sick pay, and support for vulnerable people.

2. **Identify the lessons to be learned from the above, thereby to inform the UK's preparations for future pandemics.**

In meeting these aims, the inquiry will:

- listen to the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. Although the inquiry will not investigate individual cases of harm or death in detail, listening to these accounts will inform its understanding of the impact of the pandemic and the response, and of the lessons to be learned;
- highlight where lessons identified from preparedness and the response to the pandemic may be applicable to other civil emergencies;
- consider the experiences of and impact on health and care sector workers, and other key workers, during the pandemic;
- consider any disparities evident in the impact of the pandemic and the state's response, including those relating to protected characteristics under the Equality Act 2010 and equality categories under the Northern Ireland Act 1998, as applicable;
- have reasonable regard to relevant international comparisons; and
- produce its reports (including interim reports) and any recommendations in a timely manner.