C&V Public Board Meeting

Thu 27 May 2021, 13:00 - 17:00

MS Teams

Agenda

1.
Welcome & Introductions

Charles Janczewski

2.
Apologies for Absence

Charles Janczewski

3.
Declarations of Interest

Charles Janczewski

4.
Minutes of the Board Meeting held on 29th April 2021

Charles Janczewski

4. Unconfirmed Board Minutes 29 April 2021 v3 je.NF.pdf (17 pages)

5.
Action Log – 29th April 2021

Charles Janczewski

05 - Action Log - 29.04.21 - v1.pdf (2 pages)

6.
Items for Review and Assurance

6.1.
Patient Story

Ruth Walker

6.2.
Chair's Report & Chair's Action taken since last meeting

Charles Janczewski

6.2 - Chair's Board Report 27 May 21 je.pdf (4 pages)

6.3.
Chief Executive Report

Len Richards

6.3 - Chief Executive Board Report - May 2021.pdf (3 pages)

6.4.
Corona Virus Update Report

Len Richards

- Quality and Safety - Ruth Walker / Stuart Walker
- Workforce - Rachel Gidman
- Governance - Nicola Foreman
- Operations - Steve Curry
- Public Health - Fiona Kinghorn

6.4 - Corona Virus COVID-19 Update Report.pdf (2 pages)
6.4.1 - Appendix 1 - COVID 19 Update Report je.pdf (7 pages)

6.5.
Board Assurance Framework

Nicola Foreman

6.5 - BAF Covering Report -May 2021 je.pdf (3 pages)
6.5.1- Board Assurance Framework (BAF) - May 2021- V2.pdf (25 pages)

6.6.
Performance Report

Steve Curry - Chris Lewis

6.6 - Performance Report May 2021 je.pdf (9 pages)

6.7.
Patient Safety, Quality and Experience Report

Ruth Walker - Stuart Walker

6.7 - Patient Safety, Quality and Experience Report je.pdf (16 pages)

7.
Items for Approval / Ratification

7.1.
Outcome Of Engagement On Shaping our Future Clinical Services

Abigail Harris

7.1 - Cover Paper - Shaping Our Future Clinical Services Public Engagement - May 2021.pdf (3 pages)
7.1.1- Shaping Our Future Clinical Services - Public Engagement Report - Board - Final.pdf (44 pages)

7.2.
Outcome Of Engagement On Regional Model For Vascular Surgery

Abigail Harris

7.2 - Cover Paper - South East Wales Vascular Network - Public Engagement - May 2021.pdf (5 pages)

7.2.1 - South East Wales Vascular Network - Public Engagment Report - Board - Final.pdf (145 pages)

7.3.
Endoscopy Expansion Business Justification Case

Abigail Harris

7.3 - Expansion of Endoscopy UHL - Cover paper May 2021 v2.pdf (6 pages)
7.3.1- Endoscopy BJC Exec Summary v5.pdf (22 pages)

7.4.
Board Development Plan

Nicola Foreman

7.4 - Board Development Programme 2021-2022 Report.pdf (2 pages)
7.4.1 - Appendix 1 - Board Development Programme 2021-2022.pdf (20 pages)

7.5.
Standing Orders & SFI's

Nicola Foreman

7.5 - Standing Orders & SFI's - je.pdf (2 pages)
7.5.1 - Appendix 1 - Summary of Updates to Standing Orders and SFI's-May 2021.pdf (11 pages)

7.6.
Nurse Staffing Act – Mental Health Nurse Staffing Levels

Ruth Walker

7.6 - Annual Assurance Report Nurse Staffing Act – Mental Health Nurse Staffing Levels je.pdf (3 pages)
7.6.1 - Appendix 1 - Nurse Staffing Act - Annual Assurance Report 2021.pdf (7 pages)
7.6.2 - Appendix 2 - Nurse Staffing Act - Summary of Establishment.pdf (5 pages)

7.7.
Broad Street Clinic

Abigail Harris

7.7 - Broad Street Clinic - Board paper May 21 je.pdf (3 pages)
7.7.1 - Appendix 1 - Broad Street Clinic Redevelopment Proposal.pdf (8 pages)

7.8.
Committee Minutes

Nicola Foreman

7.8.1.
COVID-19 Board Governance Group Minutes – 11th February

Charles Janczewski

7.8.1 - BGG Minutes - 11 Feb 2021.pdf (4 pages)

7.8.2.
Audit & Assurance Committee – 9th February 2021

John Union

7.8.2 - Confirmed Public Audit Mins - 9 Feb 2021.pdf (14 pages)

7.8.3.
Finance Committee – 24th February & 24th March 2021

Rhian Thomas

7.8.3 - Confirmed Finance Minutes - 24 Feb 2021.pdf (9 pages)
7.8.3 - Confirmed Finance Minutes - 24 March 2021.pdf (5 pages)

7.8.4.
Quality Safety & Experience – 16th February 2021

Susan Elsmore

7.8.4 - Confirmed Public QSE minutes - 16 Feb 2021.pdf (16 pages)

7.8.5.
Strategy and Delivery Committee – 9th March 2021

Michael Imperato

7.8.5 - Confirmed Public S&D Mins - 9 March 2021.pdf (14 pages)

7.8.6.
Mental Health Committee – 19th January 2021

Sara Moseley

7.8.6 - Confirmed MHCLC Minutes - 19 Jan 2021.pdf (13 pages)

7.8.7.
Stakeholder Reference Group – 26th January 2021

Abigail Harris

7.8.7 - Minutes of SRG Meeting - 26 January 2021v2.pdf (8 pages)

7.8.8.
Health & Safety Committee - 5th January 2021

Akmal Hanuk

7.8.8 - Confirmed Minutes H&S Committee - 5 Jan 2021.pdf (9 pages)

7.8.9.
Emergency Ambulance Services Committee – 10th November 2020

Nicola Foreman

7.8.9 - Confirmed minutes EASC - 10 Nov 2020.pdf (12 pages)

7.8.10.
Local Partnership Forum – 10th February 2021

Rachel Gidman

7.8.10 - Confirmed LPF minutes - 10 Feb 2021.pdf (7 pages)

7.8.11.
WHSSC Joint Committee Briefing – 11th May 2021

Nicola Foreman

7.8.11 - WHSSC JC Breifing - Public - 11 May 2021.pdf (3 pages)

8.
Items for Noting and Information to Report

8.1.

Corporate Risk Register

Nicola Foreman

8.1 - Corporate Risk Register Report - May 2021 je.pdf (3 pages)
8.1.1 - Appendix 1 - Corporate Risk Register Board Summary May 2021.pdf (1 pages)

8.2.
Chair's Reports

Nicola Foreman

8.2.1.
Finance Committee – 24th March & 28th April 2021

Rhian Thomas

8.2.1 - Finance Committee Chairs Report - 24 March 2021 je.pdf (4 pages)
8.2.1 - Finance Committee Chairs Report - 28 April 2021 je.pdf (4 pages)

8.2.2.
Audit & Assurance Committee – 13th May 2021 Verbal & 6th April 2021

John Union

8.2.2 - Audit Chair's Report - 6 April 2021 je.pdf (6 pages)

8.2.3.
Quality Safety & Experience – 13th April 2021

Susan Elsmore

8.2.3 - QSE Chairs Report - 13 April 2021 je.pdf (6 pages)

8.2.4.
Strategy and Delivery Committee – 11th May Verbal

Michael Imperato

8.2.5.
Mental Health Committee – 20th April 2021

Sara Moseley

8.2.5 MHCLC Chairs Report 20 April 2021 je.pdf (4 pages)

8.2.6.
Emergency Ambulance Services Committee – 9th March 2021

Nicola Foreman

8.2.6 - Chair's EASC Summary - 9 March 2021.pdf (4 pages)

8.2.7.
Health & Safety Committee – 30th March 2021

Akmal Hanuk

8.2.7 - HS Chairs Report - 30 March 2021 je.pdf (4 pages)

8.2.8.
Stakeholder Reference Group – 23rd March 2021

Abigail Harris

8.2.8 - SRG Chairs Report - 23 March 2021.pdf (3 pages)

8.2.9.
Local Partnership Forum – 22nd April 2021

Rachel Gidman

8.2.9 - LPF briefing - 22 April 2021.pdf (3 pages)

8.2.10.
NWSSPC Assurance Report - 18 March 2021

Nicola Foreman

8.2.10 - NWSSPC Assurance Report - 18 March 2021.pdf (3 pages)

9.
Agenda for Private Meeting:

1. Integrated Performance Report
2. Private Committee Minutes

10.
Any Other Business

Charles Janczewski

11.
Review of the meeting

Charles Janczewski

12.
Date and time of next meeting: Thursday, 29th July 2021 Via MS Teams

Charles Janczewski

Unconfirmed Minutes of the Board Meeting
Held on Thursday, 29 April 2021 at 9.45 a.m. – 11.15 a.m.
Via MS Teams

Present:		
Charles Janczewski	CJ	UHB Chair
Len Richards	LR	Chief Executive Officer
Gary Baxter	GB	Independent Member - University
Steve Curry	SC	Chief Operating Officer
David Edwards	DE	Independent Member - ICT
Susan Elsmore	SE	Independent Member – Local Authority
Rachel Gidman	RG	Executive Director of Workforce and Organisational Development
Abigail Harris	AH	Executive Director of Strategic Planning
Michael Imperato	MI	Independent Member - Legal
Fiona Jenkins	FJ	Executive Director of Therapies & Health Sciences
Mike Jones	MJ	Independent Member – Trade Union
Fiona Kinghorn	FK	Executive Director of Public Health
Sara Moseley	SM	Independent Member – Third Sector
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CP	UHB Vice Chair
Rhian Thomas	RT	Independent Member – Capital and Estates
John Union	JU	Independent Member - Finance
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
In Attendance:		
Nicola Foreman	NF	Director of Corporate Governance
Allan Wardhaugh	AW	Chief Clinical Information Officer
Malcolm Latham	ML	South Glamorgan Community Health Council (CHC)
Graham Robb	GR	Independent Chair Of Cardiff Youth Justice Board (YJB)
Scott Mclean	SM	Director of Operations – Children and Women
Observing:		
Joanne Brandon	JB	Director of Communications
Jacqueline Evans	JE	Head of Corporate Governance
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Akmal Hanuk	AH	Independent Member - Community
Sam Austin	SA	Chair, Stakeholder Reference Group (SRG)
Stephen Allen	SA	Chief Executive Officer - South Glamorgan Community Health Council (CHC)

Ref	Agenda Item	
UHB 21/04/001	**Welcome & Introductions** The UHB Chair welcomed everyone to the Public Board Meeting in Welsh and English and advised that the meeting was being broadcast live via MS Teams as a consequence of the COVID-19 Pandemic. The Chair welcomed Graham Robb, Independent Chair of the Cardiff Youth Justice Board to the meeting.	
UHB 21/04/002	**Apologies for Absence** Members noted that apologies for absence has been received from Stephen Allen, Chief Executive Officer - South Glamorgan Community Health Council, Sam Austin, Chair of the Stakeholder Reference Group (SRG) and Akmal Hanuk, Independent Member – Community.	
UHB 21/04/003	**Declarations of Interest** Fiona Jenkins – Executive Director of Therapies & Health Sciences (EDTHS) declared an interest as a Board member of Cwm Taf Morgannwg University Health Board (CTMUHB). Susan Ellsemore – Independent Member – Local Authority (IM-LA) declared an interest as a Cabinet Member for Social Care, Health and Well-Being For Cardiff Council.	
UHB 21/04/003	**Minutes of the Board Meeting held on 25 March 2021** The Minutes of the meeting held on 25 March 2021 were **received** and **confirmed** as a true and accurate record of the meeting. There were no matters arising that were not included on the agenda or action log, with the exception of a query from the last Board meeting concerning accident & emergency (A&E) figures 12 hour waits. The Chief Operating Officer (COO) advised that the figures were thought to be at 10%, however they were in fact between 2% and 3%, the error had been due to an issue with the axis of the graph. **The Board resolved that:** a) The minutes of the meeting held on 25 March 2021 be approved as a true and accurate record.	
UHB 21/04/004	**Board Action Log following the Meeting held on 25 March 2021** The Director of Corporate Governance (DCG) confirmed that actions **UHB20/11/014 & UHB 21/02/005, concerning** Nurse Staffing Act – Mental Health Nurse Staffing Levels, and action **UHB 21/03/008** concerning the Chief Executive Report's reference to the outcome of the engagement on Shaping Our Future Clinical Services would be brought to the Board meeting in May 2021.	

	UHB 21/03/018 concerning the Terms of Reference & Work Plan for all Committees of the Board would be brought to the Board meeting in July 2021. **UHB 21/03/023 concerning the** Agenda for Private Board Meeting – Annual Plan 21/22 action was in relation to the final sign off of the Annual Plan 2021-2022 with a date to be confirmed for a future Board meeting. The Board noted that an update on progress with the annual plan was on the agenda for discussion. **The Board Resolved that:** a) The Action Log and updates be noted.	
UHB 21/04/005	**Chair's Report & Chair's Action taken since last meeting** The Chair's report was received and the Chair gave an update on relevant matters undertaken as Chair since the previous Board meeting. The Chair gave an overview of the positive response the Communications and Engagement Team had provided during the COVID-19 pandemic. The Chair advised that clear, swift and effective communication had been an important requirement during the pandemic. It was, and remained, imperative that members of the public, our staff, partners and key stakeholders were kept as informed as possible about the work of the health board and the changes needed to make to keep everyone as safe as possible throughout the very challenging last twelve months. He advised that a lot of the communication was visible and recognised, however the substantial work undertaken behind the scenes during the pandemic should also be recognised. The Chair gave an overview of the work of the Health Charity and Arts Team and advised that the team quickly responded and were agile, responding to the needs of the Health Board's patients and staff at a time when they needed support the most. The Board noted that during the past year, art had played a huge part in the nation's emotional health and wellbeing, giving artists an outlet for their emotions and feelings. Staff participated in and created art as a way of dealing with the emotional trauma they faced. Some of the art was reflective, some art was uplifting, some art formed tributes those staff and loved ones lost due to COVID-19. These art works would be a lasting reminder of a challenging time for many. The Chair stated that he was personally grateful for the work undertaken in both areas. The Chair advised that Fixing of the common seal/Chair's Action to signed documents were detailed within the report. **The Board resolved that:** a) The Chairs Report be noted.	

	b) The Chairs actions concerning Fixing the Common Seal/Chair's Action and other signed documents be approved.	
UHB 21/04/006	**Chief Executive's Report** The Chief Executive's report was **received** and the CEO gave an update on relevant matters undertaken since the previous board meeting. The CEO highlighted: 1) CVUHB recently became members of the **Global Green and Healthy Hospitals (GGHH)**. The Board noted that: • GGHH was part of Healthcare without Harm and was a vibrant and growing international community of hospitals, health systems, healthcare facilities and health organisations dedicated to reducing the health sector's ecological footprint and improving public and environmental health, • CVUHB had pledged to tackle the climate emergency last year as a board and that joining GGHH, was in line with the ambition to deliver sustainable, carbon neutral services, and the leadership in this programme of work we have throughout the Health Board, • There was significant enthusiasm across CVUHB to tackle the climate change agenda, and that there were a number of different clinicians across the organisation who were leading on efforts and actions to reduce carbon in the atmosphere, Fiona Brennan, an anaesthetist with CVUHB had started "The Welsh Anaesthetic Forum" concerning environmental health and discussons had been undertaken with Welsh Government, for CVUHB to host a seminar/conference relating to climate change in June 2021. This would be an opportunity to bring together all of the initiatives that are taking place across Wales with a view to centering Wales as a leader in this area. 2) The **Welsh Infant Children's Genome Service (WINGS)** was launched in August 2020. The Board noted that: • WINGS was delivered by the All Wales Medical Genomics Service and hosted by CVUHB, • it was the first in the UK to routinely offer whole genome sequencing DNA test to critically ill babies and children with unexplained diseases as part of a national programme within the NHS, • With approximately 6,000 to 8,000 known genetic diseases, the traditional approach to diagnosing rare conditions required running multiple tests, with majority of patients having to wait several years for a successful diagnosis, • after a genome sequence which could take one week, they could now pinpoint the gene and then commence preparation with the parents and identify potential treatments that were known for those genetic deformities. 3) The Health Board had now concluded the formal engagement for the **Shaping Our Future Clinical Services programme**. The Board noted:	

	• That as plans develop we would continue to engage with our staff and the public, • The CEO expressed this thanks to everyone who had participated and offered feedback so far, • The responses would be shared with the South Glamorgan Community Health Council (CHC), and discussion would be held to consider the outcome of the engagement exercise and next steps, • The outcome of the engagement exercise would be published and CVUHB would consider the responses received and write a report summarising the feedback and recommending a way forward. **The Board resolved that:** a) The Chief Executives Report be noted.	
UHB 21/04/007	**Corona Virus Report** The Corona Virus update report was received and each Executive Director updated the Board on their respective areas within the report. • **Quality & Safety** The Executive Nurse Director (END) gave an update on quality and safety matters and the Board noted: • **COVID-19 outbreak position** - there were no COVID-19 outbreaks across the UHB, and there was ongoing investigation work into the COVID-19 deaths, • **Investigation of hospital acquired COVID-19** - the UHB continued to work with colleagues across Wales, Welsh Government and the Delivery Unit to standardise the investigation of hospital acquired COVID-19, and the application of the "Putting Things Right" regulations, the END advised she would keep the Quality Safety and Experience (QSE) Committee appraised of the situation, • **A Head of COVID-19 Investigations**, had been appointed and the UHB would shortly be recruiting a team of investigators to ensure that an appropriate level of review and investigation was in place in line with the All Wales Framework. A COVID-19 Investigation Oversight Group and Scrutiny panel (with Executive oversight) would be established to oversee the process, • **Concerns** – The UHB continues to receive a high volume of concerns/enquiries per week in relation to appointments at the mass vaccination centres, and were also co-ordinating approximately 100 calls per day in relation to requests to visit relatives. The END stated that they had hoped that this would start to decrease over the next few weeks as they were seeing the vaccination position improving. • **Workforce**	

	The Executive Director of Workforce & Organisational Development (EDWOD) gave an update on workforce matters and the Board noted: • the **Workforce Hubs** established for Nursing, Medical, AHP, Facilities and Primary Care brought together through a Workforce Steering Group chaired by the Interim Director of Workforce & OD once a week were now reconfigured to focus on the recovery phase and ensure the workforce is COVID-19 ready with a real focus on future proofing the workforce, • there were no COVID-19 positive patients in critical care (as at 13.04.21) however the nursing position remained challenging, • The staffing levels for Mass Immunisation centres had improved due to reduction in vaccination supplies and reduction in activity. A reserve list had been established due to the high number of Did Not Attends (DNAs), • Staff-wellbeing was being prioritised with a comprehensive full range of initiatives and support in place as well as a new initiative with Remploy to support staff with mental health issues, • 3 Staff Havens were now open (at Lakeside Wing (LSW), University Hospital of Wales (UHW) and University Hospital Llandough) UHL) with an Aroma nearby, • Employee Wellbeing Service waiting times were low - employees can be seen quickly in all areas, • Further resource had been extended for the trauma pathway , which was accessible for staff , led by the well-being service and was due to start 7 May 2021, • Wellbeing sessions were being held twice a week to support Managers, • The Health and Wellbeing lead was visiting ward areas to see staff and discuss wellbeing and was working closely with the medicine Clinical Board to support staff wellbeing • A COVID-19 health intervention co-ordinator commenced on 19 April and would support areas affected by COVID-19 by being a direct point of contact to wellbeing services and a link for line managers. Two further Health Intervention co-ordinators had also been recruited to look proactively at interventions to support health and wellbeing of staff. These posts had been supported by the Health Charity for a period of two years, • The number of referrals to Occupational Health (OH) were increasing as staff were returning to their substantive areas and managers had capacity to review staff and address their physical and psychological needs. The EDWOD advised that the workforce team were considering revalidating CVUHB's gold and platinum status of the corporate health standards and were currently scoping what was required in order to being a formal report to a future meeting. • **Governance**	

	The DCG gave an update on governance matters and the Board noted: • As the Health Board (HB) moved towards a recovery position after the second COVID-19 Wave Governance arrangements had returned to 'business as usual' from the start of the new financial year, • The Board would now return to meeting in public on a bi monthly basis and today's meeting is the last COVID-19 Board meeting for the foreseeable future, • The new COVID-19 report had been successfully introduced and used to report at each meeting of the Board since November 2020. Consideration would be given as to whether The Heath Board continued to have a COVID-19 report at the bi monthly Board Meetings. • The COVID-19 Board Governance Group had been stood down for the foreseeable future, however the protected time outlined in meeting diaries would be kept in case there was a need to reconvene the meetings in future, • From the start of the new financial year Committees of the Board had returned to business as usual with Terms of Reference and work plans for 2021/2022 for each Committee receiving approval at the Board meeting in March 2021, • The Management Executive Meeting continued to meet on a Monday each week and there wer standing items on the agenda linked to COVID-19. The Management Executive were also now considering recovery plans, • The twice weekly COVID-19 Operational Meeting has been reduced to once a week and meets on a Tuesday each week. • **Operations** The Chief Operating Officer (COO) gave an update on operational matters and the Board noted: • The revised COVID -19 operating framework previously presented to Board remained in place, with the first principle being to be 'COVID-19 ready'. Operations, working in a 4-6 week planning horizon, continued to be guided by a number of key components focusing on minimising the different types of harm as set out in the national and local framework, • the HB continued to navigate the transition between the high COVID-19 activity and prevalence, through to the non COVID-19 picture which was emerging at a significant rate, • Essential services – urgent and emergency essential services continued to be maintained in all areas, including cancer treatments, urgent and emergency surgery and in unscheduled care, • Unscheduled care – As reported to the Board last month, the second wave had been characterised by a slow reduction in COVID-19 bed occupancy from a much higher peak, together with a greater impact from hospital acquired infection. The overall position had continued to improve in recent weeks. COVID-19 admissions had fallen significantly as community	

prevalence had reduced. Hospital bed occupancy for COVID-19 patients had reduced accordingly, with the Health Board recording approximately 100 COVID-19 inpatients as at 19 April 2021 – the vast majority of these were COVID-19 'recovery' patients. Bed losses due to Infection, Prevention and Control (IP&C) outbreaks had also reduced markedly, with no wards being designated 'outbreak' status as at 19 April 2021,

- They were approximately 30 attendances per day in the A&E department that were suspected COVID, but only ones and two's of those were actually turning out to be COVID-19 patients,
- The re-emergence of non COVID-19 activity, which is re-emerging now at a rate which is greater than it re-emerged after the first the first wave. There was strong anecdotal evidence from clinical teams that the non COVID-19 re-emergence of activity was sometimes related to COVID-19 as it was not distinctly the same type of activity previously seen, so there was an impact on COVID-19 activity that was featuring in their non COVID-19 activity,
- Planned care – with the reduction in COVID-19 admissions, there was a focus on recommencing elective activity which ceased in January 2021. Theatre staff redeployed to Critical Care had been repatriated and surgical ward staff redeployed to Lakeside Wing had also returned to their specialty. The Health Board had submitted its annual plan to Welsh Government and, within it, described recovery plans which would be risk based, data driven and clinically led. The next stage of this planning process was currently being rolled out at specialty level,
- The COVID-19 footprint had been resized, there was one Ward at UHW and one area at UHL that was dedicated to COVID-19 positive area and work had begun to resize that to some extent,
- The Lakeside wing was still open although they had closed other areas of capacity and were still caring for 50 patients which was their field hospital facility,
- Cancer care – Cancer care continued to be provided as an essential service. As reported last month, whilst the Health Board had been successful in maintaining treatment activity, referral rates, backlog work and timeliness of treatment was resulting in cancer target compliance reducing transiently in the first half of 2021.
- Mental Health services – With demands on Mental Health Services continuing, the Clinical Board was re-assessing pressures on the various points of access to get a whole system view. As reported previously, increased demand along with staff absence contributed to a deterioration in compliance in 28 day access for primary mental health assessment but a recovery plan is underway. Some non-urgent mental health services previously ceased have recently recommenced.
- Primary care services remained relatively resilient despite significant pressures. However, feedback from GP leads was indicating an increased acuity in some GP presentations. There had been a small number of practices that had been supported by the primary care team within the Health Board but no GMS

practices reporting high levels of escalation. Dental, optometry and pharmacy were all reporting a green status.

- Non COVID-19 primary care was seeing a change in its demand, they were not seeing absolute changes in the numbers of patients presenting but were seeing changes in complexity with a strong view from primary care clinicians that the tail of COVID-19 impact was being seen and the complexity of some of the patients and potentially related to late presentations that they're seeing in primary care,
- Non COVID activity in secondary care was rising at a much higher rate than it did after the first wave,
- They continued to operate their green zones, the areas of protected surgical activity with remarkable results in terms of very low or in some cases for some types, absence of infection in those areas,
- some ward capacity had been repurposed back to surgery, which was purposed for COVID-19 response in anticipation and in recognition of the growth of surgical activity,
- we are working with Welsh Government to develop and accelerate recovery plans in scheduled care against the background of a waiting list that continued to grow, although fairly slowly but was ageing rapidly in terms of the length of time that patients were waiting was going up significantly,
- the recovery plan considered extending existing schemes beyond what they were already doing,
- All 60 GP practices had been actively involved in the mass immunisation programme and had been providing vaccines (see separate update on vaccination).

The COO advised that they would need to frame the recovery phase through a programme management approach and had a structured approach to the significant tasks requiring completion across a number of areas going including planned care, unscheduled care, primary care, mental health, and diagnostics.

The COO advised that in terms of productivity and efficiency, the first challenge was to get back to the levels of activity that they were doing in the pre COVID-19 period. He added that there had been significant losses and the positive national IP&C guidance had outlined how they would operate in a COVID-19 environment in which there was a threat.

The COO advised that green zones had been put in place to bring patients in and recover them. As the patient procedures were being undertaken the processes for those procedures had been affected significantly, and 30-50% of the throughput had been lost as they were undertaking the procedures in a different way with longer cleaning times between operating procedures, different routes in out of the procedure rooms and strengthened practices for the individuals undertaking the procedures, including more frequent changing of Personal Protective Equipment (PPE).

The COO advised that their first call of action would be to try recover that at a rate at which was safe, which would consist of:

- How they configure themselves i.e. Green Zone work, and
- National guidance - changes in terms of being able to bring more people into those facilities.

The COO added that they were aiming to return to 70% of pre COVID-19 activity in this quarter, with an ambition of 80% in the next quarter.

The Chair queried the Operations section of report, and the reference to the Health Board having submitted its annual plan to Welsh Government, and advised that it should state it was a draft plan, and the final plan had not yet been agreed.

The Chair advised that on behalf of the Board he would to express their gratitude to all those people, staff, who have been involved in the mass immunisation programme, including GP colleagues who had taken on administering immunisation programmes in addition to their day to day workloads.

- **Public Health**

The Executive Director of Public Health (EDPH) gave an update on Public Health matters and the Board noted:

- **Epidemiology** - During March 2021, cases remained broadly static in Cardiff at around 40 per 100k per week. In the Vale, rates declined towards the end of the month following a slight increase, with the incidence in the first week of April less than 20 per 100k per week in the Vale. The rates were equivalent to around 20 new cases per day in Cardiff, and 3 per day in the Vale,
- **Test, Trace & Protect (TTP)** - There was capacity in all local testing sites and the majority of results were received within 24 hours. People living in Cardiff and Vale could now access PCR testing for a wider range of symptoms, including headache and sore throat, in addition to the three cardinal symptoms; those exhibiting cough, high temperature and/or loss or change of taste and smell are required to isolate whilst awaiting their result, but those with other symptoms are not. Lateral Flow Tests (LFTs) are being used in healthcare, care home and school settings to screen asymptomatic staff and pupils; results are fed into the national system and positive tests confirmed with a PCR.
- the most recent statistics which were produced daily, showed:
  - In Cardiff 11.7, per 100,000 over a seven day period,
  - In the Vale 8.2, per 100,000 over a seven day period,
- these figures showed a significant decline from what has been seen over the winter period and through March and April
  - Positivity in Cardiff 1.3%,
  - Positivity in the Vale is 0.9%,
- **Vaccination update** – over 375,248 vaccinations had been administered, 276,237 of which were first doses, 98,990 of were second doses,
- 69% of adults aged 18 and over had been vaccinated with the first dose,

- A quarter of adults were fully immunised with first and second doses,
- The vaccination progress made was a major achievement as if the vaccination rates for the Four UK Nations were split, Wales came third only to Israel and the United Arab Emirates (UAE) and that CVUHB's proactive approach had played an important role in that,
- there were fewer cases either in care home residents or staff, with a really significant decline, and in schools they were still finding some clusters, highlighting they were usually small and couldn't clearly track why this had been the case.
- There was a key risk concerning arriving travellers, with over 400 arriving in Cardiff each week. There were still many reasons why people feel the need to travel, and there was now a requirement for travellers arriving from amber countries to be followed up through the National Arriving Travellers Team which is hosted by Cardiff Council in partnership, the local Public Health Team and Specialist Public Health Colleagues.
- There were still some secondary community cases in the population, and some areas of the Southern arc in Cardiff were proving to be more challenging than others
- As restrictions were eased and the team would monitor the situation carefully,
- there would be some pilots for large events planned in Cardiff in May and June 2021, and advice had been received on the required preventative testing regime,
- there was a prediction that there may be a third, smaller wave later in the summer, as opposed to the previous prediction that the wave would occur earlier than this,
- Workforce and "Did Not Attends" (DNA's) still posed to be challenging, however teams were continuously working on these issues through multiple routes and mechanisms and were managing to achieve high rates of vaccination,
- Vaccinations for the 20 to 30 age group were being scheduled, and there was a plan in place for student vaccinations,
- CVUHB were forming part of a world first randomised control trial which would assess if COVID-19 vaccine and the influenza vaccine could be administered in tandem, to support the vaccination programme currently being planned across England and Wales.

The IM-LA highlighted that there was a great preponderance of vaccination rates for staff in areas including care homes for older people, learning disabilities, mental health and domiciliary care. However, there were some outliers including less than 15% of vaccination take up amongst some staff. The business intelligence gathered suggested that this was in relation to concerns people had about fertility. The IM-LA proposed a discussion be undertaken in partnership with CVUHB and the Local Authorities to consider these concerns, and to consider the joint approach to dealing with travellers coming into Cardiff to ensure that everything was being done to prevent a third wave.

	The EDPH responded and advised that there was a slight inequality gap, however the numbers were not large. The numbers between men and women was very small and reverberate through the age groups, and associated socio economic groups. She highlighted that within the Black, Asian, Minority, and Ethnic Communities a lot of work had been undertaken and the gap in these group has decreased by 3%. She added that work was being undertaken to strengthen and improve communication and engagement in targeted areas of Cardiff and the Vale of Glamorgan to try and decrease the socio economic gap. The Independent Member University (IM-University) queried the reference within the report concerning the stability of staffing, and asked if there were any particular issues that were contributing to that instability, and if there was any strategic planning in development for a mass booster campaign in the autumn and winter months and what the issues were concerning staffing and whether it would sustainable through the autumn and winter months. The END responded that: • The challenge was that most of the staff that were currently being utilised in the mass vaccination Centre were employed on a temporary basis, • They are either temporary in the sense of they are employed in a work environment within the HB but undertake additional work through the staff bank, or they are adding extra hours to their existing working hours, or staff who have returned to practice to support the vaccination programme are being utilised, • When the mass vaccination programme was first proposed there was initially an influx of people offering to come forward and provide assistance, however the complex training programme provided through the national programme had since deterred people from offering to help, • There were some patterns of presentation that were emerging currently that might be very helpful to measure, but difficult to staff for example some of the DNA work demonstrated that people may have a vaccination scheduled at a specific time in the morning, however they do not turn up until after the evening when they finish work, therefore consideration needs to be given to staffing differently or booking appointments differently, • Continuous assessments were made each week concerning whether mass vaccination centres should stay open, • In addition to considering the COVID-19 booster vaccinations and the influenza campaigns, consideration was also being given to the other routine vaccinations such as the Human papillomavirus (HPV). Currently, the HPV campaign was slightly behind target as many of school the nurses were supporting the mass vaccination centres or vaccinating for influenza. Currently about to go back out again and to ask those people who had put themselves forward but maybe not materialised if they would like to do that **The Board resolved that:** a) The Corona Virus Report be noted.	

UHB 21/04/008	**NHS Funded Nursing Care (FNC)** The NHS Funded Nursing Care (FNC) report was received. The Board noted that: • FNC referred to the NHS funding of Registered Nursing (RN) care within care homes, where the need for nursing input had been assessed as necessary. It is a statutory requirement set out in s49 of the Health and Social Care Act and the FNC rate covers both the costs of the services provided by the RN along with funding for continence products that may be necessary, • Since 2014 HBs have used the Inflationary Uplift Mechanism (IUM) to set the FNC rate. This is made up of two components: o The 'labour' component – i.e. time spent by the care home RN in providing direct and indirect care and supervision. This is funded at the mid-point of Band 5 on the Agenda for Change pay scale; o The continence supplies component. This is uplifted annually in line with the CPI, • In 2019 Boards approved a proposal to extend the IUM for a further two years in order to allow for Welsh Government (WG) to revise and reissue the FNC Policy Guidance (which has not been updated since 2004). This also allowed the IUM to continue to operate for the full three year period covered by the NHS pay award, • The extension to the IUM ended on 31 March 2021 and HB professional and finance leads for longer term care have worked to identify options that may be appropriate to applied from April 2021 onwards, • A WG policy review had been delayed due to COVID-19 demands but they had committed to a review of the FNC policy commencing in the spring of 2021, therefore the recommended extension of the current methodology should only need to apply for the 2021/2022 year. HBs would need to review the approach adopted to set the FNC rate following this to ensure compliance with policy, The Director of Finance (DOF) stated that there was an annual requirement to agree an inflationary uplift for FNC, and that CVUHB had used a similar methodology which mirrored the approval process used in previous years. She higlighted that this inflationary uplift had been covered in the allocations provided by WG. The Board noted that it was recommended that the IUM for 2021/2022 be extended, with a commitment to review the methodology as soon as an updated policy position was available. **The Board resolved that:** a) The need for HB Boards to review the methodology be noted, b) The impacts of the COVID-19 pandemic and the lack of a contemporary policy position as key factors that limit the options available to HBs be noted	

	c) The recommendation of HB professional and finance leads; lead Executive Directors; and CEOs that the Inflationary Uplift Mechanism be retained for 2021/2022 with a commitment to review when the policy position is updated be noted, d) That the recommendation to retain the Inflationary Uplift Mechanism as the recommended option for 2021/2022, with a commitment to review the methodology when the policy position is available, be approved.	
UHB 21/04/009	**Cardiff Youth Justice Advocacy panel** The Cardiff Youth Justice Advocacy panel report was received and Graham Robb, Indepdendent Chair of the Cardiff Youth Justic Board (ICCYJB) gave an update on the Cardiff Youth Justice Services : Improvement following Her Majesty's Inspectorate of Probation (HMIP) Inspection 2020. The Board noted that: • Her Majesty's Inspectorate of Probation (HMIP) had led Inspection of Cardiff Youth Justice services in January 2020 through a joint probation, social care, health (Inc. Care Quality Council (CQC)), education and Police Inspectorates reached an overall judgement of "Inadequate" on the three core areas of Leadership and Management, Court work, and Out of Court work. This is the lowest category and the Inspection report was published in July 2020, • as a consquence improvement recommendations were made for the Youth Offending Service (YOS) Management Board, with one recomemdnations being given to CVUHB to "Ensure that its statutory duty to provide relevant and timely physical, sexual, emotional and mental health services to YOS children is fulfilled.", • In April 2020 Paul Orders, the Chief Executive of Cardiff Council appointed Graham Robb as an Independent Chair to lead a two year development strategy, which after extensive staff and partner work was launched by the Public Services Board (PSB) in June 2020, " All our Futures" Youth Justice Strategy 2020-2022", • The YJB and CVUHB have undertaken key strategic actions since June 2020 to strenghthen and develop Cardiff YJB's services, • HMIP undertook a revisit in December 2020 to look at progress to date and focus on on Leadership, Governance and partnership processes, • In January and February 2021 in collaboration with staff and partners the progress made after six months of the two year strategy, was reviewed through strategy stocktake workshops, which demonstrated that progress was being made, • A repeat visit by the HMIP led inspectorate partners is anticipated in summer 2021, this will be over three weeks and will include a significant case scrutiny exercise and group and individual interviews,	

- The YJB were currently dealing with 120 young people in the Cardiff area, these involve a range of very complex sets of circumstances for young people, including children in care right through to criminal exploitation,
- Of the 120 young people – 4 young people were accommodated in secure estates,
- support was in place for those leaving to support them in ensuring their health, education and accommodation needs are met,
- there were 60 young people on prevention and diversion work.

The CEO thanked the ICCYJB for the report and highlighted that this was an area that required a multi-agency approach, to support the vulnerable children within CVUHBs catchment area, and also included some children from outside the area who required input from a range of different agencies. He added that he had requested that the report be brought to the Board's attention as it is an area that many people will be unaware of in light of the disappointing review undertaken in January 2020. Following the review the agencies were working collaboratively in a much more structured way and the ICCYJB had been instrumental in leading the forum.

The ICCYJB advised that in terms of progress:

- They now had the right level of engagement from the HB including the UHB Chair, CEO, EDPH, and the Director of Operations, Children and Women's (DOO-CW),
- The gap in service provision was now addressed with the appropriate membership on the subcommittee, which meant that they were complaint in terms of governance,
- all of the relevant and timely services to the children were fulfilled,
- The EDPH had developed a health and well-being needs analysis, which would support ensuring that service staff are trained to understand, recognise and engage with young people in their families and monitor if the appropriate services are in place.

In addition, the ICCYJB advised that he and the UHB CEO had discussed the importance of the young people's "voice" following attending a learning session with a young person. The learning session had been useful to understand what was being done well and what needed improvement from the perspective of a young person who had received support from partnership services for a range of different needs.

He added there was a need to get this work systematised, and to capture and record the views of young people and what their plans for the future were. CYB is committed to the child friendly city standards, UNICEF and it was important that the agencies involved were doing their part.

The DOO-CW stated that the progress made and the current positive position was largely due to the personal leadership of the ICCYJB in

	making changes to the governance environment and ensuring that actions were completed. He added that each layer from Board level down to service provision provided positive assurance on progress made. The DOO-CW advised that the progress made provided an important case study on how bespoke solutions for the 120 young people could be achieved through collaborative working following the difficult inspection. He felt that the right decisions had been made which had helped with broader engagement with partners, particularly in education and social services around universal services and signposting, as opposed to lots of smaller bespoke services. **The Board resolved that:** a) the report on the Cardiff Youth Justice Services: Improvement following the HMIP Inspection 2020 be noted.	
UHB 21/04/010	**Annual Plan Update – Verbal** The verbal update on the Annual Plan was received and the Executive Director of Strategic Planning (EDSP) informed the Board that the HB had been required to submit a draft plan to Welsh Government at the end of March 2021. The Board noted that the Annual plan was still in draft status as there was recognition that there was still quite a bit of uncertainty concerning COVID-19 in terms of the context and environment, the planning for moving through the recovery phases of the pandemic and in terms of the financial position recognising that there the Senedd election had a bearing in terms of the full budget allocation expected throughout this year. The EDSP reminded the Board that the draft budget would be considered for approval in private session of the Board meeting, reflecting its draft nature. The draft had shared with the Community Health Council (CHC) and expressed her gratitude for the comments received from the Community Health counsellors. The Board noted that the plan addressed the requirement to respond to the four harms that have been identified relating to COVID-19, and that the plan linked back to the strategic goals within the “Shaping Our Future Well Being” strategy. Whilst, CVUHB are applying an annual planning cycle in accorance with Welsh Government guidance, as opposed to the traditional three year Integrated Medium Term Planning (IMPT) cycle, the Board and the pateint population could see how CVUHB still wanted to be connected to delivering against the overarching strategy. The EDSP advised that in addition to the draft annual plan, an additional report had been submitted outlining the demand for services that had been built up, and the unmet demand concerning planned care	

	activity that reflects the level of activity CVUHB were able to safely undertake during the response to pandemic. The Board noted that the initial feedback received from WG indicated that CVUHB had a strong plan, with some areas that needed to be further refined, inlcuding more detailed clarification on what CVUHB could deliver in quarters one and two concerning planned care space, for example diagnostics, surgical interventions, etc. The COO's team had been leading on this work and the draft plan was submitted to WG on the 26 April 2021. The EDSP stated that the plan will be updated and be presented to the Board for approval in readiness for the June final submission deadline. **The Board resolved that:** a) the verbal update on the Annual Plan be noted.	
UHB 21/04/011	**Any Other Business** The UHB Chair rasied an additional item of business and highlighted that the additional Public Board meetings that had been held in the preceding months, were introduced to keep the public and staff updated on CVUHB' public health response towards the global COVID-19 pandemic. Following today's COVID-19 update he was pleased to report that there had been a lot of progress in recent months including the easing of national lockdown restrictions, the significantly lower transmission rate of the virus across Cardiff and Vale, the reduction of the number of COVID-19 cases reported by the EDPH, the successful mass vaccination campaign which was ongoing, and a significant reduction in the COVID-19 related hospital admissions and bed use in recent weeks. The UHB Chair stated that given the positive progress made consideration had been given to readjusting the frequency of the monthly public Board meetings, and it had been decided to resume to holding the usual bimonthly cycle of meetings, with an assurance that the pandemic situation and frequency of the meeting will be kept under review.	
UHB 21/04/012	**Review of the meeting** The Chair asked if attendees were satisfied with the business discussions and format of the meeting, and all members indicated that they were happy with the meeting, the updates provided and the meeting format.	
UHB 21/04/013	**Date and time of next meeting:** The Chair thanked everyone for their attendance and contribution to the meeting and confirmed that the next meeting would be held Thursday, 27th May 2021 at 1:00pm via MS Teams.	

ACTION LOG
Following Board Meeting
29th April 2021

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
UHB 21/02/007	**Chief Executive Report**	The CEO stated that he would bring to a future board development session work around inequalities and diversity	**29/04/2021**	Len Richards	To be taken to the April Board Development session **Agenda item 6.2**
Actions In Progress					
UHB 20/11/014 **UHB 21/02/005**	**Nurse Staffing Act – Mental Health Nurse Staffing Levels**	A further discussion to be had at an Executive level to consider Mental Health Nurse staffing levels for feedback to the Board The End stated that this work will now be picked up as part of the IMTP Process and brought to the May Board	**27/05/2021**	Ruth Walker	To be brought to the May Board meeting **Agenda item 7.6**
UHB 21/03/008	**Chief Executive Report**	The EDSP said that they are also getting the survey responses and questionnaires back with the intention to bring all that information together and share it with the CHC and Board on the Outcome Of Engagement On Shaping our Future Clinical Services.	**27/05/2021**	Abigail Harris	To be brought to the May Board meeting **Agenda item 7.1**
UHB 21/03/018	**Terms of Reference & Work Plan for all Committees of the Board**	The DCG confirmed to bring the DHIC TOR and work plan to a future Board meeting	**29/07/2021**	Nicola Foreman	To be brought to the July Board meeting

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
UHB 21/03/023	**Agenda for Private Board Meeting – Annual Plan 21/22**	EDSP said that they will be sharing with Welsh Government draft Annual plan 21/22 and will bring back to Board the final plans	**TBC**	Abigail Harris	To be brought to a future meeting
Actions referred to Committees of the Board/Board Development					
UHB 21/03/012	**Performance Report**	The CEO commented that for the June Board development sessions to have a focus on CAHMS to get an understanding of the breadth of the issues and where the Health board plays in and how they need to bring in other organisations	**24/06/2021**	Nicola Foreman	To be taken to June 2021 Board Development session

Report Title:	**Chair's Report to the Board**								
Meeting:	**UHB Public Board Meeting**						**Meeting Date:**	**27.05.2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		**x**
Lead Executive:	**Chair of the Board**								
Report Author	**Executive Assistant to the Director of Corporate Governance**								

Background and current situation

This report includes information on the key activities that have taken place since the last Board Meeting on the 29 April 2021 together with an update on Staff Wellbeing.

Staff Wellbeing

There is a huge amount of support available and the Employee Wellbeing team has been working with managers and senior managers across the UHB raising awareness of the range of resources available to support both their own wellbeing and that of their staff.

This includes a senior manager wellbeing checklist to provide guidance on what to consider in their areas; streamlined resources to make it easier to locate specific assets; collaboration with the Chaplaincy team to ensure that staff have access to pastoral support; the Head of Employee Health and Wellbeing visiting wards to speak to staff, offer support and raise awareness of support available; twice weekly virtual wellbeing drop-in sessions open to all staff across the UHB; working with Remploy to offer vocational mental health support; working collaboratively with the Cardiff Recovery College to offer mental health training and support to all staff; a rapid access pathway for staff affected by dermatology conditions associated with Personal Protective Equipment (PPE) use and increased hand washing.

The Employee Wellbeing Service (EWS) has altered its service delivery model slightly to expand the range of services available and can now offer low intensity interventions such as guided self-help which is delivered by a team of Assistance Psychological Therapy Practitioners. This ensures that staff can access services appropriate to their needs. The EWS has ensured that staff can continue to access their range of wellbeing workshops by offering these virtually and by developing a specific YouTube channel so that they can be accessed individually or as a team at a time that suits their needs.

A total of 142 wellbeing champions have now been trained by EWS. The role of the wellbeing champions is to provide wellbeing support, information and signposting at a local level where it is needed the most. The champions receive monthly newsletters, have quarterly meetings where they can share best practice and discuss any concerns. Further training is planned throughout 2021

There are also a number of projects in progress, which when launched will provide further support to staff across the system. These include: developing dedicated staff pathway in the

Covid Rehabilitation Service; recruiting 2 Health Intervention Co-ordinators who will support the Employee Health and Wellbeing service to provide proactive and preventative interventions; introducing REACT Mental Health training which will provide staff with the confidence and ability to hold wellbeing conversations; piloting a click and collect app in University of Llandough (UHL) which will enable clinical staff to easily order hot food and drinks during their shifts; increasing the capacity of the Rapid access Trauma pathway for UHB staff to ensure it is sufficient to meet the increasing demands. Menopause cafes which were put on hold during Covid are also being reintroduced in a virtual format to ensure that all staff regardless of gender or age can access support from colleagues.

Currently support is being focused on our staff who are originally from India as they have concerns and worries about family members in their home countries. Two Q & A sessions are being held next week to gather information and support staff in the right way.

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

The common seal of the Health Board has been applied to no documents since the last meeting of the Board.

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

Date Signed	Description of Document	Background Information
19.04.21	CRI Lease of the Chapel	Use of the UHB Seal
29.04.21	Cycle to Work agreement	Cardiff and Vale University Health Board and SME HCI Limited, reviewed by Legal and Risk
16.04.21	B1 - C1 Link Corridor refurbishment	Between Cardiff and Vale UHB and nec3 Engineering

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

Chair's Action was taken in relation to:

Chair's Actions						
Date Received	**Chair's Action Details**	**Background Recommendation Approved**	**Date Approved**	**IM Approval**		**Queries Raised by IMs**
				IM 1	IM 2	
19.04.21	CRI Lease of Chapel	Use of the UHB Seal	19.04.21	Approved Michael Imperato 28.04.21	Approved Rhian Thomas 27.04.21	
16.04.21	ALN	Use of the UHB Seal	16.04.21	Approved Michael Imperato 24.04.21	Approved John Union 23.04.21	
23.04.21	Thorough Care, Aftercare and Recovery TARS Substance Misuse Service Package for Adults	Approval award for the contract for 14 months, Veat Notice	26.04.21	Approval John Union 05.05.21	Approval Mike Jones 05.05.21	
23.04.21	Open Access and Engagement (OAE) Substance Misuse Service Package for Adults	Approval award for 15 months to include extension, Veat Notice	26.04.21	Approval Mike Jones 05.05.21	Approval Michael Imperato 05.05.21	

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

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

Khan Raj 05/20/2021 15:17:34

Recommendation:

The Board is recommended to:

- **NOTE** the report,
- **APPROVE** the Chair's Actions undertaken.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**CHIEF EXECUTIVE'S REPORT**								
Meeting:	**C&V UHB BOARD MEETING**						**Meeting Date:**	**27.05.2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	✓	
Lead Executive:	**CHIEF EXECUTIVE**								
Report Author (Title):	**EXECUTIVE ASSISTANT TO THE CHIEF EXECUTIVE**								

Background and current situation:

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

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

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

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

Executive Director of People and Culture

I would like to extend my sincere congratulations to Rachel Gidman, who was appointed on Friday 30 April, as our new Executive Director of People and Culture. Rachel has been in this role in an interim capacity since the departure of Martin Driscoll earlier this year and I am delighted that she will now be taking it up on a permanent basis.

Rachel trained as nurse in Cardiff and qualified in 1994. Most of her nursing career was in the cardiology directorate where she eventually became a Cardiac Rehabilitation Sister. In 2011, she was appointed as Head of Nurse Education before taking up the role of Head of Learning, Education and Development in 2014.

Rachel has more plans to continue to invest in our workforce and the workforce of the future through innovative new programmes of work, including a digital showcase for training and development following on from Amplify 2025 which took place prior to the pandemic. I am looking forward to working alongside her in this endeavour and seeing how this work progresses and the difference it will make to our staff across the health system. I hope that we can replicate Rachel's remarkable career progression with as many staff members as possible through programmes such as Amplify 2025 and the Dragon's Heart Institute.

One year of video consultations

We have recently passed the one year milestone since we introduced the NHS Wales Video Consultation Service here at Cardiff and Vale. In that time, more than 30,000 video consultations have been held by services right across our organisation, which adds up to more than 16,000 hours of appointments.

The service has quickly become integral to how we interface with our patients, offering them flexibility to see their clinician from the comfort of their own home or without having to leave work, and has played an important role in facilitating social distancing at our sites during the COVID-19 pandemic through limiting visitor numbers. That in turn has contributed to reduced traffic, parking issues and CO2 emissions in and around our sites.

We've been planning to introduce video consultations for some time, to offer healthcare sustainably, closer to people's homes. We know that they don't suit all circumstances, but our clinicians are still exploring how we can get the best out of them, driving forward a valuable service for as many patient groups as possible.

For more information about the NHS Wales Video Consultation Service, including the growing list of Cardiff and Vale UHB services offering video appointments, please visit our video consultation webpage.

ISO 14001 Accreditation News
The UHB has recently achieved ISO 14001 accreditation recognising the work it has done as part of its environmental management programme. The ISO 14001 is an internationally recognised standard that helps organisations both minimise their negative impacts on the environment while improving their positive effects on it. The ISO 14001 maps out how organisations can improve their resource efficiency and reduce waste. Organisations signed up to the ISO 14001 must undergo systematic, independent, and objective audits to ensure that they have best practice processes in place.

The Capital, Estates and Facilities teams have worked incredibly hard to achieve this accreditation and I would like to extend my sincere thanks to everyone involved in achieving this certification. As a Health Board, we take our environmental impact very seriously and are working hard towards total decarbonisation; this is an important step on this journey. As we look to the future, and our proposal to build a new University Hospital for Wales, we will ensure that environmentalism and sustainability, as set out in standards such as ISO 14001, are at the core of our ambition.

Green Health Wales Launch
I am very excited to see staff from Cardiff and Vale University Health Board involved in the launch of a new, pan-wales network of healthcare professionals who recognise that the climate and ecological emergency is a health emergency.

Green Health Wales will work across Wales to supporting cross-departmental collaboration, empowering everyone in the health and social care sector with the tools and knowledge to address the climate crisis - transforming health care to be climate smart.

Green Health Wales are hosting a virtual launch event which is free to attend of the 29th June, 2021 in which they will share learning from both local Welsh initiatives and global sustainable healthcare projects across a breadth of speciality areas.

New Role
On Monday 10 May, I announced that I will shortly be taking a position as Chief Executive of Mid Yorkshire Hospitals NHS Trust. It has been a privilege to be CEO of Cardiff and Vale UHB. The past four years have given me so many opportunities but as always the work has been done

with a great team of people and staff around me, both in the Health Board and from the partners with whom we work.

I believe Cardiff and Vale UHB holds a unique place in Wales in the provision of health services to its population and that if it maintains the ambition to be one of the best health providers in the world, it will rightly be recognised as such.

Reflecting on my tenure here, I know that I will take with me so much learning and many fond memories. The messages of congratulations from colleagues across the organisation when the announcement was posted on social media were truly heart-warming and I am humbled that I have been able to play a small part in the incredible projects and programmes of work that have been undertaken.

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

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

Recommendation:

- The Board is asked to **NOTE** the report**.**

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	✓
3. All take responsibility for improving our health and wellbeing	✓	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✓	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	✓

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

Equality and Health Impact Assessment Completed:	**Not Applicable** Personal responsibility / Cyfrifoldeb personol

Report Title:	**Corona Virus Update Report**								
Meeting:	**UHB Board Meeting**					**Meeting Date:**	**27.05.21**		
Status:	**For Discussion**		**For Assurance**	**X**	**For Approval**		**For Information**	**x**	
Lead Executive:	**Chief Executive Officer**								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

The COVID-19 Update Report was approved by Board in November 2020 as part of the proposed changes to Governance arrangements to ensure appropriate reporting on key areas during the COVID 19 pandemic.

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

The attached COVID-19 Report (**Appendix 1)** provides an update since the last meeting in February to the Board regarding the pandemic, and covers key activities in the areas of Quality and Safety, Workforce, Governance, Operations and Public Health.

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

Provision of this report as a standing agenda item for Board ensures transparency of reporting around COVID-19 and ensures robust governance during the second wave of the pandemic.

Recommendation:

The Board is asked to:

- **Note** the attached COVID-19 Update Report.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities	x	6.	Have a planned care system where demand and capacity are in balance	x
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing	x	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right	x	10.	Excel at teaching, research, innovation and improvement and	x

care, in the right place, first time		provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	Not Applicable

COVID-19 Update Report

COVID 19 – Update Report covering key activities in relation to • **Quality and Safety** • **Workforce** • **Governance** • **Operations** • **Public Health**	**Month: May 2021**
Quality and Safety	Executive Nurse Director/ Executive Medical Director

- **Covid outbreak position** – at the time of writing there are no wards across the UHB that are currently managing COVID-19 outbreaks

- **Investigation of hospital acquired COVID-19 –** the UHB continues to work with colleagues across Wales, Welsh Government and the Delivery Unit to standardise the investigation of hospital acquired COVID-19, and the application of the Putting Things Right regulations. An Executive Led COVID-19 Investigation Oversight Group and Scrutiny Panel will be established to oversee and monitor the process of investigation, review and Redress

- **Concerns –** there are currently 5 concerns in which the person raising the concern has alleged that COVID-19 was hospital acquired.

Workforce	Executive Director of Workforce and OD

The Workforce Hub Steering Group has refocused and now meets weekly to co-ordinate proactive work around recovery

The are no staffing level issues related to COVID-19 at present.

Overseas staff coming from countries on the Government red list may now be able to quarantine in Wales which would reduce the cost significantly. Details currently being worked through.

The Health and Wellbeing of our staff is a high priority

- The Employee Wellbeing team has been working with managers and senior managers across the UHB raising awareness of the range of resources available to support both their own wellbeing and that of their staff. This includes:
  - a senior manager wellbeing checklist to provide guidance on what to consider in their areas;
  - streamlined resources to make it easier to locate specific assets;
  - collaboration with the Chaplaincy team to ensure that staff have access to pastoral support;
  - the Head of Employee Health and Wellbeing visiting wards to speak to staff, offer support and raise awareness of support available;

  - twice weekly virtual wellbeing drop-in sessions open to all staff across the UHB; working with Remploy to offer vocational mental health support;
  - working collaboratively with the Cardiff Recovery College to offer mental health training and support to all staff;
  - a rapid access pathway for staff affected by dermatology conditions associated with Personal Protective Equipment (PPE) use and increased hand washing.
- The Employee Wellbeing Service (EWS) has altered its service delivery model slightly to expand the range of services available and can now offer low intensity interventions such as guided self-help which is delivered by a team of Assistance Psychological Therapy Practitioners. This ensures that staff can access services appropriate to their needs. EWS has ensured that staff can continue to access their range of wellbeing workshops by offering these virtually and by developing a specific YouTube channel so that they can be accessed individually or as a team at a time that suits their needs;
- A total of 142 wellbeing champions have now been trained by the EWS. The role of the wellbeing champions is to provide wellbeing support; information and signposting at a local level where it is needed the most. The champions receive monthly newsletters, have quarterly meetings where they can share best practice and discuss any concerns. Further training is planned throughout 2021;
- There are also a number of projects in progress, which when launched will provide further support to staff across the system. These include:
  - developing a dedicated staff pathway in the COVID-19 Rehabilitation Service;
  - recruiting 2 Health Intervention co-ordinators who will support the Employee Health and Wellbeing service to provide proactive and preventative interventions; introducing REACT Mental Health training which will provide staff with the confidence and ability to hold wellbeing conversations;
  - piloting a click and collect app in the University Hospital of Llandough (UHL) which will enable clinical staff to easily order hot food and drinks during their shifts;
  - increasing the capacity of the Rapid access Trauma pathway for UHB staff to ensure it is sufficient to meet the increasing demands;
  - Menopause cafes which were put on hold during COVID-19 are also being reintroduced in a virtual format to ensure that all staff regardless of gender or age can access support from colleagues;
- Currently support is being focused on our staff who are originally from India as they have concerns and worries about family members in their home countries. Two Q & A session are being held in May 2021 to gather information and support staff in the right way.

We currently have 10 staff still shielding, 2 of these are working from home. The Assistant Heads of Workforce are working with the Clinical Boards to obtain further information on staff who are unable to return to work (RTW) or those who were redeployed and who may not be able to return to their substantive role.

COVID-19 Update Report

Within CVUHB a decision has been made to extend the temporary enhanced overtime pay incentive scheme for nurses in some areas. This will come to an end by 31 May 2021 at the latest and a roadmap for phasing it out has been developed

Governance	Director of Corporate Governance

The Health Boards governance arrangements have now moved back to 'business as usual'.

(a) The Board will now meet in Public on a bi monthly basis;
(b) The new COVID-19 report was successfully introduced and used to report at each meeting of the Board since November 2020. Consideration will be given as to whether we continue to have a COVID-19 report at the bi monthly Board Meetings;
(c) The Covid Board Governance Group has been stood down for the foreseeable future.

Other Governance arrangements include:

(a) From the start of the new financial year Committees of the Board have also returned to business as usual with Terms of Reference and Work Plans for 2021/2022 for each Committee receiving approval at the Board in March 2021;
(b) The Management Executive Meeting continues to meet on a Monday each week and there are standing items on the agenda linked to COVID-19 such as Policy Updates etc. The Management Executive are also now considering recovery plans;
(c) The twice weekly COVID-19 Operational Meeting has now been stood down.

Operations including Operational Framework	Chief Operating Officer

The revised COVID-19 operating framework previously presented to Board remains in place, with the first principle being to be 'covid ready'. Operations, working in a 4-6 week planning horizon, continue to be guided by a number of key components focused on minimising the different types of harm as set out in the national and local framework. Points of note since the last Board include:

Essential services – urgent and emergency essential services continue to be maintained in all areas, including cancer treatments, urgent and emergency surgery and in unscheduled care.

Unscheduled care –. The overall COVID-19 position has continued to improve in recent weeks. COVID-19 admissions have fallen significantly as community prevalence has continued to reduce (see separate update on covid prevalence). Hospital bed occupancy for COVID-19 patients has reduced markedly. All but 3 remaining COVID-19 -related in-patients were in the recovery phase as at 6 May 2021. Hospital acquired infections have seen a similar reduction.

However, the non- COVID-19 activity increase has continued and there are continuing challenges in remaining COVID-19-ready while accommodating non-COVID-19 and planned care increases.

Critical care capacity pressures have been a feature of the second wave of covid and while covid occupancy has reduced markedly, critical care remains under some pressure due to the re-emergence of non-COVID-19 demand and an increase in elective operating.

The Health Board has been adjusting its COVID-19 response and bed provision accordingly. The use of two wards at Lakeside Wing continues, but since the last meeting further ward capacity has been flexed down (in addition to the ward closures reported at the last meeting). We have continued the processes of re-designating ward capacity from medicine/COVID-19 to surgery as the Health Board continues to increase its elective activity.

Planned care – with the reduction in COVID-19 admissions there is a continued focus on recommencing elective activity which ceased in January and February 2021. The Health Board has submitted further supporting detail for its draft annual plan and a number of components in the plan are already being progressed given the potential for clinical risk. Work continues in defining the final annual plan which is to be submitted to Welsh Government at the end of quarter one.

Cancer care – Cancer care continues to be provided as an essential service. As reported last month, whilst the Health Board has been successful in maintaining treatment activity and referral rates, backlog work and the timeliness of treatment has resulted in a transient reduction in target compliance. This trend is stabilising and there is an indication that the position is starting to improve.

Mental Health services – With demands on Mental Health Services continuing, the Clinical Board is re-assessing pressures on the various points of access to get a whole system view. Clinical teams are reporting an increase in level of acuity in presentations, leading to some increase in hospital admissions. There is also evidence that adolescent presentations are increasing. The Health Board is working closely with system partners to ensuring there is a holistic response at a system level. The Mental Health Clinical Board continues in its recovery planning which recognises the delayed impact of the second covid wave on mental health services.

Primary care services remain relatively resilient despite significant pressures. However, feedback from our GP leads is still indicating an increased acuity in GP presentations. Primary Care recovery plans continue to develop and will be a key feature of our annual plan submission. These will include GMS and specialist community services backlog plans (e.g. sexual health and GMS patient reviews). A small number of practices continue to be supported by our primary care support team. At this point no GP or dental practices and no optometry and pharmacy services are reporting high levels of escalation.

COVID-19 Update Report

All 60 GP practices have been actively involved in the mass immunisation programme and have been providing vaccines (see separate update on vaccination).

In keeping with the overall reduction in COVID-19 prevalence and admissions operational planning will adjust and pivot towards the recovery process. The twice weekly covid operations response meeting which has been chaired by the Chief Operating Officer was stood down at the end of April 2021.

Public Health	Executive Director of Public Health

Epidemiology update

During April, cases of COVID-19 continued to fall in both Cardiff and Vale with rates at the end of the month below 15 per 100k per week in Cardiff (11.7), and below 10 per 100k per week in the Vale (6.7). This is equivalent to fewer than 8 new cases per day across Cardiff and Vale on average. Test positivity has also dramatically declined, at 1.3% in Cardiff and 0.7% in the Vale. Case rates and test positivity have declined across all age groups.

As case numbers have declined, individual clusters and incidents, when they occur, continue to have a significant impact on the rate.

Incidents in health and care settings remain very low, with no NHS incidents during April, and few care home positive results. Workplace incidents are now small in number, and are usually only 2 cases in a given location, without evidence of further spread.

COVID-19 admissions to hospital are now at their lowest point since the start of the pandemic. Overall mortality rates remain below the 5 year average for Cardiff and Vale.

The risk of importing additional variant strains of COVID-19 from overseas, which may have higher transmissibility and/or be less affected by vaccination, remains, with a significant number of travellers returning to Cardiff and Vale each week from overseas. Currently around 1-3.5% of these individuals test positive for Covid.

Test, Trace & Protect (TTP) update

There is capacity in all local testing sites and the majority of results are received within 24 hours. Lateral Flow Tests (LFTs) continue to be used in healthcare, care home and school settings to screen asymptomatic staff and pupils; results are fed into the national system and positive tests confirmed with a PCR (polymerase chain reaction) test. The number of workplaces offering LFT testing is increasing. LFTs are now also available to people who volunteer or who cannot work from home; Individuals are advised to test themselves twice per week, and organise a confirmatory PCR if they test positive.

The contact tracing service continues to operate within capacity, reaching both new cases and their contacts rapidly, and the partnership regional team meet daily

during the week to review incident cases and direct action to address any clusters or settings of concern.

Arriving travellers remain a significant concern because of the risk of reseeding infection in to our communities, including variant strains. Arriving travellers from 'red list' countries are required to quarantine in managed facilities (hotels) at the port of entry, none of which are in Wales. Travellers from 'amber list' countries are required to quarantine in their homes, and are monitored by the national Arriving Traveller Team to ensure they are complying with isolation and testing requirements. Any positive cases in amber travellers are traced and monitored by a dedicated team of tracers within Cardiff and Vale to ensure compliance with isolation. In addition, detailed contact tracing, isolation and testing is carried out to further reduce the risk. Local testing of cases and their contacts allows timely sequencing via the Welsh PenGU Laboratory.

Our partnership communications teams work collaboratively across the region to ensure up to date messaging is shared with local communities. In particular, close links have been forged with local Black, Asian and minority ethnic communities to raise awareness of symptoms and promote testing and vaccination.

Welsh Government has indicated that it wishes to trial a limited number of mass gathering events, several of which are in Cardiff. Local partners are working collaboratively to plan how this can be done as safely as possible.

Vaccination update

To date we have administered over 390,000 vaccinations in Cardiff and the Vale of Glamorgan. Of these 287,000 are first doses and 106,000 are second doses. Over 70% of the adult population (aged 18+) have now received at least one dose of vaccination. We have offered all people in Priority Groups 1- 9 (people aged 50+, people who have been shielding, those with underlying health conditions, unpaid carers and frontline workers) a vaccination. We have also offered vaccination to everyone aged 30 and over. We are currently offering vaccination to people from aged 25+ an appointment at our Mass Vaccination Centres and we will soon be moving into the 18-24 age group, including students, currently residing in Cardiff and the Vale of Glamorgan.

Mass vaccination centres: We now have four Mass Vaccination Centres - Splott, Pentwyn, Holm View and our recently opened Bayside MVC. Currently, Splott and Pentwyn Mass Vaccination Centres are delivering Pfizer vaccine (first and second doses) and the other centres are delivering Oxford AstraZeneca. We are continually reviewing our operational model in line with vaccine supply and workforce capacity.

Our Local Vaccination Centre (LVC) in the Western Vale has now vaccinated everyone aged 30 and over registered with the three GP practices in the Western Vale Cluster. Any person aged under 30 will attend a Mass Vaccination Centre as they will require a Pfizer vaccine due to the recent change in guidance from the Joint Committee on Vaccination and Immunisation (JCVI).

COVID-19 Update Report

Mobile teams: Our Mobile Teams have now completed second doses for care home residents and staff. They are currently offering second doses of vaccine to people who are unable to leave their homes. Mobile teams also continue to vaccinate our vulnerable communities including people from Black, Asian and minority ethnic backgrounds, asylum seekers, sex workers, and those that are homeless and traveller communities. We hold regular session at Mosques and other venues to encourage uptake in our local Black, Asian and minority ethnic communities.

GP practices: Our GP Practices are currently delivering second doses of the AstraZeneca vaccine to people aged 75+ and 65-69, in line with the 11 week interval guidance.

Community Pharmacies

Community Pharmacies commenced vaccination on 8 April. There are currently three community pharmacies delivering vaccines to people aged 30-49. The three pharmacies are Western Avenue, Central Pharmacy, Wellfield Road and Llantwit Major Well Pharmacy. The Well pharmacy in Llantwit Major is offering vaccination to military personnel and family members who meet the eligibility criteria from the MOD site in St Athan. Appointments at Community Pharmacies can be accessed through our main booking line.

E-forms:

We have a series of online forms now available at https://cavuhb.nhs.wales/covid-19/cavuhb-covid-19-mass-vaccination-programme/covid-19-forms/. These include a standby/reserve form, a 'Leaving Nobody behind' form, an opt-out form and a re-schedule form.

Communications:

As we move through the age cohorts we are continually adapting and developing our communication strategy to meet differing needs as well as addressing key issues such as Did Not Attends (DNAs).

Report Title:	**Board Assurance Framework (BAF)**							
Meeting:	Board					**Meeting Date:**	27.05.2021	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**	**x**	**For Information**	
Lead Executive:	**Director of Corporate Governance**							
Report Author (Title):	**Director of Corporate Governance**							

Background and current situation:

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

Each year the Management Executive Team agree which significant risks will impact upon the delivery of the Cardiff and Vale UHBs Strategic Objectives. This discussion took place at Management Executives on 19th April 2021 and it was agreed the following risks would added to the Board Assurance Framework for the financial year 2021/20022:

1. Workforce
2. Financial sustainability
3. Sustainable Primary and Community Care
4. Patient Safety
5. Sustainable Culture Change
6. Capital Assets
7. Inadequate Planned Care Capacity
8. Delivery of Annual Plan
9. Staff Wellbeing

These risks are all detailed within the attached BAF. In addition to the above a further risk has, since the Management Executive meeting, been agreed. One of the Health Boards Strategic Objectives 'Reducing Health Inequalities' has deteriorated as a result of COVID-19 and this needs to be reflected within the BAF. This risk is currently being developed for review ready for the July 2021 Board Meeting. The Executive Lead is Fiona Kinghorn, Executive Director of Public Health.

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

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

Since the last review in March 2021 all risks have remained at the same score.

Two additional risks have been added to the BAF:

1. Impact of COVID-19 on Staff Wellbeing
2. Impact of COVID-19 on Reducing Health Inequalities.

The risk in relation to 'Delivery of the Annual Plan 2021/2022' is a change of focus from 'Delivery of IMTP'.

Committees of the Board routinely review their risks on the BAF to provide further check and challenge and assurance to the Board when the BAF is presented in full.

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

The Strategic Objectives are mapped to the risks on the BAF so there is clarity which risks impact on the objectives.

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

Risk Management continues to develop at Cardiff and Vale Health Board. Significant progress had been made but actions were stalled for a number of months due to COVID-19. Work in this area is now progressing.

A new Board Assurance Framework (BAF) and Risk Management Strategy will be presented to the July Audit Committee and the July Board. In addition to the Strategy an action plan for delivery will also be developed to ensure continuing progress and improvement in this area.

Assurance is provided by:

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

Recommendation:

The Board is asked to:

- **Approve** the 9 risks to the delivery of Strategic Objectives detailed on the attached Board Assurance Framework (BAF) for May 2021 recognising that a further risk in relation to Reducing Health Inequalities will be presented to the next Board,
- **Note** the continuing progress which has been made in relation to the roll out and delivery of effective risk management systems and processes at Cardiff and Vale UHB.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x

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

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

Equality and Health Impact Assessment Completed:	Not Applicable

BOARD ASSURANCE FRAMEWORK 2021/2022 – MAY 2021

It is essential that Cardiff and Vale University Health Board is aware of the major risks which could impact upon the delivery of Strategic Objectives as set out in Shaping Our Future Wellbeing and its Annual Plan for 2021/22.

Strategic Objectives	Key Risks Mapped to Delivery of Strategic Objective
1. Reduce health inequalities	• Financial Sustainability • Sustainable Primary and Community Care • Sustainable Cultural Change • Planned Care Capacity • Delivery of Annual Plan 21/22
2. Deliver outcomes that matter	• Sustainable Primary and Community Care • Patient Safety • Sustainable Cultural Change • Financial Sustainability • Delivery of Annual Plan 21/22
3. Ensure that all take responsibility for improving our health and wellbeing	• Sustainable Primary and Community Care • Sustainable Cultural Change • Delivery of IMTP • Wellbeing of staff
4. Offer services that deliver the population health our citizens are entitled to expect	• Sustainable Primary and Community Care • Delivery of Annual Plan 21/22 • Planned Care Capacity • Workforce • Financial Sustainability
5. Have an unplanned care system that provides the right care, in the right place, first time.	• Financial Sustainability • Sustainable Primary and Community Care • Patient Safety • Delivery of Annual Plan 21/22
6. Have a planned care system where demand and capacity are in balance	• Planned Care Capacity • Financial Sustainability • Workforce • Sustainable Primary and Community Care • Delivery of Annual Plan 21/22
7. Reduce harm, waste and variation sustainably so that we live within the resource available	• Patient Safety • Financial Sustainability
8. Be a great place to work and learn	• Workforce • Financial Sustainability • Sustainable Cultural Change • Wellbeing of staff
9. Work better together with partners to deliver care and support across care sectors, making best use of people and technology	• Workforce • Financial Sustainability • Sustainable Primary and Community Care • Delivery of Annual Plan 21/22
10. Excel at teaching, research, innovation and improvement.	• Workforce • Financial Sustainability • Sustainable Cultural Change

- Wellbeing of staff

Key Risks

Risk	Corp Risk Register Ref.	Gross Risk	Net Risk	Change from Jan 21	Target Risk	Context	Executive Lead	Committee
1. Workforce	18,21,4	**25**	**15**		**10**	Across Wales there have been increasing challenges in recruiting healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services has led for an increasing need in clinical staff. Staff costs represent the largest expense for the NHS in Wales. The pay bill has continued to increase year on year, with a significant increase over the last three years.	Executive Director of People and Culture	Strategy and Delivery Committee
2. Financial Sustainability	16,27	**25**	**10**		**8**	Across Wales, Health Boards and Trusts are seeking to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing prudent healthcare. As well as the NHS, public sector services, the third sector, and the public have significant roles to play to achieve a sustainable health and care system in the future. Covid 19 has had a significant impact on the finances of Healthcare in Wales and the UHB has significant financial	Executive Director of Finance	Finance Committee

						pressures to now deal with.		
3. Sustainable Primary and Community Care	10,20	**20**	**15**		**10**	The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements.	Chief Operating Officer	Strategy and Delivery Committee
4. Patient Safety 	1,2,3,5,6 ,7,8,9,12 ,13,14,1 5,19,22, 23,24,25	**25**	**20**		**10**	Patient safety should be above all else for the Cardiff and Vale University Health Board. Safer patient care includes the identification and management of patient-related risks, reporting and analysis of patient safety	Executive Nurse Director/ Executive Medical Director /Executive Director for Therapies and Health Science	Quality, Safety and Experience

						incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.		
5. Sustainable Culture Change		**16**	**8**		**4**	In line with UHB's Strategy, Shaping Our Future Wellbeing and aligned to the Healthier Wales plan (2018), the case for change is pivotal to transfer our services to ensure we can meet our future challenges and opportunities. Creating a belief which continues to build upon our values and behaviours framework will make a positive cultural change in our health system for our staff and the population of Cardiff and the Vale.	Executive Director of People and Culture	Strategy and Delivery Committee
6. Capital Assets	16,17,6, 7,12	**25**	**20**		**10**	The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner.	Executive Director of Strategic Planning, Executive Director of Therapies and Health Science, Executive Director of Finance	Finance Committee & Strategy and Delivery Committee

7. Planned Care Capacity	3,4,5,14, 24	**20**	**16**		**12**	The impact of COVID 19 has had many consequences to Healthcare and in particular the continuation of the Health Board being able to undertake Planned Care both during the peak of the pandemic and any future peaks. This is due to the need to ensure that there is available capacity should there be a further peak in COVID 19 patients requiring hospital treatment.	Chief Operating Officer	Strategy and Delivery
8. Delivery of Annual Plan		**20**	**15**		**10**	The Integrated Medium Term Plan is the key planning document for the Health Board setting out the milestones and actions we are taking in the next 1 to 3 years in order to progress Shaping Our Future Wellbeing, our ten-year strategy. It is based on the health needs of our population, delivering quality services and ensuring equitable and timely access to services and sets out how we will deliver our mission Caring for People; Keeping People Well, and vision that a person's chance of leading a healthy life is the same wherever they live and whoever they are.	Executive Director of Strategic Planning	Strategy and Delivery Committee
9. Staff Wellbeing 		**20**	**15**	**New risk**	**6**	As a result of the global Covid19 pandemic, our employees have been exposed to unprecedented levels of psychological and physical distress both at home and in the workplace. Evidence indicates that, Healthcare workers	Executive Director of People and Culture	Strategy and Delivery Committee

						are at greater risk of developing mental health problems as a result. The impact of this is unlikely to be experienced equally, with people with existing mental health difficulties and people from Black, Asian and minority ethnic communities among those who are likely to be affected disproportionately		

1. **Workforce – Lead Executive Rachel Gidman**

Across the UK and in Wales there are increasing workforce challenges for healthcare professionals. Meeting the requirements of a growing population which is older and with more complex health needs as well as increasing demand on health services due to the pandemic, mass immunisation programme and urgent service recovery plans has lead for an increasing need in clinical staff. There is now a sense that our workforce capacity is being stretched thinly in an attempt to cover the number of competing and simultaneous operational requirements that could be with us for some years to come.

The size and complexity of the workforce challenge is such that addressing it will require holistic and sustained action across the system on leadership, culture, workforce planning, pay, education, well-being, retention and transforming ways of working (hybrid and flexible working). (see linkage to BAF: Leading Sustainable Culture Change and Employee Well-being).

Risk **Date added: 6.5.2021**	There is a risk that the organisation will not be able to recruit and retain a clinical workforce to deliver high quality care for the population of Cardiff and the Vale.		
Cause	• Increased workforce capacity requirement to meet funded establishment and temporary requirements which support covid-19; temporary bed expansion, community testing, mass vaccine immunisation, staff absence, increased demands on step up and step down demand for GP and CRT • Requirements of the Nurse Staffing Act and BAPM Standards. • Requirements of medical rotas to flex across Recovery plans • Workforce demographics/ageing workforce • Insufficient supply of registered Nurses at UK national level. • High nurse turnover in Medicine, Surgery and Specialist Services Clinical Boards • Impact on staff resilience due to increasing service demand and work pressure • Insufficient supply of Doctors in certain specialties at UK national level (e.g., Adult Psychiatry, General & Acute Medicine, Histopathology, Radiology, GP) • Changes to Junior Doctor Training Rotations (Deanery). • Brexit/EU settlement scheme. • On-going management required of a small number of staff with former CMO shielding letters who remain clinically vulnerable and unable to work in front line roles		
Impact	Impact on quality of care provided to the population. Inability to meet on-going demands of both pandemic and recovery plans Potentially inadequate levels of staffing Increase in agency and locum usage and increased workforce costs Low morale and poor staff resilience especially in clinical areas Higher turnover and sickness absence Poor attendance at statutory and mandatory training		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**

Current Controls	• Clinical Boards are actively reviewing workforce plans • Workforce plans are integrated with phased clinical recovery plans • Staff Turnover and retention plans are now being reviewed at CB. • International Nurse Recruitment Campaign is on-going – 185 have now been commissioned. • Re-launched nursing recruitment campaign through social media with strong branding. Events happening in May and further being planned after summer period • Strong clinical engagement with Student Streamlining • Values based recruitment. • Internal Career Development Scheme for band 5 nurses. • Nurse Adaptation and Returners Programmes are now business as usual. • Programme of talent management and succession planning. • Ward Accreditation Programme being implemented • Medical international recruitment strategies reinforced with BAPIO. • Medical Training Initiative (MTI) 2 year placement scheme. • Collaboration with Medics to fill hard to fill roles, search and selection methods, CV scanning by speciality. • On-going review of medical rotas to flex and increase medical cover capacity. • Appointment of Physician Associates to supplement MDT in a number of Clinical Boards • All Wales Single Lead Employer initiative for Junior Doctors to improve trainee experience and streamline hiring processes. • Link with Welsh Government Campaign *Train, Work, Live* to attract for Wales – GP, Doctors, Nursing and Therapies . • Enhanced overtime provisions for substantive nursing and HCSW staff to encourage take up of additional hours extended with a roadmap for phasing out by end May. • New All Wales Respect and Resolution Policy has been developed in partnership with trade union colleagues and will be launched in June, with the aim to prevent bullying and harassment and improve workplace culture
Current Assurances	The Workforce Hub Steering Group has refocused and now meets weekly to co-ordinate proactive work around workforce plans to support Recovery. Deep dive monitoring at Clinical Board and operational level being undertaken monthly to ensure nursing capacity. There are no registrant gaps in mass immunisation programme. The gaps are in administration roles due to all centres working at max capacity. Operational and workforce models being reviewed to maximise efficiencies – e.g., workforce less spread out 11 international nurses joined us in April and a further 18 are due to arrive in June, largely aimed at supporting Theatres extension and critical care. Nursing establishments are currently being reviewed now that covid has settled and this will provide for more accurate vacancy forecasting. Band 5 & 6 substantive nursing estimated to be at 91% in March. Estimate is due to nursing establishment changes not yet being verified. HCSW recruitment is going well, all permanent vacancies will be recruited to and some areas will be over recruited to where approved. Sickness absence has reduced to pre-covid trend – (5.14% March in month figure). Workforce metrics will now focus on deep dive analysis - currently being undertaken into reasons for staff turnover. Temporary recruitment remains active to support Mass Immunisation Programme. Student Streamlining engagement session recently held provided excellent feedback that students want to join C&V as an attractive place to work. Medical monitoring at Medical Workforce Advisory Group (MWAG). Medical rotas being monitored to ensure flexibility in place (RAG rated system)

Impact Score: 5	Likelihood Score: 3	**Net Risk Score:**	**15(Extreme)**
Gap in Controls	Ability to on-board international nurses more quickly due to Visa, isolation requirements and OSCE nurse facilitation capacity. National UK shortage of nurses remains which impacts on local campaigns Continuation of some staff shielding who remain very clinically vulnerable (although this has now reduced considerably).		
Gap in Assurances			

Actions	**Lead**	**By when**	**Update since March 21**
1. Recruitment Campaign in May with social media advertising	RG	From 30.9.2020	On-going permanent recruitment plan in place to underpin sustainable workforce
2. International Nurse Recruitment Campaign	RG	31.12.2021	Further commission recently confirmed for Peri-Operative and more being considered (185 total commissioned)
3. Implementation of a new Medical and Dental Bank through a Managed Service	SW/RG	From 1.4.2021	New initiative procured and being implemented imminently to create a Managed Medical and Dental Bank. This will increase supply and improve skills availability through a new bank system; dedicated central team; improved technology and a launched locum recruitment campaign.
4. Clinical Board Workforce Plans being reviewed during first quarter of 2021/22	SC/RG	30.6.2021	Specific plans being developed to support Recovery
5. Nursing establishments being reviewed	RW	31.7.2021	On-going compliance with Nurse Staffing Act and will also re-set establishments
6. New Nurse E-Rostering System being implemented during 2021/22, including Safe-Care Module and improved Bank App. functionality	RG	31.3.2022	All Wales contract has been procured. C&V will now align to all other HB's using Allocate Software.

Impact Score: 5	Likelihood Score:2	**Target Risk Score:**	**10 (High)**

2. **Financial Sustainability – Lead Executive Catherine Phillips**

Across Wales, Health Boards and Trusts set out plans to manage their financial pressures by driving out inefficiencies, while at the same time looking to derive greater value from their resources through innovative ways of working and practicing Prudent and Value Based Healthcare. The planning process in NHS Wales has been paused this year to allow organisations to focus their attention on managing the COVID 19 pandemic. The costs of which are significant and above previously planned levels. Confirmation has now been received of the level of funds available to support the UHB response to the pandemic. The funding is adequate to meet the additional costs and the UHB is now reporting a year end break even position.

Risk **Date added:** 7.09.2020	There is a risk that the organisation will not be able to manage the impact of COVID 19 and other operational issues within the financial resources available.		
Cause	The UHB has incurred significant additional costs arising from managing the COVID 19 pandemic, this includes the non-delivery of savings plans. It also has to manage its operational budget. All additional costs need to be managed within the additional resources made available by Welsh Government to manage the pandemic.		
Impact	Unable to deliver a year end financial position. Reputational loss. Improvement in the underlying financial position which is dependent upon recurrent funding provided		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	Additional expenditure in Managing COVID 19 is being authorised within the governance structure that has specifically been put in place which is reported to Management Executives on a weekly basis. This aligns with the UHB Scheme of Delegation. The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board. Financial performance is a standing agenda item monthly on Management Executives Meeting.		
Current Assurances	The UHB is now assuming an additional funding to help manage the COVID 19 pandemic in line with Welsh Government Resource assumptions. Based upon this assumed additional funding, the financial forecast is now an in year break even position at year end. The provisional year end position for Month 12 is a surplus of £0.090m Financial performance is monitored by the Management Executive. Finance report presented to every Finance Committee Meeting highlighting progress against mitigating financial risks.		
Impact Score: 5	Likelihood Score: 2	**Net Risk Score:**	**10 (high)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	To confirm COVID 19 funding assumptions with Welsh Government in a couple of specific areas. Certainty of COVID 19 expenditure and the management of non COVID 19 operational pressures		

Actions	**Lead**	**By when**	**Update since March 21**
1. Continue to work with Welsh Government to confirm additional funding to manage our recovery response to Covid 19.	CP	31/03/2022	This will continue for at least the first six months of the financial year.
2. To monitor and control additional expenditure and financial performance to ensure that the year-end forecast is within the resources available.	CP	31/03/2021	**Complete** – Year end position likely to be £0.090m surplus
3. To understand the impact of responding to the Covid 19 pandemic has had on the	CP	31/03/2022	Costs and consequences under constant review

organisations underlying position and that the costs and consequences are reflected within the 2021/22 plan.				and will be reflected in 21/22 plans and beyond.
Impact Score: 5	Likelihood Score:1	**Target Risk Score:**		**5 (Moderate)**

3. **Sustainable Primary and Community Care – Lead Executive Steve Curry**

The strategy of "Care closer to home" is built on the assumption that there are a significant number of patients that are either referred to or turn up at a Hospital setting because there is no viable alternative at the time at which they become sick. They are then typically admitted because at that stage similarly there is no viable alternative to manage/support these patients in their local setting or their place of residence. Therefore it is important to create firstly the capacity of Primary and Community Care, and then increase the capability of Primary and Community Care to be able to respond to the individual and varied needs of those patients in both crisis intervention but more commonly preventative and support arrangements. Although the underlying actions continue to be progressed it should be acknowledged that the focus has changed due to responding to Covid 19 this will inevitably cause implications for the speed of ongoing action and implementation.

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

Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (red)**
Gap in Controls	Actively scale up multidisciplinary teams to ensure capacity Achieving scale in developing joint Primary/Secondary Care patient pathways Recruitment strategies to sustain and improve GP availability and develop multidisciplinary solutions		
Gap in Assurances	No gaps currently identified.		

Actions	**Lead**	**By when**	**Update since March 21**
1. Health Pathways – to create a protocol driven of what should and can be done in Primary care/Community care.	SW/JG	31/03/2021	Health pathways launched on 14/02/2019. As at 07/05/2019 32 pathways were live. Pathways will continue to be developed until the end of the financial year. 65 pathways are now active. Chief Operating Officer has met with partners in New Zealand who are rolling it out. This continues to be rolled out. **Complete and continuing**
2. Roll out of Mental Health and MSK MDT's to reduce the primary care burden on GP's	SC	From 28 August 2020	**Complete – existing plans rolled out but continue to review effectiveness to look for opportunities for further expansion**
3. Roll out digital solutions for smart working	DT	31/03/2021	Platform procured- phased roll out plan to be implemented with completion due by end of the financial year. **Complete and continuing**
4. Other digital platforms being considered e.g. Primary Care CAHMS Assessment platform being deployed	SC	31/03/2021	**Complete**
5. Development of recruitment strategies for GP and non GP service solutions	RG	31/03/2022	GP Support Unit helps with recruitment and finding GP alternatives. The focus on a multi-disciplinary solution continues.
6. Develop Health and Social Care Strategies to allow seamless solutions for patients with health and or social needs	AH	31/03/2022	These are being developed through the Public Service Board and Transformation work and progressing well updates will continue to be provided.

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

4. **Patient Safety - Lead Executives Stuart Walker, Ruth Walker and Fiona Jenkins**

Risk	There is a risk to patient safety: Due to post COVID 19 recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Or because of sub-optimal workforce skill mix or staffing ratios, related to reduced availability of specific expert workforce groups, or related to the need to provide care to a larger number of patients in relation to post COVID 19 recovery.		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care during COVID 19 creating both longer and ageing waiting lists for planned care.		
Impact	Worsening of patient outcomes and experience, higher death rate.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25**
Current Controls	• Recovery Plans being developed and implemented across all areas of Planned Care • Maintaining Training/Education of all staff groups in relation to delivery of care • Use of Spire Hospital • Inhouse and insources activity • Additional recurrent activity taking place • Recruitment of additional staff • Hire of additional mobile theatres		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board. • CAHMS position reviewed at Strategy and Delivery Committee • Mental Health Committee aware of more people requiring support. • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes		
Gap in Assurances	Discharging patients is out of the Health Boards control		

Actions	**Lead**	**By when**	**Update since March 21**
1. Recovery plan in place and constantly being reviewed	Steve Curry	31.03.22	Plan in place which is continually been reviewed in relation to demand and capacity – see separate risk on BAF: the risk of inadequate planned care capacity
2. Waiting list position plan to be presented to Quality, Safety and Experience Committee to see if harm has occurred to those on the waiting list and what we are doing to prevent it going forward.	Steve Curry	30.06.21	To be presented to QSE Committee
3. CAHMS impact to be presented to Board Development in June due to demand and support for children increasing	Steve Curry	30.06.21	To be presented to June Board Development session
4. Review of hospital acquired COVID 19 and COVID deaths being undertaken	Ruth Walker	30.09.21	Review has commenced and will be reported once complete
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 (High)**

5. Leading Sustainable Culture Change – Lead Executive Rachel Gidman

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

Risk	There is a risk that the cultural change required will not be implemented in a sustainable way		
Cause	There is a belief within the organisation that the current climate within the organisation is high in bureaucracy and low in trust. Staff reluctant to engage with the case for change as unaware of the UHB strategy and the future ambition. Staff not understanding the part their role plays for the case for change due to lack of communication filtering through all levels of the UHB.		
Impact	Staff morale may decrease Increase in absenteeism Difficulty in retaining and recruiting staff Potential decrease in staff engagement Transformation of services may not happen due to staff reluctance to drive the change through improvement work. Patient experience ultimately affected. UHB credibility as an employee of choice may decrease		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**
Current Controls	Values and behaviours Framework in place Task and Finish Group weekly meeting Cardiff and Vale Transformation story and narrative Leadership Development Programme linked in with the launch of the Dragons Heart Institute (DHI) Management Programmes now including a virtual offering. The content will be management skills but will incorporate inclusive management skills. The additionality of data training will be offered by the Summer 2021 Talent management and succession planning cascaded through the UHB Values based recruitment / appraisal – Awareness campaign June 2021 Staff survey results and actions taken Patient experience score cards CEO and Executive Director of People and Culture sponsors for culture and leadership		

	Raising concerns relaunched in October 2018 "Neyber" launched to support staffs financial wellbeing with an emphasis on education – Awareness campaign and training to start in July 2021 Conducted interviews with senior leaders regarding learnings and feedback from Covid 19 Lessons learnt document to be completed by September 30th 2020 looking at the whole system. Discovery learning report completed in the Autumn 2020 Launch in 2021 to coincide with the DHI Proposal for Self-care leadership – Recovery for wellbeing and engagement of staff		
Current Assurances	Engagement of staff side through the Local partnership Forum (LPF) Matrix of measurement now in place which will be presented in the form of a highlight report		
Impact Score: 4	**Likelihood Score: 2**	**Net Risk Score:**	**8 (High)**
Gap in Controls			
Gap in Assurances			

Actions	**Lead**	**By when**	**Update since March 21**
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Three Programmes have been developed: (i) Acceler8 (ii) Integr8 (iii) Collabor8 (iv) Oper8 (for Directorate Managers or equivalent) Compassionate and inclusive leadership principles will be at the core of all the programmes	RG	01.04.2021	Currently all the leadership programmes are on hold due to the recovery phase of covid. Intensive learning academy bid was successful. Part of the bid incorporates a 12-month leadership programme. The current leadership programmes will be reviewed and will complement the DHI ILA Programmes to restart 2021
2. Showcase	RG	~~31.03.21~~ From Sept 21	Virtual showcase now being considered and linking with the Clinical Service Redesign and exploring catering for bigger numbers Virtual showcase – Engagement for the case for change. The design of the showcase will be aligned with Shaping our clinical services. Approval agreed in ME in Feb 2021. Tender submitted March 2021 and completed May 2021 Launch of Virtual Showcase Sept 2021
3. Equality, Diversity and Inclusion Khan Raj 05/20/2021 15:17:34 Welsh Language Standard being implemented.	RG	From 14.12.20	Equality Strategy Welsh Language Group is taking place on a bi monthly basis with senior leaders across the organisation who can influence this agenda Two Welsh Language translators now recruited. – complete and fully operational All 9 protected characteristics including Welsh language are

Inclusion - Nine protected Characteristics			sponsored by an Executive and an independent member. An emphasis on engagement, leadership and recruitment with be prioritised in 2021 with an action plan / outcome to be achieved. The RACE network will be in place by July 2021, with further networks to be established The development and dialogue is happening regarding individuals with learning disabilities gaining work experience in a structure approach pl. In collaboration with project Search Aim Sept 2021 / Jan 2022 The successful bid to be a direct employer for KICKSTART a WG initiative to assist 16 – 24 year olds to gain employed work for 6 months. Initiative starts April 2021. By April 2021 100 applications received
4. CAV Convention	RG	From 12.11.20	The CAV Convention is clinically-led and is based on the values of the Health Board. It makes it easier for clinicians to do their jobs through rapid and agile change, flexible working, unlocking resources such as budgets and staff, and more productive relationships between staff members with the needs of the patient at the heart of everything. Proposal being presented to Management Executive 12.11.20 – Complete proposing CAV convention conference in the Autumn in line with the virtual showcase. Illustrating the clinical groups progression and to formally launch the CAV convention into the health system.
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4(Moderate)**

6. Capital Assets (Estates, IT Infrastructure, Medical Devices) – Lead Executive Abigail Harris

The UHB delivers services through a number of buildings across Cardiff and the Vale of Glamorgan, from health centres to the Tertiary Centre at UHW. All NHS organisations have statutory responsibilities to manage their assets effectively: an up to date estate strategy is evidence of the management of the estate. The IT SOP sets out priorities for the next five years and Medical Equipment is replaced in a timely manner. There have also been a number of recent failures in relation to the estate which means that this risk needs to remain at its current net risk score of 20.

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

	Additional discretionary capital £0.5m for IT and £1.0m for equipment which enabled purchasing of equipment urgently needing replacement. Business Case performance monitored through Capital Management Group every month and Strategy and Delivery Committee every 2 months.
Current Assurances	The estates and capital team has a number of business cases in development to secure the necessary capital to address the major short/medium term service estates issues. Work is starting on the business case to secure funding to enable a UHW replacement to be build. The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised. The Executive Director of Strategic Planning and the Director of Capital, Facilities and Estates meet regularly with the Welsh Government Capital Team to review the capital programme and discuss the service risks. Regular reporting on capital programme and risks to Capital Management, Management Executive and Strategy and Delivery Committee IT risk register regularly updated and shared with NWIS. Health Care Standard completed annually Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group, health care standard completed annually.

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

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

Actions	**Lead**	**By when**	**Update since March 21**
1. Had to give up discretionary capital £1m allocation reduced to £500k	FJ	31.03.21	**Complete** - Prioritisation of capital managed through capital management group but overall capital position worse than last year. £1m additional capital received from WG with £750k going to Digital and £250k going to Medical Equipment.
2. The Estates Strategy requires review and refresh	AH	30.09.21	This will be presented to S&D Committee prior to approval by the Board in September 2021

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

7. Inadequate Planned Care Capacity - Lead Executive - Steve Curry

The impact of COVID 19 has had many consequences to Healthcare and in particular the continuation of the Health Board being able to undertake Planned Care both during the peak of the pandemic and any future peaks of the pandemic. There has been significant disruption to planned care and disruption to the progress which was being made after the first wave of Covid 19. This was further exacerbated by the second cessation of elective activity and despite progress been made planned care has been significantly compounded. The Health Board is now moving into a recovery phase with recovery plans developing and immediate actions taking place.

Risk	There is a risk that there will be inadequate planned care capacity due to the impact of covid 19 resulting in longer and ageing waiting lists and the ability of the Health Board to manage planned care in a timely manner going forward.		
Date added:			
Cause	Covid pandemic resulting in a cessation of elective activity and result of longer and ageing waiting lists.		
Impact	A growing waiting list for planned care activity An ageing waiting list Potential clinical risk associated with delayed access – see risk in relation to patient safety.		
Impact Score: 4	**Likelihood Score: 5**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	Clinical risk assessments by specialty to prioritise access Following risk stratifications where available i.e. Royal College of Surgeons L1 to L4 classifications Development of 'green zones' to provide confidence for low risk operating environments Increase the use of virtual consultation to avoid person to person contact Securing additional capacity within the private sector		
Current Assurances	Growth in 'green zone' activity Surgical audit to provide assurance on outcomes Growth in virtual outpatients activity Growth in diagnostics activity		
Impact Score: 4	**Likelihood Score: 4**	**Net Risk Score:**	**16 (Extreme)**
Gap in Controls	Roll out Health Board-wide risk stratification Maximise use of green pathways whilst balancing risk and outcome Virtual platforms need to be rolled out across the Health Board and clinical teams persuaded to make use Contractual arrangements are still under review – need to negotiate a contract to prolong access		
Gap in Assurances	Able to meet the highest priority caseloads – essential services Surgical audit needs to be supported to continue to provide evidence of safe and effective surgery Digital platforms need to roll out further and clinical engagement needs to result in their use		

Actions	Lead	By when	Update since March 21
1. Roll out virtual consultation platforms	Information	July onwards	**Complete** 1/3 of outpatient activity now taking place virtually.
2. Establish private sector pathways for in-patients, outpatients and diagnostics	SC	April onwards	**Complete and continuing** Private sector pathways in negotiation to continue beyond the end of the year. There has been a presentation to Management Executives and reflected in Board Reporting
3. Full assessment of risk to be undertaken	SC	May 2021	Assessment undertaken and presentations given in relation to timescales to achieve activity against various scenarios. Key measure are set out within the Annual Plan

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

8. Risk of Delivery of Annual Plan 21/22 - Lead Executive – Abigail Harris

The requirement for a three year IMTP remains suspended by Welsh Government due to the Covid 19 pandemic. However, the Health Board are still required to produce an Annual Plan for 21/22 which will reference the last approved IMTP.

Risk	There is a risk that the Health Board will not deliver the objectives set out in the Annual Plan out due to the challenge around recovering the backlog of planned activity (see separate risk), not taking the opportunity to do things differently and the potential risk associated with the Medium Term Financial position all of which could impact upon delivery of the Annual Plan or future IMTP.		
Date added:	April 20		
Cause	The focus of executive and operational efforts is on directing the organisational response creating the operational capacity to meet the immediate acute demand generated by the COVID-19 pandemic.		
Impact	The UHB may not be appropriately prepared to manage the consequences of a protracted and disruptive emergency response particularly in terms of: workforce (e.g. many will be exhausted and many will have built up leave) Infrastructure Planned care Unplanned care Financial delivery The benefits of emergency changes may not be adequately captured. There may be learning opportunities missed.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20**
Current Controls	• Welsh Government has suspended the IMTP process and Health Boards are working to quarterly operational plans that reflect the current COVID29 situation and the need to re-establish as much of our non-COVID19 activity as possible, recognising the need to continue to provide services in different ways in light of the service transformation that took place in the emergency response phase and the ongoing requirement for social distancing and infection prevention and control measures. • 'Recovery planning' with roadmap presented to Board for discussion on 29th June – planning underway with partners to reflect impact of COVID19 on communities and the need to accelerate delivery of Shaping Our Future Wellbeing and the Area Plan.		
Current Assurances	Outline draft Annual Plan presented to Board 25.02.21		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15**
Gap in Controls	Timeliness of planning requirements for Q3/4 plan issued by WG. Risk of request for multiple overlapping plans – agreement with Local Authority Directors of Social Services – to pull this into one coherent plan with more detailed specific action plans where needed.		
Gap in Assurances	RPB required to sign off Winter Protection Plan – no clear guidance but work progressing in line with framework suggested by WG.		

Actions	**Lead**	**By when**	**Update since March 21**
Monitor implementation of Annual Plan and continue to report through Strategy and Delivery Committee	AH	31/03/22	Development of Annual Plan almost finalised with approval at Board due the end of June prior to submission to WG
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10**

9. Impact of Covid19 Pandemic on Staff Wellbeing

As a result of the global Covid19 pandemic, our employees have been exposed to unprecedented levels of psychological and physical distress both at home and in the workplace. Evidence indicates that, Healthcare workers are at greater risk of developing mental health problems as a result. The impact of this is unlikely to be experienced equally, with people with existing mental health difficulties and people from Black, Asian and minority ethnic communities among those who are likely to be affected disproportionately.

Evidence

Risk	There is a risk that staff sickness will increase and staff wellbeing will decrease due to the psychological and physical impact of the pandemic. Which together with limited time to reflect and recover will increase the risk of burnout in staff.		
Date added:	6th May 2021		
Cause	• Redeployment with lack of communication / notice / consultation • Working in areas out of their clinical expertise • Being merged with new colleagues from different areas • Increased working to cover shifts for colleagues • Shielding / self-isolating / suffering from / recovering from COVID-19 • Build-up of grief / dealing with potentially traumatic experiences • Lack of integration and understanding of importance of wellbeing amongst managers • Conflict between service delivery and staff wellbeing		
Impact	• Values and behaviours of the UHB will not be displayed • Operating on minimal staff levels in clinical areas • Mental health of staff will decrease • Clinical errors will increase • Staff morale and productivity will decrease • Job satisfaction and happiness levels will decrease • Increase in sickness levels • Patient experience will decrease • UHB credibility as an employee of choice may decrease		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 - Extreme**
Current Controls	• Self-referral to wellbeing services • Managerial referrals to occupational health • External support – health for health professionals, recovery college, Mind, Samaritans • Wellbeing Q&As and drop ins (topical workshops) • Wellbeing Support and training for Line managers • Development of range of wellbeing resources for both staff and line manager • GP self-referral • Values Based Appraisals • Chaplaincy ward rounds • Appointment of new Health Intervention Team (HIT) – focus on both immediate reactive interventions and long term preventative • HIT exploring staff needs and gathering qualitative insight from staff • Increase number of wellbeing champion trained • Health and Wellbeing Strategic group • Development of rapid access to Dermatology		
Current Assurances	• Internal monitoring and KPIs within the EHWS • Wellbeing champions normalising wellbeing discussions • VBA focussing on individual wellbeing and development • Commitment from HIT staff to identify priority areas		

	• Trade unions insight and feedback from employees		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 - Extreme**
Gap in Controls	• Transparent and timely Communication especially to staff who are not in their substantive role e.g. redeployed, hybrid working • Existing proactive interventions to wellbeing		
Gap in Assurances	• Organisational acceptance and approval of wellbeing as an integral part of staff's working life • Awareness and access of employee wellbeing services		

Actions	**Lead**	**By when**	**Update since March 21**
1. Health Intervention Coordinator (1) providing reactive and immediate support to employees directly affected by COVID	NB	Immediate April 2021 – April 2022	Oversees COVID drop in support session 12th and 13th May UHW / UHL CAV a Coffee events on wards - Lakeside & Heulwyn Ward visits and support to staff Signposting of resources and support through EHWS
2. Health Intervention Coordinators (2) conducting research and exploration for long term sustainable wellbeing for the staff of the UHB	NB	Consultation by August 21 Interventions identified by Jan 22 Interventions proposed implementation April 22 - 2023	Consultation commenced across clinical boards Consultation proposed for May-July amongst all bandings of staff – clinical and non-clinical
3. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources - Improve website navigation and resources	NB	Commenced March 21 and continuing	Initial engagement with comms team Use of wellbeing champions to disperse messages Access to senior nurses and ward managers to disperse messages Key action: create Twitter account aimed at staff wellbeing and interaction for informal and accessible information
4. Training and education of management - Integrate wellbeing into all parts of the employment cycle (recruitment, induction, training and ongoing career) - Enhance training and education courses and support for new and existing managers	NB	Post consultation phase	
Impact Score: 3	**Likelihood Score: 2**	**Target Risk Score:**	**6 - Moderate**

Key:

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

Report Title:	**Performance Report**									
Meeting:	**Board Meeting**							**Meeting Date:**	**27.05.2021**	
Status:	**For Discussion**		**For Assurance**		**x**	**For Approval**		**For Information**		
Lead Executive:	**Chief Operating Officer and Executive Finance Director**									
Report Authors (Title):	**Information Manager (029 20 745602) & AD Operations (Performance) (029 21 847549)**									

Background and current situation:

The impact of COVID-19 continues to be seen across a range of key performance indicators.

The current operational context is outlined in the Operations section of the COVID-19 update report presented to the Board as a separate agenda item.

The current performance report remains a condensed report focusing on a limited number of indicators. The format of the performance report is being reviewed with a view to enhancing the scope as recovery of all services continues.

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

- Essential services were maintained in all areas throughout first and second waves of COVID-19,
- The Single Cancer Pathway came into effect on 1 December 2020. The USC 62-day target and Non-USC 31 day target are no longer reported,
- The scale and duration of the pandemic has had an unprecedented impact on the delivery of services and the Health Board's approach to recovery will need to be significantly different and not one solely based on returning services to normal. This approach will be outlined in the Health Board's 2021/2022 Annual Plan.

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

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

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

Since the first wave of COVID-19, there has been a constant balance of risk made in relation to the extent to which services could continue to operate versus the potential harm from COVID-19. The continued uncertainty regarding future demand and increased level of complexity is such that there remains risk in the system. The balance of risk applied, therefore, since the first wave will

continue, with actions guided by clinical advice, local Executive-led support groups and national guidance.

Appendix 2 provides the Finance report for the Board.

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

Recommendation:

The Board is asked to **NOTE**:

- The current position against specific performance indicators for 2020-2021.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X
Equality and Health Impact Assessment Completed:	Not Applicable								

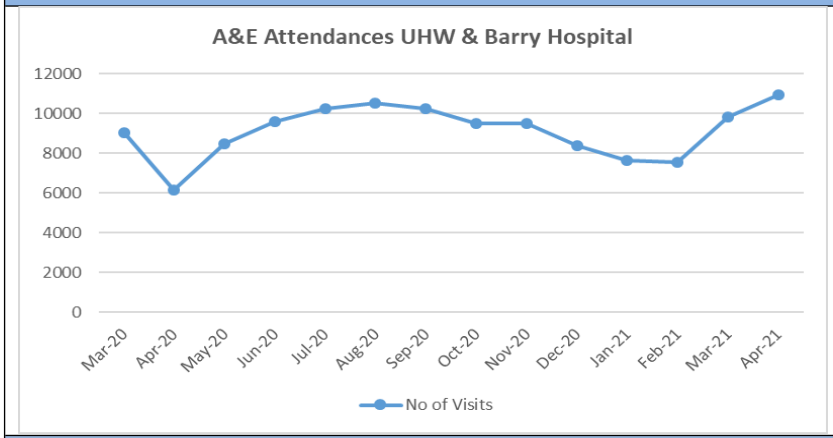
Unscheduled Care

Overview

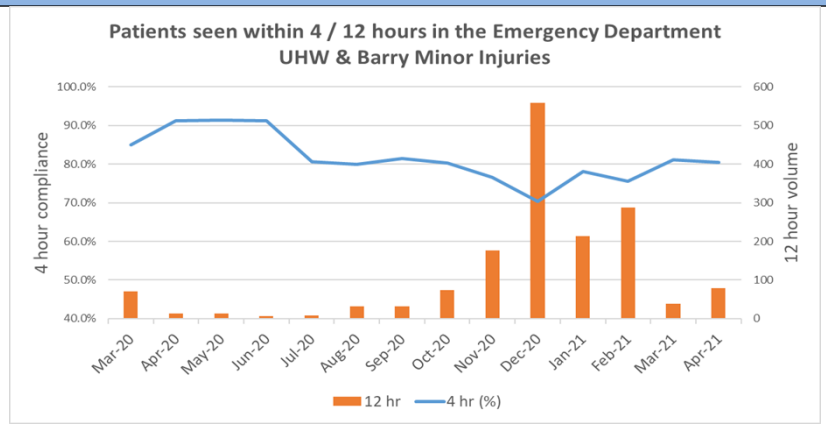
- Emergency Unit attendances have been increasing since February (7541) to March (9839) & April (10941), but remain lower than 2019/2020 levels but the service configuration is altered for covid compliance.
- 4 hour performance in EU was 81.1% in March 2021 (Mar 20 – 85.0%) and 80.4% in April (Apr 20 – 91.2%). 12 hours waits in EU have reduced in recent months and have been at their lowest levels in March (39) and April (79) since October 2020 (74).
- Ambulance handover delays reduced in March and April 2021 to 116 and 108 > 1 hour respectively.
- In March and April 2021 67.6% and 67.7% of red calls were responded to within 8 minutes, compared with 67.3% and 74.7% for the same period last year. Performance is in excess of target compliance.

Performance

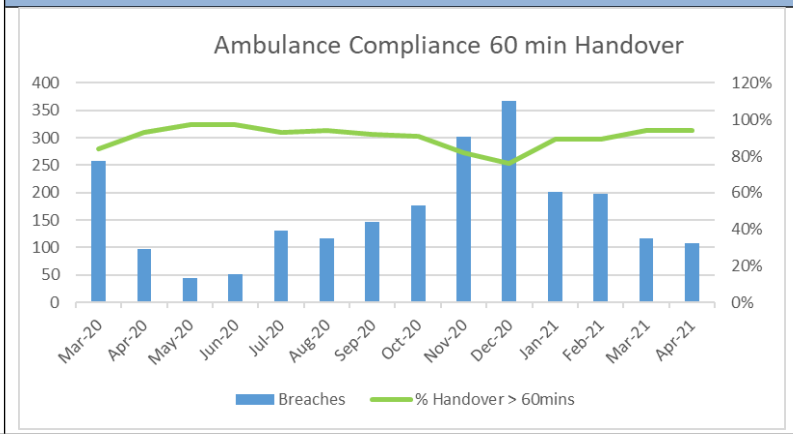
Graph 1: % A&E Attendances



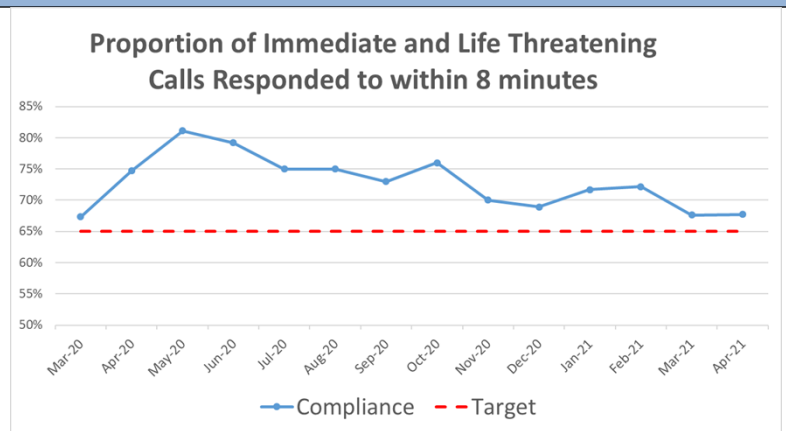
Graph 2: A&E waits – 4 & 12 hours



Graph 3: Ambulance handover > 1 hour



Graph 4: Red calls responded to within 8 minutes



Primary Care

Overview

In relation to General Medical Services (GMS):

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

In relation to GP Out of Hours (GPOOHs):

- 100% of patients prioritised as 'emergency' requiring a home visit were seen within one hour in April 2021.
- 100% of patients prioritised as 'emergency' requiring a primary care centre appointment were seen within one hour in April 2021.

Performance

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

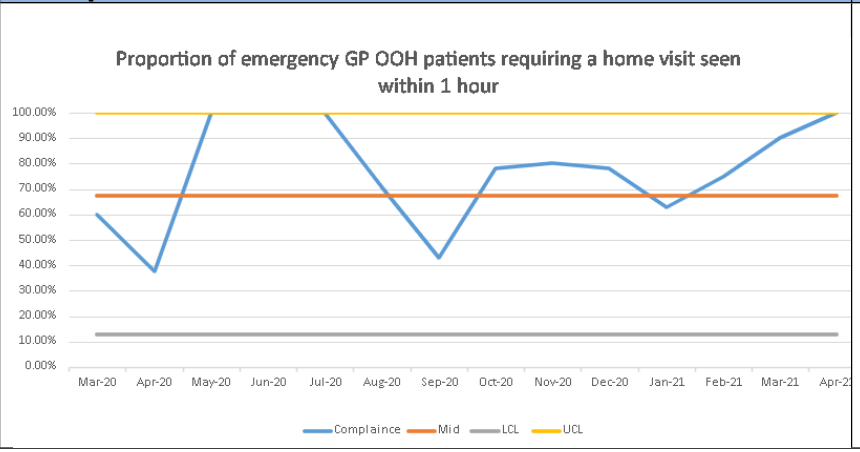
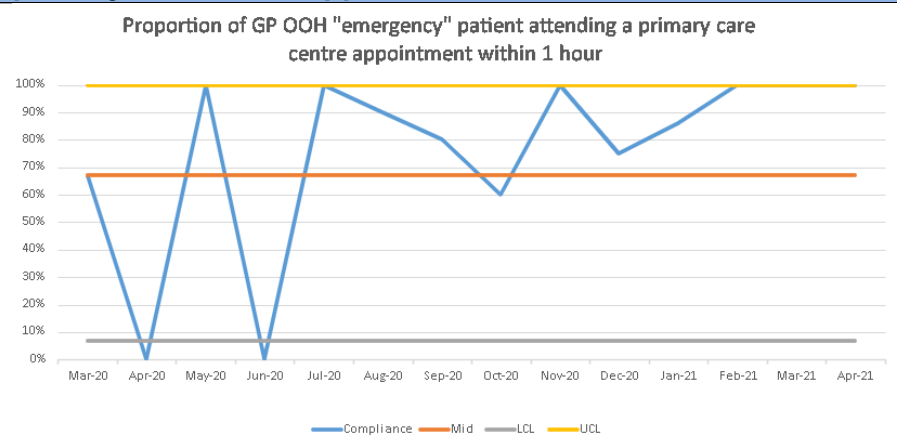


Chart 2: % of GP OOH "emergency" patients attending a primary care center appointment within 1 hour



Mental Health Measures

Overview

- Referrals have risen sharply again from February 2021 (1020) to March 2021 (1356) following 3 months (December to February) where referral volumes were high, but stable. Staff absence and backlog work continue to affect first access.
- Part 1a: The percentage of Mental Health assessments undertaken within 28 days is 13% overall and 26% for CAMHs in March 2021. Additional recruitment is underway and staff are working to balance assessment and treatment demand in the interim.
- Part 1b: 92% of therapeutic treatments started within 28 days following assessment at the end of March 2021.
- Part 2: 83% of health board residents in receipt of secondary mental health services have a valid care and treatment plan (CTP) as at March 2021.
- Part 3: 89% of health board residents were sent their outcome assessment report within 10 days of their assessment in March 2021.

Performance

Chart 1: Mental Health Referrals

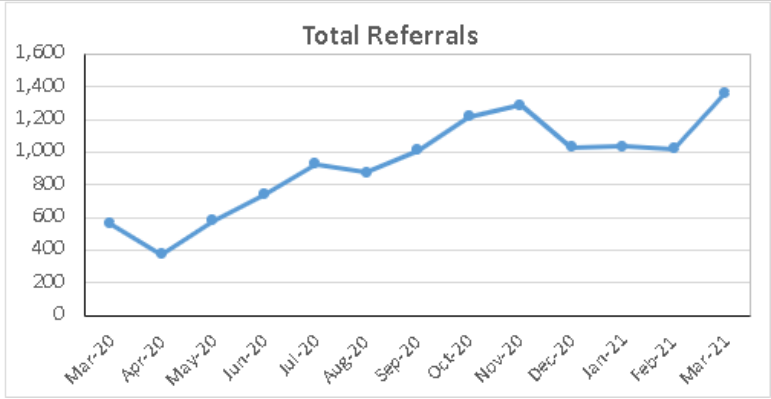


Chart 2: Performance against Mental Health Measures – Part 1a, 1b, 2 and 3

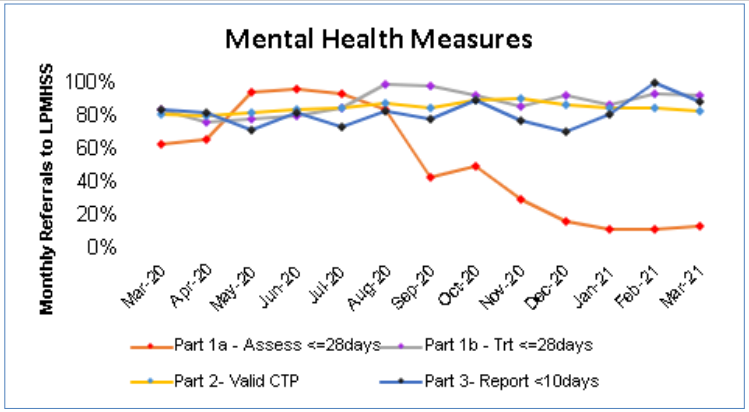
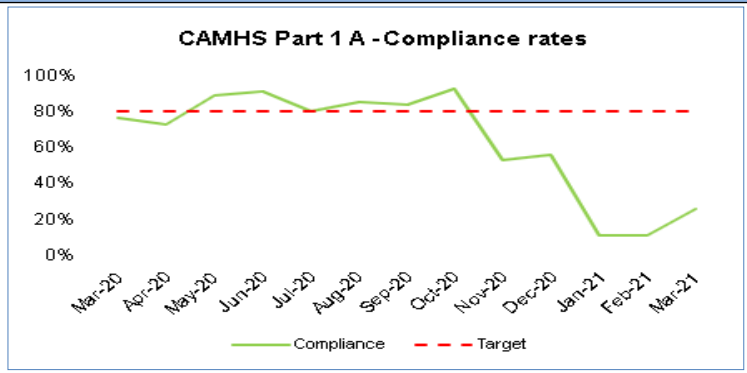


Chart 3: CAMHs Part 1a compliance



Cancer

Overview	• Referrals for patients with suspected Cancer sharply increased in March 2021, a 36.5% increase on same period last year. • SCP performance in March 2021 showed an increased from 54% in February to 66% in March 2021. It is likely to vary in the overall improvement trajectory in the next few months.

Performance

Chart 1: Cancer referrals

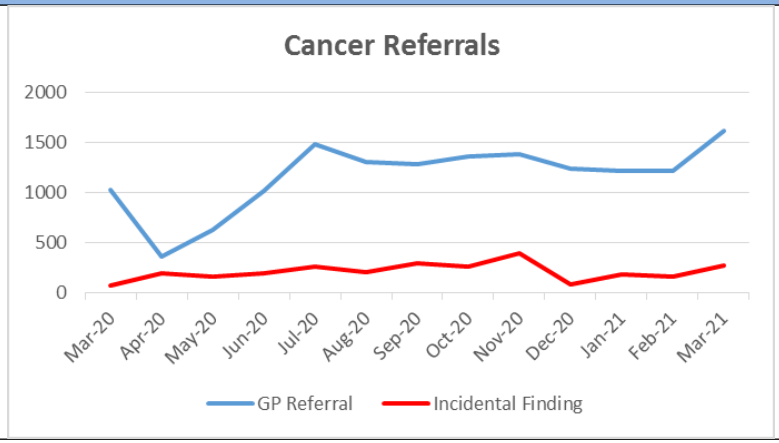
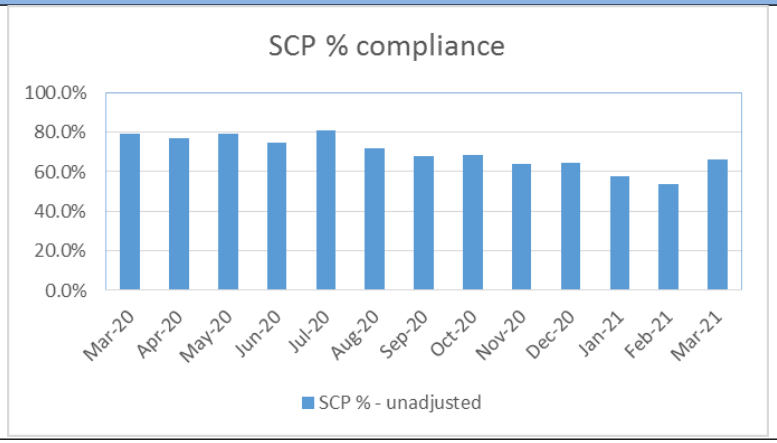


Chart 2: SCP performance



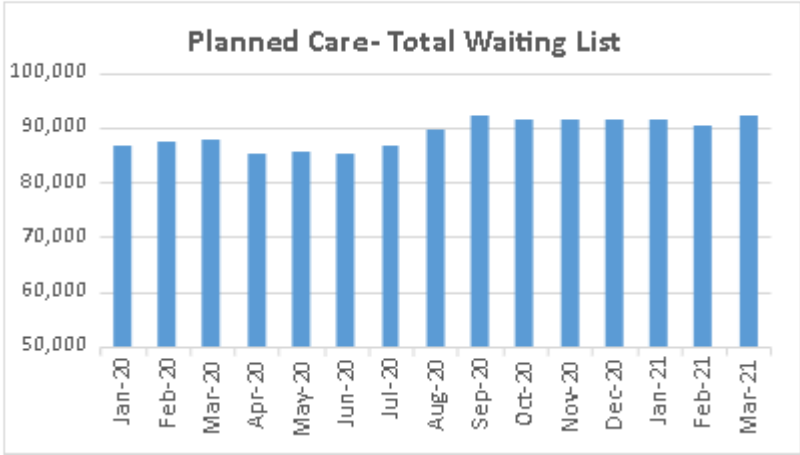
Elective access

Overview

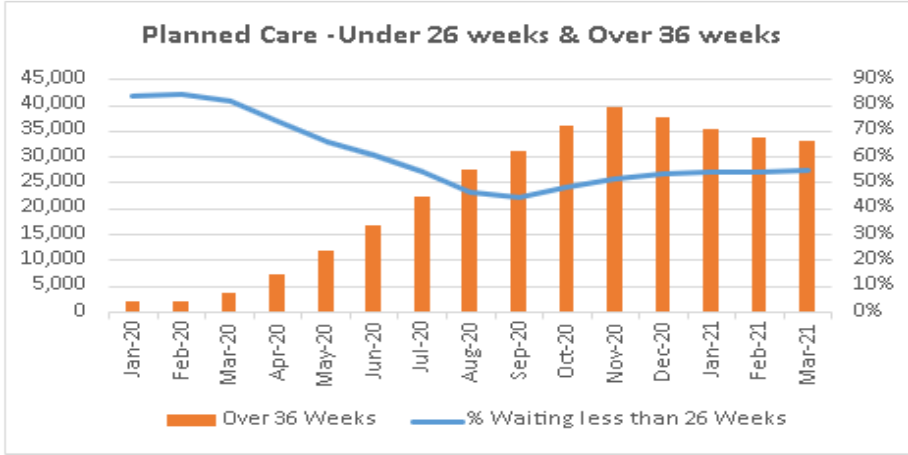
- The overall Referral to Treatment (RTT) waiting list was 92,286 at the end of March 2021, an increase of 2,149 from February. There were 32,938 patients waiting over 36 weeks for treatment for planned care, 837 fewer than at the end of February.
- Patients waiting greater than 8 weeks for a diagnostic test have reduced significantly since January (9130) and there were 4540 patients waiting over 8 weeks for a diagnostic test at the end of March.
- The total number of patients waiting for a follow-up appointment was 170,453 at the end of March. The number of Follow Up patients waiting over 100% beyond their target date was 46,695 patients.

Performance

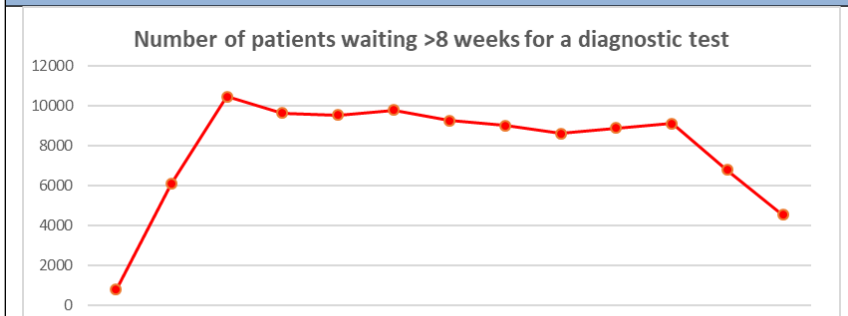
Graph 1: RTT total size of the waiting list



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

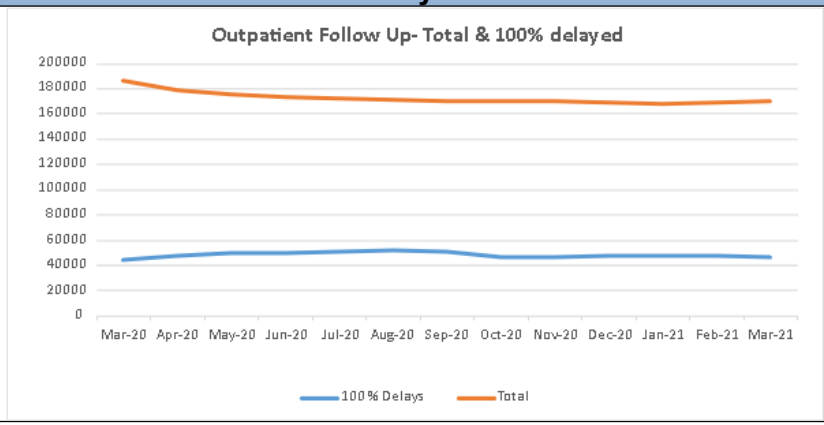


Graph 3: Diagnostics > 8 weeks



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Patients waiting over 8 weeks for a Diagnostic test	782	6105	10476	9653	9557	9804	9268	9023	8611	8885	9130	6797	4540

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



Appendix 2

FINANCE

How are we doing?

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

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

The UHB's provisional year end revenue outturn is a surplus of £0.090m which is broadly in line with the break-even position previously forecast. The UHB is also reporting that it stayed within its Capital Resource limit and achieved its creditor payment compliance target. The Board is asked to note that these are all provisional at this stage as the draft accounts are subject to External Audit scrutiny. The year-end reported position is however, not expected to materially change.

Reported month 12 position

The Welsh Government amended the monthly financial monitoring returns to capture and monitor net costs due to COVID 19 that are over and above LHB plans. The financial position reported to Welsh Government for month 12 is a surplus of £0.090m and this is summarised in the Table below:

Table 1: Financial Performance for the period ended 31st March 2021

	Draft Year End Position £m
COVID 19 Additional Expenditure	179.205
COVID 19 Non Delivery of Savings Plans	20.340
COVID 19 Reductions in Planned Expenditure	(20.823)
Total Release/Repurposing Of Planned Investments/Development Initiatives	(2.602)
Net Expenditure Due To COVID 19	**176.120**
Welsh Government COVID funding received / assumed	(176.120)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	0.000
Operational position (Surplus) / Deficit	(0.090)
Financial Position £m (Surplus) / Deficit £M	**(0.090)**

The additional COVID 19 expenditure in the 12 months to the end of March 2021 was £179.205m. £55.422m of the additional costs related to the Dragon's Heart Hospital (DHH) and there was also £123.783m of other COVID 19 related additional expenditure.

COVID 19 is also adversley impacting on the UHB savings programme with underachievment of £20.340m against the month 12 target.

Elective and other planned work has been significantly curtailed during this period as part of the UHB response to COVID 19 and this has seen a £20.823m reduction in planned expenditure.

The UHB has also seen slippage of £2.602m on the WHSSC commissioning plan and other investments due to the impact of COVID 19.

The net expenditure due to COVID 19 is £176.120m and this is matched by an equal amount of additional Welsh Government COVID 19 funding. The UHB also has a small operating underspend of £0.090m leading to a net reported surplus at month 12.

Underlying deficit position

The underlying deficit position brought forward from 2019/20 was £11.5m. Delivery of the 2020/21 plan would have reduced this to £4m by the year end. The achievement of this was largely dependent upon delivering the £25.0m 2020/21 recurrent savings schemes. Due to the pandemic the delivery of savings was circa £21.3m less than planned and this has increased the underlying deficit to £25.3m. What is unclear at the moment is whether Welsh Government will provide any financial support for this in 2021/22.

Creditor payment compliance

The UHB's public sector payment compliance performance was 96.2% at the end of March and therefore the UHB achieved its statutory target of 95% n 2020/21.

Remain within capital resource limit

The UHB successfully remained within its Capital Resource Limit (CRL) in 2020/21. Net capital expenditure was £0.104m (0.1%) below the approved CRL of £95.447m**.**

Cash

The UHB cash balance at the end of March was £3.637m.

Report Title:	**Patient Safety Quality And Experience Report**							
Meeting:	**UHB Board Meeting**					**Meeting Date:**	**27.05.21**	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**	
Lead Executive:	**Executive Nurse Director** **Executive Medical Director**							
Report Author (Title):	**Assistant Director, Patient Safety and Quality** **029 2184 6117** **Assistant Director, Patient Experience** **029 2184 6108**							

Background and current situation:

The purpose of this paper is to present an integrated Quality, Safety and Experience report which covers the period from March to April 2021.

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

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

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

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

Serious Incidents – the number of serious incidents currently being reported is much lower than normal in line with revised Welsh Government reporting requirements.

COVID-19 outbreak position – there are no current outbreaks to report. This is covered in a separate report to Board

Concerns - In March and April, 3,549, concerns were received, which is a significant increase when compared with 1,781 received in January and February. This increase reflects the extremely high volume of enquiries the Concerns Team are receiving via the Mass Vaccination and visiting lines being hosted within the Department. It is pleasing to note that the response time to formal concern is 83% despite the ongoing challenges.

Committee infrastructure - The Clinical Effectiveness Committee and Mortality Group are now well established with good engagement and are functioning well. A revised Corporate QSE Committee and Group infrastructure which introduces a new Clinical Safety Group and Organisational Learning Committee will be presented at the June 2021 QSE Committee Meeting for discussion and agreement.

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

During March to April 2021, the following Serious Incidents and No Surprises have been reported to Welsh Government:

Serious Incidents		
Clinical Board	Number	Description
Executive Nurse	1	A young person sadly took their own life.
Medicine	2	2 people experienced injurious falls resulting in head injuries (Subdural Haematomas) from which the patients sadly died. Both falls occurred on different medical wards.
Specialist	1	Post-operative extubation on CITU led to a patient's unexpected deterioration. The patient became unresponsive and required ventilation. This incident is currently under investigation to understand exactly what occurred.
TOTAL	4	

No Surprises		
Clinical Board	Number	Description
Children & Women	1	The Health Board sent a notification to Welsh Government regarding an ongoing MRSA situation on the Neonatal Unit.
TOTAL	1	

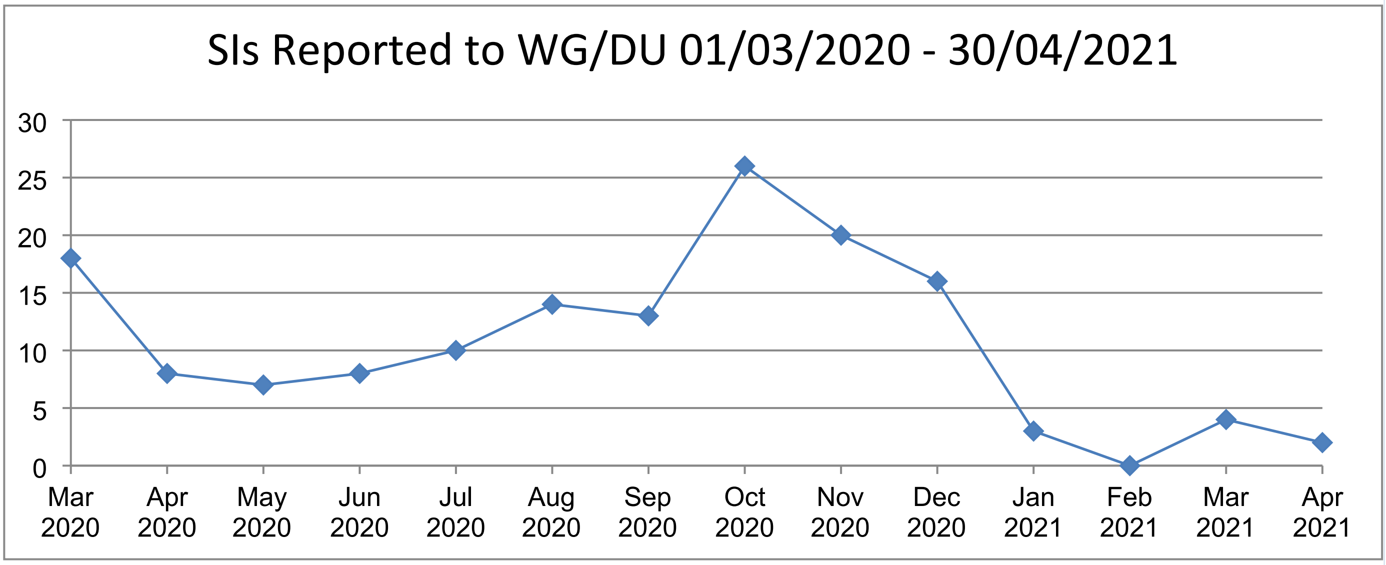
How do we compare to our peers?

Welsh Government (WG) wrote to organisations in NHS Wales on 18th March 2020 to set out SI reporting requirements during the pandemic. They reinstated usual SI reporting requirements in August 2020 and SI reporting rates returned to pre-pandemic levels.

WG has subsequently written to organisations in January 2021 to revise requirements in view of the current Coronavirus situation. From an incidents perspective, they have asked that the following be reported as SIs:

- All Never Events
- Inpatient suicides
- Maternal deaths
- Neonatal deaths
- Homicides
- Incidents of high impact/likely to happen again including child related deaths (for local decision)

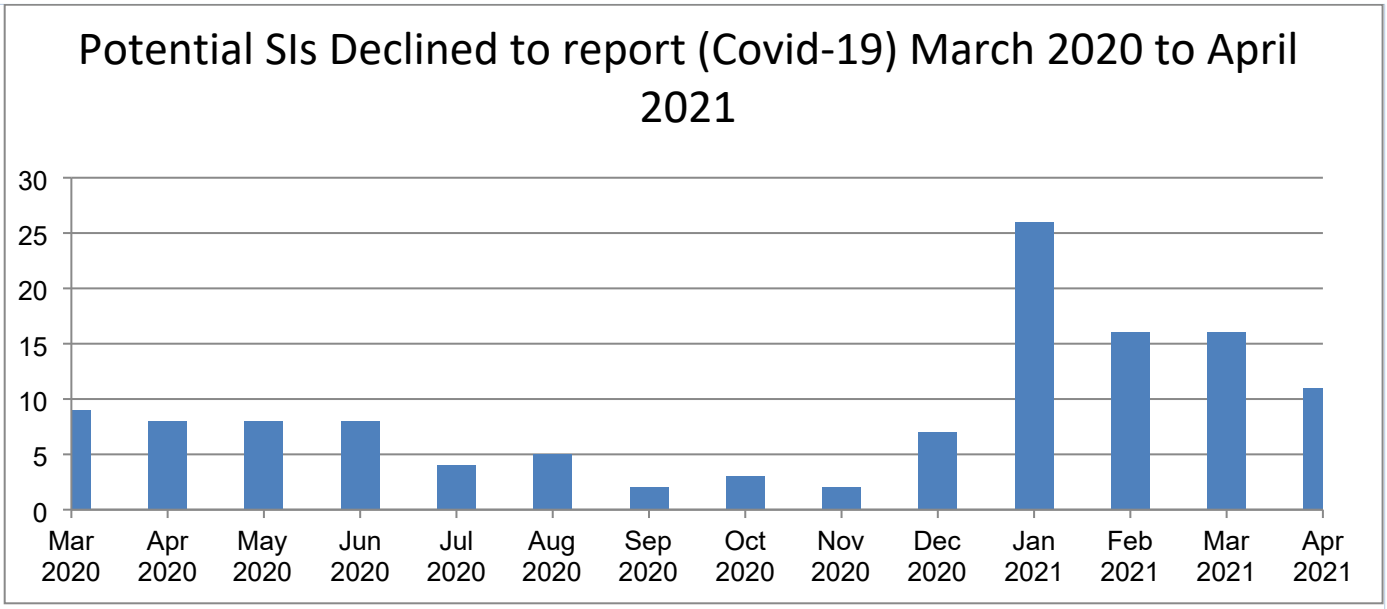
They have promoted proportionate investigation with a focus on implementing actions to ensure immediate safety and sharing of the learning identified.

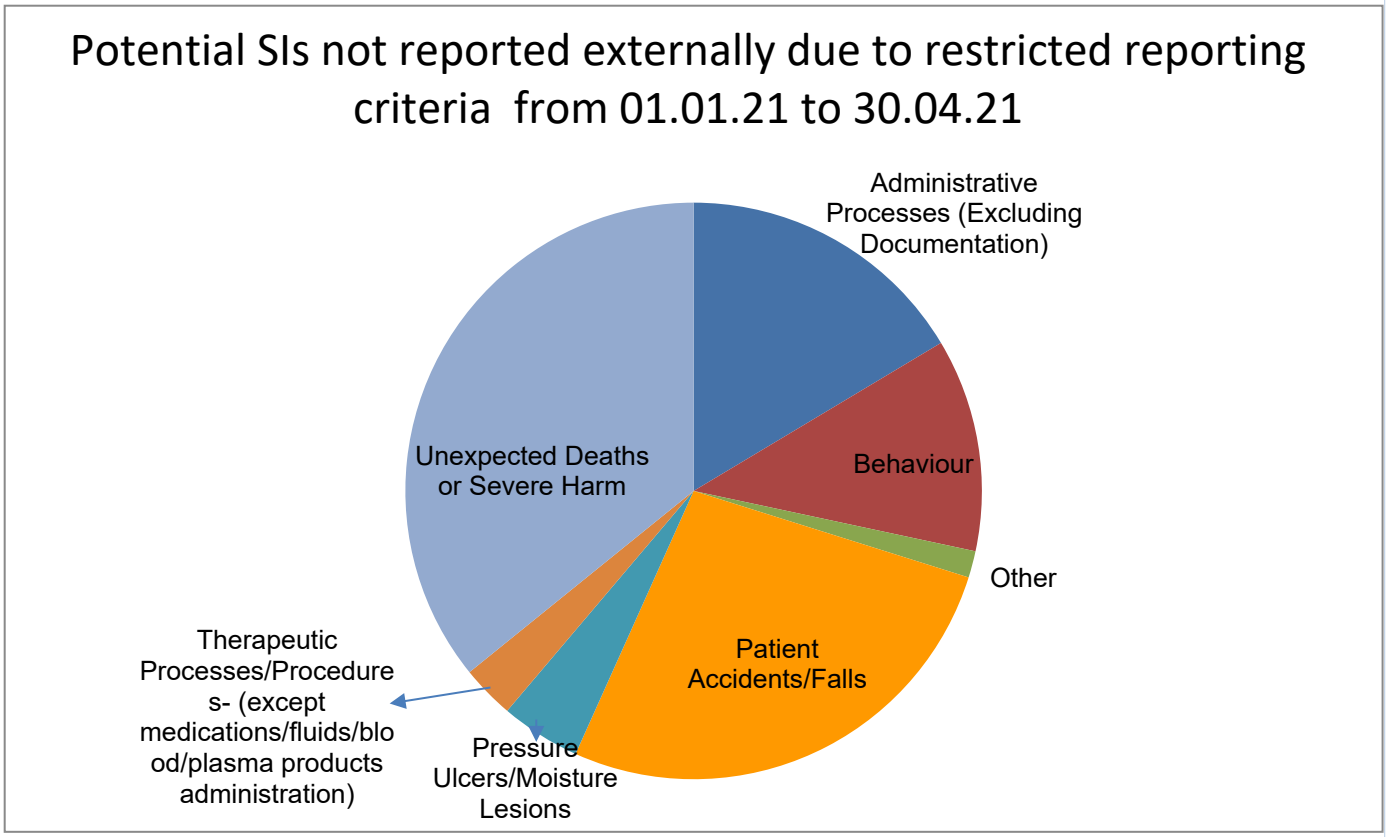


The above chart reflects the change in SI reporting criteria with a reduction in SIs between March 2020 and April 2021. Previous reports have demonstrated a comparison of reporting rates during the pandemic with the same period the previous year pre-pandemic. In August 2020 the usual reporting criteria resumed and this is associated with an increase in SI reporting as demonstrated in the chart above. This continues until January 2021 when guidance was issued to return to the restricted reporting criteria leading to significantly lower reporting rates. We continue to follow the restricted reporting guidance.

To be able to monitor incidents that would otherwise have been reported to WG/DU but not reported due to the change in criteria, an additional report type was created on Datix. The report below demonstrates the incidents that would otherwise have been considered for SI reporting if it were not for the change in reporting criteria due to COVID-19.

The chart below shows that during January and February 2021 (with extremely low SI reporting), the number of potential SIs declined to report due to COVID-19 criteria was particularly high. This shows that there is still a level of scrutiny despite not being externally reported. This enables these incidents to be robustly monitored by the Patient Safety Team to ensure that proportionate reviews and improvement plans are still being undertaken by the Clinical Boards.





The above pie chart depicts the types of incidents that would otherwise have been considered to have been SI reported from 01.01.21 to 31.04.21. In total, during this period there were 66 incidents that were assigned to this category on Datix.

Of the 66 potential SIs not reported:

23 were *unexpected deaths* (all 23 were reported by Mental Health, all were *type of incident unknown at the time of reporting* and further investigation was undertaken to determine whether an incident had occurred).

11 incidents were reported in the *Administrative Process* category and all 11 relate to the admission of a minor to an adult mental health setting (monitored by the Welsh Health Specialised Services Committee (WHSSC).

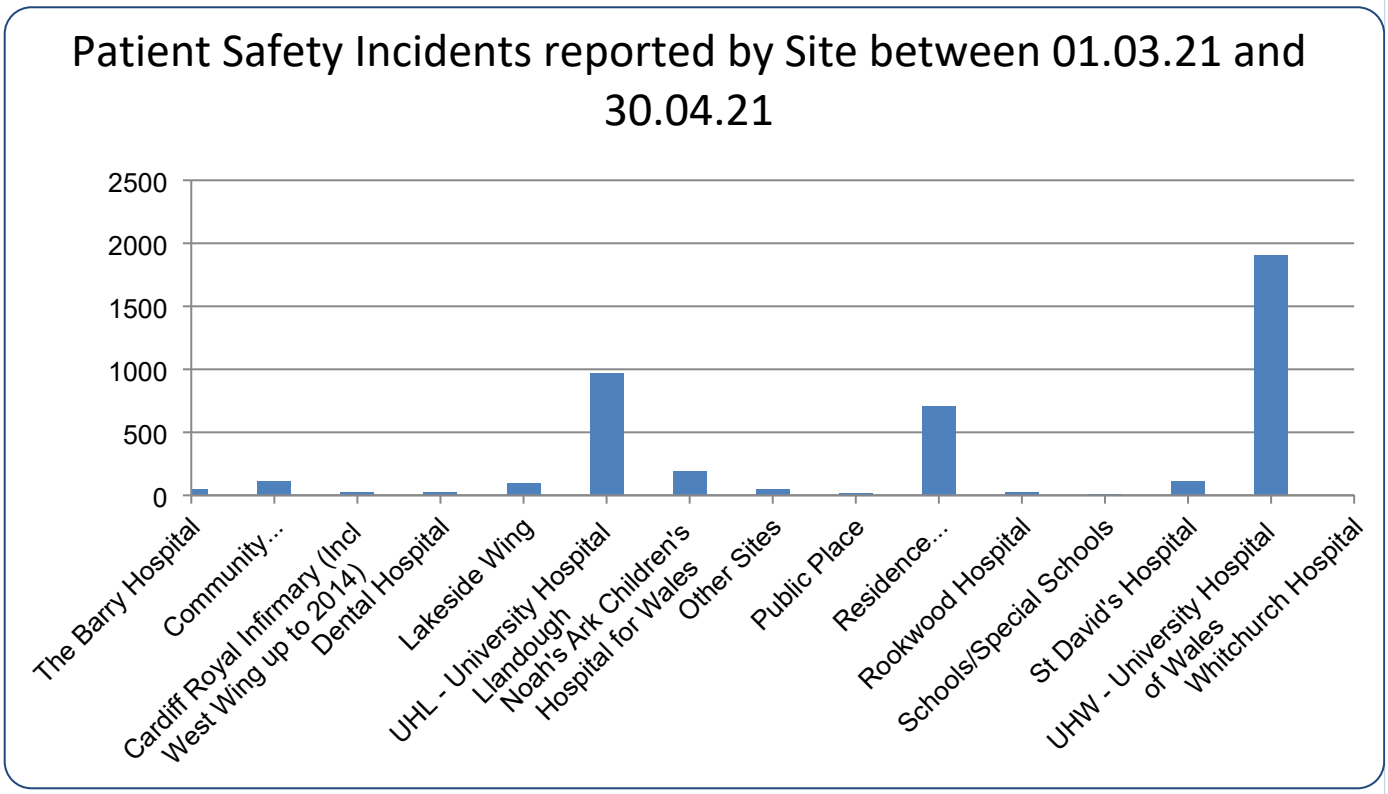
8 were reported for *Behaviour* and relate to self-harm and suicide (all reported by Mental Health).

18 were *Patient Accidents and Falls* and relate to injurious falls with moderate or major harm reported.

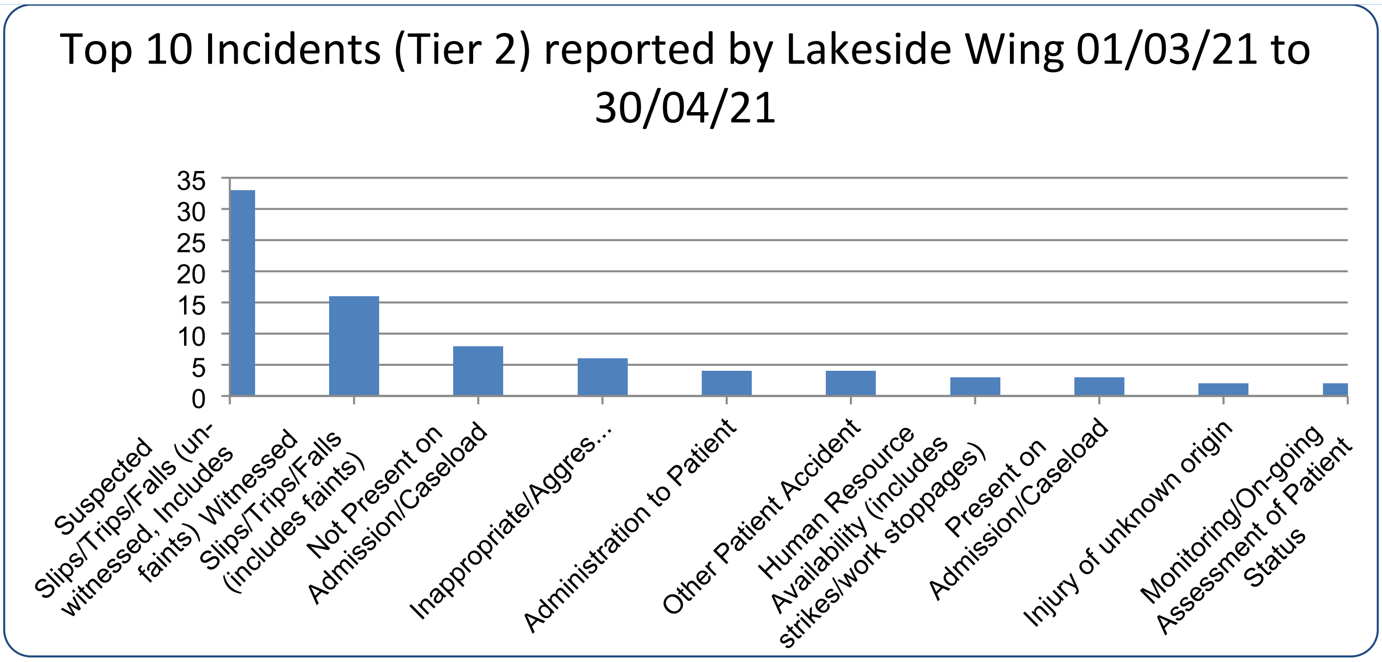
2 report Therapeutic Processes (treatment/procedure delayed) and both relate to harm caused from a lack of capacity to appropriately treat a patient due to the Covid-19 pandemic.

3 were Pressure Ulcers of moderate harm that were present on admission to hospital.

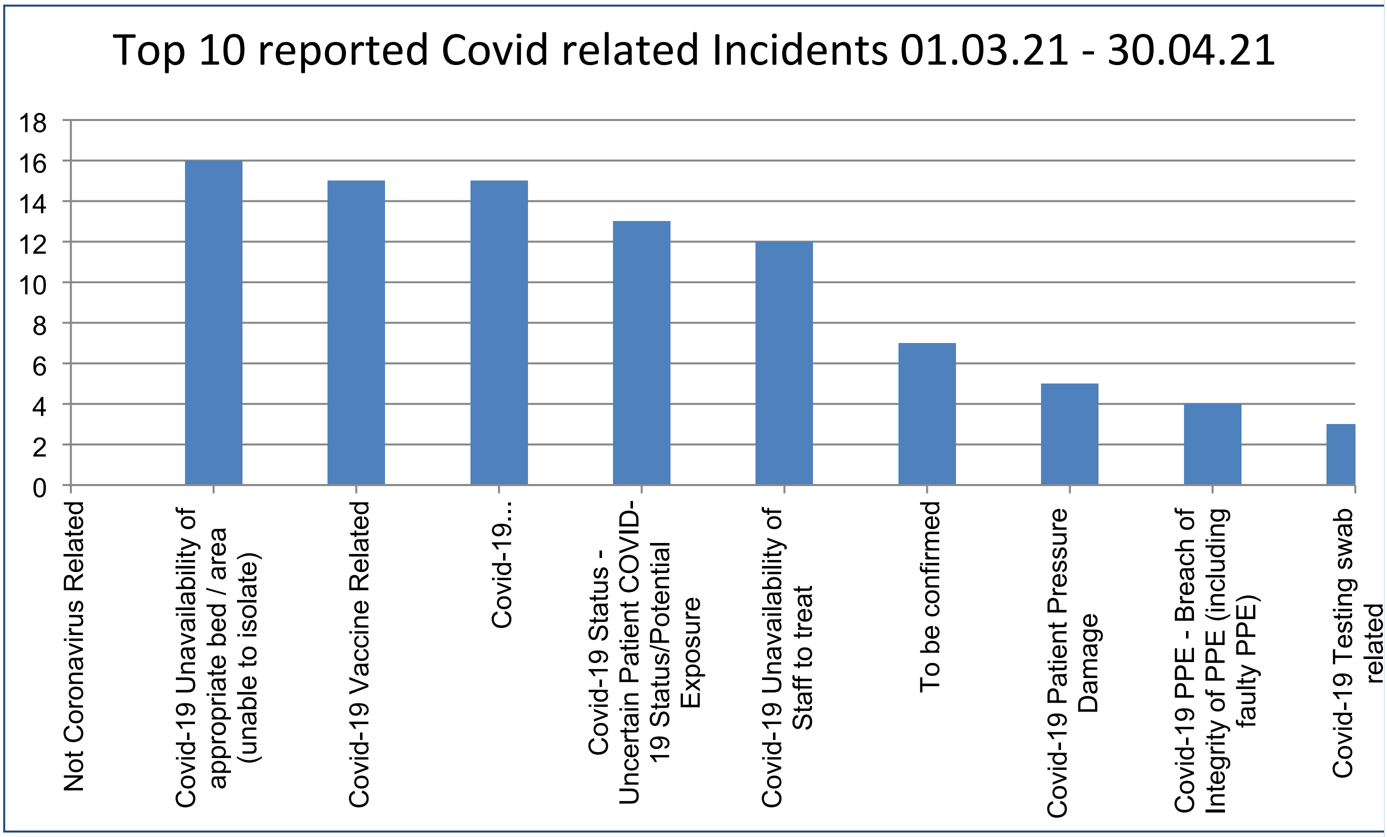
1 incident relates to *Other* which is still under investigation but can be reassigned as more details are now known; this also relates to an unexpected death in mental health.



The above chart reflects the higher incident reporting at the 2 main acute sites as would be expected between 1st March and 30th April 2021.

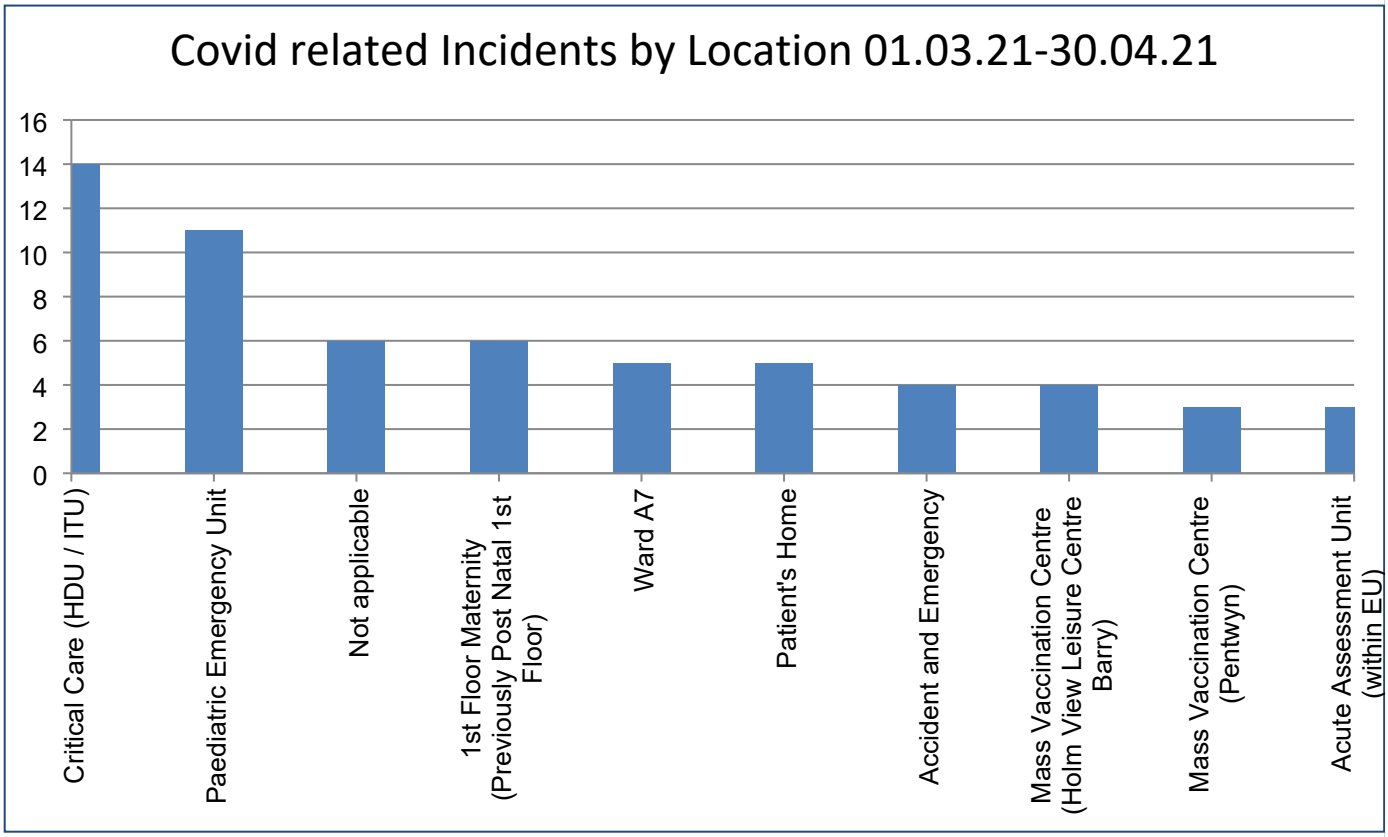


COVID-19 Related Incidents



Of the 138 COVID-19 related incidents reported between March and April 2021, a significant proportion had been incorrectly coded by the incident reporter on Datix and were not COVID-19 related and so the data for this category has been removed in the chart above. The most commonly reported COVID-19 incident between March and April 2021 was 'unavailability of appropriate bed/unable to isolate'.

This is in contrast to the highest reported COVID-19 incident from the last Board Report (which covered January 2021 to February 2021) which was 'Unavailability of staff to treat'. This category still features in the top 10 however is number 6 rather than the highest reported. Whereas in the last report it was the critical care areas reporting unavailability of staff, this has changed to predominantly the wards especially within Medicine Clinical Board.



Critical Care remains the highest reporting area for COVID-19 related incidents; the nature of the incidents are primarily related to Personal Protective Equipment (PPE) donning/doffing procedures and breach of integrity of PPE as well as ventilator support related pressure damage in COVID-19 positive patients.

Regulation 28 Reports

There have been no Regulation 28 reports in this timeframe. Whilst inquests continue to be significantly disrupted due to the pandemic. An increasing number are being rescheduled by the Coroner in order to bring them to a conclusion.

Patient Experience

As previously reported, since March 2020, the PET (Patient Experience Team) has worked very differently, utilising a variety of methods to gain patient feedback.

We are continuing to gather limited feedback using paper surveys, but are supplementing this with the increased use of electronic surveys via text, email and web link. Also, we have recently reintroduced our 3G kiosks (HappyOrNot/Viewpoint), which are currently being used to gather feedback from the Mass Vaccination Centre's (MVC).

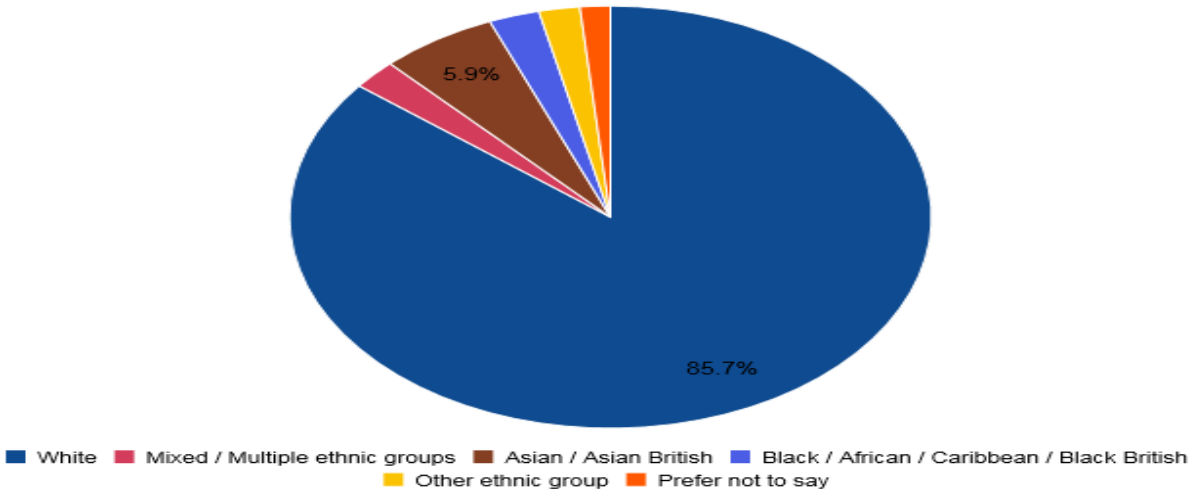
As well as being involved in many bespoke feedback projects, we are continually looking into how we can further develop the feedback systems we currently have in place. One previously mentioned example, is the introduction of the 'All Wales' Civica platform, which we hope will be in place within the next six months. We are also looking to introduce/utilise MS Forms, as an alternative to Survey Monkey.

In relation to recent/current bespoke studies in which we have been involved, examples include:

PESU (Protected Elective Surgery Unit) survey. This is currently being carried out by the team and involves texting survey links to patients discharged from PESU, within the last six months. In total, texts were sent out to 2,145 patients and to date we have had survey completions from 672 respondents. The results of this survey will be fed back to the team later this week. An ongoing inpatient survey has also been planned.

MVC (Mass Vaccination Centres) kiosk survey. We have feedback machines in all centres. The second survey question asks about the respondent's ethnicity and a breakdown of those responses is given in the following bar chart. Over 9,000 responses have been collated. 6.3% of people have chosen to complete the survey in Welsh. 98% of people are happy with their experience at the centres. With regards to ethnicity it is pleasing to note that initially 11% of people who declared an ethnicity considered themselves to be in an ethnic group other than white. However the percentage is increasing and is currently at 14.3%.

What is your ethnic group? (9196)



Other examples of bespoke studies in the design phase/currently underway include:

Staff survey – Wellbeing (Occupational Therapy).
Patient survey - Neurology virtual outpatient survey.
Patient safety Culture Staff survey - Patient safety.
Staff survey – Patient experience.
Staff survey – MVC.
Patient survey - ACHD virtual clinic survey.
Patient survey – Traumatic Brain Injury Service.
Patient survey – Prison service.
Patient survey – Virtual HIV clinic service.

Patient survey – Prostate cancer teaching videos.
Patient survey – Prostate cancer diagnosis.

MVC Videos

Introductory videos in both Welsh and English developed for citizens on what to expect at all four Mass Vaccination Centres (MVCs). These videos will also be used to support the MHSOP 'Get there together' project. Link to Bayside MVC

Expansion of Volunteers to Children's Hospital Entrances and Maternity Unit Entrance

Health Board volunteers now have the opportunity to volunteer in the entrances of the Children's Hospital for Wales and the Maternity Unit. Providing a wayfinding service, friendly face and answering any questions they can help with. Volunteers will also be encouraging visitors to wear a mask where appropriate and gelling their hands upon entering.

These volunteers have been requested by the relevant areas and trials are currently ongoing to determine when volunteers are most needed during weekdays. Including looking at the busiest times and what the needs of the visitors are.

Partnership Volunteer Project with Skill & Volunteering Cymru (SVC)

The Patient Experience Team are working in partnership with Skill & Volunteering Cymru (SVC) on a volunteer project to support at the MVCs. Currently 21 SVC volunteers have been inducted to support as meet and greet at the MVCs.

Comment from one volunteer

"The session was absolutely perfect. Everyone was very helpful. The head nurse greeted me with a warm welcome. The other volunteers introduced me to all the policies. I have great pleasure working at the vaccination centre. I greeted people and showed then the way around vaccination booth. Thank you very much for the opportunity." – SVC volunteer

Patient Experience News Padlet

The Patient Experience Team are currently developing a platform for providing up-to-date information on the Patient Experience Service utilising Padlet. This service will signpost staff to useful information about the teams embedded within the service and will be updated at set times throughout the year. As an example some of the information which will be held within this platform will be contact details, update on projects, useful information on feedback and news. This will be for all UHB staff to access with the potential of a public facing Padlet following. A draft and SOP are currently in development between members of the Patient Experience Team.

Complaints Management/Redress

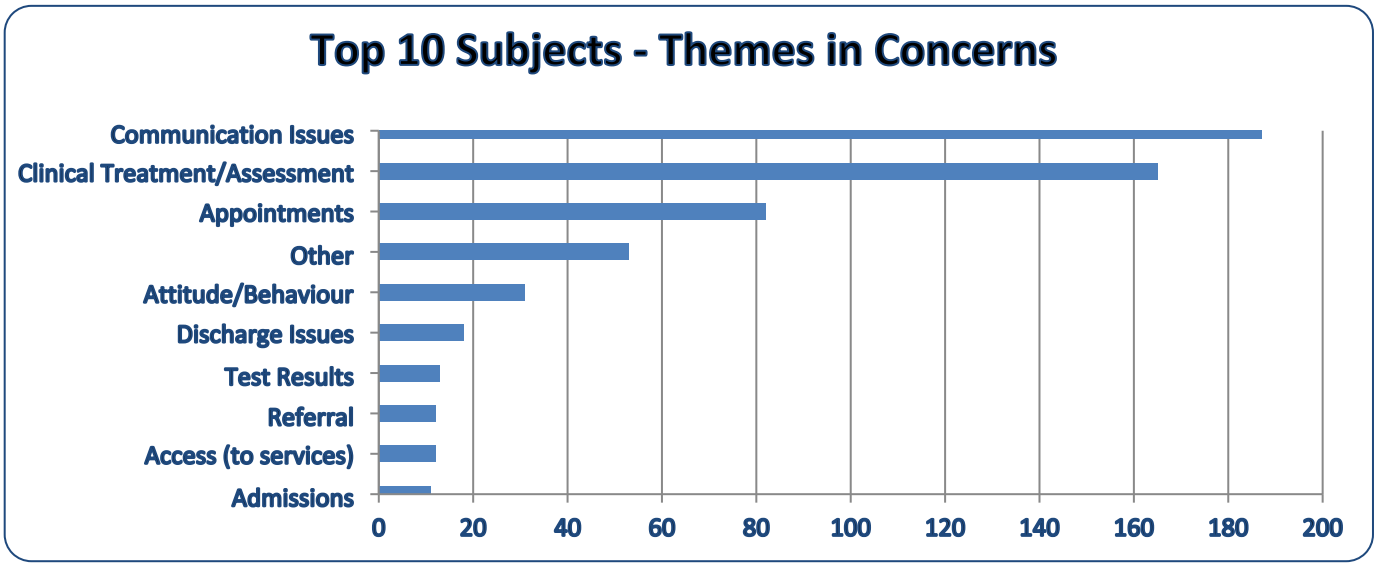
In March and April, 3,549, concerns were received, which is a significant increase when compared with 1,781 received in January and February.

This increase reflects the extremely high volume of enquiries the Concerns Team are receiving via the Mass Vaccination enquiry line being hosted within the Department. The Concerns Team also provide a 7-day booking line for relatives to arrange a visit.

Concerns	Vaccinations	Visiting calls
636	2,922	1,750 (since introduced on 2nd April)

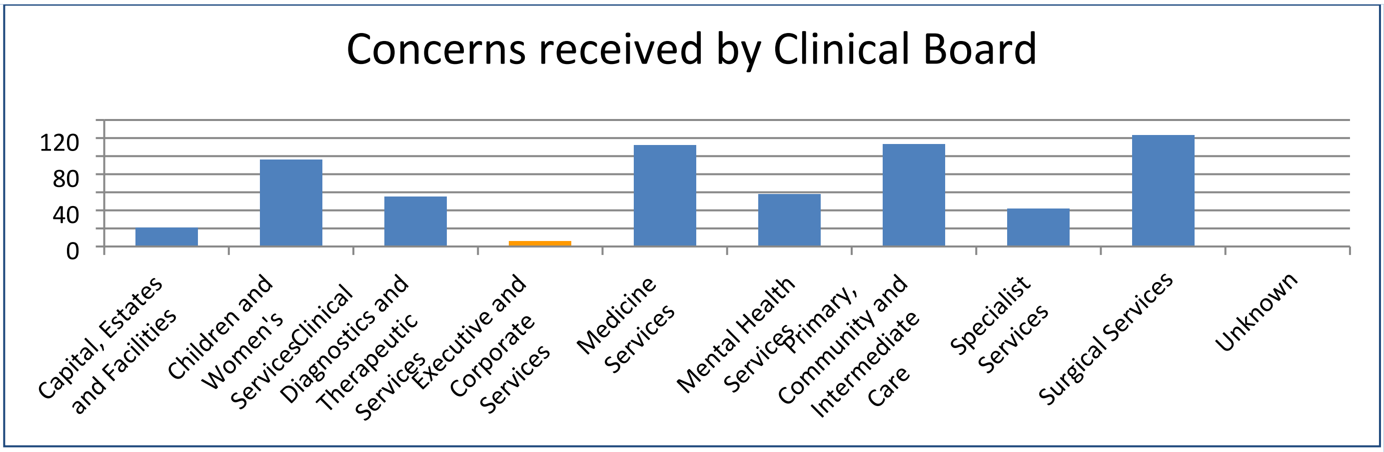
It is very pleasing to note that, despite the demand on the Health Board the 30-working day performance for concerns responses in this period was 83%, which exceeds the Welsh Government target of 75%.

The Health Board continues to receive a high number of concerns regarding communication and this is the key theme identified, with Concerns regarding clinical treatment and assessment being the second highest.



As mentioned above, poor communication is a key theme in concerns. These include concerns regarding lack of communication/follow up calls from various clinics and lack of information when families are worried about their loved ones and are unable to make contact directly to the wards via the telephone. However, we anticipate a reduction in these types of concerns now that we are able to accommodate some visiting. We will continue to monitor the trend. As well as actual visits the team continue to support virtual visits as well if appropriate and required.

We continue to receive concerns relating to staff and visitors not adhering to social distancing. Staff and our communities are reminded via social media and posters about the importance of maintain the two meters social distancing and wearing of appropriate masks.



All Clinical Boards have a higher than average number of active concerns. This is due to the high volume of patient's raising concerns relating to delays in follow-up appointments and planned procedures within the Surgical Clinical Board, and enquiries regarding the Mass Vaccination roll out sitting within PCIC Clinical Board. It would be expected that Medicine Clinical Board have a higher number of concerns based on the significantly higher number of patient contacts and level of activity they have had, in comparison to other Clinical Boards, during the pandemic. Mental Health Services has also seen an increase in concerns following a number of high profile cases.

Training

We continue to offer training as and when required. During March and April, concerns training sessions have been provided to Medicine and PCIC Clinical Boards, with very positive feedback. Medicine have requested additional sessions to be scheduled in May.

What are we doing?

The Concerns Team continue to operate a 7-day working rota which has helped support/facilitate communication between wards and relatives. This has also allowed the department to maintain social distancing.

The Patient Experience Team have also supported Virtual Visiting which has helped to allay concerns regarding relatives not being able to visit during this very difficult time. In order to facilitate visiting when possible, the Concerns Team provide a 7-day booking line to support this – on average, we receive over a 100 calls a day.

Additional staff were required to support the mass vaccination enquiry line over seven days. During March and April we received 2,922 calls. This helpline provides an opportunity for members of the public to be reassured regarding when to expect the vaccine, to be signposted appropriately and facilitate arrangements for patients with more complex needs. As indicated the team have developed some videos regarding experience in the mass vaccination centres.

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

and other routes. The Communications Team actively send out reminders about social distancing through all available media channels.

Clinical Effectiveness Committee

The UHB has established a Clinical Effectiveness Committee chaired by the Assistant Medical Director, Patient Safety and Quality. At its most recent meeting on 24.03.2021, the following key issues were noted:

PMRT - The Learning from Standardised Reviews When Babies Die – National Perinatal Mortality Review Tool - Second Annual Report was discussed. This report was based on national data. The implementation of NICE guidance for diabetes in pregnancy and how objectivity /impartiality is ensured when reviewing neonatal deaths and RCA investigations in the absence of an external member were highlighted. This will be explored further with the relevant teams and discussed in more detail at a forthcoming meeting.

PICAnet - The Paediatric Intensive Care Audit Network Annual Report for 2020 was discussed. It was noted that the refusal rate following referral for urgent paediatric intensive care transport for CAVUHB was 12.8% during 2017-2019 – this was high in relation to peers. These were cases that had been referred by a PICU Consultant but refused. Further discussion will take place with the relevant teams to ensure the data is understood in context.

National Hip Fracture Database – there has been an improvement in compliance across many criteria. It was noted that absence of delirium and mobilisation post-surgery was below the national compliance rate and that there had also been a corresponding increase in the number of patients with fractured femur who developed pressure damage. Initial exploration of the data has shown a discrepancy between our local data and national data for mobilisation. This has previously noted in the Board paper, through further discussion with the Clinical Audit Lead it was identified that the standards for Wales have been adjusted by Welsh Government, and are lower than the national standards in the report. The Clinical Audit Lead and Clinical Director will attend CEC on 11th of May to further explore and discuss the audit results and improvement planned.

NICE and HTW - Nice and HTW guidance was discussed; an overview of responses from Directorates and Clinical Boards was discussed for 2020. The level of responses was poor at 21%. Where clinical areas had responded, there was no evidence to support whether the guidance had been implemented of if there was compliance. There are significant challenges associated with the current system and process in place for providing assurance against NICE and HTW implementation. It has been identified that investment is required in this area for AMaT software and the resource to manage and administer the system.

Peer Review and Accreditation - A Peer review was noted on Type 1 Diabetes from 2018. It was agreed that peer reviews undertaken within the Health Board should be reported through CEC. Currently this information is not fully captured; investment in the Quality Assurance Team and the AMaT software will support this work.

Policy and Procedure – Non compliance - NasoGastric (NG) Tubes - An issue was raised regarding medical training for NG tubes. It was been identified through a Patient Safety Alert that the Health Board is not fully compliant with this element of the alert. . A piece of work has been initiated by an organisation learning manager to address.

NatSSIPs – Compliance with NatSSIPs was discussed and some concerns were identified. It was suggested that an internal audit on WHO Safety Checklist compliance would take place in the first instance and further improvement work is being led by a Patient Safety Organisational Learning Manager. A new medical chair of the NatSSIPs group has been appointed.

Learning from Deaths

Over the past year Cardiff and Vale University Health Board (UHB) has developed a now well-established Mortality Review Group (MRG) that meets bi-monthly, the last time being on 4th May 2021. The Medical Director is the Executive lead and all Clinical Boards have representation. The Group is also supported by specific professionals with roles directly aligned to the work including the Chief Medical Examiner (CME) for Wales.

The ultimate purpose of the group is to learn from deaths and to act on that learning.
The group is overseeing the introduction of the Medical Examiner Office function in the UHB. There is a sub-group that is developing and implementing the processes for: scanning case notes of deceased patients to the ME office; discussing causes of death for accurate death certification; appropriate referrals to HM Coroner; escalation to stage two mortality reviews and feedback.

Currently, one set of case notes is being scanned from University Llandough Hospital (UHL) to the ME office per day. From 1st June one set will be scanned from University Hospital of Wales (UHW) as well. By September 2021 it is expected that all hospital deaths will be reviewed by the ME. A business case is being developed to gain appropriate resources for this additional work. The Chief Medical Examiner and the Chief Medical Examiner Officer (CMEO) for Wales have praised the partnership working between the operational group and the ME office. The UHB is being sighted as an exemplar.

A gap in understanding of the 2019 rules for referring deceased to HM Coroner has been exposed throughout Wales. The rules were implemented to standardise the approach and to protect doctors, enabling them to fulfil their legal duties. Informal education via existing opportunities is being carried out by the CME.

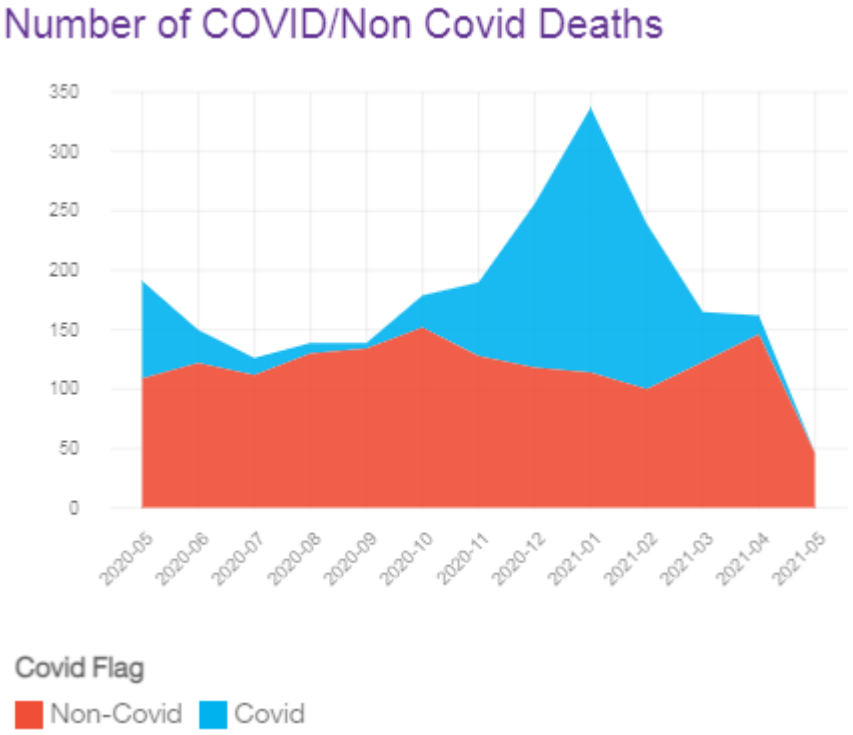
A process is established to receive to receive referrals back from the ME for a second stage review. MRG has developed a Stage 2 mortality review tool for use in the UHB. It has been adapted from the all-Wales tool and the Structured Judgement Review Tool. This is now being used for cases highlighted by the ME.

Stage two reviews are completed by MDTs led by nominated consultants. Findings should be discussed through the relevant Quality Safety and Experience committee structures and a copy of the review sent to the Organisational Learning and Quality Improvement team so that UHB-wide themes and trends can be determined.

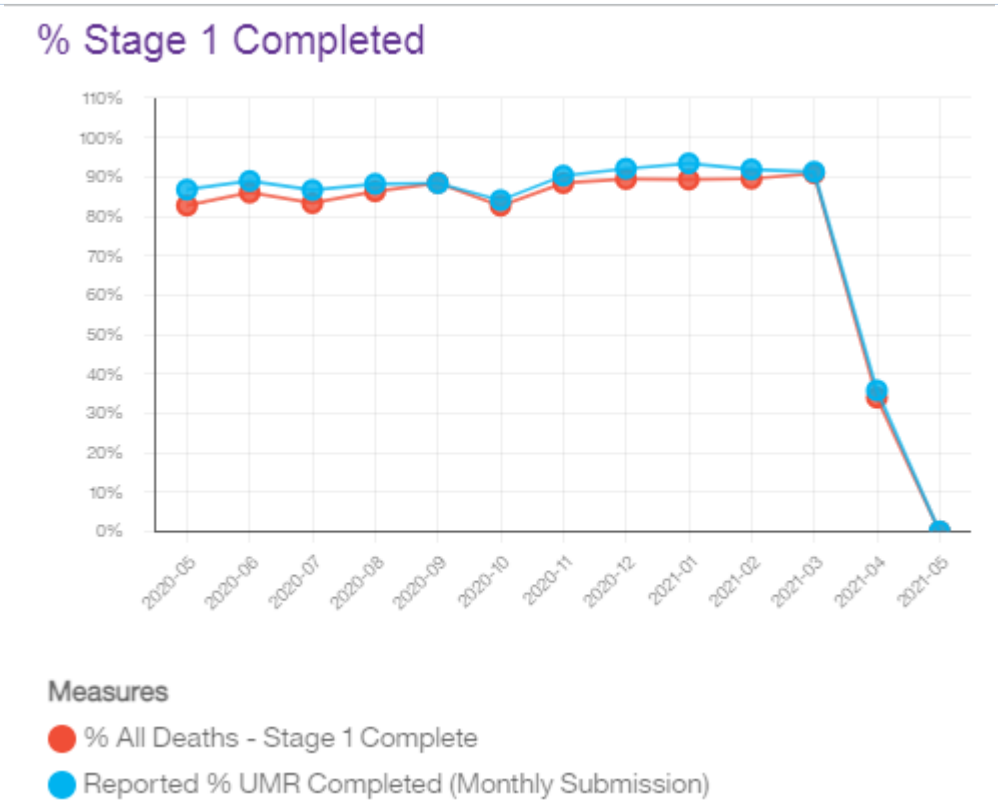
The UHB has an Electronic Mortality Audit Tool which was developed by our IM&T team. Data from this along with data from other sources feed into a mortality dashboard with a drill-down facility to individual patient records as well as performance data. A Datix Mortality module has been procured for Wales and will be implemented in due course. The full functionality of this has not been revealed yet.

At the last MRG an update was provided on the learning from hospital acquired COVID-19 deaths and an update on the changes to the Do Not Attempt Cardiopulmonary Resuscitation policy. DNACPR is a live policy that is adjusted to changes in clinical or legal circumstances as they emerge.

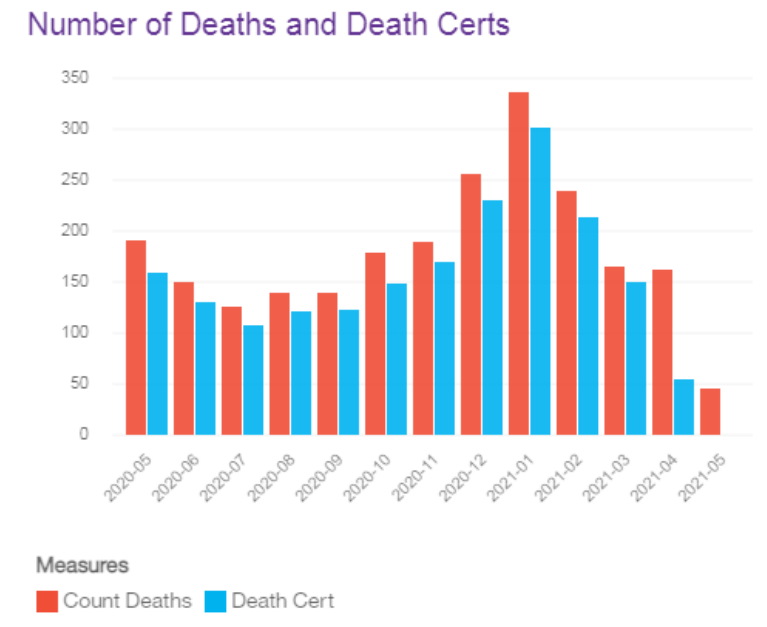
COVID-19 notwithstanding, the number of deaths/ the amount of joint work with the ME office is fairly predictable – as per the chart below.



Stage 1 mortality reviews were done by the doctor certifying the death. The ME office will gradually oversee a much more in-depth review which will include an interview with the bereaved family about the quality of care instead of the stage 1 reviews. Parallel processes are in place as we move from the in-house reviews to the ME. Reporting stage 1 compliance to Welsh Government has now ceased. The graph below shows stage 1 compliance – noting that data entry for April and May 2021 is incomplete.



The Bereavement office will continue to send details of the death certification so that this is still available electronically on the patient drill-down.



Student nurse placement in Patient Safety Department

The Patient Safety Team has been working in partnership with Cardiff University School of Nursing and has been accreddited as a Hub placement area for Student Nurses. This is the first of its nature in Wales. Student nurses will begin four week placements in the department as part of their training from May 2021.

Recommendation:

The Board is asked to:

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

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
Reduce health inequalities		Have a planned care system where demand and capacity are in balance	X
Deliver outcomes that matter to people	X	Be a great place to work and learn	X
All take responsibility for improving our health and wellbeing		Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
Offer services that deliver the population health our citizens are entitled to expect	X	Reduce harm, waste and variation sustainably making best use of the resources available to us	X
Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Outcome of Engagement on Shaping Our Future Clinical Services**								
Meeting:	UHB Board						**Meeting Date:**	27.05.21	
Status:	**For Discussion**	✓	**For Assurance**		**For Approval**	✓	**For Information**		
Lead Executive:	Executive Director of Strategic Planning and Executive Medical Director								
Report Author:	Programme Director, Strategic Clinical Redesign								

Background and current situation:
Redesigning the way we deliver our clinical services is fundamental in the delivery of the Health Board's vision for future care as set out in our Shaping our Future Wellbeing strategy. The clinical redesign programme to deliver this transformation – *Shaping our Future Clinical Services* - has been identified as an urgent priority for Cardiff and Vale University Health Board (UHB). Following discussion with the South Glamorgan Community Health Council (CHC), the Health Board undertook a seven week programme of engagement March – April 2021 to seek people's views on what is important in the redesign of our clinical services.

The attached Public Engagement Report describes the approach to engagement, provides an analysis of the feedback received, summarises key findings and provides responses to the comments received and proposed action that will be taken.

The CHC has received copies of all the feedback received and will determine its response to the engagement at a CHC Executive Committee meeting on 18th May 2021. A final Health Board position will need to take into account the views of the CHC.

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

The engagement was designed to explore views on key components of the Shaping Our Future Clinical Services programme as a part of the wider implementation of the UHB's Shaping Our Future Wellbeing strategy. The aim was to test and get feedback on our transformation ambitions as the start of an ongoing dialogue with the public, our staff and our stakeholders, fully recognising that specific service changes that are developed through the programme will require further engagement and/or consultation where there is a substantial change to the way we deliver services.

351 people responded to the engagement via an online survey. The CHC hosted four virtual public meetings (44 attendees) and the proposals were discussed at a range of external and internal stakeholder meetings. Of those who replied via the online survey, 92% strongly agree or agree that there is a need to transform some of our clinical services and 74% strongly agree or agree with the principles to transforming those clinical services.

A number of common themes emerged from the feedback received in response to the engagement questions and in other formats including comments made at the public and stakeholder events; the themes which appeared with most frequency were:

Right care, right place, right time

Communication
Digital transformation and technology
Quality
Organisation and integration of services
Physical access issues
Support for the Home First/Care closer to home concept
Workforce
Comments on specific services
Comments about primary care

The Public Engagement Report provides detail on all the themes identified, discussion of the issues raised under the theme headings, and the Health Board response to those issues.

We are grateful to all members of the public, staff, stakeholders and partners who have supported this engagement process and provided such rich feedback which we will continue to learn from and draw into the work of the programme. The contributions have provided insight from many perspectives on a range of topics and with be invaluable in shaping the next steps.

74% of respondents (213 individuals) indicated that they would be happy to be emailed about future pieces of engagement and consultation work, so we have opportunities to build on this dialogue and learn from their experience of our services and views about future configuration of clinical services.

We will use staff, stakeholder and partner feedback to build on the approach to working collaboratively and in partnership as part of the programme.

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

This engagement provided an opportunity to test a set of high level strategic principles underpinning our approach to transforming clinical services. The approach to engagement was designed with in collaboration with the South Glamorgan Community Health Council, led at Executive level by the Executive Medical Director and Executive Director of Strategic Planning and managed by the Shaping Our Future Clinical Services programme team.

Recommendation:
The Board is asked to:

- **NOTE** the content of the Shaping Our Future Clinical Services Public Engagement Report
- **CONSIDER** the views of the South Glamorgan Community Health Council, submitted directly by the CHC
- **APPROVE** the use of the engagement feedback to inform the implementation of the Shaping Our Future Clinical services programme

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	✓

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

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

Equality and Health Impact Assessment Completed:	The Assessment was an integral component of the documentation developed to support engagement and has been updated to reflect on feedback received during the engagement – Appendix F of the Engagement Report.

Shaping our Future
Clinical Services

Cardiff and Vale University Health Board

Public Engagement Report

April 2021

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

Contents

1. Executive Summary

Redesigning the way we deliver our clinical services is fundamental in the delivery of the Health Board's vision for future care as set out in our Shaping Our Future Wellbeing strategy. The clinical redesign programme to deliver this transformation – Shaping Our Future Clinical Services - has been identified as an urgent priority for Cardiff and Vale University Health Board (UHB). Following discussions with the South Glamorgan Community Health Council (CHC), the Health Board undertook a seven-week programme of engagement in March/April 2021 to seek people's views on what is important in the redesign of our clinical services.

This report describes the approach to engagement, provides an analysis of the feedback received, summarises key findings and provides responses to the comments received and proposed action that will be taken. The content of this report will inform the development of recommended next steps in the implementation of the Shaping Our Future Clinical Services programme that will be considered at the Health Board meeting on 27th May 2021. The CHC has received copies of all the feedback received and will determine its response to the engagement at a CHC Executive Committee meeting on 18th May 2021. A final Health Board position will take in to account the views of the CHC. The number of responses received is summarised below:

Number of Responses Received

Type	**Number**
Survey response	351
Responses received via email	5
Social Media	31
TOTAL	**388**

The engagement was designed to explore views on key components of the Shaping Our Future Clinical Services programme as a part of the wider implementation of the UHB's Shaping Our Future Wellbeing strategy. The aim was to test and obtain feedback on our transformation ambitions as the start of an ongoing dialogue with the public, our staff and our stakeholders, fully recognising that specific service changes that are developed through the programme will require further engagement and/or consultation.

351 people responded to the engagement via an online survey. The South Glamorgan Community Health Council hosted four virtual public meetings (44 attendees) and the proposals were discussed at a range of external and internal stakeholder meetings. Of those who replied via the online survey, 92% strongly agree or agree that there is a need to transform some of our clinical services and 74% strongly agree or agree with the principles to transforming those clinical services.

A number of common themes emerged from the feedback received in response to the engagement questions and in other formats including comments made at the public and stakeholder events; the themes which appeared most frequently were:

- Right care, right place, right time
- Communication
- Digital transformation and technology
- Quality
- Organisation and integration of services
- Physical access issues
- Support for the Home First/Care closer to home concept
- Workforce
- Comments on specific services
- Comments about primary care

The engagement has highlighted that people recognise the need to transform our clinical services and broadly support the underpinning principles for transformation. Ensuring that people have easy and timely access to the right clinician, who provides the right care and treatment, is fundamental to what people want and expect from their NHS - care that provides the right outcome for them as individuals. Transformation must have quality of care at its centre. Communication in plain language around what any changes are, how to access services and talk to clinicians is essential, as is communication between professionals in different parts of the care system.

There is much support for increasing the use of digital technology in service provision, with people citing good experience of accessing primary and secondary care services online during the pandemic. However, this is tempered with concern about those who may be digitally excluded and an emphasis on the need for alternatives being made available for those who are unable to access or use technology and the importance of continued opportunities for face-to-face consultations.

The engagement has also reinforced that transformation must develop around whole patient pathways that place the patient's wellbeing at the heart of what we are seeking to achieve, and that build greater integration and join-up of services within the NHS and with partner services. Comments about the future delivery of services in hospital and in the community, demonstrated the importance of enabling access to our facilities with a robust transport infrastructure and designing new buildings to be fully accessible to all.

Having a workforce with the capacity and training to deliver our transformation ambitions and who have buy-in to the plans is crucial to success, as is taking care of our staff. Clinicians from across different specialties are keen to get involved in shaping the programme and to share their ideas for how services could work differently in the future.

The body of this report provides detail on all the themes identified, discussion of the issues raised under the theme headings, and the Health Board response to those issues.

The Health Board will need to give careful consideration to the feedback received and the views of the CHC in determining its response to the engagement and agreeing a way forward.

2. Introduction

With our modern NHS facing a number of challenges and our population's needs changing, we must adapt the way we deliver care to meet these challenges and respond to opportunities for improved care. Over the next ten years, Cardiff and Vale University Health Board's Shaping Our Future Clinical Services programme will develop and deliver a plan for transforming the way our patients access clinical services in their homes, in the community and in hospital. This will also provide a foundation for our plans for developing our acute hospital infrastructure, including a renewed University Hospital of Wales (UHW), a hospital that will be state-of-the-art, more sustainable and energy efficient, offering outstanding care in an environment suitable for the mid-21st century.

This report describes work undertaken in collaboration with the CHC to engage with the people who use and deliver our services, to shape the early thinking underpinning this programme of work. It presents the feedback we have received during a seven-week period of engagement that ran 1 March to 19 April 2021, in which we described current challenges and our ideas about principles for service redesign. We invited people to share what is important to them about the way services are delivered in the future.

3. Background and Context

There are growing challenges facing our NHS. With a growing and ageing population, staff shortages and outdated hospital buildings, we recognise that we must change the way we deliver our care if we want to provide high-quality, safe and sustainable care for the future. The learning from having to manage and implement change at pace during the COVID-19 pandemic has reinforced the requirement for healthcare to transform as a whole system.

The Shaping Our Future Wellbeing strategy provides the context for everything that we do: for healthcare to be increasingly provided away from traditional hospitals and closer to people's homes; delivering outcomes that are important to people; providing standardised treatment, delivered efficiently; and supporting our population to lead healthy lifestyles and empower them to self-manage conditions where appropriate. This is also very much in line with the Welsh Government's strategy for health and care A Healthier Wales.

In order to support the delivery of our strategy and ensure we are fit for the future, the next step is to deliver a programme of clinical redesign. The Shaping Our Future Clinical Services programme will help to transform the way people access our clinical services in their homes, communities and in hospital, and inform the development of plans for our Shaping Our Future Hospitals programme, and our Shaping our Future Community Care programme. The programme is commencing at the same time as Welsh Government publish the National Clinical Framework, which has important implications for how our clinical services should develop and importantly how they fit into a wider learning health and care system as set out in A Healthier Wales.

4. Scope of Engagement

The engagement was designed to start a conversation, exploring views on key components of the Shaping Our Future Clinical Services programme as a part of the wider implementation of the UHB's Shaping Our Future Wellbeing strategy. The aim was to test and get feedback on our transformation ambitions as the start of an ongoing dialogue with the public, our staff and our stakeholders, fully recognising that specific service changes that are developed through the programme will require further engagement and/or consultation where there is a substantial change to the way we deliver services.

5. Approach to Communications and Engagement

A seven-week engagement period was undertaken from 1 March to 19 April 2021. Recognising the limitations of undertaking this work during the pandemic which prevented the use of typical face-to-face mechanisms for engaging with the public, the UHB worked closely with the South Glamorgan Community Health Council (CHC) to develop a blended approach to engagement. This was designed to draw on the learning and mechanisms for reaching people online which have evolved over the past year. While digital would naturally become a key area of our strategy, we also made sure that we leveraged opportunities to reach people who are not online. The approach included leveraging relationships with stakeholders and Third Sector organisations to broaden our reach as much as possible.

Our communication and engagement plan had the following key features:

Core elements	- Website as a hub for engagement (www.shapingourfuturewellbeing.com) - Survey form - Telephone number - Postal address - Engagement brochure and supporting documents (Including accessible versions such as Easy Read)
Staff updates	- All staff email/letter - Updates via Staff Connect app - Executive team videos - Banner CEO Connects COVID-19 Updates - Digital screen tiles and posters - Overview of programme in Ask Len Q&A session - Attendance and a number of staff group meetings
Stakeholder outreach	- Stakeholder letter - Communications Toolkit - Email to charities and Third Sector organisations - Attendance at a number of stakeholder meetings
Social media	- Promotion of public engagement events into community Facebook groups across Cardiff and the Vale - Facebook advertising - Ongoing social media posts - Promotion of animations (including BSL version) - Executive team videos - Presentation Video Premiere Facebook Live
Promotional assets	- Banner advert in Weekly CEO Connects newsletter - Banner on Cardiff and Vale UHB website home page - Digital screen tiles and posters around Health Board sites (including Mass Vaccination Centres) - A6 flyers distributed through Mass Vaccination Centres
Engagement events	- Public - Staff groups - Stakeholders and other organisations
Advertising	- Advertising package agreed covering digital, print and radio - Advertising package agreed for digital screens in supermarkets and shopping arcade
Content	- Translation of summary SOFCS document into top 5 languages in Cardiff and the Vale, cascaded through stakeholders and made available online - Part of 'Hope' section of Health Board COVID-19 One Year On campaign

Note: All content produced bilingually

The communications and engagement plan is attached as **Appendix A** and provides details of the key audiences and methods of communication and engagement adopted, and the meetings at which the programme was presented and discussed. A detailed insight into the communications and engagement reach will be provided to the CHC as a supplementary document.

The questions included in the Engagement Document (provided as **Appendix B**) and the online survey were as follows:

1. Do you agree with the challenges and opportunities we have set out in the 'Why do we need to transform our clinical services?'
   (Strongly agree, agree, neutral, disagree, strongly agree)
   Any further comments?

2. Do you agree that in order to meet some of our challenges and take advantage of opportunities we have set out, that there is a need to transform some of our clinical services?
   (Strongly agree, agree, neutral, disagree, strongly agree)

3. Do you agree with the principles we have set out in our approach to transforming clinical services?
   (Strongly agree, agree, neutral, disagree, strongly agree)
   Are there any others we should consider?

4. Are you supportive of the principles we have set out in the 'Which clinical services should we consider?' section?
   For Emergency and Urgent Care, for Elective Care, for Specialised Care
   (Strongly agree, agree, neutral, disagree, strongly agree)
   Any further comments?

5. Is there anything else we should consider when transforming clinical services, that we haven't thought of?

6. In your view, what are the most important aspects of your healthcare?
   - the distance I have to travel
   - seeing the right specialist
   - that it is timely
   - that it provides the best outcome for me
   - that it is delivered close to home where possible

7. If the way you receive care changes in the future, what are the most important things we need to consider I order to limit any negative impacts on your family/care givers?

8. How can we help you to ensure that more of our services can be delivered at home?

9. How would you feel about having the opportunity to receive some of your care via online technology where possible (e.g. virtual appointments from either home or a community facility)
   - I would be happy to, and have the ability to do so
   - I would be happy to but don't have access to the internet or facilities
   - I would not be happy to

10. When we are looking at the design of our hospitals for the future, what features would make your visit or stay better?

11. Are you happy to be emailed about future consultations?
    Details of the engagement, opportunities to learn more and how to share views were circulated widely to stakeholders at the start of the engagement period, with requests for their support in sharing the information within their networks and contacts. A stakeholder communications kit was provided to support this wider promotion of the engagement.

6. Mid-Point Review

A mid-point review meeting was held with the CHC on 24 March 2021 to consider the processes and responses to date and to agree any additional actions or change in approach needed for the second half of the engagement. A key focus in the discussion was how to support further engagement with those less able to get involved via online or digital routes.

Actions arising from the review:

- Additional mechanisms to increase the reach in the second half of engagement including:
  - Advertising via Capital radio, Spotify, SW Echo, Wales Online
  - Advertising in final two weeks in non-essential retail e.g. screens in Queen's Arcade and supermarkets
  - Translation and distribution of summary document in community languages, utilising links to community and faith groups established via COVID-19 work
  - Targeted engagement sessions with seldom heard voices via Diverse Cymru and Ethnic Minorities and Youth Support Team (EYST)
  - Hard copy leaflets to be made available in the Mass Vaccination Centres
  - Online staff event
  - Following up with those who signed up to public events with a reminder to complete the survey
  - Targeted social media aimed at those living in other Health Board areas

- Agreement not to hold a planned Facebook Live Q&A session aimed at the public during the pre-election period
- Check social media posts and comments to identify any feedback which should be included in considerations
- Agreement on post engagement process and key dates to enable the CHC position to be considered as part of the presentation on the outcome of engagement at the May UHB Board

7. Responses to the Engagement

The following feedback was received:

Type of Feedback	Number
Online response form	351
Emails	5
Public meetings	44 attendees
Stakeholder meetings	17 meetings
Social media posts	31

Comments made at the four public meetings were captured, verified by the CHC and considered in the analysis. The notes are provided as Appendix C. Key points made at stakeholder meetings were also considered in the analysis. It should be noted that everyone was also encouraged to complete individual response forms so there may be an element of duplication in the points captured in meeting notes and those made in response forms. A full copy of all the feedback received via the survey, meeting notes, social media and emails was shared with the CHC.

7.1 Key Themes Identified from Feedback

The engagement survey contained a mix of closed and open questions. A number of common themes emerged in the analysis of the feedback received via open questions in the survey, comments made at the public and stakeholder meetings, emails and social media posts. The CHC was involved in the agreement of these key themes which have been used as the basis of analysis of the qualitative feedback.

The key themes are set out below, with an indication of the number of times comments relating to these themes were mentioned in survey responses:

Theme	Responses across questions 1, 3-5, 7 & 8	Percentage
Right care, right place, right time	152	12%
Communication	125	10%
Digital Transformation and Technology	116	9%
Quality	103	8%
Organisation and Integration of Services	100	8%
Physical Access	90	7%
Support for the Home First/Care Closer to Home concept	80	6%
Workforce	79	6%
Comments on specific services	67	5%
Comments about Primary Care	60	5%
Scepticism about the programme	47	4%
Financial comments	35	3%
Comments relating to what services will be provided on which site and the rationale for those decisions	33	3%
Comments about Health Inequalities	30	2%
Role of clinicians	28	2%
Issues for the next steps of the programme	24	2%
Engagement Process	17	1%
Questions about the proposed location of buildings	12	1%
Environmental Impact	10	1%
Importance of adopting a preventative approach and public health programme	10	1%
Equality Issues	7	1%
Ideas for role of Wellbeing Hubs	5	0%
Dealing with the impact of COVID-19	5	0%
Design of buildings	2	0%

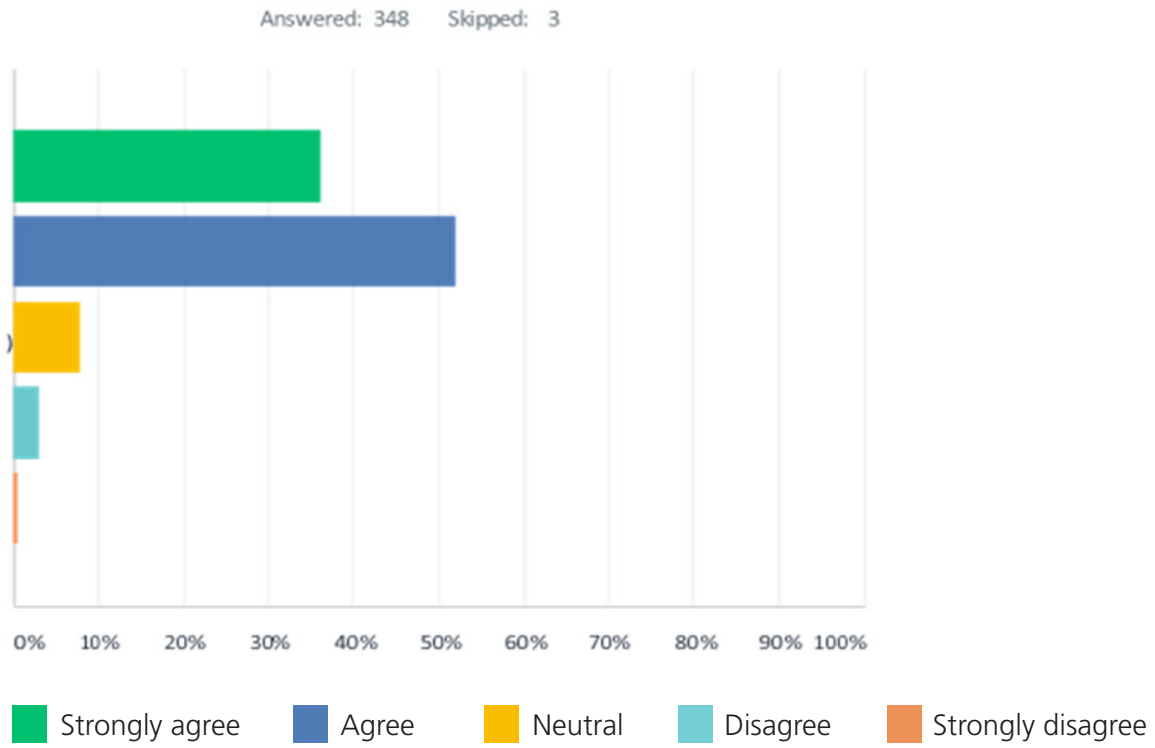
Given the breadth of the programme being explored through this engagement, and the open nature of some of the engagement questions, feedback touched on a huge range of issues under these key theme headings. Appendix D provides a breakdown of the issues raised under these themes, the detail of which will be used by the Programme Team to shape its work going forward.

Please note that while the 'Design of buildings' was a low scored theme overall, Q.10 in the survey specifically asked people to identify the features they would most like to see in the design of hospitals of the future; the feedback received to this question is set out in more detail in the next section.

7.2 Analysis of Online Survey Feedback

This section provides a breakdown of the responses to each of the questions in the survey.

1. **Do you agree with the challenges and opportunities we have set out in the 'Why do we need to transform our clinical services?'**



STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL
36.21%	52.01%	8.05%	3.16%	0.57 %	
126	181	28	11	2	348

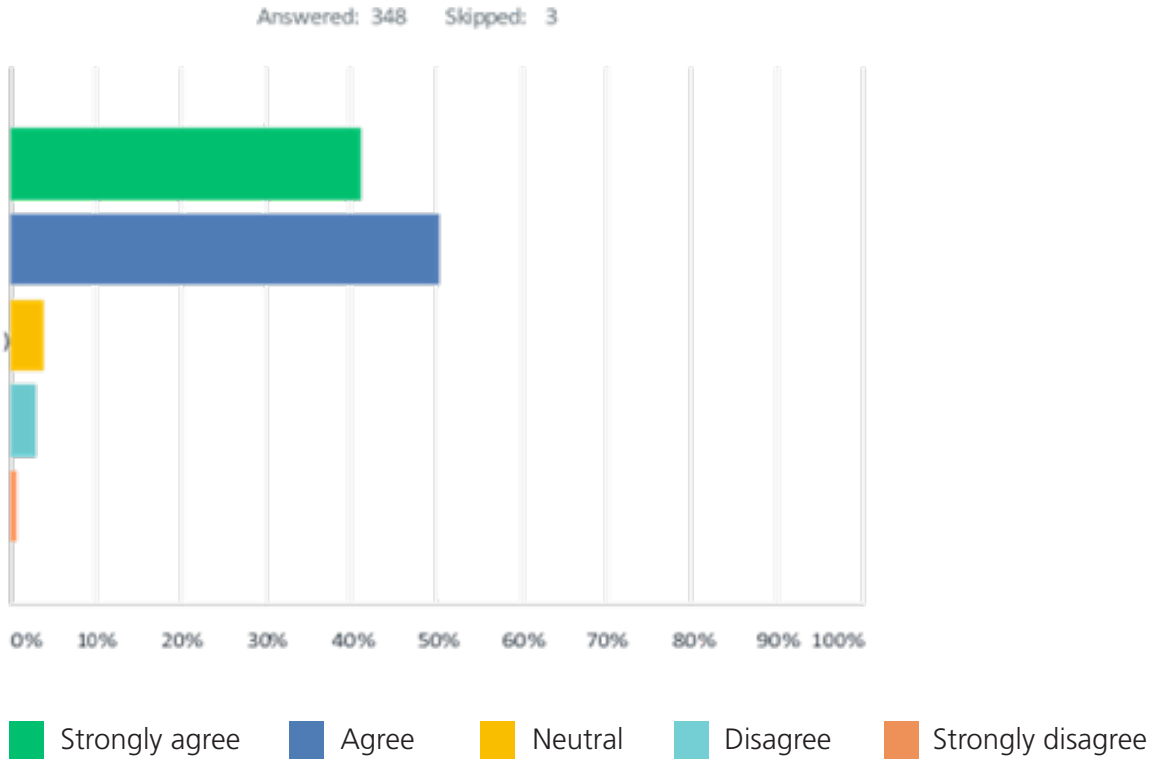
88.22% of respondents strongly agree or agree with the challenges and opportunities set out.

Any further comments?

The information from the 29 respondents who submitted data for this question was categorised 28 times against the key themes. The top 10 themes are shown below:

Themes for Question 1	Response	Percentage
Organisation and Integration of Services	6	21%
Workforce	5	18%
Comments on specific services	4	14%
Support for the Home First/Care Closer to Home concept	2	7%
Digital Transformation and Technology	2	7%
Engagement Process	2	7%
Financial comments	2	7%
Importance of adopting a preventative approach and public health programme	1	4%
Comments about Health Inequalities	1	4%
Ideas for role of Wellbeing Hubs	1	4%

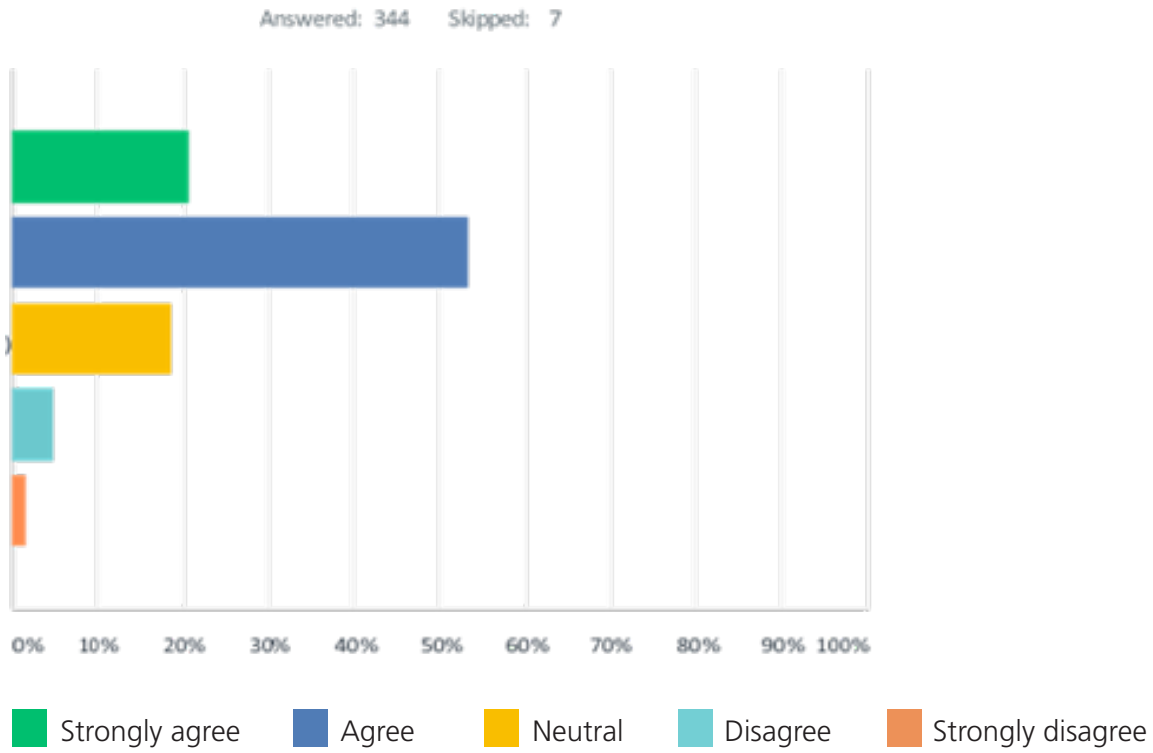
2. Do you agree that in order to meet some of our challenges and take advantage of opportunities we have set out, that there is a need to transform some of our clinical services?



STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL
41.38%	50.57%	4.02%	3.16%	0.86%	
144	176	14	11	3	348

91.95% strongly agree or agree that there is a need to transform some of our clinical services.

3. Do you agree with the principles we have set out in our approach to transforming clinical services?



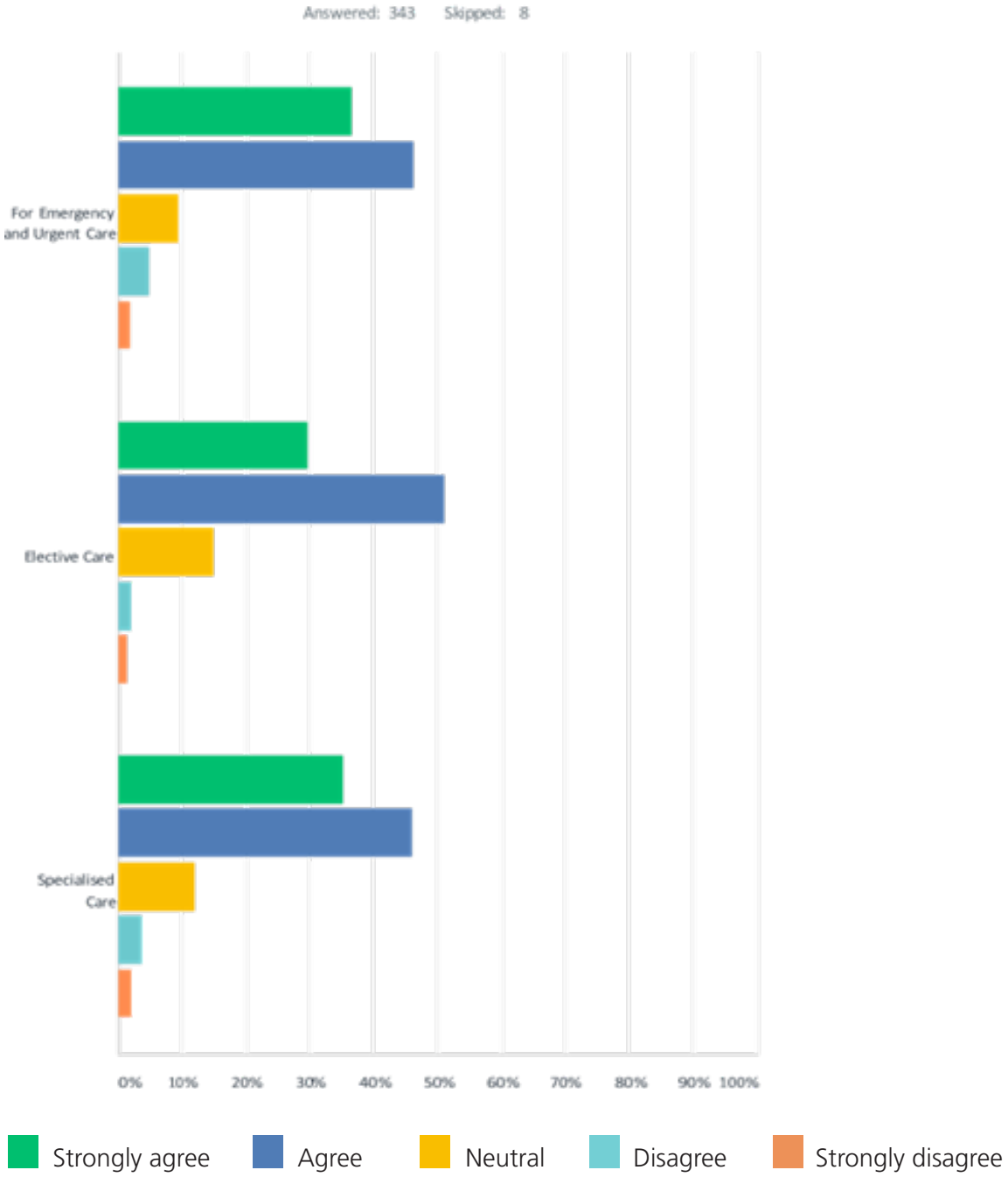
STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL
20.93%	53.49%	18.90%	4.94%	1.74%	
72	184	65	17	6	344

74.42% strongly agree or agree with the principles for transforming clinical services.
Are there any others we should consider?

The information from the 57 respondents who submitted data for this question was categorised 144 times against the key themes. The top 10 themes are shown below:

Themes for Question 3	Response	Percentage
Physical Access	18	13%
Organisation and Integration of Services	17	12%
Comments about Health Inequalities	15	10%
Quality	13	9%
Issues for the next steps of the programme	10	7%
Right care, right place, right time	8	6%
Financial comments	8	6%
Scepticism about the programme	8	6%
Comments relating to what services will be provided on which site and the rationale for those decisions	7	5%
Digital Transformation and Technology	6	4%

4. Are you supportive of the principles we have set out in the 'Which clinical services should we consider?'
For Emergency and Urgent Care, for Elective Care, for Specialised Care



STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	TOTAL
For Emergency and Urgent Care					
36.76%	46.47%	9.71%	5.00%	2.06%	
125	158	33	17	7	340
Elective Care					
29.94%	51.20%	14.97%	2.40%	1.50%	
100	171	50	8	5	334
Specialised Care					
35.40%	46.31%	12.09%	3.83%	2.36%	
120	157	41	13	8	339

83.23% strongly agree or agree with the principles in relation to Emergency and Urgent Care

81.14% strongly agree or agree with the principles in relation to Planned Care

81.71% strongly agree or agree with the principles in relation to Specialised Care

Any further comments?

The information from the 46 respondents who submitted data for this question was categorised 64 times against the key themes. The top 10 themes are shown below:

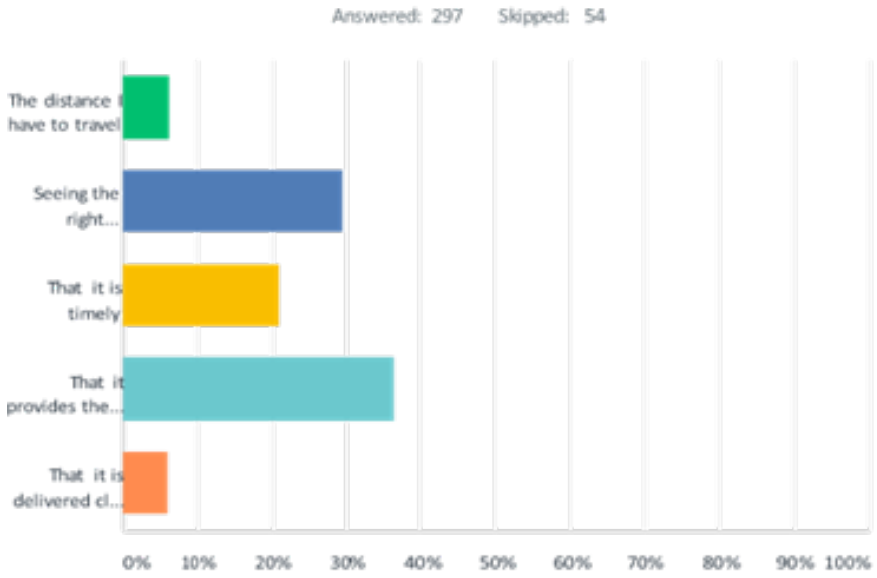
Top 10 themes for Question 4	Response	Percentage
Comments on specific services	12	19%
Right care, right place, right time	10	16%
Comments relating to what services will be provided on which site and the rationale for those decisions	6	9%
Organisation and Integration of Services	5	8%
Quality	5	8%
Support for the Home First/Care Closer to Home concept	4	6%
Workforce	4	6%
Comments about Health Inequalities	3	5%
Communication	3	5%
Scepticism about the programme	3	5%

5. Is there anything else we should consider when transforming clinical services, that we haven't thought of?

The information from the 134 respondents who submitted data for this question was categorised 159 times against the key themes. The top 10 themes are shown below:

Top 10 themes for Question 5	Response	Percentage
Comments on specific services	24	15%
Digital Transformation and Technology Issues	22	14%
Physical Access	19	12%
Organisation and Integration of Services	19	12%
Workforce	13	8%
Comments relating to what services will be provided on which site and the rationale for those decisions	10	6%
Communication	8	5%
Scepticism about the programme	8	5%
Environmental Impact	6	4%
Financial comments	5	3%

6. In your view, what are the most important aspects of your healthcare?



ANSWER CHOICES	RESPONSES	
The distance I have to travel	6.40%	19
Seeing the right specialist	29.63%	88
That it is timely	21.21%	63
That it provides the best outcome for me	36.70%	109
That it is delivered close to home where possible	6.06%	18
TOTAL		**297**

The most important aspect of healthcare identified by the respondents to the survey was 'that it provides the best outcome for me', followed by 'seeing the right specialist'.

7. If the way you receive care changes in the future, what are the most important things we need to consider I order to limit any negative impacts on your family/care givers?

The information from the 255 respondents who submitted data for this question was categorised 291 times against the key themes. The top 10 themes are shown below:

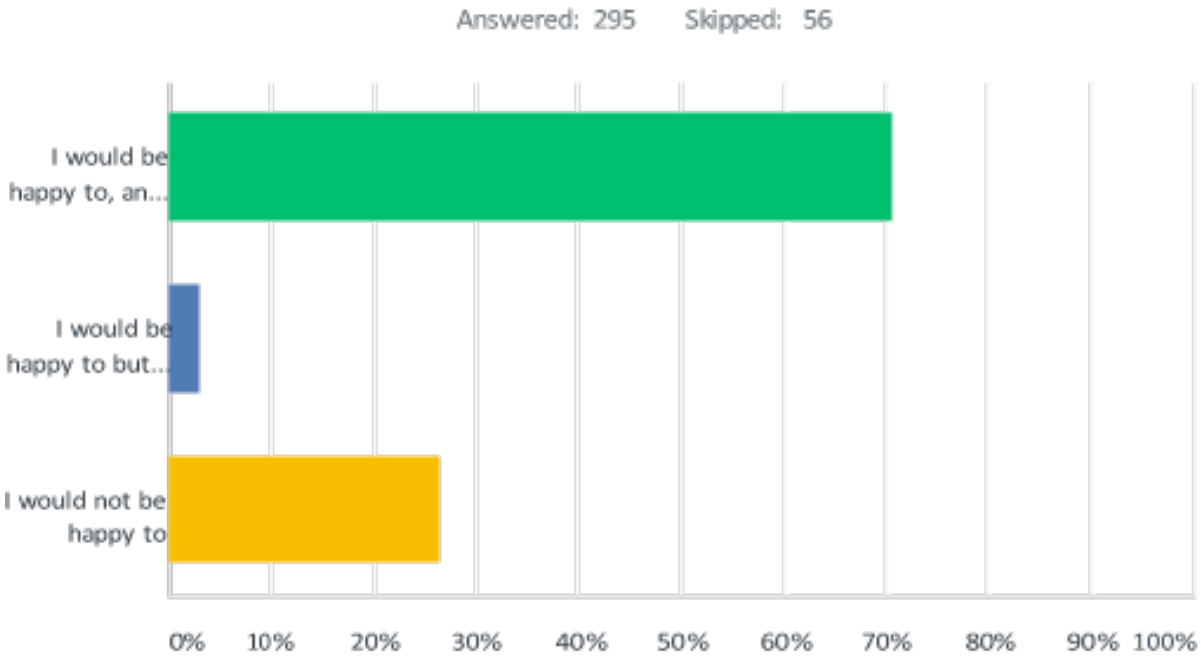
Top 10 themes for Question 7	Response	Percentage
Right care, right place, right time	89	31%
Communication	45	15%
Quality	44	15%
Physical Access Issues	36	12%
Support for the Home First/Care Closer to Home concept (more services being delivered in the home, primary care or in the community)	12	4%
Comments about Primary care	11	4%
Digital Transformation and Technology Issues	8	3%
Scepticism about the programme	8	3%
Organisation and Integration of Services	7	2%
Workforce Issues	6	2%

8. How can we help you to ensure that more of our services can be delivered at home?

The information from the 246 respondents who submitted data for this question was categorised 551 times against the key themes. The top 10 themes are shown below:

Top 10 themes for Question 8	Response	Percentage
Digital Transformation and Technology Issues	77	14%
Communication	63	11%
Support for the Home First/Care Closer to Home concept (more services being delivered in the home, primary care or in the community)	55	10%
Workforce Issues	47	9%
Organisation and Integration of Services	46	8%
Right care, right place, right time	45	8%
Quality	41	7%
Comments about Primary care	38	7%
Role of clinicians	21	4%
Scepticism about the programme	20	4%

9. How would you feel about having the opportunity to receive some of your care via online technology where possible (e.g. virtual appointments from either home or a community facility)



ANSWER CHOICES	RESPONSES	
I would be happy to, and have the ability to do so	70.85%	209
I would be happy to but don't have access to the internet or facilities	3.05%	9
I would not be happy to	26.78%	79
Total Respondents:		**295**

10. When we are looking at the design of our hospitals for the future, what features would make your visit or stay better?

Question 10 was very specific around the design of buildings and therefore had very different responses from the other questions. The responses to this question were therefore analysed separately so that the richness of information was not lost in the main key themes. Feedback from this question will be used to inform the development of our estate including the planning of UHW2.

The top 10 themes are shown below:

Top 10 themes for Question 10	Response	Percentage
Parking (cars/bikes etc)	70	13%
Privacy & dignity	53	23.5%
Clear, easy and efficient layout which is easy to navigate for all, accessible	44	31.9%
Open, light and airy, space	43	40.2%
Cleanliness & Hygiene	31	46.1%
Quality Care (timely, coordinated, effective, compassionate)	29	51.6%
Patient facilities (showers, toilets, communal seating areas, entertainment)	28	57.0%
Transport Links/Easy access/convenient location/closer to home	28	62.3%
Ambience, quiet, modern & comfortable	27	67.5%
Facilities and support for visitors and visits	25	72.3%

11. Are you happy to be emailed about future consultations?

213 respondents indicated that they were happy to be emailed about future consultations (74%).

Survey Respondent Type

In order to assess the public reach of the engagement, respondents to the survey were asked if they were a member of Cardiff and Vale UHB staff. Unfortunately, due to an error, this question was only included after the engagement had been running for two weeks; the first 65 respondents did not have the opportunity to share this information.

Of the 209 respondents who were given the opportunity to share this information, 80% (168) did not identify themselves as employees of the Health Board and 20% (41) identified themselves as an employee of Cardiff and Vale UHB staff.

Geographical Profile of Respondents to the Survey

Health Board	Responses	Percentage
Cardiff	147	42%
Not provided	109	31%
Vale of Glamorgan	76	21%
Other Areas (1 from outside of Wales)	22	6%

42% of respondents to the survey identified themselves as residents of Cardiff; 21% from the Vale of Glamorgan. 31% of respondents did not provide details of their area of residence. 6% were from other areas.

Demographic Profile of Respondents to the Survey

The survey included a series of questions designed to help us understand the reach of the engagement. **Appendix E** provides a detailed breakdown of the profile of respondents based on the responses to the equality monitoring questions included in the survey. This data is currently being analysed in more detail to better understand which sections of our community we have been less successful in reaching during this engagement, so that we can learn from this exercise and consider ways to increase and improve our reach for future work.

7.3 Other Feedback

Public Meetings

The CHC hosted four public meetings via Zoom, with simultaneous Welsh translation available. Each meeting adopted the same format of an introduction and welcome from the CHC and the Chair of the UHB followed by a presentation by the UHB and then an open Q&A session chaired by the CHC. A total of 44 people attended the meetings which were held as follows:

8 March	North and West Cardiff (2 attendees)
10 March	Central, South and East Cardiff (11 attendees)
22 March	Eastern Vale (14 attendees)
24 March	Central and Western Vale (17 attendees)

A separate meeting for Central Vale had been scheduled for 30th March but due to the pre-election period commencing on 25th March, a decision was jointly taken by the UHB and CHC to merge the Central and Western Vale meetings. The notes of the public meetings are available as **Appendix C.**

Attendees were also asked to submit individual responses to the survey. The issues raised in the public meetings were representative of many of the themes identified in the survey feedback. They have been reflected in the discussion under the themes in section 8 of this report, with an overview provided below.

There were many comments made that indicated support for the direction of travel, particularly the principles of more services being provided in the community and enabling people to receive their care closer to home, and recognition that our current hospital estate was no longer fit or purpose.

Attendees were interested in the proposed location of UHW2 and the Wellbeing Hubs, seeking clarity on the rationale for what services would be provided where and sharing ideas for the role the Hubs could play in supporting wellbeing. The importance of developing a robust transport infrastructure to support access to all our facilities was highlighted at several meetings.

There were a number of comments about the need to address inequalities, many of which had been exposed more clearly by the pandemic, and concern that increasing the provision of services through the use of technology might serve to widen existing inequalities. At the same time, several attendees shared their personal good experience with online consultations.

The meetings provided an opportunity to clarify that while the overall Shaping Our Future Wellbeing strategy covers the development of all the care provided by the Health Board, including public health and preventative work, the focus of this engagement is on clinical services. Questions about the way the Health Board is working with neighbouring Health Boards were raised as well as the impact of COVID-19 on service provision and the financial feasibility of funding the programme in the context of the cost of responding to the pandemic.

There were some concerns raised about the appropriateness of engaging during the pandemic and questions about how people could get involved who did not have access to technology.

Stakeholder Meetings

In addition to the public meetings, the clinical and programme leads took a presentation and discussion to a range of external and internal stakeholder meetings. The introductory letter circulated widely to stakeholders at the start of the engagement offered the option of specific meetings on request as well as details of the scheduled meetings. The details of the stakeholder sessions that took place are set out in the table below.

9 March	UHB Volunteers
10 March	UHB Occupational Therapy Leadership Meeting
10 March	Vale of Glamorgan Council all member briefing session
11 March	UHB Senior Workforce and OD Transformation Meeting
11 March	Youth Board, Cardiff Youth Council and Vale Youth Forum
15 March	SE Wales Regional Optical Committee
16 March	Cardiff Public Services Board
16 March	Bro Taf Local Dental Committee
17 March	UHB/Community Pharmacy Operational Group
17 March	UHB Nursing and Midwifery Board
22 March	Third Sector organisations (organised by Cardiff Third Sector Council, Glamorgan Voluntary Services and Cardiff and Vale Action for Mental Health)
23 March	UHB Stakeholder Reference Group
23 March	Joint meeting of Cardiff and Vale 50+ Forums
6 April	CHC Aneurin Bevan Planning Committee
13 April	Cardiff Council Senior Management Team
14 April	Ethnic Minority and Youth Support Team Wales (EYST)
19th April	UHB Local Partnership Forum

Attendees were also asked to submit individual responses to the survey. Notes of all the meetings have been shared with the CHC. The themes and issues raised by stakeholders were largely similar to those raised through the other engagement routes. They have been reflected in the discussion under the themes in section 8 of this report, with an overview provided below.

While welcoming the direction of travel and ambitions of the programme, external stakeholders additionally highlighted the importance of working with partners in the public and third sectors to tackle the wider determinants of health and to adopt a more preventative approach, as well as to deliver care in a joined-up system that supported continuity of care. There were also strong messages encouraging the Health Board to involve patients and carers in co-designing services.

A strong theme emerged about balancing the opportunities for widening access through the use of technology while ensuring that the needs of those who don't have access to technology are accommodated in future plans and that issues around data protection are considered.

Comments about access focused on the importance of a robust public transport system to support access to our facilities and issues relating to parking. The impact of the pandemic was another issue raised, with comments about the backlogs in elective surgery, the reluctance of people to visit services or use public transport during the pandemic and the impact that had had on early detection of cancer. Several attendees queried the cost of the proposals, how it would be resourced and how it might be affected by shortages in some clinical professions.

Some stakeholders highlighted their involvement in existing projects to develop Wellbeing Hubs and identified the potential role of community and third sector organisations in such developments. A concern was expressed about whether three Hubs in the Vale was sufficient to meet the needs of the more dispersed communities in the Vale of Glamorgan.

Discussions internally provided an added perspective around the potential role different professions might play in the future, the need to look flexibly at the skills required and the desire for staff to be involved in the programme as it develops. There were also concerns about the capacity of staff to manage change in the wake of the pandemic. In addition, there were comments about the opportunities for learning from elsewhere and the importance of integrating staff wellbeing into the programme.

Emails

14 emails were received via the Engage.Cav@wales.nhs.uk email address. 5 of the emails provided feedback on the programme; the remainder contained requests for more detail about how to get involved, copies of resources or expressed individual interest in getting involved in future work. Emails providing organisational responses to the engagement were received from Community Pharmacy Wales, Glamorgan Voluntary Services and the Vale 50+ Forum. Copies of all the emails, anonymised where appropriate, were shared with the CHC. The comments in the emails have been reflected in Section 8 of this report under the relevant themes.

Social Media

The comprehensive social media programme supporting the engagement included regular posts about different aspects of the proposals, mainly through Twitter and Facebook. 31 comments were posted and reviewed, largely echoing the themes already identified. Feedback included concerns about the impact of COVID-19 on waiting lists, about accessing services, the location of UHW2 and Wellbeing Hubs, as well as parking and digital technology not being suitable for everyone. Other comments demonstrated praise for the proposals outlined.

It is important to note that 'reactions' to social media posts were extremely positive with overwhelming support shown through the use of 'like' or 'love' reactions. It is widely accepted that only the most vocal proportion of social media users comment on social media posts, similar to contributions seen at public events.

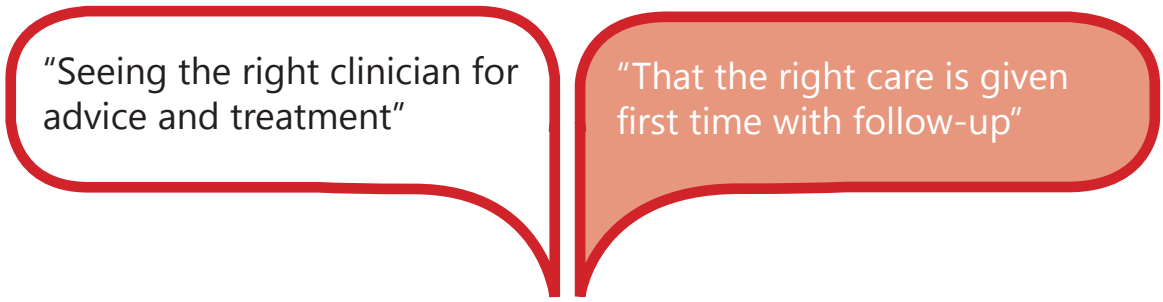
8. Consideration of Engagement Responses: UHB response, action and mitigation

This section provides an analysis of each of the key themes that have emerged through the engagement, with a commentary regarding our response to the comments received and further action that will be taken. **Appendix D** provides a more detailed breakdown of the main issues raised under these key themes, the detail of which will be considered and used by the Programme Team to shape its work going forward.

8.1 Right care, right place, right time

This key theme was the most popular theme having been identified 152 times within the respondents' feedback to the survey, 12% of all the instances when a key theme was identified within the text.

This was a theme that emerged strongly particularly in response to Question 7 about the most important things to consider to limit any negative impacts if changes are made to the way people receive care in the future. Respondents emphasised the importance of ensuring that they could get easy and timely access to the most appropriate clinician when they needed to. There were views expressed about how being able to see the right person and have the right tests and investigations done at the first visit, would reduce the need for repeat visits, and that providing a mix of online consultations and face to face visits could help to make access easier for patients. Several responses mentioned concern about waiting times, emphasising the importance of timely access to treatment required.



UHB response, actions and mitigations

We consider this to be a very important issue. It is a key principle in the design of future care pathways in which patients are directed to the right service according to agreed, integrated pathways. Furthermore, clearly defining and protecting care pathways will ensure that patients are seen in the most appropriate place and experience a more efficient process, e.g. investigations being done before seeing a specialist.

The Health Board also agree that this is an important means of improving waiting times: clear separation between "Planned and Elective Care" pathways and Urgent and Emergency pathways gives us the opportunity to reduce the impact of the latter on waiting times, delays and cancellations (as well as clinical risk). This has been an important element of our response to the COVID19 pandemic (e.g. the Protected Elective Surgical Unit).

8.2 Communication

This key theme was the second most popular theme in the survey responses having been identified 125 times within the respondents' feedback, 10% of all the instances when a key theme was identified within the text.

Providing clear guidance on how to access services, including emergency care, and navigate the health system was identified by a number of respondents. In considering changes to the way people might access clinicians or treatment, people highlighted the need to give clear advice to support people to understand what the changes were and what they would mean for patients, in a simple way that everyone can understand.

> "I don't mind being on a waiting list if I am at least told about it and reassured"

> "If services are transforming or changing, there needs to be much more communication to the public"

There were also comments about making it easy to speak to the right person and to understand what is happening in your care.

There were also some comments about ensuring effective communication between professionals across specialisms and across geographical areas.

UHB response, actions and mitigations

The Health Board recognise that this is a key area for development and improvement as a part of the redesign of clinical services.

We acknowledge the challenge of coordinating care for patients who are under the care of multiple specialist teams. Joining up care across different teams and organisations is a key principle of the Shaping Our Future Clinical Services programme and will be key to our approach in pathway redesign.

We agree that patient's being at the centre of the planning of their treatment and care plan is central to achieving the outcomes that matter to people, and that effective communication about where people are on their care pathway is very important. We will be involving patients and carers, as well as patient representative groups, in the redesign program and inviting their views on the best and most inclusive methods of keeping patients well informed about their "home to home journey" as partners in their healthcare. This will be improved through the development of 'patient held records' ensuring that patients have access and ownership of their health care records.

We have also heard from patients with long term conditions that they want more proactive ways of communicating with their clinical teams, hence we are exploring new means of doing this including the use of digital apps and questionnaires that specifically measure a patients view of their health status and outcome as well as those that measure their experience (PROMS and PREMS).

In terms of the development of the Shaping Our Future Clinical Services programme and others, we have embarked on an extensive engagement programme to support these changes as they develop and have committed a dedicated team to ensure ongoing communication and engagement with the public, our staff and stakeholders throughout the process.

8.3 Digital transformation and technology

This key theme was the third most popular theme having been identified 116 times within the respondents' feedback to the survey, 9% of all the instances when a key theme was identified within the text. It was also a theme that was raised in many of the public and stakeholder meetings.

Many people expressed their support for more services to be provided virtually or using digital technology and as the response to Q. 9 in the survey indicates, many welcome the opportunity to receive more of their care via online technology. However, many people also voiced concern that those who are unable to use technology because of cost, ability, lack of confidence or other barriers, could be disadvantaged. For those who could be digitally excluded by the increasing use of this type of technology, respondents emphasised the need to retain the option of face-to-face contact, to recognise the limitations of online consultations and for advice and support to be provided to enable more people to access and use technology as one of the ways to receive their care. The needs of patients with hearing or sight loss were highlighted.

There were also some comments from staff around the need for specialist expertise and capacity to be available to support the digital and technology infrastructure of the UHB as an organisation, across hospital and community settings.

"Don't lose the human element of care in the evolution of services"

"E consult is brilliant in primary care, this should be extended to secondary care clinicians"

"Consider the needs of those less tech savvy (e.g. the elderly) when making access and services more digital. The challenges presented by these may alienate some and negatively impact on their care"

"It is a waste of time sitting in an outpatient clinic waiting to be called, there should be greater use of video consults"

UHB response, actions and mitigations

We recognise the importance of harnessing and maximising the benefits of the digital healthcare revolution (some of which are mentioned in the engagement feedback – convenience, efficiency, safety), whilst taking care to retain the "human element" and clinical contact that is crucial to holistic patient care. Central to this is patient choice and offering high quality services through pathway design, recognising that this cannot be delivered with a one size fits all approach and ensuring that we, together, craft an individual response to how we deliver care for patients ensuring this is accessible.

We have learned from the experience of using certain digital technologies during the COVID19 pandemic. We are currently considering the positive and negative impact of this experience and ensuring that this is a consistent approach between our COVID recovery programme and Shaping Our Future Clinical Services.

We have already commenced engagement with 'harder to reach" stakeholder groups to hear their views, listens to their concerns and get their advice on minimising any negative impact of the projected widespread adoption of new technologies across global healthcare systems.

The Health Board is strengthening its approach to its digital infrastructure. Importantly, this is being jointly led by a clinician, with a strong focus on clinical benefit and patient-centred care. Our Digital Transformation programme is closely linked to the Shaping Our Future Clinical Services programme.

8.4 Quality

This key theme was identified 103 times within the respondents' feedback to the survey, 8% of all the instances when a key theme was identified within the text.

Another theme that emerged particularly in response to Question 7 (about the things to consider to limit any negative impacts if changes are made to the way people receive care in the future) focused on quality. Echoing the responses to Question 6 which asked people to identify the most important aspects of their healthcare, respondents highlighted that ensuring people had the best outcomes possible was a priority and that any changes to the way services are delivered should not compromise quality of care. Ensuring that there was a high quality of care for the elderly was mentioned in a few responses.

Some responses shared comments on their own experience of our services.

"Quality of care and patient safety"

"I have only stayed for short periods in hospital, and have found the care and attention I personally received has been excellent"

UHB response, actions and mitigations

The Health Board agrees that quality of care and patients, carers and families experience of their care is of paramount importance.

Integral to the redesign of services will be careful review of best practice, alignment to national standards and rigorous benchmarking. We regard monitoring of clinical outcomes as crucial and Quality and Safety standards will be embedded within care pathways.

Importantly, we support the principles of Value Based Healthcare in which "outcomes that matter to patients" are an equally important marker of quality of care. For this reason, we will be developing this approach within the design of the programme and will include Patient Report Outcome Measures (PROMS) and Patient Reported Experience Measure (PREMS) as key deliverables within pathway design.

8.5 Organisation and integration of services

This key theme was identified 100 times within the respondents' feedback, 8% of all the instances when a key theme was identified within the text.

Many comments were made about the importance of considering the whole patient pathway and ensuring that services and professionals are working in a joined-up and integrated way across the health and care system. The opportunity for working with Third Sector organisations who support people with specific medical conditions was also highlighted. The need for services to be organised in a way that enabled treatment of the whole person and their overall wellbeing was emphasised alongside a call for continuity of care. This was echoed in calls for the UHB to work closely with neighbouring Health Boards, particularly in meeting the needs of those living near the borders.

There was also a plea that in making changes to services, we must look at the impact on other services, to ensure the implications for the whole service model are considered and that resilience must be built in to cope with surges in demand.

The importance of developing pathways for frail older people was mentioned as well as opportunities for linking more closely with care homes as a means of reducing hospital admissions. Similarly, work with the Ambulance Service to help avoid admissions to hospital was also identified.

"Integrate and further link up clinical and social services by attaching them to Cardiff and Vale hubs."

"Very overwhelming for patients when they have a lot of professionals involved in their care and for individuals who have a number of health needs"

A number of comments were also made, particularly in the stakeholder discussions, about the opportunities for working more closely with other public and third sector partners, building on collaborative work that has strengthened during the pandemic.

UHB response, actions and mitigations

These are extremely important issues.

Pathways for frail older people is being given particular attention within the Shaping Our Future Clinical Services programme. It is a designated cross cutting theme, to ensure that the issues highlighted here (and by others) are addressed specifically across all pathways. This will also ensure that we work closely with appropriate 3rd parties, including integration between Health and Social Care. We anticipate particular benefits to the frail, older population as part of our Shaping our Future Community Care programme, which includes Wellbeing Hubs and will continue to work closely as a part of the Regional Partnership Board to develop services locally.

The Health Board has signalled its intent to work closely with neighbouring Health Boards, both in terms of patients who live close to boundaries, as well as in our role as a provider of specialist, regional services. Work that was commenced prior to the pandemic, as part of our Tertiary Service Strategy, is being incorporated into the Shaping Our Future Clinical Services programme and will inform the development of Regional and Specialist care pathways.

Working in partnership and seamless integration of services are two of the design principles of the Shaping Our Future Clinical Services programme, reflecting the intent set out in our Shaping Our Future Wellbeing strategy.

8.6 Physical access

This key theme was identified 90 times within the respondents' feedback to the survey, 7% of all the instances when a key theme was identified within the text. It was also a theme that emerged strongly from discussion at meetings.

A frequent comment or question focused on the need for there to be a good transport infrastructure to support easy access by road or public transport to our hospital and community facilities, and that this needed to be taken into consideration when looking at locations for new sites, working with local authority colleagues. The availability of parking was also raised as well as support for adopting an Active Travel approach.

A number of people highlighted the importance of ensuring that the needs of older people and people with disabilities was considered in planning the layout of sites, access to buildings, and the design of buildings themselves. Specific comments about access made in the response to the question about the design of our hospitals for the future included the need for diagnostics to be close to entrances to avoid people having to walk long distances through hospital corridors, the need for reliable lifts or escalators and good signage within buildings.

"Parking for patients and bus services"

Khan Raj 05/20/2021 15:17:34

"Need to think of sustainable travel which is really difficult to Llandough or Whitchurch/ Velindre from most of Cardiff"

UHB response, actions and mitigations

The UHB are required under law to reduce our carbon footprint. As a member of the Public Service Board are fully committed to our role in tackling the climate emergency.

We have been developing a new traffic management systems for our hospital sites as part of a wider Sustainable Travel Plan. Strict criteria for staff parking have been introduced and the UHB encourages staff and visitors to use alternative means of travel such as the park and ride scheme and public transport. This has resulted in reduced congestion on our main sites and has freed up parking spaces for visitors.

More recently, with an increased number of outpatient appointments taking place virtually an initiative to ensure the amount of time patients are waiting in the emergency department at UHW has resulted in fewer trips to hospital for many patients and reduced congestion.

Access will be a key consideration in the design of any new hospital or community building and will be subject to further engagement.

The Health Board is working with both Cardiff and the Vale of Glamorgan councils to develop plans for enabling more people to use sustainable travel options to access services and come to work. This is necessary as part of our commitment to achieving carbon zero services, as detailed in our Sustainability Action Plan.

8.7 Support for Home First/Care Closer to Home concept

This key theme was identified 80 times within the respondents' feedback, 6% of all the instances when a key theme was identified within the text.

There was a great deal of support expressed both in the survey and in the meetings for the concepts of Home First and Care Closer to Home, with many people welcoming the ambition for more services to be provided in their homes, in primary care or in community facilities such as Health and Wellbeing Centres and Wellbeing Hubs. There were a small number of comments raising concern that the vision for more services to be provided in Hubs, which might include some primary care services, indicated a plan to centralise GP services, which was not supported.

UHB response, actions and mitigations

We are very encouraged by the support received for the 'home first' concept and will take on board the concerns about the services being offered in Wellbeing Hubs. We recognise the importance of working with local people who use our services when planning where future services and facilities are located.

This work forms part of the Shaping our Future Community Care programme – the involvement of GP services and Primary and Community Care teams is integral to this. Acknowledging the importance of primary care in integrated health pathways, we are hopeful that this will be one way in which GP services, including the wider multi-disciplinary team are supported and strengthened.

8.8 Workforce issues

This key theme was identified 79 times within the respondents' feedback, 6% of all the instances when a key theme was identified within the text.

There were a range of different comments emphasising that the success of the programme would depend on there being sufficient staff with the right skills and training to deliver the proposed models of care. In response to the question about how we can enable more care to be provided in the home, some people commented on the need for there to be more staff available 24/7 in the community.

"If the aim is 'hospital at home' or rehabilitation at home, these services need to be staffed to provide just that."

Some comments focused on the importance of staff buy-in to the plans, and the role that Trade Unions could play in facilitating discussions about change. There were a few concerns raised that the pandemic might have a detrimental impact on the capacity of staff to manage change. The importance of building staff wellbeing into the programme was highlighted as well as increasing opportunities for flexible working and improving working conditions as factors affecting staff retention.

"Retaining and looking after staff"

"Transformation will only succeed if staff are motivated"

Comments from staff emphasised the role that different clinical professions could play within the programme and the need to look flexibly at staff skills across the workforce.

Comments from staff emphasised the role that different clinical professions could play within the programme and the need to look flexibly at staff skills across the workforce.

UHB response, actions and mitigations

This is valuable feedback and supports the view that we highlighted in our engagement document and presentation: workforce issues - such as those highlighted above - are amongst the most serious drivers for change, major challenges that will need to be met, but also an area of opportunity for positive change.

Given its importance, Workforce transformation has been identified as a cross cutting programme that will be integral to the design and delivery of clinical services in the future.

A plan for continued staff engagement is being developed with the support of the Local Partnership Forum which is the formal mechanism for the Health Board and Staff Representative Bodies/ Professional Organisation Representatives to work together to improve health services.

8.9 Comments on specific services

This key theme was identified 67 times within the respondents' feedback, 5% of all the instances when a key theme was identified within the text.

The open nature of many of the questions allowed people to share their views on a wide range of issues of which they had personal experience. Question 5 in particular, which invited people to highlight anything else we should consider when transforming clinical services, elicited a number of individual comments relating to the priority that should be given to improvement and development of specific services. Mental health services and services for children and young people were the service areas which were mentioned the most frequently. The full range of those services mentioned in individual responses is included in **Appendix D**, which sets out the key issues raised under each of the main themes.

"More emphasis on mental health services"

UHB response, actions and mitigations

The next phase of the SOFCS programme will involve working with individual clinical teams to develop their future care pathways. We will need to consider the feedback and comments on specific services, as well as seeking the views of relevant patient representative groups, as part of this process.
We mentioned mental ill health as an important challenge and driver for change. We will be developing mental health care pathways as part of the program and take on board the comment of emphasising this specific area.

In addition, the mental health needs and wellbeing of patients will also be considered within physical healthcare pathways, e.g. the importance of psychological support and rehabilitation programs in heart disease or following trauma.

We recognise the importance of giving mental health and physical health equal priority, recognising that many people with mental health issues die prematurely from physical health causes, and many people with physical health problems experience associated mental health issues.

8.10 Comments about primary care

This key theme was identified 60 times within the respondents' feedback, 5% of all the instances when a key theme was identified within the text.

There were a number of comments about primary care, particularly in response to Question 8 about how we can help to ensure more services can be delivered at home. These included the importance of services being integrated with GP services, ensuring that plans do not place more burden on primary care which is already under great pressure and ensuring GPs have a strong voice in the programme. Some respondents commented on the difficulty with getting access to GPs and that that their services needed to be more accessible, with more flexible and longer opening hours.

> "Pressures on GP centres and extreme difficulties booking appointments"

UHB response, actions and mitigations

Please see our response to Paragraph 8.7 which addresses some of these points, particularly those relating to the involvement and integration of General Practice services in the clinical redesign of care pathways within the Shaping Our Future Clinical Services programme and the specification and services offered in Wellbeing Hubs.

In terms of access, opening hours and other operational issues, we will take this opportunity to feedback to ongoing service improvement programmes being undertaken by the Primary, Community and Intermediate Care Clinical Board.

We recognise that there cannot be a disconnect between the Shaping Our Future Clinical Services programme of strategic change and the continuous service improvement that is being undertaken by the Health Board and, in particular, the accelerated transformation of certain services as part of COVID recovery. We are working to align and coordinate these work programmes and will need to ensure that this is communicated well to our staff and public.

8.11 Scepticism about the programme

This key theme was identified 47 times within the respondents' feedback, 4% of all the instances when a key theme was identified within the text.

Some respondents expressed frustration with ambitions of the programme, commenting that it was unnecessary and unfeasible and that services are fine as they are, that we should be investigating what services are already being provided before trying to change everything or focus too much on buildings. That waiting lists are not mentioned was commented on by one respondent.

UHB response, actions and mitigations

We acknowledge that major building works may grab headlines but have been at pains to emphasise that the Shaping Our Future Clinical Services programme is about the entire pathway journey, rather than just isolated services or buildings.

However, the buildings in which we deliver care are of equal important in the delivery of safe, sustainable services for the future. We know the current buildings infrastructure limits our ability to deliver modern clinical care and ways of working. New infrastructure will also ensure that patients have improved access to participate in research. Buildings must be designed with high quality patient care and staff wellbeing at its core: the "optimal healing and learning environments" and therefore go hand in hand with the redesign of clinical pathways.

Whilst the program is ambitious, it is important to remember the context in which the changes are set out. We know that our populations needs are changing and therefore our services need to change to support this. We are pleased that the feedback supports the need for change and will continue to apply population health data to the development of clinical pathways. This reflects the majority of feedback that we have received as well as external expert assessment of the potential of Cardiff and Vale UHB within the context of NHS Wales.

We will continue to work closely with the public, stakeholders and Welsh Government to ensure that our plans meet the needs of our population and are deliverable within carefully scrutinised timescales and business cases.

8.12 Financial comments

This key theme was identified 35 times within the respondents' feedback, 3% of all the instances when a key theme was identified within the text.

Comments under this theme highlighted some concerns about the affordability of the programme particularly in the context of the cost of the pandemic. There were also queries about whether the proposed emphasis on providing more services closer to home would be more costly, for example with equipment needed on more sites, thus requiring disinvestment from other parts of the service including a potential impact on jobs.

There were also a small number of comments relating to the relationship with the private sector, with views expressed about avoiding the use of private sector finance and concerns about the private sector cashing in on our plans.

UHB response, actions and mitigations

The UHB supports the principles of Value Based Healthcare in which "outcomes that matter to patients" are an important marker of quality of care. These principles will be embedded within the Shaping Our Future Clinical Services programme.

There will be a focus in the redesign of pathways on the delivery of services in the most effective and efficient way that provides the best value for the patient.

It is important to note that this will require different choices about where resources are invested over time to ensure balance across system but at that this stage of the process we have not yet undertaken any detailed analysis of costs as the design work has not yet commenced.

8.13 Comments relating to what services will be provided on which site and the rationale

This key theme was identified 33 times within the respondents' feedback, 3% of all the instances when a key theme was identified within the text.

Attendees at meetings and participants in the survey raised questions about what services would be provided in the Health and Wellbeing Centres and the Wellbeing Hubs. Some made suggestions for what could be provided in community facilities including access to investigations and tests. The future role of Barry Hospital was also raised by a small number of respondents.

Similarly, many people were interested in the future service mix at UHW2 and UHL, and queried the basis on which decisions about service location would be made. There were also some concerns that people might have to travel further for emergency services and specialist services.

"Not clear what the structure of the Hubs will be – what will stay/what will be taken away"

"We need better local access to speedy investigations and tests"

UHB response, actions and mitigations

The location of clinical services is being considered and planned on the basis of the design principles outlined in Shaping Our Future Wellbeing and Shaping Our Future Clinical Services. The plans for specific services and their locations are under development and will be subject to ongoing engagement.

The key principles include Home First; Care Closer to Home, holistic consideration of the home-to-home patient journey, integration of healthcare and other services, promotion of active transport and healthy travel, minimising the impact on the environment, delivering high quality clinical care in outstanding facilities when it is needed, creating an optimal healing and learning environment. Wellbeing Hubs are planned in each of our nine Primary Care clusters, co-located with Social Care and other local authority services. They will include some clinical services that are not suitable for delivery in individual GP Surgeries; the exact nature of these tests, investigations, clinic areas and community facilities is being considered in the SOFCC program.

Health and Wellbeing Centres will provide more clinical services away from our acute hospitals and we have plans for Barry Hospital, Cardiff Royal Infirmary to develop as Health and Wellbeing Centres, in addition to developing plans for a centre for the north Cardiff locality. This programme does not supplant existing or planned services in these locations, which are subject to their own plans and programs of work. The Health and Wellbeing Centres will offer diagnostic and treatment services that be optimally delivered outside of the major hospital setting (where they have traditionally been

located), without sacrificing quality or efficiency. These represent a new way of working that will be designed for better access for patients; it will require significant transformation of our digital infrastructure and our workforce.

Our current thinking around the design principles for our main hospitals (future UHL and future UHW) have been outlined in our presentations: two centres of excellence, each with a dedicated and complementary focus: (1) protected, planned elective care and high quality treatment and rehabilitation services (including in-patient mental health services) at UHL. (2) 24/7 high intensity and intensive care services, including several regional services co-located with the major university teaching and research facility at UHW. This design allows for the development of high quality care in coordinated dedicated facilities, with a grouping of co-dependent and interrelated specialties.

8.14 Comments about health inequalities

This key theme was identified 30 times within the respondents' feedback, 2% of all the instances when a key theme was identified within the text.

A number of comments were made focusing on the priority that should be given to reducing health inequalities and that above all, access must remain fair and equitable. The importance of ensuring access to healthcare and wellbeing services for black, Asian and minority ethnic communities was specifically identified. The inequalities exposed by COVID-19 were highlighted as well as concerns that future moves to provide care through digital technology might widen existing inequalities.

> "Make sure all services are readily and easily accessible to all"

Discussion at one of the stakeholder meetings highlighted the need for the Health Board to capture data relating to the protected characteristics of our patients, to better understand health inequalities and how they can be addressed.

UHB response, actions and mitigations

We are in wholehearted agreement with these comments. In addition to engaging widely with appropriate stakeholders, including a number of seldom heard stakeholders, we aim to develop better methods of capturing and analysing data regarding health inequalities and monitoring the effects of our service redesign.

We recognise that 'one size does not fit all' in the delivery of future healthcare. And whilst the delivery of some elements of a patients care digitally may be suitable for a large percentage of our population, a significant proportion are either unable to or would prefer face-to-face services.

We are committed to reducing health inequalities in line with our vision that a person's chance of leading a healthy life should be the same wherever they live and whoever they are and are refreshing plan around this with partners in light of the COVID-19 pandemic which has further exposed the gap in health and social inequalities.

8.15 Role of clinicians

This key theme was identified 28 times within the respondents' feedback, 2% of all the instances when a key theme was identified within the text.

> "Ensure you are asking and consulting with the nurses, therapists, support workers who actually carry out the work, not the people who have a vision and no experience of working in it"

That clinicians should lead the thinking in taking this programme forward was a clear message that came through from a number of meetings and survey responses. Aligned to this, people highlighted the need for those who deliver services across the UHB to have the opportunity to be involved in the development and design of plans. A number of more specific ideas were also put forward about the potential role different professionals could play in the future e.g. to use the full skill set of Allied Health Professionals in supporting the management of long term conditions.

UHB response, actions and mitigations

This is a core principle of the Shaping Our Future Clinical Services programme, which is being led by an active clinician (Associate Medical Director) and experienced clinical manager (Programme Director). The development of future care pathways will be undertaken by multidisciplinary clinical teams working within those services, right the way across the pathway, it will be centred on patient care, supported by data, workforce, planning and improvement teams.

This programme will inform and be enabled by a separate programme focussing on our future workforce and we are very pleased to see a number of ideas about future clinical roles being out forward as a part of this engagement.

8.16 Next steps of the programme

This key theme was identified 24 times within the respondents' feedback, 2% of all the instances when a key theme was identified within the text.

Discussion at the public and stakeholder meetings in particular highlighted some key messages around things that are important in taking forward the programme to the next stages of development; some are points already mentioned under other theme headings. Staff are keen to get involved and emphasised the need to give all service areas the opportunity to help shape the work going forward. Comments were also made about the need to learn from good practice elsewhere.

Partner organisations were similarly excited by the ambitions of the programme and want to work with us to deliver change. The importance of strong university research links was highlighted. There were also strong messages about the crucial voice of service users, and the partnership that needs to be built with patients and carers in co-designing future services, as well as the need for future consultations taking place before plans are worked up in detail.

> "How will the patient voice be built into clinical services planning?"

UHB response, actions and mitigations

We are delighted by the level of positive engagement we have had from the public, staff and stakeholder organisations.

We are collating feedback and lists of individuals and groups who are keen to contribute on an ongoing basis and over the next few months will continue to meet with teams from across the organisation and with partner Health Boards, Trusts and other stakeholders.
We plan to develop and communicate the structure, methodology, team membership and program of work for the next 12 months and are committed to designing services with patients and their carers and families.

We are also continuing to engage widely across other Health Services within Wales and the wider UK to ensure we learn and take best practice from outside our own organisation.

8.17 Engagement Process

This key theme was identified 17 times within the respondents' feedback, 1% of all the instances when a key theme was identified within the text.

Concerns about the appropriateness of undertaking an engagement during the pandemic were highlighted in some public meetings and in some survey responses. Equally, some people raised concerns that only those who could access and use digital routes would be able to engage effectively and questioned how we were targeting those who were not able to use technology.

Concerns about the appropriateness of undertaking an engagement during the pandemic were highlighted in some public meetings and in some survey responses. Equally, some people raised

> "I think this is an inappropriate time to be putting this on staff and the public for consultation. How widely has it been able to be distributed to the public? How are people really able to engage at present"

concerns that only those who could access and use digital routes would be able to engage effectively and questioned how we were targeting those who were not able to use technology.

There were some positive comments from people who had been involved in engagement work supporting the development of some community facilities such as Wellbeing Hubs and others who welcomed the fact that we were engaging early in the life of the programme.

UHB response, actions and mitigations

We are pleased that both members of the public, staff and stakeholders are supportive that the UHB is engaging during the early stages of the programme planning. We are keen to ensure that everyone has an opportunity to shape plans at this important stage.

Running an engagement during the pandemic is something that the Health Board in partnership with the CHC discussed at length before the programme was launched. While COVID-19 has presented us with many challenges we have also recognised that we have a number of opportunities. It was agreed that this engagement programme is broad in its approach to shape our vision for clinical redesign so seeking public feedback as early as possible would be beneficial to ensure our direction of travel is the right one.

We developed a communication and engagement strategy that capitalised on digital adoption during the pandemic but also leveraged opportunities to reach seldom heard groups and the digitally excluded through other channels as well as wider stakeholders.

8.18 Comments about the proposed location of buildings

This key theme was identified 12 times within the respondents' feedback, 1% of all the instances when a key theme was identified within the text.

The potential location of UHW2, the Health and Wellbeing Centres and Wellbeing Hubs was queried by some both in the survey and at meetings.

"Where is the Cardiff North Hub to be situated and will it be accessible by public transport?"

"Llantwit Major needs a health centre Hub"

"Where will the new hospital be?"

UHB response, actions and mitigations

Decisions on the location of a new Hospital for Wales has not yet been made and a detailed site analysis and a thorough evaluation of options will be carried out to ensure the best value, least environmental impact, most access are considered. This process will be undertaken as a part of the ongoing planning for a new hospital under the Shaping our Future Hospitals programme. At this stage, the case for change has been set out in a Programme Business case submitted to Welsh Government, so it is important to note that at this stage there is no formal commitment to replacing UHW.

The development and considerations on the individual locations of both Wellbeing Hubs and Health and Wellbeing Centres will be undertaken as a part of the Shaping our Future Community Care Programme which has its own programme of engagement. Accessibility will be a key consideration as a part of this process.

8.19 Environmental impact

This key theme was identified 10 times within the respondents' feedback, 1% of all the instances when a key theme was identified within the text.

There were a few responses which featured the importance of considering environmental impacts of the programme. There were comments about the need to consider the impact on the environment in the design of the building and also the potential impact of the way services are designed. Some highlighted the need for the approach to be as green and eco-friendly as possible and that plans provided an opportunity to look at the use of alternative technology to support sustainability and to introduce initiatives to prevent waste.

"Please consider the impact of carbon reduction in the design of buildings"

"I'd like to see more initiatives involving waste management, especially recycling, upcycling and prevention of equipment and medication being wasted"

UHB response, actions and mitigations

The UHB are required under law to reduce our carbon footprint. As a member of the Public Service Board are fully committed to our role in tackling the climate emergency.

We have developed a sustainability action plan agreed by our Board in autumn 2020. It considers improvements across eight dimensions: Energy, waste, water, people, travel and transport, procurement, biodiversity and clinical practice.

We are currently looking at updating it in response to the recently released NHS Wales action plan to enable the Welsh public sector achieve net zero by 2030. https://gov.wales/nhs-wales-decarbonisation-strategic-delivery-plan .You will see from the NHS Wales targets that net-zero new buildings are desired. Existing buildings are expected to be improved and optimised also.

We encourage staff and visitors to use alternative means of travel such as the park and ride scheme and public transport. This has resulted in reduced congestion on our main hospital sites. More recently, with a number of outpatient appointments taking place virtually an initiative to ensure the amount of time patients are waiting in the emergency department at UHW has resulted in fewer trips to hospital for many patients.

8.20 Importance of adopting a preventative approach

This key theme was identified 10 times within the respondents' feedback, 1% of all the instances when a key theme was identified within the text. It was also highlighted in some public and stakeholder meetings.

The adoption of a preventative approach to meeting future needs was identified by some respondents alongside comments about the importance of public health programmes to help people manage their own health and wellbeing, including education for school aged children. Questions were raised at some meetings about why the focus of the presentation was on clinical services and the future design of hospitals, rather than on an equally important focus on prevention and early intervention.

> "A more preventative approach to healthcare should be focused on"

UHB response, actions and mitigations

We are really encouraged by the feedback around prevention and wellness during the engagement and would like to reassure citizens and our staff that whilst we are engaging specifically on the programme that will focus on the delivery of transformed clinical services that it is clear this cannot be fully realised without focus on population health.

The UHB has recently published its plan describing our approach to public health in Cardiff and the Vale of Glamorgan during the period 2020-23 and setting out our priorities in line with Public Health Wales and the Shaping our Future Wellbeing Strategy working alongside our partners.

We will ensure that this work dovetails with our strategic programmes including Shaping our future Community Care as well Shaping our Future Clinical Services and are considering the development of a specific programme of work to support the development and delivery of plans.

There is also a role for the Shaping Our Future Clinical Services programme to ensure prevention is a focus in the delivery of its clinical services. This is relevant in not only Primary Care but in our delivery of Secondary and Tertiary care. To that end the programme team have identified the need for a prevention cross cutting programme of work that will be applied to the redesign of pathways.

8.21 Equality Issues

This key theme was identified 7 times within the respondents' feedback, 1% of all the instances when a key theme was identified within the text.

Many of the other themes highlight issues that relate to issues of equality, and the following section of this report focuses on a discussion of equality impact. However, there were also several comments which reflected specific areas which it will be important to address in the implementation of the

programme. One related to ensuring equal access to healthcare and wellbeing services for black, Asian and minority ethnic communities and another described the opportunity that a transformational approach provided to challenge heteronormative culture.

"All patients should be treated equally with dignity and respect"

"Equality for all including challenging heteronormative language and systems"

UHB response, actions and mitigations

As a part of our vision that a person's chance of leading a healthy life should be the same wherever they live and whoever they are. We are building good links with seldom heard organisations and community leaders to ensure that we are increasingly engaged in conversations around healthcare with the whole population of Cardiff and Vale and wider Wales in relation to regional and specialised services. As a Health Board we are committed to reduce health inequalities and engaging with seldom heard groups in our communities will be a significant part of this programme.

8.22 Ideas for the role of Wellbeing Hubs

This key theme was identified 5 times within the respondents' feedback, 0.4% of all the instances when a key theme was identified within the text.

A number of people commented on the opportunities offered by the development of Wellbeing Hubs and suggested roles that they could play in supporting a more holistic approach to health and wellbeing. This included support for carers, building links with education services and opportunities for Information Centres supported by Third Sector organisations.

A response from Community Pharmacy Wales highlighted the opportunity to utilise the existing network of community pharmacies into local health and wellbeing resources. Developments such as increasing independent prescribing capacity and management of common conditions through roll out of the Common Ailments Service in community pharmacies – coupled with the high density of pharmacies in more deprived areas – demonstrates what a significant role these local assets could play in helping to deliver the UHB's objectives.

"There is an extremely strong case for the network of Community Pharmacies across the Cardiff and Vale UHB area to be developed into a network of community health and wellbeing centres and to play an even greater role in the provision of clinical services to the people living in the area"

UHB response, actions and mitigations

We are pleased to see that citizens and staff share our vision for a holistic, integrated approach to health and wellbeing, to be delivered through our community facilities. It will be really important to work with stakeholders including local residents and community groups, to shape each community facility as it is developed and also as it evolves over time in response to changing needs and priorities of our local communities. Working with community groups, third sector and statutory services will be key to nurturing the development of a strong community spirit and consequent positive outcomes, such as improved public health and social resilience.

It will be important to engage the right clinical teams and partners in the development of the model of care for both our wellbeing Hubs and Health and Health and Wellbeing Centres. The work of the Shaping our Future Clinical Services programme will be closely aligned to the Shaping our Future Community Care programme which will be instrumental in developing the link between partner organisations within our communities.

We were very pleased to have already engaged with such a wide range of services including those such as community pharmacy, optometry and dental services during the engagement and very much look forward to including these teams within the redesign workshops and wider programme.

8.23 Impact of COVID-19

This key theme was identified 5 times within the respondents' feedback, 0.4% of all the instances when a key theme was identified within the text.

> "Waiting lists will be very long due to the pandemic and this will need to be properly addressed as a more urgent priority"

Some respondents to the survey as well as participants in the public meetings highlighted concerns about the impact of the pandemic on waiting lists and that dealing with the backlog would need to be a future priority for the NHS. There were also concerns about the way that COVID-19 was affecting people's confidence in accessing services and the potential impact this was having on issues like capturing cancer early.

UHB response, actions and mitigations

Key to the COVID response of the UHB has been dynamic and advanced planning – remaining one step ahead of the curve. This has required transformational change and bold decision-making. As we emerge from the second wave and rapidly roll-out the vaccines we are applying that same approach to the longer-term challenge of recovery and reconstruction. The UHB has protected essential services throughout the pandemic, maximised use of the independent sector and established highly successful Protected Elective Surgical Units ('green zones') which have ensured over 7000 patients have received treatment via this pathway since their inception. It is true however that the pandemic has resulted in many fewer consultations, diagnostic procedures and surgeries and a full recovery, therefore, will take multiple years.

The plans we continue to develop will combine the obvious need for additional capacity with a transformation of the way we deliver services. Of particular importance will be the support we provide to both our patients and staff as services evolve. It's imperative to us that our patient centred recovery plans are clinically-led and data orientated, and carefully consider the risks in both covid and non-covid populations.

The UHB sees this challenging period as an opportunity to not only recover from the pandemic, but also to reconstruct our health service in a fundamental and sustainable way. Further details of the Health Board's Annual Plan for 2021-22 will be published on the website in due course.

8.24 Design of buildings

This key theme was identified 2 times within the respondents' feedback, 0.2% of all the instances when a key theme was identified within the text.

Question 10 in the survey asked people to identify the features that would make their visit or stay better when we are designing our hospitals for the future. A wide range of ideas were put forward with the majority emphasising the importance of future hospitals being modern, welcoming, light, clean and spacious. Some people highlighted the need for privacy and quiet, and the value that could be gained from access to outdoor space and inviting space decorated with art.

Others focused on the needs of staff working in future hospitals, with comments about design needing to facilitate easy supervision and flow, minimise the risk of cross infection, provide room for therapeutic interventions, storage for equipment and wellbeing areas for staff.

There were also suggestions around helping people to navigate their way around large hospitals, with good signage and assistance being available to help people find their way around, as well as the importance of there being good access for people with a disability.

"Outdoor space for inpatients to be able to see their families and rehabilitate"

"Good access to wheelchairs at large hospitals with long corridors"

UHB response, actions and mitigations

We would like to thank citizens, staff and stakeholders for their feedback at this early stage of the planning. Everything suggested will be taken into account and must be addressed.

We envisage a thorough exercise being undertaken to design the facilities and ensure the best environment for our patients and our staff. And in addition, learning from across the UK and internationally from some of the organisations delivering exceptional care with world leading facilities.

9. Equality Impact

We are particularly interested in identifying issues emerging from the engagement which relate to potential impacts, positive or negative, of our proposals on different members of our communities. This section highlights some of the key learning we have gained from this engagement in relation to equality impacts.

Question 7 in the survey provided a specific opportunity for respondents to identify things we need to consider in order to limit any negative impacts of any changes that might be made to the way people receive their care in the future. However, comments relating to equality impacts also featured in the responses to other questions.

Physical access and building design of healthcare facilities were major themes in the feedback we received. Ensuring good access to our sites, on our sites and within our buildings, is of particular significance to some members of our community. Poor access impacts negatively but ensuring that access is improved in the future could impact positively on people's ability to receive the care they need e.g. older people or people with a disability.

Another key theme emerging from the engagement were issues relating to increasing opportunities to receive some care via online technology. This could have very positive impacts for some people, but there was a lot of feedback about the potential negative impact on those who were less able to access or use such technology. The importance of retaining the option of face-to-face consultations was a key feature of comments we received. The issue of working to address the specific needs of people with hearing or sight impairments was also highlighted.

There was a lot of support for the concepts of Home First and Care Closer to Home. For many people, the provision of more care in their own home, in primary care, or in community facilities, and the greater flexibility that facilitates, could have a very positive impact on their ability to access the care they need if they face barriers to accessing care that has previously been provided in hospital.

Another theme which has the potential to impact on particular groups in our community is communication. Feedback through this engagement focused on the importance of clear information about service changes and how to access services written in a way that is easy for people to understand. How that type of information is communicated could impact differentially on different members of the community.

In comments received about our workforce, opportunities for impacting positively by improving the offer to staff were highlighted e.g. more flexible working, training utilising a wider skill set, developing wellbeing areas and improving working conditions. However, some concerns were raised about potential negative impacts relating to the capacity of staff to deal with change in the aftermath of the pandemic and whether the cost of the new plans might jeopardise jobs.

One comment was received which highlighted that transforming our healthcare system provided an opportunity to challenge heteronormative language and systems.

The information gathered through the engagement will help to inform and shape our approach going forward; the information has been used to update the Equality and Health Impact Assessment (attached as **Appendix F**). This is to ensure that due regard is given to these issues in our planning and that appropriate action is built into implementation plans to mitigate any negative impacts and promote positive impacts. This is crucial if we are being true to our vision that a person's chance of leading a healthy life is the same wherever the live and whoever they are.

10. Conclusion

We are grateful to all members of the public, staff, stakeholders and partners who have supported this engagement process and provided such rich feedback which we will continue to learn from and draw into the work of the programme. The contributions have provided insight from many perspectives on a range of topics and with be invaluable in shaping the next steps.

74% of respondents (213 individuals) indicated that they would be happy to be emailed about future pieces of engagement and consultation work, so we have opportunities to build on this dialogue and learn from their experience of our services and views about future configuration of clinical services.

We will use staff, stakeholder and partner feedback to build on the approach to working collaboratively and in partnership as part of the programme.

We would specifically like to thank South Glamorgan Community Health Council for their collaboration and support throughout the process. We look forward to discussing this report with them as we consider the next stages of the process.

10. Appendices

The following are attached as appendices to the report:

Appendix A	Communication and Engagement Plan
Appendix B	Engagement Document
Appendix C	Notes of the public meetings
Appendix D	Key issues raised under each theme
Appendix E	Demographic profile of respondents to the survey
Appendix F	Equality and Health Impact Assessment

Report Title:	**Reorganisation of localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Engagement 2021**								
Meeting:	UHB Board						**Meeting Date:**	27.05.21	
Status:	**For Discussion**	✓	**For Assurance**		**For Approval**	✓	**For Information**		
Lead Executive:	Len Richards, Senior Responsible Officer								
Report Author:	Programme Director, Strategic Clinical Redesign & Chair of the Network Engagment Group								

Background and current situation:

Collectively, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, and Cwm Taf Morgannwg University Health Board provide vascular services in South East Wales. The current configuration of services across separate hospital sites are spread too thinly to meet the quality and safety standards set out by the *Royal College of Surgeons* and the *Vascular Society of Great Britain and Ireland.* The reorganisation of localised vascular surgery into a Vascular Network (South East Wales Vascular Network) is essential in providing a 24/7 high quality, consultant led vascular service that maintains proper clinical outcomes and patient care.

The Vascular Programme Board, comprising each of the affected Health Boards, agreed to run an 8 week engagement in February– April 202. The engagement proposed to the public that a Hub and Spoke Network model of care be established for the populations of South East Wales. With a vascular surgery hub formed at University Hospital Wales, Cardiff, with main spoke hospital services maintained at Royal Gwent Hospital, Grange University Hospital, Royal Glamorgan Hospital, University Hospital Llandough. The hub and spoke service model offers the opportunity for non-surgical care to be maintained closer to home at the spoke sites, whilst the creation of a centralised surgical hub site will offer the benefits of a high-volume arterial Centre

congruent with the clinical operating standards set out by the *Vascular Network of Great Britain and Ireland*.

The enclosed *Reorganisation of localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Engagement 2021* outlines the engagement process that was undertaken between 19th February 2021 and 16th April 2021 and sets out :

- A summary of the rationale for a Vascular Network for South East Wales
- An overview of the work that has been undertaken to develop recommendations for a vascular network for the region
- A summary of the resulting recommendations from an options appraisal from the 3 provider Health Boards
- A description of the process used to engage on the recommendations
- An analysis of the engagement responses
- A programme team response to the issues raised
- Conclusions drawn from the engagement

The engagement report describes our approach to the public engagement process, provides an analysis of the feedback received, summarises the key themes that emerged, provides responses to the comments received on key issues, and sets out the proposed actions that will be taken.

The engagement report is to be considered by Community Health Councils in May 2021.

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

The engagement process sought to explore views on key components of the proposed service changes. Public engagement events were conducted by each Health Board, with Aneurin Bevan University Health Board and Cwm Taf Morgannwg University Health Board providing engagement events for the population footprint of Powys Teaching Health Board as well as their own.

110 people responded formally to the engagement through an online survey. There were 7 virtual public meetings, 1 third sector meeting and the proposals were discussed at a range of internal stakeholder meetings. Of those who replied via the online survey, 72% agree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales.

A number of themes emerged from the feedback in response to the engagement questions. The themes that emerged in order of most frequency are:

- Organisation & integration of network services
- Location of Hub & Spoke
- Accessibility & Transport
- Care provided
- Engagement process
- Impact on other services
- Workforce
- Communication
- Financial issues
- Request for information
- General concerns

It is very important to us that the public can make their voices heard throughout this service development process. We are grateful to all members of the public, staff, stakeholders, who have supported this engagement process. The contributions made by the public have provided a wealth of insight, from many differing perspectives, and will help to strengthen the service development process.

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

This engagement has provided an opportunity to test the proposed service changes that will affect the following population footprints:

- Blaenau Gwent, Caerphilly, Monmouthsire, Newport, and Torfaen
- Cardiff and the Vale of Glamorgan
- Rhondda Cynon Taff and Merthyr Tydfil (please note that Bridgend is part of the South West Wales Vascular Network)
- South Powys (other parts of Powys served by South West Wales/North Wales Networks as well as networks in England)

The total resident population of the Health Boards taking forward this proposal is approximately 1.5 million.

The Covid-19 pandemic has altered the way in which this public engagement would otherwise be conducted. As a result, it has presented both opportunities and risks to the way that we engagement with the public and led to the development of a blended approach developed collaboratively with the CHCs, and increase in the use of social media. All engagement events were held via online communication platforms such as *Microsoft Teams* and *Zoom.*

Recommendation:
The Board is asked to:

- **NOTE** the content of the *Reorganisation of localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Engagement 2021*
- **CONSIDER** the views of the Community Health Councils, submitted directly by the CHC
- **APPROVE** the use of the engagement feedback to inform the implementation of the South East Wales Vascular Network

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	✓	6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people	✓	7. Be a great place to work and learn	✓
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✓
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✓	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	The Assessment was an integral component of the documentation developed to support engagement and has been updated to reflect on feedback received during the engagement – Appendix F of the Engagement Report.

The Future of Vascular Services in South East Wales

Public Engagement Report

May 2021

SOUTH EAST WALES
VASCULAR NETWORK

GIG CYMRU NHS WALES

Reorganisation of localised Vascular Services into a 'Hub and Spoke' model Vascular Network for the South East Wales Region: A Report on Public Engagement 2021

Status	Final report
Version Number	V1.7
Publication Date	06/05/2021

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C2. Cwm Taf Morgannwg University Health Board & Powys Teaching Health Board

C3. Aneurin Bevan University Health Board

D. Mid-point Engagement Review Report

E. Equality Impact Assessment

1. Executive summary

Collectively, Aneurin Bevan University Health Board, Cardiff and Vale University Health Board and Cwm Taf Morgannwg University Health Board provide vascular services in South East Wales. These services look after patients suffering from any condition that affects the network of blood vessels known as the vascular or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs, often with the aim of reducing the risk of sudden death, prevent stroke, reduce the risk of amputation, and improve function. Vascular services are also provided to support patients with other problems such as kidney disease.

The populations affected are Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen; Cardiff and the Vale of Glamorgan; Rhondda Cynon Taff and Merthyr Tydfil (Bridgend is part of the South West Wales Network), and South Powys (other parts of Powys served by South West/North Wales Networks as well as networks in England).

There is an increasing demand on these services due an increasing and ageing population, as well as factors such as smoking and obesity. The current configuration of services across separate hospital sites in South East Wales are spread too thinly to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons, the total resident population of the Health Boards taking forward this proposal is approximately 1.5million.

Between Friday 19th February and Friday 16th April 2021, the four Health Boards, Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board, ran a public engagement on a proposal for the reorganisation of localised vascular services into a 'hub and spoke' model Vascular Network for the South East Wales Region. Clinicians agree that this is a sustainable delivery model that will provide the best outcomes to all patients within the region and best use of skill and staff as advised by the Vascular Society.

This would mean that all major vascular operations and interventions are done in one hospital. It would not change citizens going to their local hospitals for non-complex, routine interventions, diagnostics, outpatient clinics, advice before an operation or for recovery and rehabilitation.

The purpose of this report is to inform the Joint Committee and affected Health Boards of the conduct and key findings of the public engagement on the proposal

to locate a vascular surgery hub for South East Wales at University Hospital of Wales, Cardiff, with main spoke hospital services maintained at Royal Gwent Hospital, Grange University Hospital, Royal Glamorgan Hospital, University Hospital Llandough and University Hospital Wales, and care wherever possible maintained closer to home.

110 people responded to the engagement via an online survey.

There were 7 virtual public meetings, 1 Third Sector meeting and the proposals were discussed at a range of internal stakeholder meetings.

Of those who replied via the online survey, 72% agree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales.

A number of common themes emerged from the feedback received in response to the engagement questions and in other formats including comments made at the public and stakeholder events:

The Health Boards will need to give careful consideration to the feedback received and the views of the CHC's in determining their response to the engagement and agreeing a way forward.

2. Introduction

This engagement report provides:

- a summary of the rationale for a Vascular network for South East Wales
- an overview of the work that has been undertaken to develop recommendations for a vascular network for the region
- a summary of the resulting recommendations from an options appraisal from the 3 provider Health Boards
- a description of the process used to engage on the recommendations
- an analysis of the engagement responses
- conclusions drawn from the engagement

The engagement plan for the proposed development of vascular services in South East Wales was developed collaboratively by four Health Boards, namely Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board.

The populations that are affected are:

- Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen
- Cardiff and the Vale of Glamorgan
- Rhondda Cynon Taff and Merthyr (Bridgend is part of the South West Wales Network) England).
- South Powys (other parts of Powys served by South West/North Wales Networks as well as networks in

The engagement period began on Friday 19th February and ended on the 16th of April 2021.

3. Background and Context

3.1 Rationale for a regional vascular network

Specialist vascular services aim to prevent death from aortic aneurysm, prevent stroke from carotid artery disease and prevent lower limb amputation from peripheral arterial disease and diabetes. In 2007 over 65,000[1] people in the UK

[1] https://www.vascularsociety.org.uk/_userfiles/pages/files/Document%20Library/National-Vascular-Database-2009-report.pdf

had surgery for a problem relating to vascular disease and, due to the increasing size of the aging population, demand for vascular services increase over time. The total number of patients likely to need a vascular procedure across South East Wales is approximately 1250 each year. In addition, there are currently an estimated 275,000 are living with diabetes in Wales.[2] and this prevalence is also increasing, 311,000 people in Wales could have diabetes by 2030[3] with diabetic patients having a worse outcome, as evidenced by the increasing rate of lower limb amputation in this group. Patient outcomes in South East Wales are good however they are not sustainable in the way they are currently provided.

Nationally outcomes from vascular surgery in the United Kingdom have not compared well with other countries. Until recently the UK had the highest mortality rates in Western Europe for abdominal aortic aneurysm repair[4].The Vascular Society of Great Britain and Ireland therefore published a series of recommendations[5] describing how vascular services should be organised to deliver the best outcomes for patients. They recommend that high quality urgent vascular care should be organized and delivered using integrated vascular networks. Ensuring that local assessment, diagnosis, and rehabilitation of patients in non-arterial centres (spokes) is optimised, whilst also delivering high volume interventions at arterial centres. The goal being a service which balances the needs of patient access with the provision of comprehensive safe vascular care and intervention that is sustainable.

In light of these recommendations NHS England published a national specification for the provision of vascular services in July 2013. This specification was used to assess services across England and implement networked models of care. This specification was subsequently reviewed and supported by GIRFT (Getting it Right First Time) programme report on Vascular Surgery in 2018 which advocated as its guiding recommendation[6], the development of Networked models of care for vascular services. Clinicians from across the three Heath Board Providers in South Wales have assessed this specification and agree that the key elements of which are that providers of vascular services should:

[2]https://www.diabetes.org.uk/in_your_area/wales/diabetes-in-wales
[3] ibid
[4] Howell, S.J. (2017) Abdominal aortic aneurysm repair in the United Kingdom: an exemplar for the role of anaesthetists in perioperative medicine. British Journal of Anaesthesia.
[5]https://www.vascularsociety.org.uk/_userfiles/pages/files/Document%20Library/Provision-of-Services-for-Patients-with-Vascular-Disease.pdf
[6] https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

- Serve a minimum population of at least 800,000 people to ensure an appropriate volume of procedures
- Ensure that highly experienced staff are treating sufficient numbers of patients to maintain competency
- Have 24/7 on site vascular surgery and interventional radiology on-call rotas that are staffed by a minimum of 6 vascular surgeons and 6 interventional radiologists.
- Provide access to cutting edge technology including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures.
- Provide a dedicated vascular ward and nursing staff.
- Have a specialist team to manage patients with vascular disease that includes vascular surgeons, interventional radiologists, specialist nurses, vascular scientists, diabetes specialists, stroke physicians, cardiac surgeons, orthopaedic surgeons, and emergency medicine amongst other specialities to provide a comprehensive multi-disciplinary service.

Discussions on the sustainability of vascular services in South East Wales have been taking place for a number of years. In fact, clinicians have worked together to develop the out of hours services for Vascular emergencies with a shared emergency on call rota in place, which has been running for 20 years.

However, despite developments in the rest of the UK and other parts of Wales, the South East Wales region remains the only region in the UK without a formal networked arrangement of care for all vascular services. This, along with the fragility of the wider service sustainability for the future has resulted in our clinical teams giving consideration to how this current position can be improved, as well as developing the service to be an exemplar in Wales.

3.2 Clinical Options appraisal

A lot of work has been undertaken by clinical teams exploring potential future options for the delivery of the service in the area. This has been articulated in a non-financial clinical options appraisal, undertaken in October 2014, and included options for the clinical model as well as an assessment of potential sites for an arterial centre (hub).

Options were assessed against the following:

1. Quality and safety
2. Acceptability

3. Strategic fit
4. Sustainability
5. Access
6. Achievability

With a strong rationale, clinicians arrived at a consensus on the option for a hub and spoke model of care, with the arterial centre or 'hub' being at University Hospital of Wales and 'spokes' remaining within Health Board footprints allowing services where possible to be delivered closer to home and a number of complex emergency and urgent vascular interventions to take place in one hospital.

This option reflects the model of care advocated in recommendations from the VSGBI but was also consistent in other specialised services including Major Trauma Networks which were developed and launched in England in 2012. A hub and spoke model allow a balance between local access for the population and ensuring sustainability of service, improved access to training for staff with higher volumes of surgery or intervention in one centre leading to improved patient outcomes.

The recommendation on the hub site was also based on the 6 key criteria and included consideration of collocated services, including; Neurosurgery, Nephrology, Cardiology.

Clinical engagement has taken place throughout the service development process and there remains good clinical consensus. A letter confirming that the work undertaken during the clinical option appraisal process in 2014 remains valid has recently been received by the Chair of the Joint Vascular Programme Board. Indeed, the clinical body indicated the preferred option including the site choice for the hub had now been strengthened since the Major Trauma Centre was launched in September 2020 at University Hospital Wales.

4. Scope of the public engagement

During October 2020, a report was shared with the Vascular Programme Board which outlined a potential approach to engagement and consultation on the proposals for the service. This was supported and a two-stage process of engagement followed by consultation agreed, subject to appropriate engagement with Community Health Council colleagues.

Organisations that were identified as needing to be part of the consultation and engagement were Aneurin Bevan University Health Board, Cardiff and Vale

University Health Board, Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board, as commissioners of these services for their local population.

Further to the decision made by Programme Board, a workshop was held in November 2020 to agree the scope of the engagement and consultation and to have discussions that would inform the gaps in a skeletal draft engagement document.

As a result of these discussions, it was agreed that the scope of the engagement phase would be to:

- Inform people what vascular services are and how they are currently organised
- Explain the challenges facing the services
- Engage in discussions about potential/only viable option and aid understanding on this
- Hear what is important to people in this discussion prior to a period of formal consultation

It was however noted that given the extensive work that had been undertaken on a clinical option appraisal and formulation of ideas regarding a hub and spoke model of delivery, that this information should also be shared at the engagement phase, so as to offer as much information as possible, in order to explore with members of the public, and interested stakeholder views on the process that has been followed and whether there is any other information that should be considered.

The affected Community Health Councils considered the proposals for engagement together at their meeting held on 13th January 2021. There was explicit support expressed by both Cwm Taf Community Health Council and Aneurin Bevan Community Health Council, with further discussions taking place with both Powys and South Glamorgan CHCs. Following further assurances relating to process and remit, there was subsequent agreement by all CHCs to commence the engagement as proposed.

5. Approach to communication and engagement

To ensure a consistent approach was adopted across the region, an engagement group was established comprising engagement, communications, workforce, clinical and planning leads from each of the affected Health Boards.

Plans for local engagement activity, to be undertaken in line with the overall plan, were agreed between each Health Board and the respective CHC. It was agreed that it is the responsibility of these organisations to lead the programme of engagement and consultation in their respective areas, however overall co-ordination is being held within the programme structure.

Recognising the limitations of undertaking this work during the pandemic, which prevented the use of face-to-face mechanisms for engaging with the public, the Health Boards worked closely with Community Health Councils (CHCs) to develop a blended approach to engagement. This was designed to draw on the learning and mechanisms for reaching people virtually which have evolved over the last year including advice from intermediary Third Sector organisations who have been finding ways to reach different communities. It had the following key features:

Core elements	- Telephone number and answer phone set up - Postal address and inbox - Specific email address for programme established - Survey form created online as well as being available in the summary document
Web pages	- Web pages hosted on each Health Board website - Template supplied with content and useful documents (including main document, summary, FAQs and easy read version of summary) - Link to survey and all relevant contact details including; telephone number, postal address etc.
Staff/ public updates	- Inclusion in newsletters - All staff emails - Digital screen tiles and posters - Letter and assets to GPs
Stakeholder outreach	- Stakeholder letter

	- Communications Toolkit
Social media	- Promotion of public engagement events - Series of social media posts and subsequent visuals - Videos of key spokespeople for the network talking about proposed changes
Promotional assets	- Posters - Digital screen tiles - Leaflets/flyers - Teams Background - PowerPoint template
Engagement events	- Public engagement events arranged in each Health Board area

Note: All assets were created bilingually

A mid-point review meeting took place on Wednesday 24th March, to review the processes and responses received to date and determine whether any adjustments needed to be made to the engagement for the remaining period.

Emerging themes were also shared with the steering committee for the programme.

Please see appendix 2 for the detailed Engagement Plan.

5.1 Engagement during the Pre-election period

After commencement of the public engagement on the 19th February pre-election dates were confirmed by the Welsh Government and advice provided via a Welsh Health Circular[7] on the 11th March. The advice sets out the guidance on the permitted activity during a pre-election period and is set out below. In considering this guidance, further advice was sought from the Consultation Institute and discussion took place with the Board of CHCs. It was concluded that the engagement did not meet the criteria for pausing the process, however in order to mitigate the risk of politicisation within the engagement process, it was

[7] https://gov.wales/sites/default/files/publications/2021-03/senedd-election-2021-guidance-for-nhs-wales.pdf

agreed public events would not be held during the pre-election period. Therefore, the engagement process was continued through this period.

5.2 Engagement questions

In agreement with the CHCs, the engagement asked for individuals in the region and organisations to consider the following specific questions:

1. From reading this discussion document, do you have a good understanding of what vascular services are?
2. From reading this document, do you understand how services are currently organised?
3. From reading this document, do you have an understanding of the challenges that are currently facing vascular services?
4. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for vascular services in South East Wales?
5. Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?
6. What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?
7. Would you agree/disagree that spoke arrangements need to have a consultant led ED and an emergency surgery response on site?
8. Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements.
9. Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?
10. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement in South East Wales?
11. Do you have a view on the options that have been considered as part of this, are there others we should consider?
12. Do you have any comments on the process that is being undertaken to consider the best configuration of vascular services in South East Wales?
13. Do you have an alternate view on the proposals put forward within this document for the configuration of services?

5.3 Public sessions

Public session were arranged for each Health Board area. Powys citizens were offered to attend online public sessions held by both Aneurin Bevan and Cwm Taf Morgannwg University Health Boards.

Minutes of the public meetings are attached (appendix 3). Attendance at the sessions was not high, however as members will note from the minutes attached, the conversations were rich and far-reaching.

The organising and delivery teams for each Health Board Areas were agreed as:

Cwm Taf Morgannwg & Powys

Clinical Leads: Mr Kevin Conway, Consultant Vascular Surgeon and Mr Mike Rocker, Consultant Vascular Surgeon

Management Lead: Marie-Claire Griffiths, Assistant Director of Strategic Planning and Commissioning

Business Support: Michelle Lloyd, Business Support Manager

Powys Teaching Health Board Lead: Adrian Osborne, Assistant Director, Engagement and Communication

Aneurin Bevan & Powys

Clinical Leads: Mr Peter Lewis, Consultant Vascular Surgeon and Mr David Lewis, Consultant Vascular Surgeon

Management Lead: Chris Dawson-Morris, Assistant Director of Planning

Powys Lead, Adrian Osborne, Assistant Director, Engagement and Communication

Cardiff and Vale

Clinical Leads: Mr Richard Whiston, Consultant Vascular Surgeon and Mr Kevin Conway, Consultant Vascular Surgeon, Mrs Cath Twamley, Head of Nursing for Surgery

Management Lead: Mr Mike Bond, Director of Operations Surgery Clinical Board & Mr Alun Tomkinson Clinical Board Director Surgical Clinical Board

6. Summary of mid-point review report

A mid-point review of the engagement process was conducted by the engagement group on 24th March 2021 which aimed to scrutinise and evaluate progress in engaging with the public and staff. Following this initial review reviews took place between planning and engagement leads and CHCs.

At that time a total of 66 survey responses had been received and the public events had been completed. The survey responses at the time of the mid-point review had not been analysed by Health Board area.

Actions arising from the review:

- Following up with those who signed up to public events with a reminder to complete the survey.
- Agreement to continue through the pre-election period but not to hold any further public meetings.
- Agreement not to hold a planned Facebook Live Q&A session aimed at the public during the pre-election period.
- Check Facebook posts to identify any comments made which should be included in the consideration of feedback.
- Agreement on post engagement process and key dates to enable the CHC position to be considered as part of the presentation on the outcome of engagement at the May Health Board Boards.
- Additional FAQ to clarify spoke arrangements.
- Additional presentation slides to clarify potential impact on residents of each HB area.

Please see appendix 4 for the Mid-point Review report.

7. Responses to the engagement and reach

The below table outlines the feedback that was received during the engagement period including number of respondents and method of feedback:

Type of Feedback	Total number of respondents/reach	Comment
Survey respondents	110	
Email/correspondence received by email	3	

Public meetings	29	Minutes of meetings attached as Appendix 3
Third Sector Stakeholder meeting	4	4 third sector organisations represented Minutes of meeting attached as Attached as Appendix 3
Social media advertising reach	60,486	948 link clicks
Web page reach	Aneurin Bevan UHB English webpage: 1446 Welsh webpage: 30 Cardiff and Vale UHB English webpage: 631 Welsh webpage: Cwm Taf Morgannwg UHB English webpage: 1,132 Welsh webpage: 20 Powys THB English webpage: 270 Welsh webpage: 29	

Comments made at the public meetings were captured, verified by the CHCs and considered in the analysis. Key points made at the third sector stakeholder meeting, as detailed in the engagement plan, were also included in the analysis. It should be noted that everyone was also encouraged to complete individual response forms so there may be an element of duplication in the points captured

in meeting notes and those made in response forms. A full copy of all the feedback received via the survey and meeting notes has been shared with the CHC's.

7.1 Key Themes

The engagement survey contained a mix of closed and open-ended questions. A number of common themes emerged in the analysis of the feedback received via open questions in the survey, comments made at the public and stakeholder meetings, emails and social media posts. These key themes have been used as the basis of analysis of the qualitative feedback.

The key themes are set out below, with an indication of the number of comments relating to these themes were mentioned in survey responses:

All Questions	401	%
Organisation & Intergration of Network Services	86	21%
Location of Hub & Spoke	63	16%
Accessibility & Transport	52	13%
Care Provided	44	11%
Engagement Process	42	10%
Impact on other services	39	10%
Workforce	33	8%
Communication	15	4%
Financial Issues	13	3%
Request for information	8	2%
General Concerns	6	1%

7.2 High level summary of online feedback by engagement question

Question 1. From reading this discussion document, do you have a good understanding of what vascular services are?

ANSWER CHOICES	RESPONSES	
Yes	94.55%	104
No	1.82%	2
Not sure	3.64%	4
TOTAL		110

95% of respondents said they had a good understanding of what vascular services are, having read the discussion document.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question1	5	%
Organisation & Intergration of Network Services	2	40%
Accessibility & Transport	1	20%
General Concerns	2	40%

Question 2. From reading this document, do you understand how services are currently organised?

ANSWER CHOICES	RESPONSES	
Yes	90.91%	100
No	4.55%	5
Not sure	4.55%	5
TOTAL		110

91% of respondents said they understand how services are currently organised, having read the document.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 2	5	%
Location of Hub & Spoke	1	20%
Workforce	1	20%
Care Provided	1	20%
Impact on other services	1	20%
Engagement Process	1	20%

Question 3. From reading this document, do you have an understanding of the challenges that are currently facing vascular services?

ANSWER CHOICES	RESPONSES	
Yes	89.09%	98
No	4.55%	5
Not sure	6.36%	7
TOTAL		110

90% of respondents said they have an understanding of the challenges facing vascular services, having read the document.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Questions 3	8	%
Location of Hub & Spoke	2	25%
Workforce	2	25%
Care Provided	1	13%
Financial Issues	2	25%
General Concerns	1	13%

Question 4. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement for vascular services in South East Wales?

ANSWER CHOICES	RESPONSES	
Yes	30.84%	33
No	49.53%	53
Not sure	19.63%	21
TOTAL		107

31% of respondents felt there was other information we should consider.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 5	38	%
Request for information	4	11%
Location of Hub & Spoke	5	13%
Organisation & Intergration of Network Services	6	16%
Accessibility & Transport	2	5%
Workforce	4	11%
Care Provided	3	8%
Impact on other services	3	8%
Financial Issues	2	5%
Communication	4	11%
General Concerns	1	3%
Engagement Process	4	11%

Question 5. Do you agree/disagree with the national evidence and recommendation from the clinical option appraisal that a hub and spoke model would improve vascular services and patient outcomes in South East Wales?

ANSWER CHOICES	RESPONSES	
Agree	72.48%	79
Disagree	11.93%	13
Not sure	15.60%	17
TOTAL		109

72% of respondents agree that a hub and spoke model of care would improve vascular services and patient outcomes in South East Wales.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 5	38	%
Request for information	4	11%
Location of Hub & Spoke	5	11%
Organisation & Intergration of Network Services	6	11%
Accessibility & Transport	2	11%
Workforce	4	11%
Care Provided	3	11%
Impact on other services	3	11%
Financial Issues	2	11%
Communication	4	11%
General Concerns	1	11%
Engagement Process	4	11%

Question 6. What are your thoughts on the hub being identified as the University Hospital of Wales Cardiff given the dependencies on other services that are located there?

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 6	86	%
Location of Hub & Spoke	17	20%
Organisation & Intergration of Network Services	25	29%
Accessibility & Transport	21	24%
Workforce	3	3%
Care Provided	7	8%
Impact on other services	10	12%
Financial Issues	1	1%
Engagement Process	2	2%

Question 7. Would you agree/disagree that spoke arrangements need to have a consultant led ED and an emergency surgery response on site?

ANSWER CHOICES	RESPONSES	
Agree	88.99%	97
Disagree	1.83%	2
Not sure	9.17%	10
TOTAL		109

89% of respondents agreed that spoke arrangements need an Emergency Department and emergency surgery response on site.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 7	22	%
Location of Hub & Spoke	4	18%
Organisation & Intergration of Network Services	9	41%
Workforce	3	14%
Care Provided	4	18%
Impact on other services	1	5%
Communication	1	5%

Question 8. Subject to your view on the above, would you agree/disagree with the suggested spoke arrangements.

ANSWER CHOICES	RESPONSES	
Agree	67.59%	73
Disagree	11.11%	12
Not sure	21.30%	23
TOTAL		108

68% of respondents agreed with the suggested spoke arrangements.

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 8	25	%
Request for information	1	4%
Location of Hub & Spoke	4	16%
Organisation & Intergration of Network Services	6	24%
Accessibility & Transport	2	8%
Care Provided	5	20%
Impact on other services	1	4%
Financial Issues	1	4%
Communication	1	4%
Engagement Process	4	16%

Question 9. Do you have any thoughts on the process that has been followed to date to consider the future configuration of vascular services in South East Wales?

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 9	39	%
Request for information	1	3%
Location of Hub & Spoke	3	8%
Organisation & Intergration of Network Services	5	13%
Workforce	1	3%
Care Provided	5	13%
Impact on other services	8	21%
General Concerns	1	3%
Engagement Process	15	38%

Question 10. Is there any other information you think we should consider in order to decide whether we should move towards a networked arrangement in South East Wales?

ANSWER CHOICES	RESPONSES	
Agree	36.96%	34
Disagree	16.30%	15
Not sure	46.74%	43
TOTAL		92

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 10	60	%
Location of Hub & Spoke	4	7%
Organisation & Intergration of Network Services	13	22%
Accessibility & Transport	13	22%
Workforce	4	7%
Care Provided	3	5%
Impact on other services	8	13%
Financial Issues	3	5%
Communication	5	8%
Engagement Process	7	12%

Question 11. Do you have a view on the options that have been considered as part of this, are there others we should consider?

ANSWER CHOICES	RESPONSES	
Yes	16.98%	18
No	50.94%	54
Not sure	32.08%	34
TOTAL		106

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 11	15	%
Location of Hub & Spoke	5	33%
Organisation & Intergration of Network Services	3	20%
Accessibility & Transport	1	7%
Workforce	3	20%
Impact on other services	1	7%
Financial Issues	1	7%
Engagement Process	1	7%

Question 12. Do you have any comments on the process that is being undertaken to consider the best configuration of vascular services in South East Wales?

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 12	18	%
Organisation & Intergration of Network Services	2	11%
Accessibility & Transport	1	6%
Workforce	1	6%
Care Provided	4	22%
Impact on other services	2	11%
Financial Issues	1	6%
Communication	1	6%
Engagement Process	6	33%

Question 13. Do you have an alternate view on the proposals put forward within this document for the configuration of services?

ANSWER CHOICES	RESPONSES	
Yes	18.10%	19
No	71.43%	75
Not sure	10.48%	11
TOTAL		105

The information from the respondents who submitted data for this question was categorised against the key themes. The themes are shown below:

Question 13	31	%
Location of Hub & Spoke	13	42%
Organisation & Intergration of Network Services	3	10%
Accessibility & Transport	1	3%
Workforce	4	13%
Care Provided	4	13%
Impact on other services	2	6%
Financial Issues	1	3%
Communication	2	6%
Engagement Process	1	3%

7.3 Analysis of survey respondent type

In order to assess the public reach of the engagement, survey respondents were asked if they were a member of Health Board staff, the general public, a current or past patient, a carer of a current or past patient or a stakeholder.

Carer of a current/previous patient	7
Current / previous patient	24
General public	47
Not Stated	4
Staff	24
Stakeholder	4
Grand Total	**110**

The Geographical Profile of Respondents to the Survey

Health Board	Number	%
Aneurin Bevan University Health Board	42	38%
No Postcode	9	8%
Unidentifiable	6	5%
Powys	10	9%
Cardiff and Vale University Health Board	29	26%
Cwm Taf Morgannwg University Health Board	14	13%
Total	110	

Demographic Profile of Respondents to the Survey

The survey included a series of questions designed to help us understand the reach of the engagement.

Respondent Age profile

ANSWER CHOICES	RESPONSES	
18-24	0.00%	0
25-34	10.38%	11
35-44	11.32%	12
45-54	17.92%	19
55-64	29.25%	31
65 and over	31.13%	33
TOTAL		106

Respondent gender profile

ANSWER CHOICES	RESPONSES	
Male	39.62%	42
Female	56.60%	60
Prefer not to say	3.77%	4
TOTAL		106

Respondent Ethnicity

ANSWER CHOICES	RESPONSES	
White	97.12%	101
Mixed/multiple ethnic groups	0.96%	1
Asian/Asian British	0.00%	0
Black/Black British	0.00%	0
Arab	0.00%	0
Prefer not to say	1.92%	2
TOTAL		104

Welsh speaking respondents

ANSWER CHOICES	RESPONSES	
Yes	4.76%	5
No	95.24%	100
TOTAL		105

7.4 Issues raised at public meetings

In agreement with CHCs each Health Board held a minimum of 2 public meetings via Zoom, with Welsh translation available. A total of 29 people attended the meetings which are broken down as follows:

Health Board	Date	Time	Number of Attendees
Aneurin Bevan & Powys	Wednesday 10th March, 2021	14:00hrs	7 members of the public
	Tuesday 16th March, 2021	18:00hrs	5 members of the public
	Wednesday 17th March, 2021	18:00hrs	2 members of the public
Cardiff and Vale	Tuesday 16th March 2021	19:00 hrs	1 member of the public
	Thursday 18th March 2021	19:00 hrs	6 members of the public
Cwm Taf Morgannwg & Powys	Thursday 11th March 2021	14:00hrs	3 members of the public
	Tuesday 23rd March 2021	18:00 hrs	5 members of the public

The notes of the public meetings are available as appendix 3.

The issues and themes raised in the public meetings are very similar to those represented in the analysis of the survey feedback.

The comments raised suggest support for the proposed model. Attendees were interested in the proposed location of and services delivered within the Hub and

Spokes, and furthermore appeared interested in the issue of access and transport.

Themes from each of the public sessions are set out below:

Aneurin Bevan University Heath Board & Powys teaching Health Board public engagement session themes identified were:

- Support of proposed change to services
- Travel and parking
- How will care pathways work in future
- How to make sure we are getting the services where possible closer to home and that we are not making people travel lots of miles
- Really clear on how people will flow through from local spokes to the hub
- Ensuring links with other services and development of benefits with centralisation of services and make sure that we get links with other services such as Rheumatology

Cwm Taf Morgannwg University Health Board, & Powys teaching Health Board themes identified were:

- Transport and transport related costs
- Health Board using face to face events for engagement going forward
- Links for Bridgend questions
- Llandough Hospital being the spoke for the University Hospital of Wales
- Liaising with diabetic patients, national support groups and stakeholders
- Site of follow up outpatient appointments.
- Having two spokes in Aneurin Bevan and whether or not this was still valid after changes in the Royal Gwent as a result of the Grange Hospital opening.
- The impact of covid recovery on the proposals.
- Obtaining views of patients who do not use IT or social media.
- Implications on WAST
- Parts of Powys affected by changes

Cardiff and Vale University Health Board themes identified were:

- The rationale for the creation of a Vascular Network is sensible and logical.
- Transport, parking, and accessibility needs to be considered throughout the design of this service.

- Suitability of University Hospital Wales in regard to impact on other services, geographic location and infrastructure requirements.

Attendees at all meetings were all asked to submit individual responses to the survey.

7.5 Issues raised at Third Sector meeting

Four Third sector organisations attended a dedicated engagement session.

Points were raised around:

- Support for the proposed model, in line with other similar services with high volume centres to improve patient outcome.
- Taking learnings from other networks
- Highlighting the importance of timely treatment and audit of outcomes

7.6 Issues raised through social media

The comprehensive social media programme supporting the engagement included regular posts about different aspects of the proposals, mainly through Twitter and Facebook. A number of comments were posted and reviewed, largely echoing the themes already identified. Feedback included concerns about the impact of the provision for Bridgend citizens and the centralisation of services in Cardiff creating health inequalities. Other comments demonstrated praise for the proposed model.

It is important to note that 'reactions' to social media posts were positive with support shown through the use of 'like' or 'love' reactions. It is widely accepted that only the most vocal proportion of social media users comment on social media posts, similar to contributions seen at public events.

7.7 Issues raised via email

The South East Wales Vascular programme team received email correspondence that expressed a variety of views and issues. From the emails the following themes were identified:

- Support for digitalisation of services but with concern for health inequalities
- The logic of the Vascular Network is sensible and uncontroversial

- Patients hold the vascular surgery staff and services overall in extremely high regard
- The timing of the engagement may be unfortunate

8. Consideration of Engagement Responses and Vascular Programme response, action and mitigation

This section provides an analysis of the key themes that have emerged through the engagement, with a commentary regarding our response to the comments received and further action that will be taken.

The document is intended to demonstrate that all the issues and concerns have been considered in a balanced, rational, proportionate, and transparent way. In addition, we describe those areas where the engagement has identified issues that would require further action or mitigation to ensure the safe, effective, and sustainable delivery of a new model of care for vascular services.

Note that a number of sub themes have been grouped together for the purposes of response and to reduce duplication in response.

8.1 Organisation and integration of Networked services

Responses which highlighted issues relating to the implementation and organisation of a networked model of care formed one of the largest key themes with 113 comments. There were a number of comments that were supportive of the model proposed and several areas that highlighted specific ideas or issues related to service provision and integration within the proposed network and in both hub and spokes.

The table below quantifies the sub-themes identified in the responses and elaborates on what was considered important within this theme.

Organisation & Intergration of Network Services - Sub themes	Total = 113	%
Hub and Spoke issues	30	35%
Model of Care for the network	26	30%
Facilities at each hospital & are they sufficient for now/future	13	15%
Facilities in the spokes and how they will work	12	14%
How will you ensure better working collaboration with cross over services and Health boards	11	13%
Hub facilities requiring investment/expansion	9	10%
Facilities are in the hubs and how do they work	4	5%
Issues relatiing to confidence of health boards to deliver as promised	2	2%
Have other areas tried this model and what was the outcome?	2	2%
Preventative screening, assessments & follow up should be close to patients home	1	1%
There are too many services being located at the heath	1	1%
What happens to the vacant space at the Grange?	1	1%
Centralising all tertiary services does not work	1	1%

Sub themes – The proposed model of care, proposed services delivered at the hub and spoke facilities at each Hospital and adequacy for the future

The most common categories of responses related to the proposed model of care and clarity over current vascular services within the proposed hub and spokes and whether they were sufficient at present and in the future.

It is important to note that in response to the mid-point review additional steps were taken to ensure greater clarity around the proposed model for the spoke sites were clear.

Currently vascular surgery and intervention for local residents takes place at 3 main hospital sites:

- University Hospital Wales, Cardiff
- Grange University Hospital, Cwmbran
- Until September 2020 the Royal Glamorgan Hospital, Llantrisant[8]

Vascular surgical services for the Aneurin Bevan UHB population were previously provided at the Royal Gwent Hospital before the changes that took place in November 2020, resulting in a move of these services to the Grange Hospital.

[8] At the time of writing there is an urgent temporary arrangement in place for Cwm Taf Morgannwg residents. Patients are currently being seen in Cardiff and Vale University Health Board as the service became undeliverable due to the lack of specialist staff.

"Run on weekends and open up the NHS system to a full 7 day a week service including doctors' surgery"

Whilst vascular surgery units within South East Wales currently perform well, it is important to remember the context in which this engagement has been undertaken. The need for change arose out of a number of national reviews of vascular services in the UK requiring a minimum population for safe, and effective and sustainable vascular surgery. The Royal Surgical Colleges and The Vascular Society of Great Britain & Ireland support the view that it is no longer desirable to provide urgent or emergency vascular surgery outside a fully centralised service or a formalised clinical network with a designated single arterial surgery centre providing a 24/7 on-site service. The evidence shows that patients have better outcomes if they receive their treatment at larger, high-volume specialist centres that are also fully equipped with the full range of necessary specialist support services e.g. 24/7 interventional vascular radiology.

Due to being one of the last areas in the UK not working as a part of a formalised vascular network, there is concern about key risks to the existing vascular surgical services in South East Wales, namely sustainability of services in the region. Other concerns include: vascular surgery being delivered across 3 (currently 2) hospital sites, several consultant staff approaching retirement age, and vascular surgery continuing to become specialised and distinct from the general surgery profession. Vascular arterial interventions and surgery require both a highly skilled and specialised surgical and radiological workforce and equipment. As the technology and equipment has developed over recent years, interventions and outcomes for patients have improved. Training and co-dependant services have also become more specialised – meaning that in order to deliver this level of specialist and complex care, we need to concentrate our specialist staff and services in fewer places so that:

- they can be provided on a 24/7 basis,
- they have immediate access to supporting specialist services and;
- they provide sufficient volumes of patients to enable clinical staff to be trained in and maintain their specialist skills.

It will not be possible to attract or train the medical workforce required to maintain this level of specialist care on more than one acute site for the population of South East Wales.

This proposed direction of travel has already been partially implemented as Emergency Vascular surgery 'out of hours' for the region is already centralised at the proposed hub site and in October 2014, senior clinicians from across the region recommended the move towards a fully networked model of care for all complex vascular interventions, and more specifically, articulated their agreement on the hub and spoke model set out. This has been supported at the South East Wales Vascular programme board who have unanimously supported this proposed model of care to ensure that the services can deliver sustainable care for the future. This means that South East Wales will not only be able to deliver a service that has the capacity to meet the growing needs of patients, but also a service which would become a centre of excellence in the UK.

A single arterial centre (Hub) will offer enhanced opportunities for its surgeons to sub-specialise and promote innovation and research. Bringing the most complex vascular surgery and interventions into one unit as a part of a network of care gives us the opportunity to change the way the services work and build on best practice from all existing vascular units within South East Wales. Most importantly it will help us improve outcomes for patients whilst ensuring that care wherever possible, including investigations, appointments, and rehabilitation, will remain closer to home.

Sub themes - Collaboration

The variety of responses we received demonstrates that ensuring a high-quality service will mean ensuring that many different elements work well and will require effective partnership working and collaboration.

Importantly, the establishment of the network itself promotes and develops collaboration across health care providers to ensure better outcomes for patients.

"Increase expertise at other hospitals as well"

As a part of the existing programme a variety of specialties and professions across Health Boards are engaged and involved. If the proposed model is supported any implementation plan will ensure that each specialty, profession, and team involved in or impacted by the delivery of vascular services are included within the implementation planning. More specifically a more detailed staff engagement process will be undertaken across all provider Health Boards.

We are also asking other vascular networks within Wales and the wider UK to advise us on delivering the best service for patients based on their experiences and learning as well as making links with other similar clinical networks within Wales.

Sub themes – Issues around centralising services and ensuring services closer to home

Several respondents emphasised the issue of centralising services and ensuring that services were delivered closer to where patients lived.

The nature of the proposed clinical model ensures that patients will only be treated at the proposed hub for a small but highly specialised part of their care. This means that wherever possible we will deliver care and treatment closer to a patient's home, this includes outpatient appointments, tests and rehabilitation.

There are both medium and long-term opportunities to strengthen and develop services closer to home that could reduce the need to travel to spoke hospital sites. Health Boards are committed to working with partners including other Health Board Partners in Powys but also local community services and third sector partners to develop plan that support care closer to home.

Sub themes - Resourcing, capacity and adequacy of facilities at the proposed Hub site, UHW

A number of respondents emphasised the issue of adequate resourcing at the proposed Hub and the need to ensure funding for any building work or new equipment. Because we are bringing three existing vascular units together, we know that resources are already available to support the delivery of these services. If the model of care is supported and if existing resources and capacity is found to be inadequate for the increase in vascular activity within the Hub, we will deal with this through the programme process. Any investment for workforce, building work or new equipment will require a business case to be presented to the health board boards.

Specific issue - Capacity released at the Grange Hospital

There was one specific concern raised about the use of capacity that would be released as a result of the transfer of some vascular services to UHW.

Vascular patients utilised beds within the wider general surgery pool, rather than a physically separate area. The centralisation would give general surgery some

additional flexibility for their activity planning, which will be particularly valuable when finalising and operationalising recovery plans over the coming months.

8.2 Accessibility & Transport (including parking)

Accessibility was the second most cited issue with 71 individual respondents. In order to further understand what was considered important within this category the table below quantifies the key sub-themes in the response.

Accessibility & Transport	Total = 71	%
Need to take into consideration the distance patients need to travel	18	35%
Car parking in the heath is an issue	17	33%
What public transport & cost have been taken into considerations for patients?	11	21%
Ease of access to the heath building need to be taken into consideration for elderly/ disabled	11	21%
Need to take into consideration patients ability to travel	5	10%
How will patient transport work between sites	5	10%
Has the carbon footprint of patient travel been taken into consideration?	2	4%
Ambulance times travelling to Cardiff are already high - rush hour traffic	1	2%
Has visitor access been taken into consideration for people being treated in the hub long term	1	2%

Sub theme – Car parking

There were several concerns raised about the congestion and lack of car parking at the UHW site.

> *"I don't mind this, however the parking at UHW is a lot worse than royal Glamorgan and the grange. But perhaps more accessible via public transport. Is there already too many big services operating from UHW is there capacity for this hub too?"*

The likely increase in the number of patients to UHW is moderate. Cardiff and Vale UHB recognises that it will be imperative to ensure that family and friends are able to access the hospital on a timely basis, particularly when the patient might have been transferred to the hospital for an emergency treatment. The UHB has been developing a new traffic management system for the University Hospital of Wales site as part of a wider Sustainable Travel Plan. Strict criteria for staff parking have been introduced and the UHB encourages staff and visitors to use alternative means of travel such as the park and ride scheme and public transport. This has resulted in reduced congestion on the site and has freed up parking spaces for visitors.

More recently, with a number of outpatient appointments taking place virtually an initiative to ensure the amount of time patients are waiting in the emergency

department at UHW has resulted in fewer trips to hospital for many patients and reduced congestion on the Heath Park site.

It is also worth noting that there are no parking charges at hospitals in Wales.

Sub theme - Travel distance and costs

Those patients who are likely to be affected by increased travel are those living in the area of South Powys, with their nearest emergency hospital being the Prince Charles Hospital in Merthyr Tydfil or the Grange University Hospital in Cwmbran, the answer is potentially, but only if they are undergoing specialist or complex surgery or intervention and only for this specific part of their treatment.

"Patients have to travel further for treatment "

There is a need to balance the potential benefits of a single larger centre with any extra time and distance to travel.

Our intention when developing the proposed model of care is that we can improve the ways our multi-disciplinary teams work across the whole South East Wales Network. A Multi-Disciplinary Team includes surgeons, interventional radiologists, physicians, nurses, therapists. This means that we ensure care, such as out-patient appointments with the surgeon can take place locally. Improving the way our teams work will also allow us to reduce the amount of time patients can expect to spend in hospital having their operations by using new techniques such as Enhanced Recovery After Surgery (ERAS), making use of minimally invasive (endovascular) technologies, as well as maximising the use of high-quality imaging and telemedicine.

The clinicians involved in the initial 2014 clinical options appraisal agreed that the University Hospital of Wales should act as the hub for the network based on a number of criteria including quality, safety, sustainability and strategic fit. This proposal decision was also made with the recognition that the proposed model of care will affect the highly specialist one component of the patient's health-care pathway and that wherever possible tests, outpatient appointments, and other routine treatments will be provided closer to home by their local hospital.

We recognise that regional centres do create challenges for patients, relatives and visitors, and should the proposed model be supported, we will work closely with teams at the University Hospital of Wales to build on their experience of delivering specialised care for Wales to deliver innovative solutions for visitor access.

Sub themes - Patient transport issues and impact on the Ambulance service

We recognise that travel to UHW may create challenges to some of our patients. For those unable to travel by private car, access to NHS transport, known as Non-Emergency Patient Transport ("NEPT") is an important service that will enable them to access health care services at the Hub. We are already working closely with the Welsh Ambulance Service Trust ("WAST") who provide the NEPT service. If the proposed model is supported, we will carry out thorough and robust planning measures alongside them to ensure that we can meet the increased needs that this service change will cause. As with travel by car, this proposed service change only affects one part of patients' care. Tests, out-patient visits and other treatment will continue to take place at the patient's local hospital. To reduce further the need for travel, we intend to improve the way our multi-disciplinary teams work. This means that we can re-organise the service so that even more of the care, such as out-patient appointments, can take place locally.

"It should be easy for patients to get to"

Sub theme - Access to the Heath site for elderly/disabled patients

Accessibility at the University Hospital Wales site is important for certain groups, such as persons with disabilities and the elderly. The UHW site is compliant with the Equalities Act (2010) that sets out a minimum threshold for disability-compliant access infrastructure. The UHW site benefits from:

- Park and ride access into the site
- Two disability lifts, one located at the rear near the Y Gegin restaurant and an access lift from the ground floor to the first floor located at the front of the building in the concourse
- Push-pads for doors are put at a disability-friendly height
- Wheelchairs that are available from the ambulance service desk in the concourse
- Additional lifts are located in the multi-story car park

In addition, the Patient Experience team organises the efforts of volunteers who are able to guide and direct patients and visitors to where they need to be, and assist them where necessary. We also work hand-in-hand with St Johns ambulance charity who provide transportation to members of the community.

However, we recognise that the size and age of the building does create challenges for those who do have mobility issues. The new Lakeside Wing has

meant that although the overall amount of disability car parking spaces has increased, some of these spaces have been relocated in order to accommodate the new facility. Despite these changes, the drop off zones remain the same.

Recent changes to the way we work at UHW means that virtual appointments are being offered and provide an alternative to face-to-face consultations. We are also looking at innovations to our health care pathways to offer 'See-on-Symptoms' consultations.

Specific issue - Carbon footprint for increased travel times

The predicted volume and distance for additional travel is very small as CTM patients are already treated at UHW and distance between Newport and Cardiff for the AB patients is approximately 17 miles. For a significant proportion of the AB catchment population, UHW is only marginally farther than The Grange.

Specific issue – Ambulance travel times during rush hour

The access arrangements for blue light emergency transfers to UHW are well developed and will be improved following the lane enhancement work on Manor Way to enable timely access for time critical patients.

Specific issues – Visitor access for patients staying 'long term' at the hub

The proposed model of care aims to transfer patients to a hub for a small but specialised element of their care with the aim of ensuring that patients receive their as close to home as possible. If the proposed model is supported then Visitors' access will be addressed through the implementation planning which will take place through the Vascular Network Programme and by C&V UHB in respect of the development of the Hub.

As part of the development, we have been undertaking a number of interviews with patients looking at the experiences of patients, families and carers of existing vascular services and what could be improved. Work will be undertaken within the hub project to further develop outline plans to provide specialist support for families and carers. There will also be practical advice, signposting and support provided to families and carers to make appropriate accommodation and transport arrangements working alongside third sector and other public sector services should this be required.

8.3 Hub and spoke location

Issues and comments raised in relation to the hub and spoke locations and services delivered was the third largest theme.

The table below quantifies the sub-themes identified in the responses and elaborates on what was considered important within this theme.

Location of Hub & Spoke	Total = 68	%
Services should be provided at a local level (in the community)	25	40%
Residents of Powys are having services taken away from them.	9	14%
The Hub should be located in The Grange	8	13%
The Heath is already over crowded/ under performing	6	10%
What services will be delivered in the spoke?	6	10%
All sites should remain and their facilities expanded	4	6%
Spokes should provide emergency services and their facilities expanded	4	6%
The Hub should be located in Neville Hall	3	5%
The Hub should be located in the Royal Glamorgan Hospital	2	3%
Will there be room to expand the service in the Heath?	1	2%

Sub themes – Services should be provided locally

It is important to highlight that the benefits of a Hub and Spoke networked model of care allow the balance between sustainability of service, improved patient outcomes and services closer to home wherever possible.

The nature of the clinical model ensures that patients will only be treated at the proposed Hub for a small and highly specialised part of their care. This means that wherever possible we will deliver care and treatment closer to a patient's home, this includes outpatient appointments, tests and rehabilitation.

There are both medium and long-term opportunities to strengthen and develop services closer to home that could reduce the need to travel to spoke hospital sites. Health Boards are committed to working with partners including other Health Board Partners in Powys but also local community services and third sector partners to develop plans that continue to deliver on plans and support care closer to home wherever possible; the use of virtual outpatient clinics being an important example.

The proposed model of care for the network ensures that patients across South East Wales will still have access to a 24/7 emergency department and a general surgery emergency service in spoke hospitals, the main spoke sites for each of the areas are proposed as:

Aneurin Bevan University Health Board spoke arrangements– Grange University Hospital

The principal spoke hospital within the Health Board will be the Grange University Hospital, where our main emergency department is located. This site will provide initial assessment and stabilisation of any acute vascular patients who may present, prior to transfer to the hub at the University Hospital of Wales. In addition, as part of our 'Clinical Futures' model of care, other hospitals will be used for vascular surgical patients where care can be provided safely and effectively as close to their homes as possible e.g. for outpatient clinics and post-treatment rehabilitation.

A summary of services that would be provided on different sites is shown below:-

Health Board Site	Proposed Vascular Services
Grange University Hospital (principal spoke site)	• Initial assessment and stabilisation of any patients presenting to emergency department with acute vascular conditions • Interventional radiology e.g. angioplasty • Non-invasive vascular imaging ('vascular lab' work) • CT angiography • On-demand inpatient assessment (nurse led)
Royal Gwent Hospital	• Day case procedures e.g. varicose veins • Outpatient clinics (vascular surgeon and vascular nurse delivered), including 'hot' clinics for rapid access • Ward assessment of patients on request e.g. diabetes and Care of the Elderly patients • Post-treatment rehabilitation / step down for general medical care • Non-invasive vascular imaging ('vascular lab' work) • CT angiography • Pre-operative anaesthetic assessment (face to face where required) • On-demand in/outpatient assessment (nurse led)
Nevill Hall Hospital	• Outpatient clinics, including 'hot' clinics for rapid access • Ward assessment of patients on request e.g. diabetes and Care of the Elderly patients • Post-treatment rehabilitation/ step down for general medical care • Non-invasive vascular imaging ('vascular lab' work)

	• CT angiography • On-demand patient assessment (nurse led)
Ysbyty Ystrad Fawr	• Possible future outpatient clinics • Ward assessment of patients on request e.g. diabetes and Care of the Elderly patients (vascular surgeon and vascular nurse delivered) • Post-treatment rehabilitation / step down for general medical care • CT angiography • On-demand patient assessment (nurse led)
Ysbyty Aneurin Bevan	• Post-treatment rehabilitation/ step down for general medical care • On-demand patient assessment (nurse led)
Chepstow Community Hospital	• Post-treatment rehabilitation/ step down for general medical care • On-demand patient assessment (nurse led)
County Hospital, Pontypool	• Post-treatment rehabilitation / step down for general medical care • On-demand patient assessment (nurse led)
Virtual / Telemedicine (where clinically appropriate)	• Outpatient appointments (consultant and nurse-led) • Pre-operative anaesthetic assessment

Cwm Taf Morgannwg University Health Board – Royal Glamorgan Hospital, Llantrisant serves the more densely populated area of the Health Board namely the Rhondda valley. The vascular surgical and Interventional Radiology service for the Health Board were based in this hospital until September 2020, until an urgent temporary change of service (service moved to University Hospital of Wales) due to a loss of specialist clinical staff. The Royal Glamorgan Hospital has retained the necessary therapy inputs to manage these patients with complex needs. Vascular outpatients clinics and ward-rounds take place twice weekly on the Prince Charles Hospital site. It is important to note Bridgend is served through the South West Wales Vascular Network which is already established and was in place prior to the Bridgend Boundary Change. The Bridgend Boundary Change was an administrative change that did not change the patient pathways to ensure continuity of care.

Cardiff and Vale University Health Board

It is important to note that there is no change to where services will be delivered for Cardiff and the Vale residents. Those requiring access to 24/7 emergency department and general surgery emergency service will continue to access this at the University Hospital if Wales.

Rehabilitation will be provided at Llandough Hospital Vale of Glamorgan.

As a part of the delivery of the Health Board strategy, Cardiff and Vale is developing a programme to develop and deliver a clinical services plan over the next 10 years that will continue to focus on care closer to home wherever possible which will include: delivery of some services where possible digitally (virtual appointments for example).

Sub themes - Sites should remain and facilities expanded

The Royal Surgical Colleges and The Vascular Society of Great Britain & Ireland support the view that it is no longer desirable from a service quality, safety and sustainability perspective to provide urgent or emergency vascular surgery outside a fully centralised service or a formalised clinical network with a designated single arterial centre providing a 24/7 on-site service. The evidence shows that patients have better outcomes if they receive their treatment at larger specialist centres serving a minimum population of 800,000 people. This number is required to provide a sufficient critical mass of patients, thereby providing the sufficient demand for specialised services and volume of demand to train for and maintain clinical specialist skills. No Health Board in the South East Wales region can meet this minimum population criteria alone.

A single arterial centre (hub) will offer enhanced opportunities for its surgeons to train, sub-specialise and promote innovation and research. Bringing the most complex vascular surgery and interventions into one unit as a part of a network of care gives us the opportunity to change the way the services work and build on best practice from all existing vascular units within South East Wales. Most importantly it will help us improve outcomes for patients whilst ensuring that care wherever possible including investigations, appointments and rehabilitation will remain closer to home.

Sub themes - Location of the hub

The most important driver for the development of vascular networks and establishing specialist centres are to improve patient outcomes.

During the 2014 clinical options appraisal and subsequent review earlier this year. Options on the hub site were reviewed against key criteria including: Quality and Safety, Acceptability, Strategic Fit, Sustainability (ability for the services to be fit for now and the future), Access and Achievability.

Quality and Safety was given the highest priority and alongside acceptability, strategic fit and sustainability, given the range of services established at the University Hospital Wales site, its position as a specialist provider of major trauma, interventional cardiology and cardio-thoracic surgery and the co-dependencies between them and the vascular service, the preferred option for the hub was identified by senior doctors from all three Health Board providers as the University Hospital of Wales, Cardiff.

There were concerns raised about performance and capacity at UHW. Questions of performance were due to a low submission of data to the National Vascular Registry in 2019. Cross checking with other data sources show the Cardiff and Vale Unit to have acceptable outcomes for vascular surgery and interventional radiology. Capacity on the vascular ward in University Hospital of Wales was reduced due to demands placed on the hospital by the Covid-19 pandemic. By August 2021 the unit will be returned to its former capacity of 36 acute vascular beds.

Cardiff and Vale UHB is working closely with other health boards on the following:

A review of services provided at a regional level to identify those that might safely and appropriately be delivered at other hospitals. This would free up theatre time and beds to support patients who require more complex care and treatment. Proposals for service change arising from this work would be subject to further engagement with stakeholders and the public.

Arrangements to ensure that patients are returned to their nearest hospital as soon as the specialist part of their treatment is complete, as the support of family and friends is important to a patient's recovery. Repatriation protocols are being developed to support this work. Existing protocols such as in neurosurgery and Major Trauma are already delivering benefits, enabling patients to return to a local hospital as soon as clinically appropriate, releasing capacity in the UHW specialist service.

Cardiff and Vale UHB is also developing a Clinical Services Plan as a part of the Shaping our Future Clinical Service Programme which will include consideration

of what services could move off the UHW site to University Hospital Llandough which would similarly be subject to further engagement and consultation.

Cardiff and Vale UHB has identified a number of critical enablers that would support the delivery of a vascular hub service:

- Increased theatre capacity in line with modelling for additional vascular activity
- Increased ward capacity in line with modelling for additional vascular activity
- Additional theatre equipment – a detailed inventory of equipment and future anticipated needs is being compiled for planning purposes
- Hybrid theatre with timetabled sessions for vascular surgeons to deliver minimally invasive and "hybrid procedures".
- High quality imaging in standard operating theatres as part of recommended quality assurance along with access to the highest quality surgical instruments.

There are plans being developed to address each of these, dependent on the outcome of engagement.

Sub theme – Powys residents will be disadvantaged as access to services will be reduced AB & CTM to review

A key principle of the proposed network model is that each element of the service is undertaken in the hub only if that is necessary on clinical grounds e.g. specialist inpatient care and vascular operations in theatre. All elements that can be delivered safely and effectively more locally e.g. rehabilitation and outpatient care will continue to be undertaken within the spokes. Access to all of the latter services will therefore remain unchanged for Powys residents.

"The travelling issues some patients may experience getting to a hospital possibly much further away"

8.4 Care provided

Care Provided	Total = 45	%
Specific suggestions for improvements to care	28	64%
Concern over patients not being treated promptly in vascular and other services	17	39%

There were a range of comments suggesting improvement in current vascular services, these comments will be reviewed by vascular teams within provider

Heath Boards and also the programme team so that these can be taken in account in both the delivery of services now and development of services for the future.

"I do agree, the wait times are huge at the moment"

There is understandable concern about the impact of the COVID-19 pandemic on the delivery of services. All provider Health Boards have developed plans to support both the response to COVID and recovery. The primary driver for this service development is to improve the quality and standard of care in line with national service recommendations and will be constantly monitoring progress and outcomes through the vascular clinical audit programme.

"Further delays on treatment delayed by COVID-19 need to be avoided at all costs"

Provider Health Board have protected essential services throughout the pandemic but recognise that the pandemic has resulted in fewer consultations, diagnostic procedures and surgeries and a full recovery, therefore, will take careful planning over multiple years. Further details of the Health Board's Annual Plan's for 2021-22 will be published on websites in due course.

8.5 Engagement Process

A total of 44 comments related to the process undertaken.

The table below quantifies the sub-themes and specific comments identified in the responses and elaborates on what was considered important within this theme.

Engagement Process	Total = 44	%
Need more information before forming a view on the proposal	21	47%
Analysis - Has an options appraisal been done? What data has been analysed?	5	11%
Would like more clarity on some areas of proposal	4	9%
Time taken to undertake engagement	3	7%
Sceptisicsm over process	3	7%
The consultation could have been betted advertised	3	7%
General engagement comments	3	7%
Issues with digital engagement	1	2%
Engaging with hard to reach groups	1	2%

Sub themes – More information/clarity on the proposal before forming a view

Considerable emphasis was placed at the engagement sessions on ensuring that participants had full information and understood the nature of the service and of

the proposals for change. A list of FAQs was maintained and updated in response to queries to further enhance information and understanding during the process.

Sub theme – Options appraisal and data in the engagement documentation to support the proposal

The options appraisal was again considered and supported by the programme clinical advisory group and steering committee in early 2021. This group includes senior clinicians from all three provider Health Boards from a range of professions.

The national vascular registry (NVR)provides an invaluable opportunity to benchmark the unit's performance in a UK wide context. The NVR provides comprehensive annual reports on process, performance and outcomes in vascular and endovascular surgery. These reports are in the public domain.

Sub theme - Time taken to undertake engagement

Although discussion started in 2014 this work was undertaken by the vascular surgeons to identify the options and test the need and appetite for service change. Following this process there was a view formed and supported across the 4 SE Wales Health Boards that this was a desirable proposed way forward. There have been a range of regional and local service changes that have taken corporate clinical and planning resources – both expected and unexpected - that have impacted on the timescale for this proposed service reconfiguration.

Since this time the body of evidence to support the options appraisal undertaken has grown and examples of improved care where networks have already been formed demonstrated.

More recently the COVID pandemic halted planning for a period of 12 months.

Sub themes - Reach of the engagement including digitally excluded

Running the public engagement during the pandemic is something that the Health Boards in partnership with the CHC discussed at length before the programme was launched. While COVID-19 has presented us with many challenges we have also recognised that we have a number of opportunities to reach communities digitally and support and seek feedback from specific stakeholders. It was agreed that seeking public feedback sooner rather than later would be beneficial given the current emergency temporary transfer of vascular surgery services away from Cwm Taf Morgannwg Health Board and the uncertainty around the relaxation of COVID restrictions.

We therefore developed a communication and engagement strategy that capitalised on digital adoption during the pandemic but also leveraged opportunities to reach third sector stakeholders and the digitally excluded through other channels as well as wider stakeholders.

Sub themes – Scepticism over process

There are 3 comments that relate to the process itself and the ability to influence a decision on the proposed model at this stage.

Although a number of discussions have taken place and a considerable body of evidence has been developed over the last few years that supports the principle of a regional network, the purpose of this engagement is to see if there is any other feedback, evidence or issues to take into account when considering the proposed model of care for the network in South East Wales. It is also important for us to understand the impact of the proposals so that we can mitigate possible adverse impacts of any change for patients, their carers or family.

8.6 Workforce

Workforce	Total = 38	%
Limited workforce presents a challenge to patient care/ treatment	12	36%
Staff could be shared between sites (if consultants would travel)	8	24%
How will staff skills be kept up to date?	10	30%
Services would benefit from an MDT approach	3	9%
Patients wanting to see their regular consultant	1	3%
Complaints of poor patient care	2	6%
Suggested collaboration with Bristol	1	3%
We need to make sure there is no compromise to working in unfamiliar environments with un	1	3%

Sub theme – challenges with limited workforce

One of the drivers for a move towards networked models of care has included the sustainability of workforce. With vascular surgery becoming increasingly specialised this challenge is likely to increase. Clinicians feel that the proposed model will attract skilled staff to Wales and to the region to ensure that these services can continue to develop by both attracting and retaining skilled staff by offering opportunities to work within a centralised vascular hub. This has been evidenced in similar networks such as the Major Trauma Network for South Wales launched in 2020, which attracted many staff from across the UK and from overseas.

It is also important that the network provides training and experience for all staff groups. A multi professional training and education plan for the region has been developed by the programme clinical advisory group.

Sub theme – Sharing of workforce across sites

The premise of a networked model of care is to allow the sharing of expertise across a number of organisations. Whilst we appreciate there may be a number of staff who will remain within their local Health Board, a network provides additional opportunities for professional development, joint working, communication and best practice sharing.

Sub theme – High Quality and well-trained staff including staff skills

> *"I am not sure of all the services which this hospital provides but I would assume it to be a busy hospital. As long as they have enough qualified staff for the operations is the main priority"*

One of the benefits and drivers of the development of a network for those services which are specialised or who have specialised elements are to ensure that high quality staff can be attracted and retained by offering increased opportunity to develop skills and knowledge within a specialised centre (hub). Through the development and regular review and assessment of whole network training and educational plans we can ensure equity of access for staff across the whole region, in turn ensuring improved outcomes for patients.

Specific issue - Collaboration with specialists in Bristol

The clinical teams collaborate regularly with colleagues in Bristol, sharing learning opportunities and when necessary, transferring patients for complex procedures that cannot be delivered at UHW. This collaboration will continue in a future network service.

Specific issue - Unfamiliar environments, travelling teams

We know we currently have expert teams working in three sites; by connecting them as a part of a network we will build on their strengths. It is important to emphasise that the surgical and Interventional radiology consultant teams already take part in a regional rota and therefore work together as one team and take part in a regular multi-disciplinary team meeting. If a fully networked model is implemented, then this will in practice be a natural evolution of existing

collaborative practices and should drive up standards beyond the current performance.

If the model of care proposed is supported, the vascular hub will be double the size of the existing unit at UHW and will be developed by an implementation team drawing upon expertise from all three provider Health Boards.

We believe that a Hub of this size as a part of a wider network, properly implemented, will be highly attractive to medical staff. We accept that this may be different for certain other staff groups, and that these may be less inclined to transfer from their current posts. A strong training and development programme starting very early in the process will therefore be an essential requirement. We will ensure that the programme team work closely with Health Improvement and Education Wales to facilitate this.

If the proposed model is supported, a skilled and dedicated workforce working as one team familiar with the network would be essential to its success and this would be a core element in implementing the network model.

8.7 Impact on other services

Impact on other services	Total = 52	
Services are interdependent on each other/ requires closer MDT working	11	28%
The Heath Hub would need sufficient services	2	5%
Other services should be engaged to assess the impact this will have	11	28%
Have future needs been taken into consideration	6	15%
Can the heath accommodate a Hub without negatively impacting on other services	7	18%
What is the impact on other departments (emergency transport/radiology/ all vascular/ Auto	15	38%

Sub themes – Service interdependencies, engagement and MDT working

We wholeheartedly agree with the requirement for closer working across multi-disciplinary teams and organisations. The aim of a network is to enable not only sustainable care for the future but to apply consistent high standards across the region and to ensure better, more joined up care for patients and their carers.

The selection of UHW as a proposed hub takes account of the importance of having key interdependent and complementary services co-located on that site (e.g. Neurosurgery, Cardiac Surgery, Major Trauma).

Sub theme – sufficient capacity within supporting services at the Hub to mitigate negative impact

Careful consideration of demand and capacity has been undertaken as part of the planning process. This has been informed by activity data from across the region and full reassurance has been achieved that the capacity plans for the new service are robust. If the proposals are supported, then more detailed planning will be undertaken across all supporting services within UHW.

8.8 Communication

Communication	Total = 21	%
Better communication between teams	7	47%
How will families and patients have the changed communicated to them	4	27%
Hub and Spokes need excellent communication	4	27%
How will patients and family remain in contact if they live far away?	6	40%

Sub theme – Communication between teams and between hub and spokes

The development of a formal networked model of care will provide a structure that allows not only the hub and spoke organisations but also teams and different professions to communicate more effectively with one another.

There has already been increased communication and collaborative working across the four Health Boards and different teams working within them, to develop the proposed model of care and to progress a number of work streams within the programme.

Improved communication has also been observed in the development of Networks across the UK and within other clinical networks within Wales.

Sub theme – Communication between clinicians and patients and their families/carers

The respective clinical teams place a high value on effective and compassionate communication with patients, and all see this as a priority to maintain and enhance within a future network model. Multi-disciplinary discussion and sharing of best practice will form the basis of achieving this

"How will patients get feedback /future appointments with consultants who carried out their operation?"

Sub theme – Contact and communication between patients and their families

In addition to the above, the teams will ensure that all facilities and opportunities (including use of technology) will be made available to allow for good communication between patients and their families e.g. during inpatient stays.

8.7 Financial issues

Financial Issues	Total = 13	%
The health board is under funded	3	23%
Request more money from Welsh Government	2	15%
What are the financial implications of this decision	2	15%
Investing in moving the department there is a waste of money	1	8%
Ensure adequate medicine cover factored in as part of costs	5	38%

Sub themes - Value for money and financial implications

"Involve the patient first not what just good for the NHS and it financial needs"

The clinical benefits for patients having access to a vascular network and centralised hub for complex vascular surgery have been clearly demonstrated. In launching this engagement, health boards are already committed to ensuring the patients of South East Wales have access to equitable, appropriate care to meet their specialist needs. The matters being engaged upon relate to how this should be achieved. Ensuring value for money and optimising the quantum spent on vascular will be subject to further scrutiny through the commissioning process.

8.9 Requests for information & general concerns raised

Request for information	Total = 8	%
What affect will this have on patient outcomes/ waiting lists/ patient prioritisation	5	63%
Would like more information in the local community (GP's, community nurses etc.)	3	38%

General Concerns	Total = 6	%
Have other parts of the country tried this- how did it work?	1	17%
Are patient outcomes worse the further out a patient lives?	1	17%
Further delays on treatment delayed by COVID-19 need to be avoided at all costs.	1	17%
What services come under vascular?	2	33%
Does the need to treat patients need to rethinking?	1	17%

The continuous improvement in patient outcomes and waiting times is one of the major drivers of the network proposal, with all national evidence indicating that regionalisation will have a positive effect on these. This has been the documented experience of virtually all other networks in the UK.

"Are sacrifices to be made in outlying areas to demonstrate an overall average improvement?"

There is no known evidence of patient outcomes being adversely affected by the distance between their homes and the hub. The key factor is the ability of a network to ensure that all patients requiring acute vascular care are brought to a hub with

full expertise and critical mass to respond to all their needs in the most effective manner.

Vascular disease is any condition that affects the network of your blood vessels. This network is known as your vascular or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These are often one-off procedures, in the main, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services also provide support to patients with other problems such as kidney disease. Note that cardiovascular services are delivered by a separate specialty and are not covered by the vascular surgery team.

9. Equality Impact

We are particularly interested in identifying issues emerging from the engagement which relate to potential impacts, positive or negative, of our proposals on different members of our communities. This section highlights some of the key learning we have gained from this engagement in relation to equality impacts. This will help to inform and shape our approach going forward; the information has been used to update the Equality and Health Impact Assessment (attached as Appendix 5). This is to ensure that due regard is given to these issues in our planning and that appropriate action is built into implementation plans to mitigate any negative impacts and promote positive impacts.

Comments relating to equality impacts featured in the responses to the engagement survey questions.

Physical access and building design of healthcare facilities were major themes in the feedback we received. Ensuring good access to our sites, on our sites and within our buildings, is of particular significance to some members of our community. Poor access impacts negatively but ensuring that access is improved in the future could impact positively on people's ability to receive the care they need e.g. older people or people with a disability.

Another theme which is likely to have a negative impact on patients, relatives and carers from socio-economic disadvantaged areas is transport. It is anticipated that some may experience increased difficulty in travelling due to low income, disability, age, poor transport provision, lower number of households with access to their own car. Being required to travel to an unfamiliar hospital and experience longer journey times could be particularly difficult and disorientating

for people. Early transfer of the patient back to the 'local' hospital would help to mitigate long period in unfamiliar surroundings. In addition, in order to mitigate against the negative impact of transport it is considered that the service should promote transport links and provide easy to read information to patients, families and carers in order to make their journey as easy as possible.

Another theme which has the potential to impact on particular groups in our community is communication. Feedback through this engagement focused on the importance of clear information about service changes and how to access services written in a way that is easy for people to understand. How that type of information is communicated could impact differentially on different members of the community.

10. Conclusion

We are grateful to all members of the public, staff and the Community Health Councils who have supported this engagement process. The contributions have helped to strengthen the service development process providing insight from many perspectives.

In this report we have described the themes from the engagement process and set out from the Programme Team our response, action and mitigations. We believe this report provides a good reflection of the engagement process.

We look forward to discussing this report with Community Health Councils as we consider the next stages of the process.

11. Appendices

A. The Future Provision of Vascular Services for the Population of South East Wales: A Discussion Document

THE FUTURE PROVISION OF VASCULAR SERVICES FOR THE POPULATION OF SOUTH EAST WALES : A DISCUSSION DOCUMENT

Aneurin Bevan University Health Board

Cardiff & Vale University Health Board

Cwm Taf Morgannwg University Health Board

Powys Teaching Health Board

CONTENT

1. INTRODUCTION

This document is being shared with people across South East Wales, to start a conversation about how Vascular services are organised in the future. It aims to share information and gain your views about :

- What vascular services are
- Which people may be in need of vascular care
- How vascular services are currently provided
- The challenges facing vascular services
- The options we have started to consider about how we could respond to these challenges
- A preferred way for organising services
- What may be the advantages and disadvantages of any future changes

After considering the issues contained within the paper, we hope you will share your views, thoughts and ideas with us. We have offered a questionnaire at the end of this document, but should you wish to tell us about issues that are broader than this, please do not hesitate to do so.

Your responses should be with the team co-ordinating this by xxx/xxx/xxx.

Following this period of engagement, we may need to enter a more formal period of consultation about the services. If you would be interested in continuing the conversation with us, please let us have the best contact details to keep you engaged with the conversation.

We recognise that this document will have some medical terms associated with Vascular surgery within it. We have added a 'Glossary of Terms' to the end of the document to help with this.

We have also completed an equality impact assessment which you can view at appendix C. We will use the information gained through the engagement process to increase our understanding here.

2. WHAT ARE VASCULAR SERVICES?

Vascular disease is any condition that affects the network of your blood vessels. This network is known as your **vascular** or circulatory system. The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood

flow to organs. These are often one off procedures, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services are also provided to support patients with other problems such as kidney disease

Vascular disorders can reduce the amount of blood reaching the limbs, brain or other organs, causing for example severe pain on walking or strokes. Additionally vascular abnormalities can cause sudden, life threatening, blood loss if abnormally enlarged arteries burst. Vascular specialists also support other specialties, such as major trauma, cardiology, diabetic medicine, stroke medicine, kidney dialysis and chemotherapy.

The core activities of vascular specialists are:

- Preventing death from abdominal aortic aneurysm (AAA);
- Preventing stroke due to carotid artery disease;
- Preventing leg amputation due to peripheral arterial disease;
- Symptom relief from peripheral arterial and venous disease;
- Healing venous leg ulceration;
- Promoting cardiovascular health;
- Improving quality of life in patients with vascular disease;
- Assisting colleagues from other specialties with the control of vascular bleeding;
- Providing a renal access service for patients requiring haemodialysis.

Aneurin Bevan University Health Board; Cardiff and the Vale University Health Board; Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board have worked together for a number of years to discuss the best way of delivering vascular services, and already have a number of shared arrangements already in place (eg out of hours rota) We are therefore collectively talking to you about the future of vascular services, following which we may enter a period of more formal consultation on the services.

3. **WHO NEEDS THESE SERVICES?**

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are currently an estimated 200,000 people with diabetes mellitus in Wales, and prevalence is increasing. Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

Risk factors for vascular disease include:

- Being over the age of 50
- Smoking
- Being overweight
- Having abnormal cholesterol
- Having a history of cerebrovascular disease or stroke
- Having heart disease
- Having diabetes
- Having a family history of high cholesterol or high blood pressure
- Having high blood pressure
- Having kidney disease or haemodialysis

Early diagnosis is key to successfully treating vascular related disease. Patients will be admitted with a variety of both emergency and planned vascular conditions and not all patients will go on to require a complex surgical or interventional radiology procedure. Emergency care is immediate treatment to save a life or limb, urgent care is planned treatment within a limited number of days.

Patients who receive vascular services may have:

- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the body's main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need a limb amputation

Not all patients admitted to a specialist service will need a complex surgical or interventional radiology intervention, however due to the nature of their condition, these patients need specialist assessment and care provided in a specialised vascular unit.

Vascular services are provided to the populations of South East Wales with the exception of Bridgend who receive care from the South West Wales vascular network. This is a population of approximately 1.6 million people.

To give a sense of demand for services, the following shows activity across the Health Boards for the 2019 year:

Matric	Period	Aneurin Bevan University Health Board	Cardiff & Vale University Health Board	Cwm Taf Morgannwg University Health Board	Powys Teaching Health Board	South East Wales Total
Population		600,000	472,000	450,000	132,500	1,654,500
Total Outpatient Appointments	**2019**		**2391**	**2340**	**N/A**	**4731**
New Patients	2019		867		N/A	**867**
Follow ups	2019		1524		N/A	**1524**
Total number of Cases/ Procedures	2019	456	437	355	N/A	**1248**

4. HOW ARE SERVICES CURRENTLY PROVIDED?

National Context

The last few years have seen great changes in vascular services in the UK, partly stimulated by challenges such as poor surgical outcomes and the introduction of national screening for AAA, but also endorsed by a specialist group trying to improve its quality and performance. This has meant a contraction of the service into a smaller number of higher volume centres to improve outcomes. Whilst complex in-patient work is concentrated in a single network centre, outpatient and outreach services for the entire network are provided locally so that patients attending smaller network hospitals are not disadvantaged.

Since 2001, the Vascular Society of Great Britain and Ireland (VSGBI) has funded and maintained a registry of index arterial procedures (National Vascular Registry – NVR). In 2008, data from the previous five years in the UK were included in a European report (Vascunet), that suggested the UK had the worst elective abdominal aortic aneurysm (AAA) mortality rates in Europe (7.5% versus 3.5% European average). These data were supported by similar results from the Vascular Anaesthesia Society audit and the Intensive Care Database. The main conclusion was that many patients were being treated in small UK centres undertaking a limited number of AAA repairs, with poorer outcomes. Studies have consistently shown that higher volume centres produce better outcomes for many surgical procedures, and this is well recognised for aortic aneurysm surgery. The conclusion was that concentrating aortic surgery in higher volume centres should improve surgical outcomes. Subsequently similar conclusions regarding improved outcome for patients have been drawn with regard carotid surgery and lower limb revascularisation.

With the exception of the populations in South East Wales, all other parts of the country have networked arrangements in place for the provision of vascular services and have centralised vascular surgery.

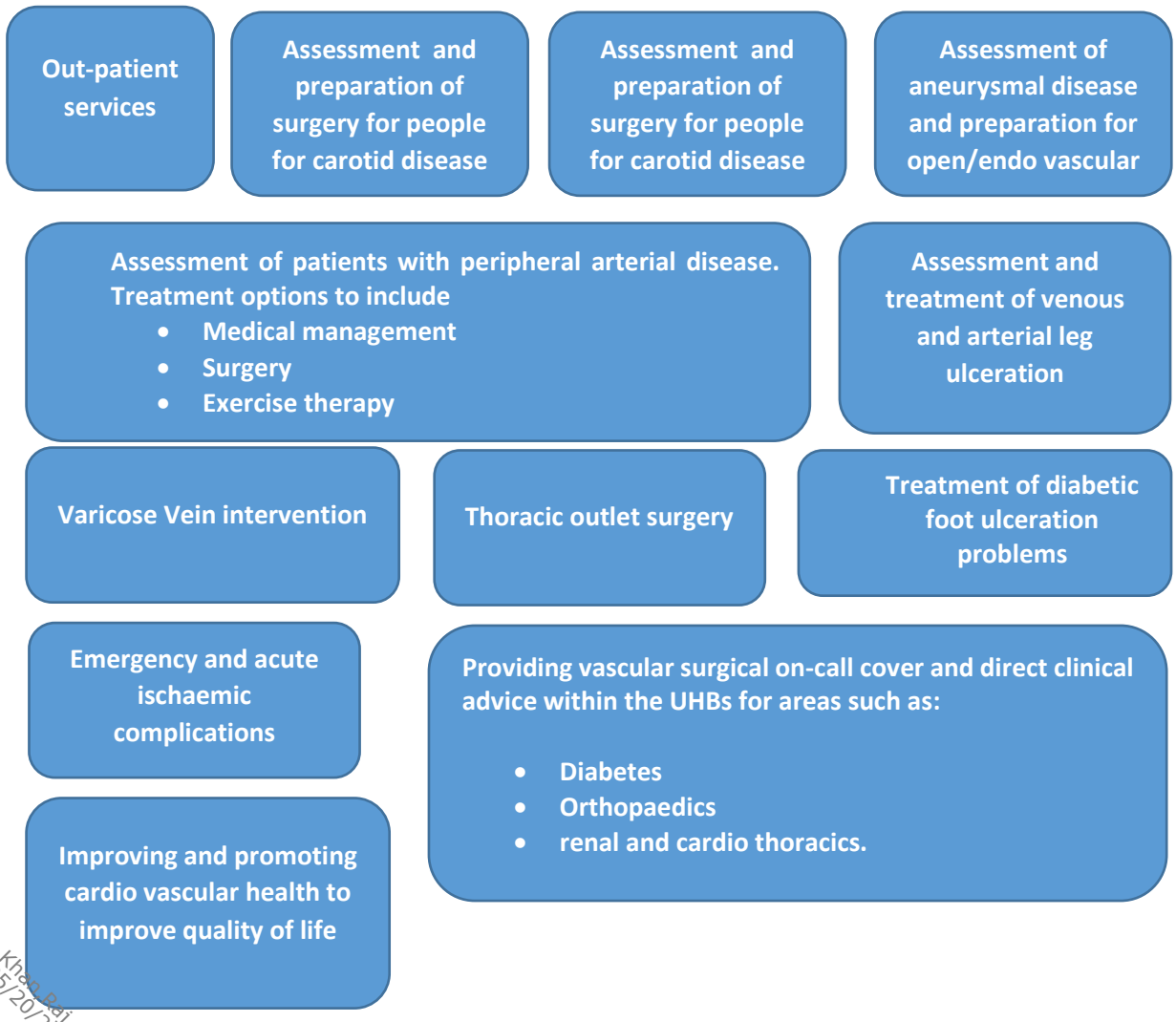
Local Context

Collectively, Aneurin Bevan University Health Board, Cardiff and the Vale University Health Board and Cwm Taf Morgannwg University Health Board provide Vascular services to the following populations:

GWENT	CWM TAF MORGANNWG	CARDIFF & THE VALE OF GLAMORGAN	POWYS
Blaenau Gwent	Rhondda	Cardiff	South Powys
Caerphilly	Cynon	Vale of Glamorgan	
Monmouthshire	Taff Ely		
Newport	Merthyr Tydfil		
Torfaen			

- *Note that the population of Bridgend is served by the South West Vascular network*

A summary of the services that are provided is offered here (you can find a simplified description of all in the glossary of terms:



To deliver these, each Health Board has full access to:

- A vascular team that comprises vascular surgeons, vascular anaesthetists, vascular interventional radiologists, clinical nurse specialists, podiatrists, tissue viability nurses, physiotherapists, occupational therapists, social workers, pharmacists and members of the prosthetics team. The teams are used to working across Health Board boundaries.
- A dedicated vascular ward. There is a provision for inpatient facilities along with day case access for various veins and minor day case surgery. Outpatient clinics are held in each Health Board area.
- Access to Doppler ultrasound, Computer Tomography (CT) and Magnetic Resonance (MR) Angiography..
- Vascular clinics within their area and has weekly interventional radiology clinics in which patients are consented for interventional radiology procedures.
- An interventional radiology suite with high quality rotational fluoroscopic imaging, in a room which is equipped for a full range of anaesthetics. The rooms can be used for endovascular aneurysm repair, combined vascular surgery and interventional radiography techniques.
- Day Case and Short Stay Facilities for minimally invasive varicose veins procedures are performed under local anaesthetic.
- Operating Theatres
- Vascular team access to a critical care unit
- Pathways in place for those patients presenting with critical limb ischaemia (CLI)
- Out of hours arrangements (which are already managed across Health Board sites). Normally, vascular patients are referred to the admitting general surgical on call team and depending on the urgency, the patient is either assessed by the emergency surgeon or referred directly to the vascular surgeon.
- In hours interventional radiology
- Out of hours interventional radiology which is managed via an on call rota, meaning that outside of normal working hours, the patients are admitted by the on call surgical team at UHW and assessed. If emergency interventional radiology input is required, the case is discussed with the vascular surgeon on for the region, who will in turn contact the on call interventional radiologist.

It should be noted however that at the time of writing, temporary arrangements have had to be put in place to support Cwm Taf Morgannwg whose vascular service has recently become unsustainable. There are therefore temporary

arrangements in place with services being provided to patients from Rhondda, Cynon, Taff Ely and Merthyr Tydfil by vascular services in Gwent and Cardiff and the Vale of Glamorgan

5. HOW DO WE PERFORM?

The following information provides information about how well each of the Health Boards in South East Wales does in respect of the key areas of vascular service provision:

- **Abdominal Aortic Aneurysm**

An **abdominal aortic aneurysm** (AAA) is a bulge or swelling in the **aorta**, the main blood vessel that runs from the heart down through the chest and tummy. An AAA can be dangerous if it is not spotted early on. It can get bigger over time and could burst (rupture), causing life-threatening bleeding

In the UK in 2019, 3445 people underwent surgery for abdominal aortic aneurysm. Of these, 80 people were from the South East Wales region. 44 were from the Aneurin Bevan University Health Board area, 21 from the Cardiff and Vale University Health Board area and 15 from within Cwm Taf Morgannwg Teaching Health Board.

The National AAA screening programme recommends that patients have treatment within 8 weeks of referral (56 days). The actual wait nationally is on average 69 days. Performance in the South East Wales region is set out below:

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
Elective Infra-renal Cases	**2019**	**44**	**21**	**15**	
Type of elective infra-renal AAA repairs	2019	64% EVAR	62% EVAR	60% EVAR	61% EVAR
Average time from assessment to procedure	2019	67	68	111	69
Average length of stay for open repair	2019	9	9	9	7
Average length of stay for EVAR	2019	1	3	2	2
Risk adjusted survival	2017-2019	98.40%	94.40%	98.20%	98.60%

The average length of stay for patients in the South East Wales region is in line with the national range.

The Vascular Services Quality Improvement rated all three health boards in South East Wales 'Green' on a green, amber, red scale for elective abdominal aortic aneurysm outcomes.

- **Lower Limb bypass for peripheral arterial disease**

Peripheral artery bypass is surgery to reroute the blood supply around a blocked artery in one of your legs. Fatty deposits can build up inside the arteries and block them. A graft is used to replace or bypass the blocked part of the artery. In the UK between 2017 and 2019, 18'090 people had a bypass of this kind. 6'807 of these were undertaken as an emergency and 11'283 as a planned procedure. Of these, 497 were in the South East Wales region.

Nationally, the average length of stay for a patient who has had a planned surgery is 5 days and average length of stay for a patient admitted as an emergency is 14. How Health Boards in the South East Wales region compare is outlined below

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**206**	**209**	**82**	
Average Length of stay	2017-2019	7	9	9	7
Risk adjusted survival	2017-2019	97.8%	96.8%	99.0%	97.6%

The Vascular Services Quality Improvement rated one of the Health Boards in the South East Wales area as green, and two of the health boards as 'Amber' due to a slightly higher than expected length of stay in hospital.

- **Lower limb bypass angioplasty and stenting**

Angioplasty is a procedure to open narrowed or blocked blood vessels that supply blood to your legs. Fatty deposits can build up inside the arteries and block blood flow. A stent is a small, metal mesh tube that keeps the artery open. Angioplasty and stent placement are two ways to open blocked peripheral arteries. Between 2017 and 2019, 23'881 procedures of this kind were carried out across the UK. Of these 6'605 patients were admitted as an emergency, and 17'276 as planned procedures.

The number of patients across the South East Wales region during this period is recorded as 265, however there are some challenges with validation of the data in both Aneurin Bevan and Cardiff and Vale University Health Boards, .so the actual figure is likely to be much higher.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**25**	**90**	**150**	
Average Length of stay	2017-2019	0	2	0	100%
Risk adjusted survival	2017-2019	92.50%	97%	99.30%	98.40%

The Vascular Services Quality Improvement rated One Health Board in the region as 'Green' on a green, amber, red scale for lower limb angioplasty and stenting, and two red based on incomplete data sets.

- **Major lower limb amputation**

There are occasions when the blood flow in the legs cannot be increased and an operation is not possible. In these cases, and amputation of the leg may be required. During 2017 – 2019, there were 10'022 procedures of this kind undertaken across the UK. The average length of stay for patients nationally is 23 days. All 3 Health Boards in the South East Wales region have higher lengths of stay than the national average.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2017-2019**	**132**	**113**	**86**	
Average time from assessment to procedure	2017-2019	8	10	37	7
Average length of stay	2017-2019	29	40	27	23
Risk adjusted survival	2017-2019	98.4%	96.2%	96.0%	95.4%

The Vascular Services Quality Improvement rated all three health boards in South East Wales 'Green' on a green, amber, red scale for lower limb amputation outcomes.

- **Carotid endarterectomy**

A **carotid endarterectomy** is a surgical procedure to unblock a carotid artery. The carotid arteries are the main blood vessels that supply the head and neck. During 2017 and 2019, there were 4'141 of these procedures carried out in the UK. The recommended time from symptom to treatment is 14 days.

75 of these patients were from the South East Wales region and were all treated underneath the minimum timescale of 14 days. The average national length of stay for patients who undergo this procedure is 2 days. 2 of the 3 Health Boards are within this range, with one reporting a higher length of stay than the national average.

Metric	Period	Aneurin Bevan UHB Figures	Cardiff & Vale UHB Figures	Cwm Taf Morgannwg UHB	National
No. of Cases	**2019**	**49**	**4**	**22**	
Median time from symptom to procedure	2019	12	8	8	12
Median Length of stay	2019	1	7	2	2
Risk adjusted stroke free survival	2017-2019	96.60%	100%	98.60%	98.10%

The Vascular Services Quality Improvement rated two of three health boards in South East Wales 'Green' on a green, amber, red scale for carotid endarterectomy outcomes. Cardiff and Vale University Health Board were rated 'Red' due to a low ascertainment rate i.e. an incomplete data set.

6. WHAT ARE THE CHALLENGES FACING THESE SERVICES?

Vascular services need to be provided in a safe and sustainable way that is consistent with National guidelines and best practice. The key challenges facing the service at this time are summarised below:

- **A growing need for the service –** There is an increasing demand on vascular services across the South East Wales region due an increasing population and worsening rates of diabetes. There are a number of issues that contribute to this:
  - **Age** - Vascular disease and its consequences increase with age. Our 65 to 84 and 85+ age groups are projected to have the largest increase by 2036, when an estimated one in four people in Wales will be aged 65 and over. These projections will have significant implications for the way in which we design and provide health (and increasingly integrated health and social care) services. With an increasing population and especially an increasing older population it is even more important that we support the people living in our communities to live long and healthy lives, free from the limiting effects of multiple chronic conditions.
  - **Diabetes –** There is a diabetes epidemic in Wales. There are more than 194,000 people over the age of 17 diagnosed with diabetes and, we estimate, a further 61,000 people living with undiagnosed Type 2. This takes the total number of people living with diabetes in Wales now to over 250,000. It is not just the raw figures that are concerning. Wales' prevalence as a proportion of its population is 7.4% - the highest in the UK and Western Europe. The number of people with diabetes has been steadily increasing and has doubled in the last 20 years. NHS Wales estimates 11% of our adult population will have the condition by 2032. This is mainly a result of the drastic increase in Type 2 diabetes. This is unsustainable, both for our health service and wider society. Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher. Prevalence of peripheral arterial disease was 4.5% in the general population but increased to 9.5% in people with diabetes. It is likely that the great increase in the number of patients with diabetes over the next decade will have the biggest impact on vascular services. Many of these patients present as an emergency and are at high risk of amputation. Prompt treatment of the infected diabetic foot can minimise the risk of subsequent amputation. Lower limb amputation is carried out

more than 20 times as often in people with diabetes than it is in people without diabetes. Only around half of people who have lost a leg because of diabetes survive for two years.

- **Smoking -** Smoking is a major cause of vascular disease and over 80% of vascular patients are current or ex-smokers. Smokers are at greater risk of complications from vascular interventions because of cardiac and respiratory co-morbidity and the longer-term success of vascular intervention is reduced in patients who continue to smoke. (HSE 2007)

- **Obesity –** Obesity and being overweight are linked to several factors that increase risk for cardiovascular disease. Almost 60% of adults in Wales are currently overweight or obese, of which 24% are obese. There is evidence of an upward trend in recent years. It is estimated that the percentage of adults who are overweight or obese will increase to around 64% by 2030 if the current pattern continues.

- **Minimum population requirements -** A minimum population of 800,000 is considered necessary for an Abdominal Aortic Aneurysm screening programme and is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units meet this requirement.

- **Meeting quality standards -** Not all units are able to currently achieve the quality indicators individually as units. These are:
  - The Vascular society recommends a vascular unit should be performing 60 elective aneurysm repairs per year. Collectively in SE Wales 99 aneurysm repairs were performed in 2019. No units individually reached the required number.

- The Vascular society recommends a vascular unit should be performing 40 carotid endarterectomies per year. Collectively in SE Wales 75 were performed in 2019.
- Between 2017-19 497 bypass procedures and 331 major limb amputations were performed in SE Wales.

- **Workforce –** A workforce survey undertaken by the Vascular Society for Great Britain and Ireland in 2019 concluded that both the number and complexity of vascular surgery procedures per capita population is increasing year-on-year. Worldwide there is a shortage of vascular surgeons to meet increasing demand and this shortfall is significant in the UK. There are a few workforce challenges to note:
  - Vascular services need to be organised to allow reasonable volumes of elective activity to exist alongside an acceptable consultant emergency on call rota thus ensuring appropriate critical mass of infrastructure and patient volumes.
  - The vascular society recommend 1 surgeon per 100,000 of population. (it was previously 1 per 130,000 population). This would mean that South East wales should have 14 consultants supporting vascular services in the area. It actually has 9 surgeons across the 3 provider Health Boards. Seven of these cover on-call arrangements too which means there is very little opportunity to foster learning and growth in the workforce.
  - There is challenge in recruiting to vascular posts in Wales and even where appointments happen, retention proves very difficult.
  - The age profile of current consultants and vascular nurse specialists makes it very difficult to succession plan.
  - Disparate teams mean that there is little opportunity for people to specialise however this is something that we know would attract more consultants and specialist therapists.

- **Services spread across South East Wales –** The National Vascular Registry has shown a constant improvement in vascular surgical outcomes over the last 10 years. However, as shown above this could be improved further by concentration of services into a single arterial hub. The Getting It Right First Time (GIRFT) report showed co-location of vascular services with other specialist services such as nephrology, major trauma and interventional radiology improve outcomes. This is not currently the case within the South East Wales region.

- **Patient outcomes -** There is strong evidence that case volume influences outcomes. The 31 highest volume hospitals (which perform 57% of all elective Abdominal Aortic Aneurysm procedures in the UK) have mortality rates that are under half those seen in the 32 hospitals with the lowest volume of procedures. These data lend support to the current move towards performing major arterial surgery in larger volume units in order to further optimise outcomes. The Royal College/national professional view, is that it is no longer acceptable to provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service.

All of the issues outlined above mean that services are becoming increasingly unsustainable and could become unsafe unless changes to the way services are organised and delivered are made.

The service models emerging nationally across the UK all enable sustainable delivery of the required infrastructure, patient volumes, and improved clinical outcomes and are based on the concept of a network of providers working together to deliver comprehensive patient care pathways, centralising where necessary and continuing to provide some services in local settings. There are a number of reviews and reports that support this which include:

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012) (http://www.vascularsociety.org.uk/library/quality-improvement.html)
2. Getting it right first time (2018) (https://gettingitrightfirsttime.co.uk/wp-content/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf)

7. WHAT OPTIONS HAVE WE CONSIDERED TO RESPOND TO THE CHALLENGES?

Our focus must be on long term resilience and sustainability of vascular services, therefore, changes to how the services are currently being delivered will be required to ensure that everyone in need of vascular care receives it without unnecessary delay.

Our aim is to create vascular services that:

- Achieve best practice agreed by experts, to get the best outcomes for patients and the best chance of survival
- Ensure we have more doctors with the right specialist skills
- Meet national standards

The issues outlined in the previous chapter that are facing the service have been emerging over recent years. Unsurprisingly therefore, our clinicians and senior leaders have already been giving some thought to how they may respond to the challenges.

During 2014, senior clinicians across the Health Boards undertook a clinical option appraisal about the best way that services may be organised in the future. They tested the following options for future delivery which would help reduce the risks of future delivery:

Option 1	**Do nothing** – Continue to deliver all services as they are with a thin layer of regional co-ordination to share best practice
Option 2	**Centralise delivery** - All services are delivered to the three Local Health Boards by a central team, located in one of the provider Health Boards. A single site for all vascular surgery services in South East Wales.
Option 3	**Single hub and spoke model**-Some functions, services and procedures (or elements of such) are delivered at scale by a central team, within one provider Health Board – the hub. These would only be provided at this central site location for SE Wales. Other functions and services are delivered on a more local basis, through spokes.

Option 4	**Multiple hubs** - Each LHB leads on a specific function or functions within the overall service, on behalf of all LHBs across SE Wales, e.g. arterial surgery.
Option 5	**Outsourcing -** All services are provided for Health Boards in South East Wales by another provider, which is not one of the constituent Health Boards of the network, but for which the network acts as the commissioner of the service.
Option 6	**A whole of South Wales option.** Widening the scope to include that which is currently provided by the South West Wales Vascular Network, to establish a joined up network across all of South Wales. If this was a viable option at this stage of the development of both networks, this would again then open up a range of future options to be considered, including many of the above, but on a wider South Wales basis. The initial option of considering this approach in this way at this stage was worth considering however, if only to discount it at this stage.

A range of clinical and managerial staff appraised the options against the following criteria:

- Quality & Safety (highest priority)
- Acceptability
- Strategic Fit
- Sustainability (ability for the services to be fit for now and the future)
- Access
- Achievability

They also considered the growing evidence base and used this to inform the proposed future service model for vascular surgery services in SE Wales. This includes a number of recommendations and published evidence of the Department of Health (DH) in England, the Vascular Society of Great Britain and Ireland (VSGBI), the Royal College of Radiologists (RCR), the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and all relevant NICE Guidance.

Based on considering the evidence, and a full range of issues, the outcome from the clinical option appraisal was that the most feasible option for the future

delivery of vascular services in South East Wales is considered to be a hub and spoke model, managed through a clinical network as outlined in option 3.

There are a number of areas across the UK that are already configured in this way, and a number of reports and recommendations that support a networked arrangement for the organisation and delivery of vascular services with strong evidence that improvement to outcomes for patients undergoing vascular surgical procedures are seen as a result of centralising vascular surgery to a Major Arterial Centre. A more detailed description on the way we may organise delivery against a hub and spoke model is outlined in the following chapter.

8. PROPOSED SERVICE MODEL

There is strong National and International evidence that patients who need vascular interventions will receive a better quality of care and have a better chance of survival when they are treated and cared for by specialists (including vascular surgeons, interventional radiologists, nurses and therapists) who see a large number of these patients, which helps specialists to develop and maintain expertise in their field of work.

Based on considerations over recent years, there is good clinical consensus to proposed that if supported, the new vascular service will be based on a hub and spoke model and will have:

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging);
- Outpatient management of patients with peripheral arterial disease;
- Inpatient spells, emergency and elective activity;
- Day case activity;
- Multidisciplinary outpatient follow up of patients receiving vascular surgery/endovascular interventions;
- Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care;
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.
- A dedicated vascular day case facility in both hub & spoke to allow day case surgical & interventional radiology procedure.

It is proposed that the hub and spokes have the following components:

HUB	**SPOKE**
➢ Emergency Vascular Service: • Amputations and "*nibbling*" • Aneurysm surgery;	➢ Emergency Vascular Service:- • Angiogram; • Angioplasty

• Patients requiring CEA within 48 hrs of index event; • Peripheral arterial reconstructions.	• As noted above, the "front door" will remain the patient's local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service; • Rehabilitation.
➢ **Elective Vascular Service:** • Abdominal Aortic Aneurysm • Endovascular aneurysm repair • Carotid endarterectomy	➢ **Elective Vascular Service:-** • Venous surgery angiography and angioplasty; • Outpatient clinics

Based on this, the main procedures that are expected to transfer from each of the current sites to any future hub are the following:

- ➢ Iliac and femoral artery procedures
- ➢ Carotid
- ➢ Open Abdominal Aortic Aneurysm
- ➢ Endovascular Abdominal Aortic Aneurysm
- ➢ Open Thoracic Aortic Aneurysm
- ➢ Thoracic endovascular aortic repair (TEVAR)
- ➢ Operations on vena cava
- ➢ Other artery.

To achieve delivery, there will be a number of infrastructure requirements for both the hub and the spoke:

HUB	SPOKE
➢ Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward; ➢ Hybrid theatre, with experienced vascular theatre staff; ➢ Scheduled elective lists (IP / DC); ➢ Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub; ➢ Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available on-site to support the vascular service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients ➢ Interventional radiology suite with access to nursing staff trained in vascular procedures. ➢ Out-patients clinics	➢ Mixed surgical wards but with ring fenced vascular beds; ➢ CEPOD theatre model; ➢ Interventional radiology; ➢ Scheduled elective DC lists; ➢ Outpatient Clinics – including access to nurses/therapists experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. To support this, it is also assumed that each of the spoke sites will have the following: ➢ A consultant led Emergency Department (A&E); ➢ An Emergency General Surgery service.

Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the co-dependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, the preferred option for the hub is identified as the University Hospital Wales, Cardiff. Given the need for consultant led A&E and a general surgery emergency service, the spokes for each of the areas are proposed as:

- **Aneurin Bevan University Health Board** – Grange University Hospital and Royal Gwent Hospital
- **Cwm Taf Morgannwg Teaching Health Board** – Royal Glamorgan Hospital, Llantrisant
- **Cardiff and Vale University Health Board** – Llandough Hospital Vale of Glamorgan

It is important to note that as patients begin their recovery and rehabilitation journey, that this too will be provided from a hospital/community setting which is much more local to them

Patient 1 : Mrs Edmunds

Mrs Edmunds is an 81 year old lady who has lived in Crickhowell all her life. Ten days ago, while getting ready for bed, her husband noticed that she was slurring her words and her right arm seemed clumsy and weak. Worried that his wife was having a stroke Mr Edmunds dialled 999 and Mrs Edmunds was taken to Grange University Hospital by ambulance.

On admission to hospital she was assessed by the Acute Stroke Team and underwent a CT scan of her brain and the next day underwent an ultrasound scan (duplex scan) of her carotid arteries (these are the arteries in the neck that supply the brain). The duplex ultrasound scan showed that Mrs Edmunds had a 90% narrowing in her left carotid artery. The Acute Stroke Team told Mr Edmund's that he had done exactly the right thing.

The Stroke Physican telephoned the Vascular Surgical Regional Coordinator on the same day that the duplex scan was performed. After discussion with the duty Vascular Surgeon Mrs Edmunds was offered the choice between an operation at University Hospital of Wales (UHW) to "clear out" the blockage in her carotid artery (carotid endarterectomy) or continuing with medication. The Vascular Surgeon at UHW felt that, on balance, the operation would reduce her risk of stroke more than medication alone.

After discussion with her husband Mrs Edmunds decided that she would like to go ahead with surgery. She was transferred to Cardiff as a “day of surgery admission” and underwent left carotid endarterectomy under local anaesthetic. As is usually the case, she made an uncomplicated post-operative recovery and was allowed to go home to Crickhowell the next day. She was offered the choice of a telephone follow up consultation or a clinic appointment with a vascular surgeon at Nevill Hall Hospital in Abergavenny 6 weeks after the operation. At follow up she had fully recovered from her stroke and had made a good recovery from her operation.

9. ADVANTAGES/DISADVANTAGES & IMPACT

WHAT ARE THE ADVANTAGES OF THE PROPOSED CHANGES?

There are significant benefits to the model proposed:

- A sustainable delivery model that will provide the best outcomes to all patients within the region as advised by the Vascular Society. The vascular surgeons will work as a team to provide a resilient vascular surgical workforce model for the region's patients.

- Patients admitted to the 'Hub' will be nursed on a specialist vascular ward and receive daily review, including weekends, by a consultant vascular surgeon ('Consultant of the Week') working within a specialist multi-disciplinary team.

- Patients admitted to the 'Hub' will have on site access 24/7 to both vascular surgery and vascular interventional radiology.

- Aside of surgery, all other parts of a patient's treatment and rehabilitation will happen in their own area (with the exception of Powys residents who may access services in Cwm Taf Morgannwg or Gwent).

- Rapid access to diagnostics and interventions forms part of a high quality service. The need for this has been an important driver for centralisation, as it requires around the clock working, which larger units are better placed to provide. The units would be staffed by vascular specialists and would operate 24 hours a day, seven days a week.

- Performing all complex procedures at central units would ensure all patients have their surgery at a high volume hospital by an experienced vascular specialist, using the latest technology and techniques

- Centralisation should ensure improved facilities for patient care (dedicated vascular wards), investigation (larger radiology units with 24/7 interventional radiology) and treatment (vascular operating theatres and staff, vascular anaesthetists, improved facilities for endovascular management, better critical care).

WHAT WOULD THE IMPACT BE?

The proposals could mean:

- Patients would potentially need to travel further for their operation, as would their visitors
- Patients would be treated at a centre carrying out higher volumes of complex work, which is linked to improved outcomes
- Patients would be treated by a surgeon or interventional radiologist carrying out large volumes of complex work
- Patients would be able to access the full range of procedures 24/7

ARE THERE ANY DISADVANTAGES TO THE PROPOSALS ?

Some patients from the Aneurin Bevan and Cwm Taf Morgannwg areas will need to travel to University Hospital of Wales - rather than the Royal Gwent or Royal Glamorgan Hospitals - to receive surgery, as they do now out of hours. Powys residents will need to go to University Hospital of Wales for their surgery rather than to the Grange University Hospital in Cwmbran.

10. HOW YOU CAN CONTRIBUTE : ENGAGEMENT AND CONSULTATION.

This is the beginning of our conversation with you about Vascular services in South East Wales. We would like to hear your thoughts about what you have read. Specifically:

- Whether you have an understanding of what vascular services are
- How services are currently provided
- The challenges facing the services and some of the options that have been considered for the future organisation and delivery of the services.

A questionnaire is attached at to aid your response. It should be returned to:

South East Wales Vascular Programme
Woodland House
Maes Y Coed Road
Cardiff
CF14 4HH

WHAT NEXT?

When this engagement exercise has ended, the 4 Health Boards will consider all the feedback and share this with the individual Health Boards and the relevant Community Health Councils. We will also publicly make available a report that outlines a summary of what has been received. We will consider all the issues and whether there are any mitigating actions that need to be taken. We will also use the information received to update the Equalities Impact Assessment.

Subject to further discussions with the Community Health Councils, we may wish to enter a period of formal consultation and should we do that we will once again invite your views.

B. Engagement Plan

STAKEHOLDER GROUP	SPECIFICALLY	PRODUCT	RESPONSIBLE	HANDLING PLAN/RELEASE DATE
Comms leads	All affected HBs	All core documentation for posting on HB websites	Programme Manager	Ensure ready to run and cascade with: Launch of documents Cascade through established networks and mechanisms
General Public	Population of Aneurin Bevan University Health Board • Blaenau Gwent • Caerphilly • Monmouthshire • Newport • Torfaen	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	ABUHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Population of Cardiff & Vale University Health Board • Cardiff • Vale of Glamorgan	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	C&V Planning/engagement lead	Day of launch through existing public cascade mechanisms
	Affected population of Cwm Taf Morgannwg University Health Board • Rhondda • Cynon • Taff Ely • Merthyr Tydfil	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line	CTM Planning/engagement lead	Day of launch through existing public cascade mechanisms

		resources ie videos		
	Affected population of Powys Teaching Health Board • South Powys	Core document Summary document EQIA Invite to online events/presentations Access to websites and on-line resources ie videos	PTHB Planning/engagement lead	Day of launch through existing public cascade mechanisms
Welsh Government	Director General Health and Social Care	Letter from chair of Vascular Joint Programme Board (Ann Lloyd) signposting towards resources website etc	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch
Patients, their families and carers	Patients who have received services since 2019 (linked to timescales outcomes reported in NVR report) with reference to inviting views from families and carers too	Letter from relevant consultant/MDT Core document Summary document Invite to online events/presentations Access to websites and on-line resources ie videos Access to a telephone line for discussion	Planning leads with MDT teams	Week of launch
NHS Wales	All CEOs of HBs and Trusts in Wales: Aneurin Bevan University Health Board Betsi Cadwaladr University Health Board Cardiff and Vale	Letter from Chair of Joint Vascular Board Ann Lloyd identifying launch and signposting towards all products	Chair of Vascular Board – engagement lead (CH) to draft	Following approval at Boards and just before launch

	University Health Board Cwm Taf Morgannwg University Health Board Hywel Dda Health Board Powys Teaching Health Board Swansea Bay Health Board Velindre NHS Trust Welsh Ambulance Services Trust			

Community Health Councils	AB CHC C&V CHC CTMCHC PCHC	Report to joint Board CHCs 13 Jan 21 Receipt of all documentation	Programme Manager	Launch day
Third Sector Organisations	GAVO TVA PAVO CAVOC	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Launch day
National bodies/organisations including Professional Societies and Royal Colleges concerned with the delivery of Vascular Surgery	Plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day
National Voluntary Organisations	Plotted by programme	Core document, summary document and signpost to online resources and opportunities	Programme Manager	Launch day

Local authorities and elected representatives	CEOs & Leaders of the councils	Core document, summary document and signpost to online resources and opportunities	Health Board leads	Via local cascade mechanisms requesting sharing with staff and members

National Politicians	Members of the Senedd and Members of Parliament	Core document, summary document and signpost to online resources and opportunities	Programme Manager	via a letter from Chair of vascular group
Stakeholder Reference Groups	ABUHB SRG C&V SRG CTM SRG PTHB SRG	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Trade Union Partnership Fora	ABUHB TUPF C&V TUPF CTM TUPF PTHB TUPF	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
EQIA Targeted groups	Local Diabetic groups National Stroke Association and any local stroke groups	Core document, summary document and signpost to online resources and opportunities	Programme Manager as links to programme EQIA	Group contacts to be sourced by programme manager
Town and Community Councils	All town and community councils in Gwent, Cardiff, Vale of Glamorgan, Rhondda, Cynon, Taf Early and Merthyr and South Powys	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch
Local Medical Committees	Aneurin Bevan LMC	Core document, summary	ABUHB lead C&V lead	Via local cascade mechanisms on

	Cardiff and Vale LMC Cwm Taff Morgannwg LMC Dyfed-Powys LMC	document and signpost to online resources and opportunities	CTM lead Powys lead	day of launch
Public Service Board and Regional Partnership Boards	Powys Regional Partnership Board Powys Public Service Board	Core document, summary document and signpost to online resources and opportunities	ABUHB lead C&V lead CTM lead Powys lead	Via local cascade mechanisms on day of launch

C. Public Engagement notes

C1. Cardiff and Vale Public Engagement Notes - 16.03.021

Audience: Public Meeting

Meeting Details: Tuesday 16 March at 7.00 pm on Zoom

Number of attendees: 1

UHB Presenters: Alun Tomkinson; Kevin Conway; Gininna Conway; Abigail Harris

Also in attendance:

CHC - Malcolm Latham, Chair; Stephen Allen; Caroline Harris; Amy English

UHB - Victoria Legrys; Alaa Khundakji; Daniel Marsh; Andrea Bird; David Williams; Anne Wei

Interpreter – Gwnfor Owen

Following a welcome and introduction by the CHC and UHB, the UHB gave a presentation. The meeting was opened up for Q&A and discussion:

- A concern about repatriation. Currently there exists a problem in the system, won't this become more difficult with patients from additional Health Boards involved?

UHB response:

- *Cardiff and Vale UHB has been working with Cwm Taf for the last 6 months and repatriating to Cwm Taf hospitals. A good working relationship exists between the vascular teams and we are successful in discharging rapidly. We are planning a similar relationship with Aneurin Bevan UHB and they have multiple sites. Work is on-going at University Hospital Llandough to prepare for becoming a spoke site.*

- Recruitment. There is a national shortage of Interventional Radiologists and for this proposal a critical mass of support staff will be required. Are you preparing for this risk?

However, I believe the idea is very sound.

UHB response:

- *Currently, we have 24/7 on-call cover by interventional radiologists with 7 full-time consultants. For our population we should have 8. However, we have a trainee who has indicated a wish to work in SE Wales. There are shortages in the rest of Wales but we are in a fortunate position in SE Wales.*

- A related, supplementary concern about the availability of a critical mass of staff and being able to cope following the Covid pandemic. Would it be necessary to outsource work to address the backlog?

UHB response:

- *No vascular services are outsourced. Because of the immediate needs of those requiring vascular surgery we don't have waiting lists. While it may be necessary to wait in hospital for this, there is no list of people waiting at home.*

- I think the logic of the network for vascular services is sound but there may be some travel issues to deal with for those in other areas who must travel further.

- What will be the protocol for patients who experience problems following vascular surgery after they have left the hub?

UHB response:

- *Repatriation to the spoke hospital will enable physiotherapists, occupational therapists and others to offer rehabilitation but, if there is a problem, it will be picked up quickly by the vascular team. There will be cover at the spokes for wound care but if in-patient care at the hub is needed, the patient will transfer back.*

- Yn Gymraeg / In Welsh: A question about transport and the accessibility of University Hospital Llandough and a supplementary question about the possibility of patients being seen as close as possible to friends and family.

UHB response:

- *Consultant, Kevin Conway expressed an awareness of the difficulties having recently seen patients who'd needed to take 3 buses to see him at Prince Charles Hospital. He had been pleasantly surprised how well virtual clinics and phone clinics had worked during the pandemic and how they had saved the effort of travelling. He hoped to expand the use of virtual clinics having found that many elderly people could use the technology and responded well. However, there would always be hospital transport for those needing to be seen in person.*
- *In addition, the Health Board is working with the local authorities to improve transport links to both hospitals and there are Park and Ride services.*
- *The Health Boards will be seeking to see more patients closer to home and are mindful of access issues.*
- *In this model, the separation for rehabilitation allowed a model suitable for this service.*

- Yn Gymraeg / In Welsh: What are the day to day connections with cardiology services and will the change affect this?

UHB response:

- *Assurance was given that the vascular surgeons work closely with cardiologists and are in constant communication with them. These changes will further improve the close working.*

- From the point of view of the residents of Cardiff and the Vale of Glamorgan, do these changes mean any real change or improvement in service?

UHB response:

- *It would be an improved service, firstly because Cardiff and Vale UHB currently has 3 vascular surgeons and when the network is complete would have 11. It also gives people the opportunity to develop speciality intensivist and sub-speciality skills. This development gives the opportunity to develop our services significantly.*
- *The emphasis on rehabilitation and prehabilitation is very important for outcomes and has probably been neglected in the past. This is good for*

the vascular surgeons but above all for the patients.

- Will the fact that patients from neighbouring Health Boards are referred to UHW cause a delay in treatment for Cardiff and Vale residents?

UHB response:

- *The intention is to develop a consultant of the week and also a surgeon of the week timetable. Also, to develop 'hot clinics' where patients will be seen on the same day or the next day. The network will allow us to justify the case for a hybrid theatre and state of the art technology which without vascular redesign we couldn't have. In summary, this is a win-win improvement in service for all patients and staff alike.*

- Assurance was sought that Cardiff and Vale residents would not have to wait in a longer queue because of being treated alongside residents from elsewhere.

UHB response:

- *Assurance was given, supported by details: previously the service had access to 19 beds but it would have 38 beds; previously operations took place on 3 days but in future there would be 8 days of theatre per week. There would be an increase in radiology capacity and an increase in the capacity for out-patients. All the component parts would improve the robustness and resilience of the service for Cardiff and Vale residents.*
- *Additionally, the presence of vascular surgeons in a hospital provides a good resource for other surgeons, e.g. for those doing bowel or kidney operations. Having vascular surgeons nearby can make a real difference and is one of the key reasons why it has to be co-located with the Major Trauma Centre in Cardiff. The residents of Cardiff could be assured of being in a safer place.*
- Hospital acquired infection rates. Knowing that there were some problems in cardiac services last year, the public might like assurance that Cardiff and Vale UHB have this under control.

UHB Response:

- *Acknowledged that we had learnt a huge amount from Covid in the last 12 months and described how we had divided the hospital into zones and*

kept time critical surgery separate. In the green zones, 5000 patients had been treated and there had been no cases of Covid or MRSA or other hospital acquired infections. Noted that the Health Board was keen to maintain those protected elective zones. In the emergency zone it was more difficult to protect patients from post-operative infections. Overall there had been a significant learning and change in practice.

At 7:52 pm, the CHC Chair called for final questions. There were none. The CHC Chair then thanked the speakers for their answers and those attending for their questions and observations. He noted that the CHC would formally respond to the Health Board and asked people attending to encourage others to fill in the questionnaire. Alun Tomkinson thanked people for spending their time on the engagement and hoped they were reassured.

18.03.2021

Audience: Public Meeting

Meeting Details: Thursday 18 March from 7:00 – 8:00 pm via Zoom

Number of attendees: 6

UHB Presenters: Richard Whiston; Mike Bond; Catherine Twamley

Also in attendance: CHC - Malcolm Latham, Chair; Stephen Allen; Amy English

UHB - Abigail Harris; Vicky Le Grys; Daniel Marsh; Andrea Bird; David Williams

Interpreter - Gwnfor Owen

Following a welcome and introductions to the presenters and his colleagues by CHC Chair, Malcolm Latham, the UHB gave a presentation. The meeting was then opened up for Q&A and discussion:

- Suitability of University Hospital of Wales (UHW) to be the hub. In acknowledging that surgery was the most complex part of the vascular service, asked whether the building had the capacity and was in good enough condition to take on the extra workload safely.
- Diagnostics. Wanted to check understanding that diagnostic procedures and other parts of the vascular service would be undertaken at spoke hospitals.
- Governance. Who would have oversight of the service if three Health Boards were involved? Would there be clear leadership and an integrated service, which would be what was required to produce the best outcomes?

UHB response:

- *Confirming the intention to bring expertise to the network hub at UHW, described the plans for a hybrid theatre which would have both surgical and x-ray capacity. There would be changes to accommodate patients from the other Health Boards, for example, the new rehabilitation facility at University Hospital Llandough (UHL) would release beds at UHW as South Glamorgan patients moved to their spoke.*
- *Regarding diagnostics, the plan was that these appointments should take place as close to home as possible to avoid travel to Cardiff. Recent*

positive experience of telephone and virtual appointments replacing outpatients' clinics was highlighted.

- *Advised that the Chief Executives of the three Health Boards had meet last week at Vascular Programme Board and approved key papers and that the Board met every 2 months to oversee the governance of the Vascular Programme.*
- *Noted that part of the work of the Vascular Programme, similar to that of the Major Trauma Centre Programme, was to put in place a robust structure. There were formal leads for the network e.g. the clinical lead was Peter Lewis, Vascular Surgeon, Aneurin Bevan UHB. This was intended to ensure transparency across the network. There were mutually agreed policies in place but the Health Boards had yet to define and agree a host organisation for vascular services. This role would usually be with the hub, i.e. with Cardiff and Vale UHB.*
- *Emphasised the experience of the Major Trauma Centre in showing successful practice where clear protocols and pathways facilitated working together and implementation across a network. Agreed that this was an important question and it was fortunate for the UHB that it had been raised to allow the opportunity to set out their position.*

- Protocols. In the case of someone suffering an embolism or aneurysm while out in Cwmbran, would s/he be taken to The Grange or UHW?

UHB response:

- *Speed of treatment is important but also expertise. Most such cases already come to UHW as emergencies. It is clear from data across the UK that it is important to get a patient to the right centre. For planned surgery, patients will be brought from the spoke to the hub as that is where the surgeons will be. There will be occasional instances where the consultants will need to go to spoke hospitals to treat and they are prepared to do that.*

- Transfer of patients. Would these transfers be by ambulance? Question whether the programme had worked with the Welsh Ambulance Service Trust (WAST) and whether they were fully aware of proposals.

UHB response:

- *Confirmation that discussions had taken place and arrangements were in place.*

At 19.57 hrs, Malcolm Latham, Chair asked for any final questions. He thanked the meeting for feeding in questions, comments and observations and noted that the CHC would formally respond to Cardiff and Vale UHB. The Health Board thanked the CHC for hosting and the audience for contributing to the event.

C2. Cwm Taf Morgannwg & Powys Teaching Health Board Public Engagement Notes - 11.03.2021

FIRST SOUTH EAST WALES VASCULAR ENGAGEMENT EVENT

11TH MARCH 2021

2:00PM – 3:30PM

(LIVE EVENT VIA TEAMS)

Panel Members

Mr Kevin Conway	Vascular Surgeon
Dr Stuart Hackwell	Locality Group Director, Rhondda & Taff Ely Locality
Marie-Claire Griffiths	Assistant Director of Strategy & Commissioning
Hannah Davies	Physiotherapy
Lee Leyshon	Assistant Director, Engagement & Communication

In Attendance:

Adrian Osborne, Assistant Director, Engagement & Communications, Powys Teaching Health Board

Michelle Lloyd, Business Support Manager, Cwm Taf Morgannwg University Health Board

Ben Screen, Senior Welsh Language Translator, Cwm Taf Morgannwg University Health Board

1. Marie-Claire Griffiths opened the public engagement event, welcome all and ran through the agenda for the day. Attendees were asked if they required Welsh language translation and it was noted that no Welsh language translation was required for this event.
2. Marie-Claire Griffiths commenced with a presentation around the South East Wales Vascular Network.
3. Panel members introduced themselves and gave a brief overview of their roles at slide 3 of the presentation.
4. Dr Stuart Hackwell presented slide 5 to the group which outlined what the aims are of the engagement i.e. to start a discussion with citizens about how vascular services are organised in the future.
5. Mr Kevin Conway presented slides 6 – 16 to the group which outlined:-

- What are vascular services?
- Who needs vascular services?
- How are services provided now?
- Why are we talking about them?
- Measures of how well organisation do?
- History of discussion to date
- Have we given thought to where the hub might be?
- What about the spokes?

6. Marie-Claire Griffiths presented slides 17 to 20 which outlined:-

- What would this mean for patients?
- How can you get involved?
- We want to hear your views?
- How can you contact us?
- Questions?

Marie-Claire Griffiths outlined the areas where we would like people to get involved as part of the engagement, these included views on:-

- The recommendation that a hub and spoke model will improve patient outcomes
- The proposal for UHW in Cardiff to be the Hub
- The suggested Spoke arrangements
- Any other information we should consider in deciding the future of vascular services
- The process undertaken to reconfigure services
- Any alternative view on the proposals put forward

Attendees were encouraged that if they should have any further questions, thoughts, comments or views in addition to any that they may have today to visit the website at : https://cwmtafmorgannwg.wales/sewalesvascular

In addition, questions can also be received via email to: sewales.vascular@wales.nhs.uk, a phone line with voicemail is also available the number for which is: 02921 836068, or the public can search #sewalesvascular on social media.

7. Questions:

The following questions were asked:-

Question 1 - Whether there should be two spokes in Aneurin Bevan and whether or not this was still valid after changes in the Royal Gwent as a result of the Grange Hospital opening.

Mr Kevin Conway responded to say that he had spoken to his colleague David Lewis about this and although the original Options Appraisal said that there should be a single spoke in each Health Board, it is slightly more complicated because of the way that the Grange University Hospital is set up. It is actually a specialist care centre so that means it has all the emergency services so it has got an emergency unit, it has the operating theatres and critical care unit but it does not have all of the rehabilitation services and outpatient facilities that the Royal Gwent Hospital had before. So, it is not a straight answer but Mr Conway's understanding was that at least initially it will be spread across the Grange University Hospital and the Royal Gwent Hospital.

Question 2 – Marie-Claire Griffith took this question from the pre-prepared 'Frequently Asked Questions'. What is a vascular network?

The aim of a Vascular Network is to improve patient outcomes and ensure that services are sustainable and equitable for the population they serve. A vascular network provides coordinated vascular services for a population across a wide geographical area and involving a number of different hospitals. Vascular services across NHS England and North Wales and West Wales have already been reconfigured into network models of care for a number of years. Most networks operate a 'hub and spoke' model of care which focuses major urgent and emergency vascular surgical procedures to be performed in one specialist hospital, the 'Hub'. Whilst minor procedures, investigations assessments, recovery following surgery and outpatient appointments still take place in local hospitals, the 'Spokes'.

Question 3 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. What is the difference between a hub and a spoke?

The crucial differences between a hub and a spoke are the seriousness of the conditions treated and the complexity of the procedures undertaken. The Hub

receives all vascular emergencies requiring vascular or endovascular intervention, along with all vascular inpatient urgent care. It has dedicated vascular inpatient beds in a ward staffed by nurses with an interest in vascular surgery. A spoke hospital provides everything other than complex and emergency vascular care and has no dedicated vascular hospital bed.

Question 4 - For those patients who do not have IT or social media how are their views obtained?

Marie-Claire Griffiths responded stated that posters have been developed and shared across GP surgeries, mass vaccination centres, posted on hospital TV screens which outlines that there are a number of options for the public to share their views with us. These include:-

- Via our website https://cwmtafmorgannwg.wales/sewalesvascular
- By email to the address: sewales.vascular@wales.nhs.uk
- By phone to 02921 836068 (there is also a voicemail service)
- Or via social media by searching #sewalesvascular

Lee Leyshon also advised that the public can also write to the Cwm Taf Morgannwg University Health Board with their questions, views or comments and also stated that the Health Board are open to any addition suggestions for engagement.

Question 5 – Which part of Powys does this affect?

Marie-Claire Griffith responded stating that this change primarily affects the South Powys area as that is the area at the moment that receives it vascular services through Aneurin Bevan University Health Board, other parts of Powys are either served through the South West or the North of Wales and also England.

Kevin Conway – added that as the Network Representative he had met with Powys Teaching Health Board Commissioners recently and that we are currently just looking at South Powys but we are looking at the potential to cover as far West as Ystradgynlais and as far North as Llandrindod Wells but that is only discussion but going back to the answer primarily it is only South Powys that will be affected.

NOTE **further confirmation was received from Powys following this response to say that pathways for Ystradgynlais and Llandridod Wells patients are not affected by these proposals and their pathways remain unchanged.

Question 6 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. How many patients do the changes affect?

The total number of patients likely to need a vascular procedure across South East Wales is approximately 1250 each year. This estimate is based on the numbers from the year 2019, which saw 456 patients treated at the Royal Gwent Hospital, Newport, 355 patients treated at the Royal Glamorgan Hospital, Llantrisant and 437 treated at University Hospital of Wales in Cardiff.

Question 7 - What are the implications on Welsh Ambulance Services NHS Trust? (WAST)

Marie-Claire responded to say that conversations are ongoing with the Welsh Ambulance Services NHS Trust ensuring that they are involved and engaged with all the plans. There may be some implications on patient transport but these will be able to be predicted and managed. Robust demand and capacity planning will be undertaken with WAST so that any implications are understood. We will be looking to support patients to their return to their own home for recovery in the first instance but if they can't they will go to their local hospital so there will be some impact for WAST in terms of patient transport but we are engaged with WAST so that they will be prepared for any changes that could happen.

Question 8 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. Why do vascular surgical services need to be changed**?**

We want to make sure that we provide the best care possible for people needing vascular surgery in South East Wales. We know that:-

· Vascular surgery is becoming increasingly specialised and the evidence shows that patients have better outcomes if they receive their treatment at larger specialist centres

· The Royal Surgical Colleges and The Vascular Society of Great Britain & Ireland support the view that it is no longer desirable to provide urgent or emergency

vascular surgery outside a fully centralised service or a formalised clinical network with a designated single arterial centre providing a 24/7 on-site service.

· A lack of specialist staff to cover the existing vascular units means that we cannot deliver the service safely, the way we have done in the past, and provide the opportunities for staff development and training that other centralised vascular services can. 9. Why the University Hospital of Wales as the hub

Question 9 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. How do vascular services work elsewhere in Wales?

The population of North Wales are served by a network with Ysbyty Glan Clwyd, in Rhyl, as the Hub. Vascular clinics, investigations, diagnostics, vascular access and varicose vein procedures are provided by three spoke district hospitals, in Betsi Cadwaladar University Health Board. In South West Wales the population are served by a network with Morriston Hospital as the hub site and spoke services provided in several hospitals in Hywel Dda and Swansea Bay University Health Boards areas.

Question 10 - Is there any impact of covid on recovery proposals we are all aware of long waiting lists after the pressures of the last year?

Mr Kevin Conway responded to say that we do not expect an impact as vascular care tends to be an urgent and emergency service, so if someone needs to have an operation or procedure we can do this within a few days or weeks. We do not tend to have waiting lists so do not expect it to be impacted by covid.

Question 11 - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. What happens next?

When this engagement exercise has ended, we will consider all of the feedback and share this with the individual Health Boards and the relevant Community Health Councils. We will also publicly make available a report that outlines a summary of comments, questions and suggestions that have been received. We will consider all of the issues and whether there are any mitigating actions that need to be taken. We will also use the information received to update the Equalities Impact Assessment. Subject to further discussions with the Community Health Councils, we may wish to enter a period of formal consultation and should we do that we will once again invite your views.

Question 12 - Can you clarify who will undertake the follow up outpatient appointments and where these will be undertaken?

Mr Kevin Conway responded to say that we will endeavour to do these in your local spoke hospitals, but some patients will need to go to hub hospitals where there are complex wounds but the majority will be in local spoke hospitals.

Marie-Claire Griffiths reiterated how people can contact us to ask questions, share comments and views. Comments to be received by the 16th April 2021. Attendees were informed that today's event was recorded and can be shared. Details of the second event were shared which is being held on the 23rd of March 2021 from 6pm – 7.30pm. Attendees and panel members were thanked and the event was closed.

Summary of Themes

- **Site of follow up outpatients appointments.**
- **Having two spokes in Aneurin Bevan and whether or not this was still valid after changes in the Royal Gwent as a result of the Grange Hospital opening.**
- **The impact of covid recovery on the proposals.**
- **Obtaining views of patients who do not use IT or social media.**
- **Implications on WAST?**
- **Parts of Powys affected by changes.**

23.03.2021

FIRST SOUTH EAST WALES VASCULAR ENGAGEMENT EVENT

23re MARCH 2021

6:00PM

(LIVE EVENT VIA TEAMS)

Panel Members

Mr Kevin Conway	Vascular Surgeon
Dr Stuart Hackwell	Locality Group Director, Rhondda & Taff Ely Locality
Marie-Claire Griffiths	Assistant Director of Strategy & Commissioning
Jo Mclaughlin	Physiotherapy
Kate Rowlands	Vascular Nurse Specialist
Lee Leyshon	Assistant Director, Engagement & Communication

In Attendance:

Michelle Lloyd, Business Support Manager, Cwm Taf Morgannwg University Health Board

Ben Screen, Senior Welsh Language Translator, Cwm Taf Morgannwg University Health Board

A minutes silence was held for all those lost during the Covid-19 pandemic.

1. Marie-Claire Griffiths opened the public engagement event and welcome all. It was noted that the event was being recorded so that it can be uploaded to the Cwm Taf Morgannwg Webpage so that those who were unable to join can watch the session and listen to the question raised. Attendees were asked if Welsh language translation service was require and it was noted that no Welsh language translation was required for this event.

2. Marie-Claire Griffiths commenced with a presentation around the South East Wales Vascular Network and rang through the agenda for the event.

3. Panel members introduced themselves and gave a brief overview of their roles at slide 3 of the presentation.

4. Dr Stuart Hackwell presented slide 5 to the group which outlined what the aims are of the engagement i.e. to start a discussion with citizens about how vascular services are organised in the future.

5. Mr Kevin Conway presented slides 6 – 16 to the group which outlined:-

- What are vascular services?
- Who needs vascular services?
- How are services provided now?
- Why are we talking about them?
- Measures of how well organisation do?
- History of discussion to date
- Have we given thought to where the hub might be?
- What about the spokes?

6. Marie-Claire Griffiths presented slides 17 to 20 which outlined:-

- What would this mean for patients?
- How can you get involved?
- We want to hear your views?
- How can you contact us?
- Questions?

Marie-Claire Griffiths outlined the areas where we would like people to get involved as part of the engagement, these included views on:

- The recommendation that a hub and spoke model will improve patient outcomes
- The proposal for UHW in Cardiff to be the hub
- The suggested Spoke arrangements
- Any other information we should consider in deciding the future of vascular services
- The process undertaken to reconfigure services
- Any alternative view on the proposals put forward

Attendees were encouraged that if they should have any further questions, thoughts, comments or views in addition to any that they may have today to visit the website at : https://cwmtafmorgannwg.wales/sewalesvascular

In addition questions can also be received by letter to the Health Board Headquarter Offices, via email to: sewales.vascular@wales.nhs.uk, a phone line with voicemail is also available the number for which is: 02921 836068, or the public can search #sewalesvascular on social media. To be received by the 16th April 2021.

7. **Questions:**

Question - For those patients who do not have IT or social media how are their views obtained?

Marie-Claire Griffiths responding by stating that posters have been developed and shared across GP surgeries, mass vaccination centres, posted on hospital TV screens, GP practice screens which outlines that there are a number of options for the public to share their views with us. These include:-

- Via our website https://cwmtafmorgannwg.wales/sewalesvascular
- By email to the address: sewales.vascular@wales.nhs.uk
- By phone to 02921 836068 (there is also a voicemail service)
- Or via social media by searching #sewalesvascular

The public can also write to the Cwm Taf Morgannwg University Health Board with their questions, views or comments. The Health Board are open to any addition suggestions for engagement.

Question - Marie-Claire Griffiths took this question from the pre-prepared 'Frequently Asked Questions. How many patients do the changes affect?

Kevin Conway responded by stating that it is difficult to quantify exactly but we can look at the total population that the Health Board covers and we can tell you the number of operations that we undertake per year, realistically from the Cwm Taf area we are looking at several hundred patients per year will be affected whether they require inpatient treatment or outpatient treatment. I think there are a slightly higher number of patients from the Gwent valley will be affected, probably somewhere between 300 and 500 per year outpatient and inpatient treatment, for South Powys it is a smaller number probably less than 100 patients per year.

Marie-Claire Griffiths added that we do have some figures which are included in the engagement documentation which you can find on the website which show

that the total number of patients likely to need a vascular procedure across South East Wales is approximately 1250 each year. This estimate is based on the numbers from the year 2019, which saw 456 patients treated at the Royal Gwent Hospital, Newport, 355 patients treated at the Royal Glamorgan Hospital, Llantrisant and 437 treated at University Hospital of Wales in Cardiff.

Question - **What are the implications on Welsh Ambulance Services NHS Trust? (WAST) (this question was taken from the FAO's)**

Marie-Claire responded to say that conversations are ongoing with the Welsh Ambulance Services NHS Trust ensuring that they are involved and engaged with all the plans. There may be some implications on patient transport but these will be able to be predicted and managed. Robust demand and capacity planning will be undertaken with WAST so that any implications are understood. We will be looking to support patients to their return to their own home for recovery in the first instance but if they can't they will go to their local hospital so there will be some impact for WAST in terms of patient transport but we are engaged with WAST so that they will be prepared for any changes that could happen.

Question – Have you engaged with diabetic patients in primary and secondary care yet? Also have you been in contact with national support groups, County Borough Councils and Stakeholder Reference Groups?

Marie-Clare Griffiths responded that yes we have, the Health Board has a robust stakeholder list with whom we ensured we shared the engagement documentation with, this list included local groups and County Borough Councils. The documentation has also been shared with the Cwm Taf Morgannwg Stakeholder Reference Group and our Chief Executive wrote a letter to all our stakeholders, including the Stakeholder Reference Group and invited them to attend the engagement events. Specifically because of the links with diabetes we have written to the diabetic associations and stroke associations and we have also undertaken an exercise where we have linked in and passed information to past patients of our vascular services as well.

Question – Does this mean that the University Hospital Llandough is the spoke hospital for Cardiff and Vale patients?

Kate Rowlands responded to say that at the moment there is a lot of planning that has been going on but it is hoped that all the plans are in place for us to have some beds over in Llandough Hospital so we would be able to use those to transfer patients from the acute ward at the University Hospital of Wales, for

those patients who required further rehabilitation, in order to get them home, those patients will be moved to Llandough Hospital and their discharge further planned from there.

Question - Is there any impact of covid on recovery proposals we are all aware of long waiting lists after the pressures of the last year?

Kevin Conway responded to say that vascular services are probably unique, there is no waiting list for vascular services, most vascular conditions need to be treated promptly when they present. The plans sit outside the covid recovery plans and we do not envisage any impact either of covid recovery or vis versus us on the covid recovery plans.

Marie-Claire Griffiths reiterated how comments/views or questions can be shared with us.

Question - Can you clarify who will undertake the follow up outpatient appointments and where these will be undertaken?

Marie-Claire Griffiths responded to say that we will endeavour to do these in your local spoke hospitals. Kevin Conway stated that one of the areas that has been successful as a result of covid is virtual clinics, using both telephone follow up and video conferencing, feedback from patients has been really good so where we can patients will be followed up virtually, if the patient needs to be seen because they have a wound or because they have an ongoing problem, we will endeavour to see them at a local spoke hospital rather than bringing them back to a hub, although there is occasionally reasons to bring patients back if they require further imaging or further treatment but on the whole patients will be followed up virtually or at spoke hospitals.

Question – Will the Health Board provide transport or cover transport costs for patients or carers who need to travel to Cardiff?

Marie-Claire Griffiths responded to say that building on the response that Kevin just gave we will endeavour to minimise the transport that is required for follow up appointments to minimise the need for patients and carers to travel to Cardiff. If there is that requirement then there are already transport links that are established between hospital sites so that we can look to support patients and carers to travel through those means and if there are any costs and if this is a problem for patients then we can certainly look into our policies that look at

support covering costs for patients and carers who do struggle to be able to travel to Cardiff.

Question – So what are the next steps?

Marie-Claire Griffiths responded to say that this is our opportunity to speak to you and hear your views and we want to hear your thoughts and reflections and we want you to share your views with us. We will be collating all of the information we receive through all of the different channels and the South East Wales region, we will be making sure that we have addressed any concerns and captured any of the implications and thoughts as part of our planning process and we will be working closely with local Community Health Councils to share the views and any concerns that we might have had from the public or patients as part of this. We will then be having conversations with the Community Health Councils as to what the next steps for this are but we don't know the next steps explicitly until we have had the opportunity to hear from you and hear the views of the public.

Marie-Claire Griffiths reiterated that we will consider all of the feedback and share this with the individual Health Boards and the relevant Community Health Councils. We will also publicly make available a report that outlines a summary of comments, questions and suggestions that have been received. We will consider all of the issues and whether there are any mitigating actions that need to be taken. We will also use the information received to update the Equalities Impact Assessment. Subject to further discussions with the Community Health Councils, we may wish to enter a period of formal consultation and should we do that we will once again invite your views.

Marie-Claire Griffiths outlined again ways in which views and questions can be shared in relation to this engagement.

Question – Please can you inform the public that they can also contact the Cwm Taf Community Health Council with any comments/views or questions that they may have.

The contact number for the Cwm Taf Community Health Council is : 01443 405830

Marie-Claire Griffiths outlined that :-

Should you have any feedback in relation to today's event, our engagement and involvement processes or in particular around any of the following areas, we would be happy to receive your feedback by emailing it to: CTT_Planning&PartnershipsTeam@Wales.nhs.uk

- Timings of the event
- Format
- Speakers available
- Usefulness of visuals
- Usefulness of the session
- Feeling that queries were answered
- Or any other suggestions about how we can continue to improve the way we engage.

Question – For those of us in the Bridgend area, can you provide links for us to follow up with the same questions?

Marie-Claire Griffiths stated that any questions from the Bridgend area, firstly you can always contact the Community Health Council but equally if you want to use either the SE Wales Vascular email address or the Planning & Partnerships email address we would be happy to pick up your questions and link you with the most appropriate contact details for the SW Wales area.

Question – Are Cwm Taf Morgannwg planning to undertake more live events like this in the future?

Marie-Claire Griffiths responded to say, yes if there is a specific request to do another live event on the SE Wales Vascular Network then we would be happy to do that to support this engagement process. We would also be happy to undertake other live events in the future on areas.

Lee Leyshon informed attendees that certainly throughout the experience of covid where we have had to drive a lot of our work and day to day lives online, whether that is for schooling or whether it is for work, public engagement is there as well. It is strange to think about life without covid but the sort of access that online access gives us is really helpful and is something that we would want to keep in any engagement activity going forward but equally nothing substitutes face to face engagement which we would want to undertake as well after covid. Your feedback about these types of events, how the timing was, the format of the event is really helpful because we are testing these processes as well, so any information that you can give us is really helpful and gratefully received as that will inform what we do going forward in the future.

Marie-Claire Griffiths thanked the panel and attendees and closed the event.

Summary of Themes

- **Transport and transport costs**
- **Health Board using live events for engagement going forward**
- **Links for Bridgend questions**
- **Llandough Hospital being the spoke for the University Hospital of Wales**
- **Liaising with diabetic patients, national support groups and stakeholders**

C3. Aneurin Bevan University Health Board

10.03.2021

Aneurin Bevan University Health Board

Vascular Services Network

Public Engagement Meeting

Date: 10/03/21

Time: 2pm

Attendees:

Name	Organisation	
Christopher Dawson-Morris	Assistant Director of Planning ABUHB	Panellist
Mr. David Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Mr. Peter Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Heather Barne	Head of Podiatry & Orthotics, ABUHB	Panellist
Annie Clothier	Vascular Clinical Nurse Specialist, UBUHB	Panellist
Kristian Glover	Assistant Vascular Practitioner, ABUHB	Panellist
David Hanks	Head of Service Planning, ABUHB	Panellist
Nicola Jones	GE Healthcare	Attendee
Liz Power	Citizen	Attendee
Pat Powell	Gwent Association of Voluntary Organisations	Attendee
Isobel Jones	Welsh Ambulance Services Trust	Attendee
Geoffrey Davies	Powys Community Health Council	Attendee
Rhiannon Davies	Citizen	Attendee
Gemma Lewis	Powys Teaching Health Board	Attendee

When a patient is referred to a spoke who would they be seen by? Will it be a consultant? Will it be a nurse? What will be the situation when they arrive at the spoke?

We will still take GP referrals in the same way as we do now. There is an electronic referral system where the consultants triage the referrals online. Depending on the referral the consultant will decide on the most appropriate clinic for the patient.

The choices now, due to COVID, have made us realise that a lot of patients like telephone consultations rather than face to face consultations. If you've got a wound, telephone consultations may not be suitable, if someone has a hearing problem then telephone consultations may not be suitable but for almost all other patients they appreciate the fact that they do not need to drive to the hospital and park and relatives don't need to take time off work. So in addition to the telephone consultations we do a virtual consultation via a video link and the software is called 'Attend Anywhere'. You only need a mobile phone or an iPad to do it and we've done a lot of successful online consultations like that and that means the patient or relative can show you a bit of the patient, so if they have a problem with their foot they can you a picture over the internet. It's all secure so there are no problems with patient confidentiality. Other than that we will still be doing outpatient clinics in the spokes that I have mentioned and depending on the condition the patient may be seen by a Vascular Nurse Specialist or a Consultant.

Please could a copy of the presentation be sent to review the information in it and also to share it with Primary Care colleagues in Powys?

Yes of course this will be shared following the session to all that attended today. A similar version is included in the resources on the website.

Why has it taken this long and what are the timeframes for implementation of centralisation structure if it goes ahead?

I don't think it will help going back over the past history of this except to say that it has taken too long. We hope to start the new service off in September /October 2021. There is a fairly long history to developing this service and we are pleased to have got to this point.

You are saying that this new model, you are doing it to improve outcomes, am I right in thinking that the hub is the basis for the outcomes being improved? Why is the hub going to improve outcomes? Are you able to say how outcomes are going to be improved through the hub and spoke model?

In the UK, this dates back to publications by Professor Peter Holt who looked at volume outcome measures. For index operations namely aneurism repair in carotids and found out that there was a unacceptably high mortality rate in small centres. That there was an obvious link to volume in that the larger centres had much better outcomes that's stimulated a lot of centralisation in England and the improvement in outcomes was maintained. The National

Vascular Registry publishes those outcomes every year and you can see a funnel plot / graph showing the relationship between volume and outcome. You asked why that happens, it's been looked at and it's very difficult to put your finger on exactly why it happens. There's some research from the USA that shows that busy surgeons get better outcomes but that isn't a finding across the board, there are other studies that show that busy surgeons aren't the important thing. I think most of us believe that it is the whole package. As much as I or Peter would like to think that we are a really important link in the chain, equally as important are things like the care you get on the ward. The proposal is that we would have a ward of 35 beds and one would imagine and hope that those 35 beds will be over-seen by one or two Senior Sisters that are familiar in caring for vascular surgery patients and who have recruited and trained a team of highly skilled nurses under their wing who will also provide better care for patients. You've then got Emma Richards who is the Vascular Network Coordinator, and roles like that in a bigger unit make sure that patients get seen quicker and quicker in vascular surgery is better and you get better outcomes. It's multi-faceted the definite is that you can't argue with the data that you get better outcomes.

How will the hub model improve you working with other specialities such as Rheumatology?

We will still have a significant presence in spoke hospitals. I know I will be spending a significant proportion of my week here at the Royal Gwent Hospital doing my professional supporting activities. That means that people knock on my door and ask me vascular surgery questions. We have the Diabetes Service here at the Royal Gwent Hospital, which is important. Peter has made good relationships with multiple colleagues in multiple specialties and they know we are very easy to access and very happy to be spoken to at any time. I suspect we will be spending 50% or more of our time either at the Royal Gwent Hospital or up and down the valleys.

What change will it make to the patients in South Powys and more particularly Crickhowell area? Would it be fair to say that the principal difference to us is that for an initial consultation we would be directed to the Grange University Hospital and then onto University Hospital Wales? Nevill Hall Hospital to University Hospital Wales?

It is important to split outpatients and inpatients. The Outpatient service for patients in Gwent and South Powys will remain very similar to what it is at the

moment and it may even be better, we may even provide more services in Nevill Hall Hospital or even Brecon on an outpatient basis.

All patients (and this is the minority) that need to go into hospital for a big operation instead of going to the Grange University Hospital will go to the University Hospital Wales.

It's a similar process that we underwent about six years ago when we transferred vascular services from Nevill Hall Hospital down to the Royal Gwent Hospital. We still provided an Outpatient service in Nevill Hall Hospital and Brecon but any of the smaller narrative patients that required admission for major surgery went down to the Royal Gwent Hospital which in the future will be University Hospital Wales.

We actually discussed South Powys among the four vascular surgeons in our weekly business meeting. The four of us are very keen to increase our presence in South Powys, and even venture further north seeing patients closer to their homes. The exact logistics of that still need to be worked out but there is certainly a willingness from our part.

I am a vasculitis patient. Vasculitis services in Wales in general are known to be particularly poor. Will this make any change to the Vasculitis Service?

No it won't. The only time we really get involved with vasculitis patients is for iloprost infusions and we don't do anything because the rheumatologists don't have inpatient beds they've used us in the past. There's no reason if a patient needs an iloprost infusion can be admitted under any speciality, General Medicine would be the ideal one because iloprost infusion is just a protocol for administering the infusion.

There may be some change in the course of time as we develop better relationships with Rheumatologists in Cardiff in particular as it is a bigger unit. If they are providing treatments for vasculitis that that we don't have locally then that would be much easier way for providing that for local patients.

With a centralised service there is much more potential for individuals to develop niche interests. If a surgeon wanted to link up with a Rheumatologist and do joint clinics I'm sure that would be exactly what a regional specialist centre would be expecting and wanting.

Main Themes of Session

- How our pathways work

- How to make sure we are getting the service right up front and that we are not making people travel lots of miles
- Really clear on how people will flow through from local hubs right to the centre
- We think about how we start to develop some of the specialties and some of the wider benefits that come from the centralisation of services and make sure that we get links with other services such as Rheumatology.

16.03.2021

Aneurin Bevan University Health Board Vascular Public Engagement Event

Tuesday 16th March, 2021

18:00hrs via Microsoft Teams

Name	Organisation	
Mr. David Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Mr. Peter Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Heather Barne	Head of Podiatry & Orthotics, ABUHB	Panellist
Kristian Glover	Assistant Vascular Practitioner, ABUHB	Panellist
David Hanks	Head of Service Planning, ABUHB	Panellist
Karen Newman	Assistant Director of Communications and Engagement, ABUHB	Staff Member
Amy Sullivan	Engagement Development Manager, ABUHB	Staff Member
Adele Skinner	Engagement Officer, ABUHB	Staff Member
Tony Crowhurst	Disability Advice Project	Attendee
Councillor Judith Pritchard	Caerphilly County Borough Council	Attendee
Janine Harrington	Citizen	Attendee
Susanne Maddax	GAVO	Attendee
Councillor Val Smith	Monmouthshire County Council	Attendee

Has there been technological progress that requires specialist equipı means it is more sensible to have services on one site?

Specialist equipment and medicines evolve all the time and Vascular S went through an incredible evolution in the late 1990's and early 2000 minimally invasive techniques really catapulted us into the future. The procedures are ubiquitous throughout the Northern hemisphere, USA Europe. The demand for specialist equipment will always be there and always evolve and it's not a static playing field. Equipment is expensive being assessed and installed as we speak.

Is there going to be room within the University Hospital of Wales as there seems to be lots of things that seem to be pushed there? Will you have an extra building there and how are you going to manage that?

An extremely good planner called Johnathan Haxton, who has now very sadly passed away, completed an extremely complex piece of work on demand and capacity taking data from all three of the Health Board's and that data has been accepted. It means that we will have a large ward of 30 – 35 patients with the potential to have one ward sister or an old fashioned matron looking after a large ward with lots of senior nurses under their wing to make sure that they are all passionate about looking after Vascular Surgical patients. We don't have that at the moment and we think that's one of the things that will probably improve our outcomes in the short, medium and long term.

The other capacity issue is getting into an operating theatre as a surgeon and there are two types of operating theatres that we use: conventional ones and we have secured capacity for that and we also use what's called a hybrid operating theatre when we have fixed high quality imaging in a fully specked out operating theatre so that patients who will be advantaged by high quality imaging can get it immediately and there is a process where the business case for that is being sent to Welsh Government really as we speak.

You mentioned Neurosurgery and my question is based on that. You talked of the large ward of 30 patients, will the level of that be almost one down from Intensive Care? I have experience of T4 Neuro where it's not quite Intensive Care but it's a similar level of nursing. Is that the plan for this proposal that it will be a higher level than specialist care?

There are fairly strict definitions about Critical Care so there is level one and level two units and that depends on the organ support that the patient needs. We wouldn't be providing a Critical Care service on another ward but Vascular Surgical patients by definition often have multiple co-morbidities so they are often diabetic, they may have had strokes, they may have had heart disease, COPD and a lot of them have got social needs on top of that and you need a group of nurses that really understand the complexities of those patients not only to furnish the care they need but to also to get the outcomes that we are so passionate about achieving. Interestingly, this was one of the by-products of centralising Neurosurgery in Cardiff and prior to that Neurosurgical patients that needed support post operatively went to the general Critical Care unit but by putting the whole population into the South Wales centre meant that the critical

mass of patients meant that they were able to develop for all intents and purposes a specialist Neuro Intensive Care. This meant that the staff looking after them were dedicated specialists. Critical mass is a key element to making things viable.

Will a copy of today's presentation be available to be circulated?

Yes. They can be sent out following the meeting.

How do you link in with prevention services such as dietary advice?

As a Surgeon and a trainer I teach my medical students that although I can do some quite clever surgeries, if I make sure that every patient I see has their cardiovascular risk factors managed appropriately, I'm doing a lot better for society than I am by doing occasional big operations. So it is fundamental to us and that's only really happened over the last 20years that our knowledge about risk factor management has increased but also Vascular Surgeons have taken on the role rather than just being a Surgeon and just operating, we have a more holistic approach to the patients now. That interaction goes on in every clinic and it goes on in every teaching session.

Comments:

- Your proposals are sensible and we are fully supportive of them. We wish you the best of luck. Thank you for a very informative talk and for making it so convenient as well. There is one thing that always concerns me and that is the transport issue and it can worry people that live in a rural area but that is something that needs resolving elsewhere.
- I represent a group of patients with Ehlers-Danlos Syndrome (EDS) and there is currently no centre of excellence in Wales. We have people in our group that have to go to London to get letters written by Consultants who will support their welfare rights and applications and we feel this is completely wrong. For a few years no, we have been endeavouring to convince the Welsh Government that some sort of centre of excellence should be established in South Wales to deal with the Welsh population. From our point of view, people in England are far better treated than people in Wales. If there is anyone with experience of EDS we are not allowed to swap from one Health Board to another. Coming into areas that we are talking about today, one of our people has had his gallbladder removed which we understand is a relatively simple operation but it wasn't taken into account that he has EDS and the people operating on

him were failing to understand why he wasn't healing. This is a classic instance of where a lack of knowledge and a lack of an operation being done by a group of people who knew exactly what was going on having a detrimental effect on this particular patient's outcome. The idea of you setting a group up here which brings together people who are excellent in the treatment of Vascular disease is a great idea and we would thoroughly support that but we would want there to be a way that when EDS is being treated on a pan Wales area, we plead that there will be a centre of excellence eventually but people from your group would need to offer their services to patients with EDS.

- *(Comment placed in meeting chat)* We waited a long time to get a hospital like the Grange but yet we would be using the Cardiff Heath again as the main centre. We have had issues with travel to Velindre for cancer services and dental hospital and out of county access being stopped. We are working in Gwent towards integration and care closer to home and preventative services to hopefully prevent people becoming more complex and needing surgical interventions in secondary Care.
- *(Comment placed in meeting chat*) It would be beneficial to engage third sector support for patients that spans secondary and community care

Main Themes of Session:

- Fully supportive of Vascular Service change
- How the pathways / service will work
- Travel and location

17.03.2021

Aneurin Bevan University Health Board

Vascular Services Network

Public Engagement Event

Wednesday 17th March, 2021

18:00hrs via Microsoft Teams

Name	Organisation	
Mr. David Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Mr. Peter Lewis	Consultant Vascular Surgeon, ABUHB	Panellist
Heather Barne	Head of Podiatry & Orthotics, ABUHB	Panellist
Christopher Dawson Morris	Assistant Director of Planning, ABUHB	Panellist
David Hanks	Head of Service Planning, ABUHB	Panellist
Amy Sullivan	Engagement Development Manager, ABUHB	Staff Member
Eddie Bowen	Citizen	Attendee
Richard Morgan Evans	Citizen	Attendee

If all major surgery is going to be carried out in UHW, what sort of affect will this have on parking there for visitors and the ambulance service delivering patients to the hub and then back out to the spokes?

The Health Board recently moved 900 administrative staff off the UHW site into a new Headquarters which has significantly increased the availability of parking. Also opened a new Park & Ride service two junctions down on the A48 so that has vastly improved the situation there.

With Ambulances queuing outside hospitals at A&E I'm not sure on what the effect of logistics of movement is going to be under these circumstances?

We work very closely with the Welsh Ambulance Service in terms of the service planning and the numerous committees that David

mentioned as part of his presentation. They are well involved in understanding any changes in journeys and flows that would be required. It is part of the planning process, making sure that we have that factored in.

What sort of time do you think this major surgery and rehabilitation will take?

It depends on the procedure being carried out. If you go in for a carotid operation on your neck you'll be out the following day.

If you go in for an amputation you'll probably be in UHW for a short period of time before being transferred for rehabilitation and ongoing care into one of the ABUHB hospitals.

What timelines are we looking at here if the more major vascular surgery is moving to UHW?

This is an engagement process and assuming we don't have to do a follow up public consultation then we'll be looking towards the end of this year to start to implement that change. We're looking at the autumn for implementation.

Why was UHW chosen? I'm conscious it is a tertiary centre for many services already.

There was a fairly rigorous option appraisal process that went on for quite some time and UHW came out on top. Aneurin Bevan and Cwm Taf were considered. That appraisal was around adjoining services, the major trauma centre and other services that are in UHW.

With initial surgery at UHW and then onwards journey back to peripheral hospitals for recovery – would you see that including the Grange University Hospital or are we talking Royal Gwent Hospital and Nevill Hall Hospital?

Much of the outreach work and repatriation will take place across all of our sites, in Nevill Hall, at the Royal Gwent and in the community as-well.
Comments:
- I have no objections whatsoever to the hub being in Cardiff.

- I have participated in Peter Lewis's clinics held in Cwmbran and think they are a very good idea particularly under the COVID circumstances.

- I accept the centralising of service and more people involved and gaining more experience.

Main Themes of Session
- Fully supportive of Vascular Service change

- Car Parkking at UHW

- Timelines of implementation

D. Midpoint Review Report

VASCULAR SERVICES ENGAGEMENT MID POINT REVIEW REPORT

12/04/2021

1. Introduction

This report sets out the progress to date against the plan for public engagement on proposed changes to vascular services in South East Wales.

The public engagement plan for the proposed development of vascular services in South East Wales was developed collaboratively by four Health Boards, namely Aneurin Bevan University Health Board, Cwm Taf Morgannwg University Health Board, Cardiff and Vale University Health Board and Powys Teaching Health Board.

2. Background and Context

Work has been underway for many years regarding the sustainability of vascular services in South East Wales. It remains the only region in the UK without a formal network in situ, although clinicians have worked well together over time to enable joint arrangements to be put in place, particularly during out of hours provision.

There is a range of guidance and reference points that propose that a networked arrangement is the most appropriate configuration for vascular services which is a view supported by clinicians across the three provider Health Boards. A lot of work has been undertaken through clinical teams in exploring potential future options for the delivery of the service in the area, and these were first articulated in a clinical option appraisal undertaken in 2014.

With a strong rationale, clinicians, through their work over many years have arrived at a consensus opinion for a hub and spoke model, with the hub being at University Hospital of Wales and spokes remaining within Health Board footprints.

Clinical engagement has taken place throughout the service development process and there remains good clinical consensus. A letter confirming that the work undertaken during the clinical option appraisal process in 2014 remains

valid has recently been received by the Chair of the Joint Vascular Programme Board. Indeed the clinical body indicated the preferred option had now been strengthened since the location of the Major Trauma Centre was identified at University Hospital Wales.

2.1 Requirements on managing change in NHS Wales

The guidance on changes to NHS services in Wales proposes a two stage process to the management of change that requires consultation and engagement. It should be noted that there is also provision in the guidance for the management of urgent temporary change which is a situation that applies to Cwm Taf Morgannwg University Health Board who had to make this arrangement for vascular services during COVID-19 as the service became unsustainable. The approach to engagement has sought to enable good governance and management of the change as well as enabling the temporary arrangements in place for Cwm Taf Morgannwg to be formally engaged and consulted upon.

3. Engagement Plan

The engagement plan was developed in collaboration with health board engagement leads and the Community Health Councils to support the engagement process.

An Equality Impact Assessment was also completed and used to inform the engagement plan.

1. Scope of Engagement

During October 2020, a report was shared with the Vascular Programme Board which outlined a potential approach to engagement and consultation on the proposals for the service. This was supported and a two stage process of engagement followed by consultation agreed, subject to appropriate engagement with Community Health Council colleagues.

Organisations that were identified as needing to be part of the consultation and engagement were Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board, as commissioners of these services for their local population. It is the responsibility of these organisations to lead the programme of engagement and consultation in their respective areas, however overall co-ordination is being held within the programme structure.

Further to the decision made by Joint Programme Board for a two stage process, a workshop was held in November 2020 to agree the scope of the engagement and consultation and also to have discussions that would inform the gaps in a skeletal draft engagement document.

As a result of these discussions it was agreed that the scope of the engagement phase would be to:

- Inform people what vascular services are and how they are currently organised
- Explain the challenges facing the services
- Engage in discussions about potential/only viable option and aid understanding on this
- Hear what is important to people in this discussion prior to a period of formal consultation

It was however noted that given the extensive work that had been undertaken on a clinical option appraisal and formulation of ideas regarding a hub and spoke model of delivery, that this information should also be shared at the engagement phase, so as to offer as much information as possible, in order to explore with members of the public, and interested stakeholders views on the process that has been followed and whether there is any other information that should be considered.

The affected Community Health Councils considered together, the proposals for engagement at their meeting of 13th January 2021. There was explicit support expressed by both Cwm Taf Community Health Council and Aneurin Bevan Community Health Council, with further discussions taking place with both Powys and South Glamorgan CHCs. Following further assurances about process and remit, there was subsequent agreement by all CHCs to commence the engagement as proposed.

2. Stakeholders

There are a number of stakeholders that have been considered in this engagement and a variety of methods employed to reach those stakeholders.

All Health Boards have well established mechanisms through which they enable cascade and delivery of engagement and consultation materials and these are

being used for this programme. There are also national groups and professional bodies that have been given the opportunity to get involved in the engagement; these were profiled within the programme. Given that the engagement and consultation will be happening within a Covid19 context, different ways of engaging the population have been established

The table below outlines the stakeholder groups together with a high level summary of the actions and responsibilities being undertaken.

Please see appendix 1 for the Vascular Engagement Plan

3. The Engagement Document

The main engagement document and summary document were formally approved by the Health Boards at their meetings in January 2021.

4. Methods of Communication and Engagement

So far…

Web pages	• Web pages hosted on each Health Board website • Template supplied with content and useful documents; including FAQs, Easy Read etc • Link to survey and all relevant contact details including; telephone number, postal address etc Web pages: www.abuhb.nhs.wales/sewalesvascular www.cavuhb.nhs.wales/sewalesvascular cwmtafmorgannwg.wales/sewalesvascular www.pthb.nhs.wales/find/sewalesvascular
Staff/ public updates	• Inclusion in Health Board newsletter • All staff email • Digital screen tiles and posters • Letter and assets to GPs
Stakeholder outreach	• Stakeholder letter • Communications Toolkit

Social media	• Promotion of public engagement events • Ongoing social media posts • Videos of key spokespeople explaining rationale for the network
Promotional assets	• Posters • Digital screen tiles • Leaflets • Teams Background • PowerPoint template
Engagement events	• Online public engagement events run in collaboration with CHC

Note: All content translated into Welsh.

Next steps…

Advertising	• Facebook advertising • Digital displays and posters in MVCs
Outreach to public event attendees	• Email follow up to all sign ups, encouraging them to fill out the survey
Social media	• Updated Communications toolkit and social media assets

5. Responding to the Engagement

Responses are being captured using the following methods:

- Email via a generic email address
- Online
- Telephone
- Capturing of notes during public and stakeholder meetings
- Full and comprehensive analysis of survey data

4. Mid-Point Review

The rest of this document will review the responses received to date and has informed discussion around the need to make any adjustments to the engagement for the remaining period. It must be noted that a full and comprehensive analysis of the data received through the online survey has yet to be completed, however emerging themes have been captured through the summary data and notes from public engagements.

As of 23rd March 2021, 66 responses have been received with the majority being online responses to the survey.

All responses, including notes of public sessions are being shared with the Community Health Councils.

1. Responses to date

While a comprehensive analysis of the data is forthcoming, a summary of the data has been included in appendix 1. This details key insights from the 66 responses that we have had to date (23rd March 2021) from the online surveys and notes taken from the public engagements. The insights we can draw from the summary data do not differentiate responses from separate University Health Boards and Teaching Health Boards.

Number of attendees at public engagement events					
Cardiff and Vale UHB		**Cwm Taf Morgannwg UHB**		**Aneurin Bevan UHB**	
16/03/2021	1	11/03/2021	3	10/03/2021	7
18/03/2021	6	23/03/2021	5	16/03/2021	5
				17/03/2021	2

2. Key Emerging Themes

Please note that Powys Teaching Health Board has integrated with the three remaining University and Teaching Health Boards for public engagement, and

therefore a discrete set of themes for Powys Teaching Health Boards cannot be offered here.

Cardiff and Vale University Health Board:

- The rationale for the creation of a Vascular Network is sensible and logical
- Transport, parking, and accessibility needs to be considered throughout the design of this service
- Suitability of University Hospital Wales in regards to impact on other services, geographic location and infrastructure requirements

Aneurin Bevan University Health Board:

- There is support for the rationale behind the creation of a Vascular Network
- Transport, parking, and accessibility needs to be considered in terms of becoming a spoke site
- How will pathways and services work after implementation

Cwm Taf Morgannwg University Health Board:

- Transport, parking, and accessibility needs to be considered in terms of becoming a spoke site
- Implications of the new service on other existing services, such as the Welsh Ambulance Service Trust
- The impact of Covid-19 recovery on the proposals for the Vascular Network

3. Demographic Profile of Respondents

From the summary data, which does not differentiate the responses collect by particular University or Teaching Health Board, the following insights can be drawn. Please note that each point is relative to the overall amount of respondents who chose to answer each question:

- The majority of respondents are in the 45-45 years old category (37.50%). 16-24 and 16 Under categories are the least represented age demographic
- The majority of respondents are female (70.83%). Men are represented at 27.08% and 2.08% chose Prefer not to say.

- 100% of the respondents did not state that they identify as Trans
- The majority of respondents are in full time work
- The majority of respondents stated their ethnic group as White (95.24%)
- The majority of respondents stated that they do not consider themselves a fluent Welsh speaker (93.75%)

1. **Public Event Schedule**

Public online events have been arranged during the engagement period. An agreement was reached by the Health Boards and CHCs to complete all the public events by 25th March ahead of the Pre-Election period.

2. **Additional Actions taken**

A number of actions were agreed during the first half of the engagement to respond to issues raised at public sessions and to ensure sufficient information was in the public domain to allow intelligent consideration of the proposals:

- Additional FAQ to clarify spoke arrangements
- Additional presentation slides to clarify potential impact on residents of each HB area

5. **Post Engagement Phase:**

The programme team will continue to receive and log responses to the engagement. This information will be shared with health boards and CHCs.

Responses will be analysed by the programme team and themes identified.

A report will be produced which will include the findings of the engagement. This will be discussed with the CHCs in May and the Vascular Joint Programme Board, to consider and agree next steps including whether to proceed to consultation.

E. Equality Impact Assessment

VASCULAR HUB AND SPOKE NETWORK FOR SOUTH EAST WALES
EQUALITY IMPACT ASSESSMENT EVIDENCE DOCUMENT
Introduction

This document presents the evidence collected to date in support of the equality impact assessment (EIA) process for the development of a Hub and Spoke Vascular Network service to serve South East Wales. The Equality Act 2010 places a positive duty on public authorities to promote equality for the nine protected characteristics [1] and requires Welsh public bodies to demonstrate how they pay 'due regard' when carrying out their functions and activities. Equality is about making sure people are treated fairly. It is not about treating 'everyone the same' but recognising that everyone's needs are met in different ways. In the context of this work we are required to assess the impact of policies and services on equality. The purpose of this is to ensure that, as far as is practicably possible, the opportunities for promoting equality and human rights for people with protected characteristics are maximised and any actual or potential negative impact is eliminated or minimised.

The Human Rights Act 1998 also places a positive duty to promote and protect rights. We clearly recognise the importance of putting human rights at the heart of the way our services are designed and delivered. We believe this makes better services for everyone, with patient and staff experiences reflecting the core values of fairness, respect, equality, dignity and autonomy.

In addition we recognise that Wales is a country with two official languages: Welsh and English. We have a responsibility to comply with the new Welsh Language (Wales) Measure (2011). This will create standards regarding Welsh which will result in rights being established that will ensure Welsh speakers can receive services in Welsh. The importance of bilingual healthcare for all patients in Wales is fundamental and is particularly important for four key groups – people with mental health problems; those with learning disabilities; older people and young children. Research has shown these groups cannot be treated safely and effectively except in their first language (Welsh Language Services in Health, Social Services and Social Care, 2012)[2]. Our consideration of equality takes account of this. EIA requires us to consider how the development of a centralised Vascular service, including an arterial centre (Hub), supporting non arterial units (spokes) and a

comprehensive rehabilitation pathway, operating within a network structure for South East Wales, may affect a range of people in different ways. The EIA will help us answer the following questions:

- Do different groups have different needs, experiences, issues and priorities in relation to the proposed service changes?
- Is there potential, or evidence that the proposed changes will promote equality?
- Is there potential for, or evidence that the proposed changes will affect different groups differently? Is there evidence of negative impact on any groups of people?
- If there is evidence of negative impact, what alternatives are available? What changes are possible?
- How will we monitor impact in the future?

This document is not intended to be a definitive statement on the potential impact of the vascular centralisation on protected characteristic groups. The document's purpose is to describe our understanding at this point in the EIA process of the likely impact.

Background

A collaboration between Cardiff and Vale, Cwm Taf Morgannwg and Aneurin Bevin University Health Boards, has been coordinating the development of proposals for a centralised vascular service for South East Wales. Emergency Vascular services have already been centralised at the University Hospital of Wales (UHW).

The project is being led through the SE Wales Vascular steering committee, which is overseeing the work, and is supported by a clinical advisory group, operational group and a number of workstreams. The work will lead on the development of a clinical model and pathways including a comprehensive rehabilitation pathway, operating within a network structure for the region.

Through the steering committee, clinical reference group, clinicians and stakeholders have been working together to examine national guidance and to develop service models to improve care, treatment, rehabilitation and outcomes for vascular patients.

Rationale

Vascular disease accounts for 40% of deaths in the UK, many of which are preventable. The report 'The provision of services for patients with Vascular Disease
(Vascular Society, 2014)[3] compiles key recommendations to deliver standards for the care of vascular patients. The evidence is consistent

that the best outcomes following elective and emergency interventions are achieved by concentrating inpatient care into arterial centres, this ensures the most efficient use of staff, specialist equipment and facilities.

A minimum population of 800,000 is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service; maintain competence among vascular specialists and nursing staff; ensure the most efficient use of specialist equipment, staff and facilities; and the improvement in patient outcome that is associated with increasing caseload. A minimum population of 800,000 would be appropriate but for a world class service a larger catchment area will be required. The population of SE Wales (the resident population of the Health Boards taking forward this proposal is approximately 1.6 million (StatsWales 2016). The current configuration of services across separate hospital sites across South East Wales are too small to meet the quality and safety standards set out by the Vascular Society and the Royal College of Surgeons. None of the current individual units in SE Wales meet this requirement.

Benefits to the whole population will derive from an Inclusive Vascular System that provides for the needs of patients in its region by moving patients to the hospital best able to provide suitable care, freeing resources at other units.

At present, there is no vascular network or designated arterial centre operating across or within South East & Wales. Evidence demonstrates that the introduction of an arterial centre (hub) supported by non arterial units (spokes) and a comprehensive rehabilitation pathway, working in an integrated and mutually supportive way, is expected to raise the quality of services, reduce deaths, and reduce regional limitations and variations in services.

Expected outcome

The SE Wales Vascular service aims to ensure patients have appropriate, timely access to reliable, safe, high quality and sustainable services at all points along their care pathway, in line with best practice standard requirements, and evidenced through key performance indicators.

The proposal is to establish an arterial centre operating within an integrated Vascular network for South East Wales. This will provide patients with the right level of service 24 hours a day, 365 days a year.

The arterial centre or 'hub' will be supported by a network of non-arterial units or 'spokes', and rehabilitation provided through specialist and local rehabilitation services.

Rehabilitation is a process of assessment, treatment and management with ongoing evaluation by which the individual, and their family and carers, are supported to achieve their maximum potential. It is a key part of the patient pathway, commencing before admission to an arterial centre, continuing through the inpatient phase to discharge from the hub or spoke into the community and is a true enabler to achieving the best outcomes for individuals.

How it will be delivered

Based on considerations over recent years, there is good clinical consensus to proposed that if supported, the new vascular service will be based on a hub and spoke model and will have:

- Diagnosis and assessment of vascular disease (including the input of the vascular laboratory and diagnostic imaging);
- Outpatient management of patients with peripheral arterial disease;
- Inpatient spells, emergency and elective activity;
- Day case activity;
- Multidisciplinary outpatient follow up of patients receiving vascular surgery/endovascular interventions;
- Seamless repatriation of patients following rehabilitation care pathways particularly for post amputation care;
- Limb Fitting Service – the vascular service must ensure its patients have access to a local limb fitting service, which meets the standards set by The British Society of Rehabilitation Medicine.
- A dedicated vascular day case facility in both hub & spoke to allow day case surgical & interventional radiology procedure.

It is proposed that the hub and spokes have the following components:

HUB SPOKE

➢ Emergency Vascular Service: ➢ Emergency Vascular Service:-

- Amputations and "*nibbling"*
- Aneurysm surgery;
- Patients requiring CEA within 48 hrs of index event;
- Peripheral arterial reconstructions.
- Angioplasty
- Angiogram;

• As noted above, the “front door” will remain the patient’s local hospital, defined as a Local Hospital with an Emergency Department and an Emergency General Surgery Service;
• Rehabilitation.

- **Elective Vascular Service:**

• Abdominal Aortic Aneurysm
• Endovascular aneurysm repair
• Carotid endarterectomy

- **Elective Vascular Service:-**

• Venous surgery angiography and angioplasty;
• Outpatient clinics

Based on this, the main procedures that are expected to transfer from each of the current sites to any future hub are the following:

- Iliac and femoral artery procedures
- Carotid
- Open Abdominal Aortic Aneurysm
- Endovascular Abdominal Aortic Aneurysm
- Open Thoracic Aortic Aneurysm
- Thoracic endovascular aortic repair (TEVAR)
- Operations on vena cava
- Other artery.

To achieve delivery, there will be a number of infrastructure requirements for both the hub and the spoke:

HUB SPOKE

- Dedicated vascular surgery ward(s). Beds will need to be staffed by an appropriate skill mix of nurses who have been trained in the care of vascular patients. Doppler investigation will need to be available on the ward;
- Hybrid theatre, with experienced vascular theatre staff;
- Scheduled elective lists (IP / DC);
- Anaesthesia – elective vascular services will have dedicated vascular anaesthetic input, from anaesthetists experienced in dealing with vascular patients and with a special interest in this area. This may include anaesthetists from Spoke sites given the opportunity to support elective lists in the hub;
- Intensive Treatment Unit (ITU) and High Dependency Unit (HDU) – Facilities with full renal support must be available onsite to support the vascular
- Mixed surgical wards but with ring fenced vascular beds;
- CEPOD theatre model;

- Interventional radiology;
- Scheduled elective DC lists;
- Outpatient Clinics – including access to nurses/therapists

experienced in ulcer and wound dressing. Doppler ultrasound machines should be available. To support this, it is also assumed that each of the spoke sites will have the following:

- A consultant led Emergency

Department (A&E);

- An Emergency General Surgery service. service. Bookable HDU/ITU with sufficient beds will need to be available for elective patients
- Interventional radiology suite with access to nursing staff trained in vascular procedures.
- Out-patients clinics

Given the range of services already in situ on the University Hospital Wales site, its position as a specialist and tertiary provider, and the co-dependencies between them and the vascular service, particularly major trauma, interventional cardiology and cardio-thoracic surgery, the preferred option for the hub is identified as the University Hospital of Wales, Cardiff. Given the need for consultant led A&E and a general surgery emergency service, the spokes for each of the areas are proposed as:

- **Aneurin Bevan University Health Board** – Grange University Hospital and Royal Gwent Hospital
- **Cwm Taf Morgannwg Teaching Health Board** – Royal Glamorgan Hospital, Llantrisant
- **Cardiff and Vale University Health Board** – Llandough Hospital Vale of Glamorgan

It is important to note that as patients begin their recovery and rehabilitation journey, that this too will be provided from a hospital/community setting which is much more local to them.

Who needs these services?

The prevalence of vascular disease increases with age. Average life expectancy continues to rise especially in males. This suggests that demand for vascular services is likely to increase over time. There are currently an estimated 200,000 people with diabetes mellitus in Wales, and prevalence is increasing.[1] Vascular disease is the major cause of morbidity in diabetes and the risks of disease progression are higher, with an epidemic of diabetic foot disease expected in the next decade.

1. Diabetes UK
Risk factors for vascular disease include:
- Being over the age of 50
- Smoking
- Being overweight
- Having abnormal cholesterol
- Having a history of cerebrovascular disease or stroke
- Having heart disease
- Having diabetes
- Having a family history of high cholesterol or high blood pressure
- Having high blood pressure
- Having kidney disease or haemodialysis

Early diagnosis is key to successfully treating vascular related disease. Patients will be admitted with a variety of both emergency and planned vascular conditions and not all patients will go on to require a complex surgical or interventional radiology procedure. Emergency care is immediate treatment to save a life or limb, urgent care is planned treatment within a limited number of days.
Patients who receive vascular services may have:
- Had a stroke and are at risk of having further strokes
- Blocked arteries in the legs causing pain which may deteriorate further and threaten the leg
- A bulge in the wall of the body's main artery which needs repair to prevent it rupturing
- Untreated or untreatable arterial blockages which mean they need a limb amputation

Not all patients admitted to a specialist service will need a complex surgical or interventional radiology intervention, however due to the nature of their condition, these patients need specialist assessment and care provided in a specialised vascular unit.

Vascular services are provided to the populations of South East Wales with the exception of Bridgend who receive care from the South West Wales vascular network. This is a population of approximately 1.6 million people.

Where are we now?
Equality impact assessment is an ongoing process that runs throughout the course of the decision making process, and through implementation and review.

This paper defines the proposal for change and the rationale, sets out

the expected outcomes and who will be affected by the proposal, and considers potential impacts on different groups and any possible actions for reducing or eliminating disadvantage.
Stakeholder engagement is an important part of the development of the proposals. Stakeholders have been involved in reviewing the EIA and further opportunities will be taken to assess the impacts as the work progresses.

What the evidence tells us on the need for change

The case for change is founded on firm clinical evidence and guided by national and international good practice.There is strong evidence that case volume influences outcomes. The 31 highest volume hospitals (which perform 57% of all elective Abdominal Aortic Aneurysm procedures in the UK) have mortality rates that are under half those seen in the 32 hospitals with the lowest volume of procedures. These data lend support to the current move towards performing major arterial surgery in larger volume units in order to further optimise outcomes. The Royal College/national professional view, is that it is no longer acceptable to provide elective or emergency vascular cover outside a fully centralised service or a formalised modern clinical network with a designated single site for all arterial interventions providing a 24/7 on-site service. There are a number of reviews and reports that support this which include:

1. Vascular Society of Great Britain and Ireland Provision of service for patients with vascular disease (2012) http://www.vascularsociety.org.uk/library/quality-improvement.html
2. https://gettingitrightfirsttime.co.uk/wpcontent/uploads/2018/02/GIRFT_Vascular_Surgery_Report-March_2018.pdf

What are the potential impacts on protected characteristic groups?
EIAs require analysing impacts on the basis of protected characteristics: sex; disability; race; religion or belief/non belief; age (younger people and older people); sexual orientation (lesbian; gay and bi-sexual people); gender reassignment; pregnancy and maternity; and marriage and civil partnerships. We have been gathering evidence to inform our assessment of the potential impact of the proposed establishment of a vascular hub and spoke model network on patients, families and carers, staff, and other stakeholders.

Looking at a range of national research evidence has helped us to consider the potential impact. In particular, we are aware that many

people who share certain protected characteristics such as disability, older age, younger people and some minority ethnic groups also face social and or economic disadvantage. Looking at socio-economic disadvantage goes some way to showing due regard to equality considerations. There will also be other distinct areas that are not driven by socio-economic factors but which relate directly to people with different protected characteristics. The proposals under consideration for the establishment of a vascular network will result in the concentration of life-saving treatment for a relatively very small number of patients but with the most serious disease. Non arterial units and a comprehensive rehabilitation service will ensure that as a patient's condition improves responsibility for ongoing care will transfer to healthcare facilities closer to home. The key issue for the protected characteristic groups would seem to be one of access as evidence tells us that some traditionally underrepresented groups' access to health facilities is disproportionately low when compared to the general population. The same can be said with regard to good health outcomes.

Below, from review of national evidence and research, discussion concentrates on the 'at risk groups' and the sections of the population which are likely to be most affected by the Vascular proposals (those groups that are expected to experience impacts which are disproportionate to those experienced by the general population). There is also reference to health care needs in general.

The first observation to make is that Vascular disease tends not to be closely associated with particular equality groups; are not simple to predict on the basis of socio-economic characteristics. Of the protected characteristics, none are particularly susceptible to Vascular disease. However, a few groups are certainly key to consider in this assessment. A literature review was carried out as a first stage of gathering evidence to inform the EIA. The results are provided below against each of the protected characteristics. There has also been engagement with stakeholders through work to develop the rehabilitation pathway.

Age

Engagement with stakeholders on the rehabilitation element of the patient pathway identified that the involvement of carers and family in rehabilitation is more difficult the further away rehabilitation is from local support mechanisms. It should be recognised that patients are not always able to return 'home', or to the setting they came from. Older patients will have different co-morbidities such as dementia or medical requirements, and it will be necessary to ensure that staff in the vascular

network has all the skills required to care for these patients.

Race
There will be a need to consider requirements of those patients who may require translation or interpretation services, and access to volunteers or staff who can converse in a chosen language.

Disability
Rehabilitation services should give choice to patients with preexisting mobility issues. Specific patient needs, such as bariatric needs should be considered to ensure the ability to provide equipment across boundaries and within social care sector. As well as physical disability, there is a need to consider learning disabilities and mental health. It is recognised that the involvement of carers/family in any programme is more difficult the further away rehabilitation is from local support mechanisms, and patients are not always able to return to the 'home/setting' they came from.

Communication needs in these client groups may be more challenging and care should be adapted accordingly. There are specific standards under the All Wales Standards for Communication and Information for People with Sensory Loss[4] that apply directly to emergency and unscheduled care and these outline the staff training requirements, communication systems and patient needs information which should be provided by health boards. Improved service will reduce the rates of disability and increase socioeconomic functioning.

Marriage and civil partnership
No impacts upon this protected characteristic are anticipated.

Pregnancy and maternity
No impacts upon this protected characteristic are anticipated.

Religion or belief (including lack of belief)
It will be important to note that staff consider and recognise that patients' personal beliefs may lead them to ask for a procedure for mainly religious, cultural or social reasons or refuse treatment that you judge to be of overall benefit to them[5]. There are also many issues in relation to prayer, diet, death and dying rituals that would have to be considered.

Sexual orientation
Despite an appreciation that awareness of sexual orientation and gender identity issues in the health and social care sector has improved,

Lesbian , Gay, Bisexual and Trans (LGBT) patients in Wales report significant barriers to health and social care services[6] . Feedback provided at a Stonewall event indicated that service providers often use inappropriate language when dealing with LGBT patients, and make assumptions about patients' sexual orientation or gender identity. This makes LGBT people feel anxious about accessing health or social care and creates barriers to honest discussions about their health needs. Moreover, it can lead to serious health risks. There is a need to ensure that patients' needs and personal circumstances are taken into consideration when providing care along the patient pathway, including any implications for rehabilitation services.

Stonewall has commended work by healthcare employers around setting up LGBT staff networks, putting zero tolerance policies in place towards discrimination, and taking a more active approach to LGBT community engagement as having improved the experiences of staff and their patients. Health boards should continue to seek to make progress in this area.

Transgender

Trans* is an umbrella term used to describe the whole range of people whose gender identity/or gender expression differs from the gender assumptions made at birth. In 'It's just Good Care: A guide for health staff caring for people who are Trans' 2015[19] Trans* people must be accommodated in line with their full-time gender expression. This applies to toilet facilities, wards, outpatient departments, accident and emergency or other health and social care facilities, including where these are single sex environments. Different genital or chest appearance is not a bar to this. Privacy is essential to meet the needs of the trans* person and other service users. If there are no cubicles, privacy can usually be achieved with curtaining or screens. For people who are still in transition, any compromise must be temporary. The wishes of the trans* person must be taken into account rather than the convenience of nursing staff. An unconscious patient should be treated according to their gender presentation. Absolute dignity must be maintained at all times. It also states that breaching privacy about a person's GRC or gender history without their consent could amount to a criminal offence. A medical emergency where consent is not possible may provide an exception to the privacy requirements. All these issues, as well as others, could be mitigated through training.

Welsh Language

Public services have a responsibility to comply with the Welsh Language

(Wales) Measure. This has created standards which establish the right for Welsh language speakers to receive services in Welsh. There is a risk that the location of the arterial centre within the Vascular network may impact negatively on Welsh language users. Service users who prefer to communicate in the medium of Welsh may be required to access services at sites which do not have sufficient Welsh speaking staff. This could affect the service user's ability to communicate with service providers in their preferred language. Meeting the information and communication needs of patients who speak Welsh will need to be taken into account. 'Language is the core of establishing and expressing identity. Responding sensitively to language, whilst focusing on the individual is an essential principle of maintaining dignity and respect in care within a bi-lingual setting (Welsh Language Services in Health, Social Services and Social Care, 2012)[7].

Socio-economic status

While socio-economic status is not a protected characteristic under the Equality Act 2010, there are new legal socio-economic duties for public bodies that will come into force in March 2021 and will apply to any decision made from this date. The overall aim of the duty is to deliver better outcomes for those who experience socioeconomic disadvantage.

The report Transport and Social Exclusion: Making the Connections (Social Exclusion Unit, 2003) highlighted the current challenges faced by socially excluded groups in accessing health and other services. They found people who are socially excluded are more likely to experience a number of factors that in themselves have a negative impact on gaining access to health services. These may include low income, disability and age, coupled with poor transport provision or services sited in inaccessible locations. It also found that the location of health services and the provision of transport to health services can reinforce social exclusion and disproportionately affect already excluded groups.

What are the potential impacts on NHS staff?

Proposals to establish a Vascular network may affect NHS staff as the final configuration may require staff to have to travel to new workplaces and work more flexibly across health board boundaries.

There is anecdotal evidence that the establishment of a Vascular network and arterial centre within South Wales would improve recruitment and retention for those clinicians who wish to practise in such a structure. It would also ensure the arrangements for the delivery of Vascular services in South East Wales are on a par with the

structures in the rest of the UK.
Staff will be engaged and consulted on the proposals and any staff affected by the final outcome will be supported by the NHS Wales Organisational Change Policy (2009). A partnership approach with trade union colleagues will be ensured to achieve an effective transition to any new arrangements.

What are the human rights implications of the Vascular development?
The EIA needs to be cognisant of the European Convention on Human Rights incorporated into domestic law through the Human Rights Act 1998 as well as international treaties.
Everyone has the right to participate in decisions which affect their human rights. The convention on the rights of people with disabilities contains protection of the right to participate in decisions and access to support for participation and access to information.
The assessment so far has indicated *Article two: the right to life*, and *Article eight: the right to respect for private and family life, home and correspondence,* are of particular relevance and potential impact to the development of the Vascular network.

Right to life (taking reasonable steps to protect life): It is anticipated that having a regionalised service, with the most complex care provided from an arterial centre, will improve clinical outcomes which will have a positive impact on individuals' right to have their life protected.

Right to respect for private and family life, home and correspondence: the improved quality of care possible through a vascular network structure should result in patients spending less time in hospital. However, increased travel distances could have a negative impact on the right to maintain family life. This would apply to the patient and individual members of the family. This is not an absolute right and any interference should be justified, lawful, necessary and proportionate.

Initial summary conclusion
We believe that the introduction of a vascular network, including rehabilitation and the development of both an arterial centre and nonarterial units, is intended to improve patient care and outcomes for Vascular disease including timeliness of access, quality of outcome and improved equality of access and reduce inequalities. We believe that the proposed service redesign does not introduce any additional obstacles; improving standardisation for access and specialist
treatment should improve outcomes across all social groups. At this

stage, this assessment indicates that there are a relatively small number of cases not currently treated at a centralised site (UHW) and, from national evidence and research, the majority of cases are male and over aged 65.

For those visiting patients whilst being cared for at an arterial centre, longer and more complex journeys are likely to be necessary for some. Being required to travel to an unfamiliar hospital and longer distances could be particularly difficult and disorientating for people. Journey times will be increased for users of public transport, which is highly relevant in terms of equality groups. Car ownership amongst most equality groups and, particularly, socially deprived communities tends to be lower than average, requiring a high reliance on public modes. Early transfer of the patient back to a 'local' hospital would help to mitigate long periods in unfamiliar surroundings.

What happens next?

The work of the South East Wales Steering Committee, Clinical Advisory Group, Operational Group and a number of workstreams, is continuing to plan for a Vascular service, and enter a period of engagement with the arterial centre being located at UHW and a number of supporting non arterial units and a comprehensive rehabilitation pathway, operating within a network structure for South East Wales. The EIA will continue to be reviewed to further develop and refine this assessment and to ensure.

Report Title:	**Expansion of Endoscopy Services at University Hospital Llandough**								
Meeting:	**UHB Board**						**Meeting Date:**	**27.05.2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**X**	**For Information**	
Lead Executive:	**Executive Director of Strategic and Service Planning**								
Report Author (Title):	**Director of Capital Estates and Facilities**								

Background and current situation:

The attached executive summary (appendix 1) sets out the rationale for development of two additional endoscopy suites at University Hospital Llandough and makes the case for a capital investment of £6.18m to be funded from the All Wales Capital Programme. The full BJC is available on request.

The current facility at UHL includes three endoscopy suites associated support facilities together with a decontamination facility. However, these facilities do not meet the standards required for Joint Advisory Group (JAG) accreditation.

The Welsh Government has advised all Health Boards in Wales that their endoscopy suites should be JAG accredited and in a pre-JAG visit undertaken in November 2019, whilst the service were compliant with most criteria the facilities were identified as needing remedial works with extra toilet facilities and patient changing areas being of particular concern.

Approximately 70% of the patients treated within the Directorate are cancer patients and are therefore a high risk cohort of patients. Other high risk cohort patients are complex BSW NRC/ LAC patients, surveillance patient and genetic patients.
Following COVID-19 the Directorate is at approximately 70% capacity to pre COVID and therefore is currently only treating cancer patients. This means that there is an immediate necessity to look to additional capacity to address the ever increasing demand into the service, the backlog accumulated as a result of COVID-19 and specifically to treat the high risk surveillance and genetic patients in order to mitigate any potential clinical risk.

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

- The current facility does not meet JAG accreditation standards which is now a requirement of Welsh government and this investment would resolve this issue
- The current facilities do not provide sufficient capacity to address the current and future demand on the service

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

Endoscopy services within the Health Board provide care for inpatients and day cases as well as an acute (out of hours) GI bleed service. Endoscopy constitutes a significant part of the diagnostic services strategy and is part of the gastro-intestinal and lung cancer diagnostic and therapeutic pathways. The two existing units across the Health Board are currently working at

capacity yet with increasing demands the service has unacceptable waiting times which have been associated with a number of serious incidents related to delayed diagnosis of cancer. Some improvement in waiting times and reduction of waiting lists and referral to treatment (RTT) has been made within the last year by clinical and clerical validation plus additional activity, including waiting list initiatives, Saturday lists and outsourcing to local private providers. However, this has been expensive and has not always delivered the high standards of care provided by the in-house team and whilst it may improve waiting times in the short term, it is not a sustainable option for the future.

The addition of two new endoscopy suites together with the reconfiguration of the space to improve the changing and WC facilities and an expansion of the decontamination unit will enable to service to:

a) Manage the demand for symptomatic patients with particular relevance to RTT for outpatients, limiting delays for inpatients thus avoiding excess length of hospital stay, timely management of emergencies such as GI bleeding or stents for patients with obstruction and avoiding overdue surveillance waits.

b) Achieve the specific targets set for Endoscopy services with particular relevance to Bowel Cancer Screening Wales, Service & Financial Frameworks and Cancer Diagnosis Pathways.

c) Allow expansion of bowel cancer screening service due to introduction of Faecal Immunochemical Test (FIT) tests and lower age limit for screening.

d) Ensure compliance with targets for the investigation and ultimately treatment of lung cancer patients as many of these patients require bronchoscopy prior to this.

e) To ensure compliance with targets for patients without malignant disease who require diagnostic bronchoscopy particularly those with interstitial lung disease.

f) Provide a diagnostic and therapeutic medical thoracoscopy service, in line with British Thoracic Society (BTS) standards, for the increased number of patients presenting with pleural effusion as a consequence of primary or secondary malignancies.

g) To achieve the quality standards adopted throughout the UK and more recently within Wales for implementation of the Global Rating Score (GRS) for Endoscopy services and Joint Advisory Group (JAG) accreditation.

h) To meet the imposed requirements for infection prevention and control (IP&C) as a result of the global COVID-19 pandemic. OGDs (upper GI) are considered aerosol generating procedures (AGPs), there is a significant extra downtime for additional cleaning between cases. Current Endoscopy rooms are only fitted with ventilation systems that can perform 15 air changes per hour, meaning currently the service has to leave the room to settle for 30mins between cases and then perform deep cleaning. Increasing the air flow to 20 air changes per hour would enable the waiting time to be significantly reduced to 12 minutes.

Currently 2 rooms are utilised to perform OGD lists and swapping between each procedure to reduce operator downtime. This method achieves 70% of the pre-COVID capacity.

Service Scope

The proposed new model of care will further enable the Directorate to meet its obligations in terms of:

- Welsh Government waiting time targets e.g. referral to treatment, cancer and bowel cancer screening targets;
- Achieving the quality standards adopted throughout the UK and more recently within Wales for implementation of the Global Rating Score (GRS) for Endoscopy services and JAG accreditation;
- Patient focused care;
- Fit with National and Regional Plans
- Meeting the IP&C requirements imposed as a result of the COVID-19 pandemic.

The services provided will include:

- Endoscopic upper and lower GI procedures;
- Endoscopic upper and lower GI procedures (surgical);
- EUS and bronchoscopy procedures;
- Bowel Screening Wales (BSW) National Referral Centre / Local Assessment Centre procedures;
- Emergency inpatient procedures;
- Training functions.

A summary of the projected capital costs is shown below:

	£000
Works costs	3,850
Fees	527
Non-works costs	248
Equipment	1,271
Contingency	372
Total Gross	**6,269**
VAT Reclaim	88
Total Gross	**6,181**

The table below shows the additional recurrent revenue costs (excluding capital charges, depreciation and impairment):

		Cost £'000
Endoscopy	Direct Pay Costs	1,862.9
	Non Pay Costs	1,036.7
Clinical Diagnostics	Direct Pay Costs	458.4
	Non Pay Costs	46.8
Capital, Estates and Facilities	Cleaning	50.8
	Estates	38.3
	Waste	4.9
	Security (incl TDSI & CCTV)	3.7
	Energy Combined	75.7
	Water	7.6
	Rates	26.1
Total		**3,611.8**

Capital Charge and Depreciation

A summary of the capital charge and depreciation is provided below and it is anticipated that these costs will be supported by Welsh Government on approval of the BJC

Capital	£m
Building / Engineering	4,910
Equipment	1,059
Total capital cost per cost forms	5,969
Impairment	3,387
Reversal of impairment	0
Building / Engineering Depreciation	28
Equipment Depreciation	208

Project Milestones

Milestone	Target Date
Submission of Business Justification Case to Welsh Government	May 2021
WG approval of the BJC	July 2021
Start on Site	September 2021
Completion and Handover	September 2022

Recommendation:

The Board is asked to:

- **NOTE** the content of the attached BJC
- **SUPPORT** the submission of the Business Justification Case to seek approval from Welsh Government for the capital funding identified, whilst the UHB finalise the revenue costs required to operate the facility. These costs have been included in the UHB recovery plan which has been submitted to Welsh Government for funding support.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities	x	6.	Have a planned care system where demand and capacity are in balance	x
2.	Deliver outcomes that matter to people	x	7.	Be a great place to work and learn	x
3.	All take responsibility for improving our health and wellbeing		8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect	x	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	x	Long term	x	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*								

Development of the Endoscopy Unit at University Hospital Llandough

Business Justification Case: Executive Summary

May – Draft v5

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1.0 INTRODUCTION

1.1 Overview and Introduction

This business case seeks the approval for a capital investment of £6.18m to enable the further development of the Endoscopy Unit at University Hospital Llandough (UHL). This will enable to the Health Board to deliver multi-disciplinary, patient focused care to include diagnosis, treatment and endoscopic surveillance procedures for inpatients and outpatients whilst supporting sustainable endoscopy services as part of the Welsh Government National Endoscopy Programme.

2.0 STRATEGIC CONTEXT

2.1 Introduction

This section provides an overview of the context within which the investment will be made. It sets out:

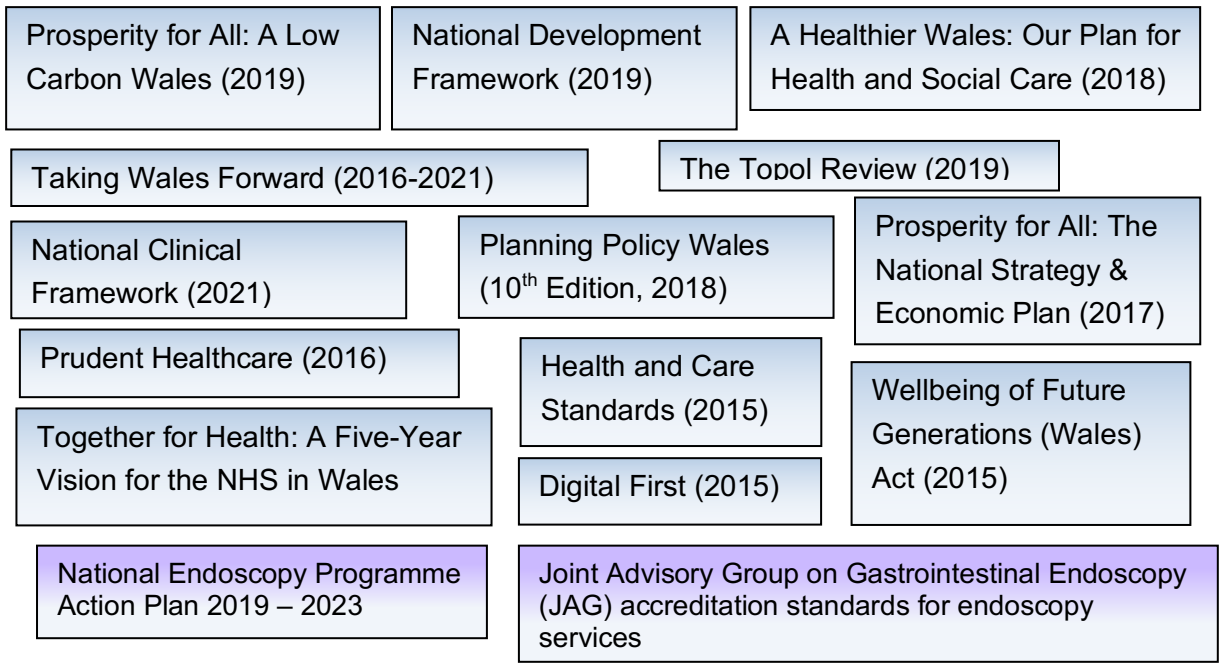
- An overview of the organisation – the size and role of Cardiff and Vale University Health Board and the scale and nature of the demand in the area that it serves;
- The national, regional and local strategies that underpin this investment.

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

As a teaching Health Board, there are very close links to Cardiff University, which boasts a high-prowfile teaching, research and development role within the UK and abroad. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Training the next generation of clinical and non-clinical professionals, in order to develop expertise and improve clinical outcomes is a key priority for the Health Board.

The population served by the Health Board is growing rapidly in size, projected to increase by 10% between 2017-27, higher than the average growth across Wales and the rest of the UK. An extra 36,000 people will live in Cardiff over the next five years who require access to health and wellbeing services.

The Health Board is confident that the strategic drivers for this investment and associated strategies, programmes and plans are consistent with national, regional and local strategy and policy documents. Some of the key Welsh Government policies that have shaped this Business Justification Case (BJC) are:



Executive Summary Figure 1: Key Strategies and Policies

This BJC reflects the principles and priorites of the Health Board's strategy Shaping Our Future Wellbeing and also takes account of all relevant regional and local strategic and recovery programmes and supporting projects. This BJC aligns with the Health Board's programme of clinical service redesign, Shaping Our Future Clincal Services, on which the Health Board has just concluded initial public enagement.

In particular, this BJC is an absolutely key enabler of the Health Board's post-COVID recovery programme to address capcity and backlog challenges for both planned care and diagnostics and sits alongside wider emerging plans for regional capacity expansion. The case takes into account the UHB's estates and digital programmes. The BJC is in line with the Health Board's 2021/22 annual plan in the context of the approved 2020-23 IMTP priorites.

3.0 CASE FOR CHANGE

The project's spending objectives will typically address one or more of the following five generic drivers for intervention and spend. These are:

- To improve the quality of public services in terms of the delivery of agreed outcomes (effectiveness). For example, meeting new policy changes and operational targets.
- To improve the delivery of public services in terms of outputs (efficiency). For example, by improving the throughput of services whilst reducing unit costs.
- To reduce the cost of public services in terms of the required inputs (economy). For example, through 'invest to save' schemes and spend on innovative technologies.
- To meet statutory, regulatory or organisational requirements and accepted best practice (compliance). For example, new health and safety legislation or building standards.
- To re-procure services in order to avert service failure (replacement). For example, at the end of a service contract or when an enabling asset is no longer fit for purpose.

The specific investment objectives for this business case are:

Investment Objective 1: Quality and Safety of Services	
Specific	Services that deliver quality care and meet agreed clinical, quality and safety standards
Measurable	Evidenced by: ▪ The service remaining open and continuing to provide endoscopy services to the population of the Health Board; ▪ The service and facility meeting all regulatory requirements including achieving JAG accreditation and decontamination standards
Achievable	Providing functionally suitable facilities appropriately sized to clinical, quality and safety standards
Relevant	This objective ensures the service will: ▪ Provide compliance with legislation, regulations and JAG accreditation standards / performance and alignment with NEP regional solutions; ▪ Support rapid adoption of best practice; ▪ Provide clinical effectiveness, including: o Delivering improved outcomes for patients; o Reducing clinical risks, including improving waiting times; o Supporting training, research & development; o Improves consistency in practice and raises overall standards.
Time-bound	Service remains open throughout the development of the new facilities and meets regulatory requirements upon commissioning
Investment Objective 2: Provide a High Quality Environment	
Specific	To provide facilities that comply with statutory standards and best practice

Measurable	Evidenced by: ▪ Meeting accreditation requirements as stipulated by JAG; ▪ Meeting HBN and HTM requirements wherever possible or to agreed derogations
Achievable	Providing functionally suitable facilities through best practice compliance to enable the Health Board to deliver high quality care
Relevant	This objective is consistent with the priorities of the Health Board's IMTP, Shaping Our Future Wellbeing Strategy, Prudent Healthcare principles and contributes to the development and sustainability of services.
Time-bound	Upon commissioning of the new facilities
Investment Objective 3: Access / Capacity	
Specific	To ensure that the changing needs and expectations of a growing and aging population and increased demand due to greater incidence of disease and growth of screening programmes are met in line with Health Board clinical strategies and national guidance standards and that the solution does not destabilise other clinical services/developments.
Measurable	Evidenced by: ▪ Facility meeting demand for current services; ▪ Meeting WG timescales for both urgent and routine requests; ▪ Meeting KPIs ▪ Providing increased capacity to ensure growth in patient demand is met.
Achievable	Providing functionally suitable facilities with sufficient capacity to meet the demands of the current patient population over the next 10 years.
Relevant	This objectives will ensure access to services is optimised with: ▪ Service capacity that will meet demand in a timely way; ▪ Meeting Bowel Screening Wales and the IBD National Standards 2020; ▪ Services delivered in an appropriate environment as defined by national standards including JAG accreditation.
Time-bound	Upon commissioning of the new facilities.
Investment Objective 4: Effective Use of Resources	
Specific	To maximise the use of available resource and provide an environment that promotes improved service efficiency
Measurable	Evidenced by: ▪ Meeting capacity and turnaround times as measured by KPIs
Achievable	By providing a dedicated staffing resource for a more reactive service maintained within overall revenue affordability
Relevant	This objective will promote improved service efficiency through improved productivity and improved flows
Time-bound	Upon commissioning of the new facilities

Executive Summary Table 1: Investment Objectives

In agreeing the objectives for this project, the team has also identified measurable benefits which are detailed within the management case section of this business case.

3.1 Current Arrangements

The current Endoscopy service is based on two sites, University Hospital Wales (UHW) and University Hospital Llandough (UHL) and sits within the Medicine Clinical Board.

At UHW, there are two endoscopy rooms, a decontamination room, a reception and waiting areas for outpatients and a recovery area. As well as a range of upper and lower gastro-intestinal (GI) procedures the unit provides Endoscopic Ultrasound (EUS) and bronchoscopy services and provides staff for one paediatric endoscopy list performed in the Children's Hospital. Emergency procedures may be performed in Theatres or Critical Care units. A greater proportion of inpatient procedures are provided at UHW.

The unit at UHL comprises four endoscopy rooms with a dedicated decontamination room for the cleaning and storage of endoscopes located nearby. There is a reception/waiting area for outpatients, accessed from ward West 1 corridor, a stage 1 recovery ward with 9 trolleys (currently shared male/female) and a discharge / stage 2 recovery area. As well as a range of upper and lower GI procedures for inpatients and outpatients, oesophageal and colonic stent procedures are performed within the Unit. Bronchoscopy and endobronchial ultrasound scan (EBUS) lists are performed by Respiratory Consultants. All cardiff and vale bowel screening lists are performed at UHL which is also a national referral centre (NRC) for the assessment and management of complex polyps from screening centres throughout Wales and is a regional centre for oesophageal endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD) with regionalisation of the upper GI cancer service.

3.2 Business Need

3.2.1 Current Issues

Endoscopy services within the Health Board provide care for inpatients and day cases as well as an acute (out of hours) GI bleed service. Endoscopy constitutes a significant part of the diagnostic services strategy and is part of the gastro-intestinal and lung cancer diagnostic and therapeutic pathways. The 2 existing units across the Health Board are currently working at capacity yet with increasing demands the service has unacceptable waiting times which have been associated with a number of serious incidents related to delayed diagnosis of cancer.

Some improvement in waiting times and reduction of waiting lists and referral to treatment (RTT) has been made within the last year by clinical and clerical validation plus additional activity, including waiting list initiatives, Saturday lists and outsourcing to local private providers. However, this has been expensive and has not always delivered the high standards of care provided by the in-house team and whilst it may improve waiting times in the short term, it is not a sustainable option for the future.

3.2.1.1 GRS and JAG

The Global Rating Scale (GRS) was introduced in England during 2005 and adopted by Wales in April 2007. It assesses how each unit gives a patient centred service by measuring twelve items. Six relate to clinical quality (appropriateness, information/ consent, safety, comfort, quality and timely delivery of results) and six relate to the quality of patient experience (equality, timeliness, choice, privacy and dignity, aftercare and ability to provide feedback to the service). Each of the items have 4 levels (A to D) and units should aspire to at least level B performance in all areas plus 2 week maximum wait for USC/urgent referrals and maximum 8 week for routine or surveillance procedures to provide what is perceived to be a quality service, and to be able to be accredited by the Joint Advisory Group for Endoscopy (JAG). UHL was assessed previously in November 2011 and met all criteria for accreditation except for timeliness. Due to the issues highlighted above, the service will not be able to meet the required standards in future without further expansion of capacity. The Welsh Government has advised all Health Boards in Wales that their endoscopy units should be JAG accredited.

In November 2019, a further pre-JAG visit was undertaken. The service were compliant with most criteria, except for some minor building adjustments that specified extra toilet amenities and again timeliness.

3.2.1.2 COVID-19

By utilising weekend working through insourcing, the service had dramatically reduced waiting times by the beginning of 2020. However, with the onset of the global pandemic in early 2020, endoscopy was temporarily halted for all but the most urgent of cases. This has resulted in the service developing a significant backlog of cases over the following 6 months.

The service were fortunate to be able to use the local Spire Hospital for endoscopy during the pandemic, providing additional capacity, however, this capacity is no longer available to the Health Board.

To cope with ongoing increasing activity, new consultant appointments have been made in Gastroenterology, Colorectal and Upper GI Surgery and further training has been provided for Nurse Endoscopists in Gastroscopy (OGD) and Colonoscopy. The service therefore is now in a position to staff and undertake lists, but has no spare capacity to provide them, consequently there is an urgency to increase the number of endoscopy rooms within the Health Board.

3.2.2 Service Trends and Demand

3.2.2.1 GI Endoscopy

a) National increase in colonoscopy referrals: It is anticipated that colonoscopy referral rates and activity for symptomatic patients will increase by 5-10% per year in coming years (data from British Society of Gastroenterology). Referral rates in Wales have historically been significantly lower than England and will therefore be additional demand as rates "catch up" as well as an increase with time.

b) NICE NG12 guidelines: This guideline covers identifying children, young people and adults with symptoms that could be caused by cancer. It outlines appropriate investigations in primary care, and selection of people to refer for a specialist opinion. It aims to help people understand what to expect if they have symptoms that may suggest cancer. Because GI symptoms are common and not specific for cancer an increasing number of patients are referred for endoscopic investigation of symptoms. NICE calculated a 10-15% increase in demand for lower GI investigations as a result of these guidelines and this has been observed locally.

c) Public awareness campaigns: In an attempt to diagnose cancer earlier, a number of campaigns have been launched to raise public awareness of symptoms that may be associated with cancers of the upper GI tract, colon, lung or pleural space. There has been a recent CRUK-Bowel Screening Wales (BSW) awareness campaign to improve update of bowel cancer screening. This has increased demand for endoscopic procedures for diagnosis.

d) GPs have introduced new cancer decision support tool software that recognises keywords, for example persistent diarrhoea and increased platelets that flag up patients who have alarm symptoms requiring urgent suspected cancer (USC) referral.

e) Withdrawal of barium enemas in the Radiology department as a lower GI investigation and replacement with colonoscopy for young, fit patients or CT colonoscopy (CTC) for older patients who may then be referred for an endoscopic procedure (as there is a high yield of pathology on CTC). This was due to the poor detection rates for significant pathology on barium examinations.

f) Improved detection rates for colon polyps as techniques and equipment improve, leading to increasing numbers of patients requiring long term follow up surveillance procedures. At least 20% of patients having an index colonoscopy procedure will require further endoscopic investigations for surveillance as per national guidelines.

g) Bowel Cancer Screening (BSW) and planned expansion of the screening programme: All BSW procedures across Cardiff and Vale are performed by accredited endoscopists at UHL. In 2017/18, 483 colonoscopy or sigmoidoscopy procedures were performed (as index, repeat or surveillance tests). In the next 5

years there will be a steady rise in numbers to 1307 in 2021/22 as Faecal Immunochemical Testing (FIT) is introduced, the threshold positivity level is reduced and the screening age range expands to incorporate 55-59 age group (see Table 3). Also, in a post-COVID era, the compliance with health screening has also been reported to have risen significantly, creating further demand. Therefore concluding the BSW will require a further 5 additional lists by 2021/22, rising to 14 lists by 2023/24.

h) Local expertise in complex endoscopic procedures: As well as for polyps detected in the symptomatic population, UHL is a national referral centre (NRC) for assessment and resection of complex polyps detected through bowel cancer screening. There has been an increase in the number of procedures performed and due to their complexity, they can be very time consuming. As the number of BSW cases increases in Wales, from 3281 currently to 6071 in 2022/23, more patients will be referred to the NRC (currently a single operator service in Wales, provided by Cardiff and Vale University Health Board). It is not only the number of cases affecting workload but the increasing complexity which means some patients require most, or sometime all, of one session to complete a procedure.

i) Procedures under general anaesthesia (GA) or propofol sedation: GA or propofol is required by some patients e.g. some with learning difficulties, anxiety, multiple repeated procedures, previous experience or inability to cope with conscious sedation and for some complex or prolonged procedures such as ESD or laparoscopic assisted endoscopic resection. There are currently 2 funded GA lists per month in main theatres but ideally these should be performed within the Endoscopy unit and with increasing demand for more complex procedures it is anticipated that one list per week will be required

j) Inflammatory bowel disease (IBD) standards: As part of the 2013 NICE IBD Standards, which the Health Board is required to meet, patients with suspected IBD, are to have endoscopic assessment within 4 weeks of referral. Patients requiring endoscopy because of a relapse of their IBD, should have access to investigations within 72 hours, or in more urgent situations, within 24 hours.

3.2.2.2 *Bowel Screening*

April 2021 will see plans for bowel screening optimisation in Wales. This will result in an expansion of the age range for eligibility from 60-74 to 50-74 years, and an increase in test sensitivity.

	Baseline Last 12 month activity data17/18	18/19	19/20	20/21	21/22	22/23
Cardiff and Vale UHB	483	483	559	715	872	905
Total in Wales	3281	3282	3749	4708	5787	6071

Executive Summary Table 2: Bowel screening – projected activity and demand 2018- 2023

3.2.2.3 *Bronchoscopy/Endobronchia Ultrasound*

There are currently 3.5 lists of bronchoscopy and endobronchial ultrasound (EBUS) performed per week in Cardiff and Vale – 3 lists per week at UHL (predominantly out patients) and 0.5 lists at UHW (mainly in-patients). It is expected that the number of patients requiring bronchoscopy and/or EBUS for diagnosis or monitoring of disease and/or EBUS will increase. It is anticipated that 1.5 further weekly bronchoscopy sessions will be needed - 1 for Interstitial lung disease (ILD) done by Dr Ben Hope-Gill who provides the regional ILD service (an estimated 8 patients per month) and a further 0.5 lists for interventional work such as EBUS. There is no capacity within the endoscopy units to accommodate this at present.

3.2.2.4 *Thoracoscopy Service*

There is a need to start a medical thoracoscopy (MT) service, led by Dr Helen Davies at UHL. This will require an additional list per fortnight (0.5 lists per week).

The development of a medical thoracoscopy service is now mandated by the announcement that Thoracic Surgery services will move to Swansea. Currently there is no provision for a medical thoracoscopy service and there is a need to be able to manage pleural disease effectively in Cardiff.

Medical thoracoscopy is increasingly used to diagnose and treat patients with a pleural effusion (presence of fluid in the cavity around the lungs). In other centres it is commonly used for this purpose. As it is performed with sedation, under local anaesthetic, it avoids the need for patients to undergo surgery and the risks this may entail. The Endoscopy Unit and its staff are in an ideal position to provide this service. It is anticipated that the demands would be met with provision of one endoscopy list per fortnight.

If Medical thoracoscopy was available within Cardiff and Vale then, in the 12 month period approximately 12 patients would have had pleural biopsies taken utilising this procedure rather than Video Associated Thoracoscopic Surgery (VATS). As well as these, other patients for whom VATS was not appropriate, e.g. due to the high anaesthetic risk, would benefit from re-introduction of MT to the UHB. These patients currently are regularly

monitored and no histological diagnosis is achieved; occasionally they are referred out of area for the test with the inherent costs involved. Both approaches can generate excess patient morbidity, both psychological and physical especially in those eventually proven (on clinical or radiological grounds) to have an underlying malignancy. In addition, frequently symptoms develop in this cohort necessitating pleural intervention and therefore either OP review or hospital admission. Outpatient data confirms that this group has increased significantly over the last 3 years; anticipating this increase, it is currently estimated that, at present, 20-35 patients annually would benefit from MT and its availability within Cardiff and Vale.

An illustration utilising 2014 data suggests that performing MT in these 12 patients would represent a saving of:

a) 482 days of "patient waiting" for outpatient appointments or admission for their surgical procedure;

b) 29 outpatient appointments (OPA);

c) 74 inpatient bed days.

Most importantly MT would minimise patient stress as their investigations would be performed in a swifter, streamlined manner and obviate the need for:

a) Delays associated with further OPA, pre-assessment clinics and bed waits (ward bed availability) and;

b) A general anaesthetic with its associated complications.

In financial terms introducing MT could save the Health Board, at a minimum:

- £4640 in outpatient costs – assuming an average OPA cost of £160
- £19,400 in inpatient costs
- £24,040 p.a.

However, in addition there would be savings through (a) freeing up Anaesthetists' time to perform other duties e.g. alternative operative lists, pre-operative clinics etc; (b) increasing operating time for Thoracic Surgeons through removal of VATS for "effusions of unknown aetiology" from their lists; (c) release of hospital beds otherwise taken up by these patients allowing other patients to be admitted to the Cardiothoracic ward for their procedures; (d) reduction of waiting lists as a consequence of (c); (e) reduction of Emergency Unit visits by patients with persistent symptomatic pleural effusion.

3.2.3 Service Vision

The vision for the Cardiff and Vale Endoscopy service is the provision of endoscopy services that enable the delivery of multi-disciplinary, patient focused care to include diagnosis, treatment and endoscopic surveillance procedures for both inpatients and outpatients.

Due to the current constraints and the increasing demand on the current service, the vision includes expansion of the current endoscopy services to increase capacity to meet the ongoing, growing demand for endoscopy procedures and the ability to address the backlog created by the COVID-19 pandemic. This will be achieved through maximising efficiencies and streamlining pathways.

By expanding the current endoscopy service by providing 2 further endoscopy rooms in the 2020/21 financial year would facilitate the service to meet the targets highlighted below, however, it is anticipated that a further, third, room will be required by 2021/22 in order to:

a) Manage the demand for symptomatic patients with particular relevance to RTT for outpatients, limiting delays for inpatients thus avoiding excess length of hospital stay, timely management of emergencies such as GI bleeding or stents for patients with obstruction and avoiding overdue surveillance waits.

b) Achieve the specific targets set for Endoscopy services with particular relevance to Bowel Cancer Screening Wales, Service & Financial Frameworks and Cancer Diagnosis Pathways.

c) Allow expansion of bowel cancer screening service due to introduction of Faecal Immunochemical Test (FIT) tests and lower age limit for screening.

d) Ensure compliance with targets for the investigation and ultimately treatment of lung cancer patients as many of these patients require bronchoscopy prior to this.

e) To ensure compliance with targets for patients without malignant disease who require diagnostic bronchoscopy particularly those with interstitial lung disease.

f) Provide a diagnostic and therapeutic medical thoracoscopy service, in line with British Thoracic Society (BTS) standards, for the increased number of patients presenting with pleural effusion as a consequence of primary or secondary malignancies.

g) To achieve the quality standards adopted throughout the UK and more recently within Wales for implementation of the Global Rating Score (GRS) for Endoscopy services and Joint Advisory Group (JAG) accreditation.

h) To meet the imposed requirements for infection prevention and control (IP&C) as a result of the global COVID-19 pandemic. OGDs (upper GI) are considered aerosol generating procedures (AGPs), there is a significant extra downtime for additional cleaning between cases. Current Endoscopy rooms are only fitted with ventilation systems that can perform 15 air changes per hour, meaning currently the service has to leave the room to settle for 30mins between cases and then perform deep cleaning. Increasing the air flow to 20 air changes per hour would enable the waiting time to be significantly reduced to 12 minutes. Currently 2 rooms are utilised to

perform OGD lists and swapping between each procedure to reduce operator downtime. This method achieves 70% of the pre-COVID capacity.

3.2.4 Proposed Model of Care

The proposed new model of care will further enable the Directorate to meet its obligations in terms of:

- Welsh Government waiting time targets e.g. referral to treatment, cancer and bowel cancer screening targets;
- Achieving the quality standards adopted throughout the UK and more recently within Wales for implementation of the Global Rating Score (GRS) for Endoscopy services and JAG accreditation;
- Patient focused care;
- Fit with National and Regional Plans
- Meeting the IP&C requirements imposed as a result of the COVID-19 pandemic.

The services provided will include:

- Endoscopic upper and lower GI procedures;
- Endoscopic upper and lower GI procedures (surgical);
- EUS and bronchoscopy procedures;
- Bowel Screening Wales (BSW) National Referral Centre / Local Assessment Centre procedures;
- Emergency inpatient procedures;
- Training functions.

3.3 Proposed Scope

This section describes the potential scope for the project in relation to the investment objectives and business needs.

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

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

This business case sets out the need for the maximum scope therefore seeing the addition of endoscopy capacity that meets all statutory requirements including JAG accreditation and enables the Health Board to deliver future projected capacity.

3.4 Main Benefits

This section describes the main outcomes and benefits associated with the implementation of the investment of the identified scope in relation to the identified business needs.

Benefits are expressed in relation to the developed appraisal criteria that were derived from the investment objectives as follows:

- **CRB** - cash releasing benefits (e.g. avoided costs);
- **Non CRB** - non cash releasing benefits (e.g. staff time saved);
- **QB** - quantifiable benefits (e.g. achievement of targets);
- **Non QB** - non-quantifiable or qualitative benefits (e.g. improvement in staff morale).

Benefits are expressed in relation to the developed appraisal criteria that were derived from the investment objectives as follows:

Investment Objective	Main Benefits	Stakeholder Group	Category
Investment Objective 1: Quality and Safety of Services	An enabler to achievement of JAG accreditation	Patients/ Staff/ Health Board	QB
	An enabler to meeting the requirements of the National Endoscopy Programme	Patients/ Staff/ Health Board	QB
	Contribute to the delivery of a safe inpatient service with minimal risk	Patients/ Health Board	QB
	Capsule endoscopy can be delivered from an appropriate clinical area, mitigating governance risk	Patients/ Staff/ Health Board	Non QB
	Enable the Directorate to improve upon its training programme for staff in training	Staff/ Health Board	Non QB
	Expansion of the decontamination facilities will allow for appropriate chemical storage (this is currently on the Directorate's risk register)	Staff/ Health Board	Non QB
Investment Objective 2: Provide a High Quality Environment	Improve patient dignity and privacy	Patients	Non QB
	Provide an improved patient experience	Patients/ Health Board	Non QB
	Improve the staff working environment, morale and well-being	Patients/ Staff/ Health Board	Non QB
	Improved ventilation to aid Aerosol Generating Procedures (AGPs)	Patients/ Staff/ Health Board	QB

Investment Objective	Main Benefits	Stakeholder Group	Category
	Improved ventilation in decontamination to comply with WHTN guidance	Staff/ Health Board	QB
	Allow for appropriate social distancing for staff utilisation appropriate PPE and following IP&C guidance	Patients/ Staff/ Health Board Wider Community	Non QB
	Allow for a staff only bathroom in case of decontamination	Staff	Non QB
Investment Objective 3: Access / Capacity	Provide increased capacity and timeliness of procedures and enable the Directorate to meet standards and targets set by NICE, WG, IBD, BSW, JAG and others	Patients/ Staff/ Health Board Wider Community	QB
	Reduce and maintain the surveillance waiting list	Patients/ Staff/ Health Board Wider Community	QB
	Provide an opportunity, in the future, to look at the possibility of introducing new services eg a new regional thoracoscopy service and to look at opportunities for further service redevelopment	Patients/ Staff/ Health Board Wider Community	Non QB
	Provide the opportunity to offer propofol sedation and nasopharyngeal lists	Patients/ Staff/ Health Board Wider Community	Non QB
Investment Objective 4: Effective Use of Resources	Expansion of the decontamination facilities will mitigate a single point of failure risk if machines break down	Health Board	Non QB
	Enable the installation of electronic tracking and tracking	Patients/ Staff/ Health Board	Non QB

Executive Summary Table 3: Main Benefits

4.0 AVAILABLE OPTIONS

This section describes the options considered by the Health Board and the assessment of the benefits and costs of those that were shortlisted.

4.1 Development of Options

In consultation with the Medicine Clinical Board including clinical and managerial staff, along with staff from capital and estates, and strategic and service planning the following list of options were identified and assessed:

- Option 0: Business as Usual – Under this option the Endoscopy Units would remain at 6 rooms i.e. 4 at UHL and 2 at UHW.
- Option 1: Expand or build new UHW unit
- Option 2: New purpose build unit at UHL
- Option 3: Expand UHL Unit

During an option appraisal workshop each option was scored against the benefit criteria. The summary results of this exercise were as follows:

Benefit Criteria	Weighted Scores			
	Option 0	Option 1	Option 2	Option 3
1. Maximising access to services	24	48	240	216
2. Improving the clinical quality of services	20	40	200	180
3. Optimising the environmental quality of services	8	16	80	72
4. Improved strategic fit of services	10	30	70	80
5. Meeting training, teaching and staff support needs	21	35	70	49
6. Making more effective use of resources	72	56	48	72
7. Providing flexibility for the future	12	96	108	96
8. Optimising the sustainability of services	15	45	50	35
9. Practicality and timeliness of delivery	60	24	30	48
TOTALS	**242**	**390**	**896**	**848**
RANK (weighted)	**4**	**3**	**1**	**2**

Executive Summary Table 4: Benefits Scoring

Sensitivity analysis was undertaken by changing the ranking of the benefit criteria to evaluate the impact on the overall score for each option. The analysis included applying reverse, high, low and no weightings to the criteria.

The results indicated that even if the weighting of the benefit criteria were to be changed there is still no overall resultant impact on the order of the options and Option 2 would remain the non-financial preferred option.

4.2 Economic Appraisal Key Findings

A summary of the economic appraisal are summarised in the table below:

Economic Cost	Option 0	Option 1	Option 2	Option 3
	£000	£000	£000	£000
Net Present Value (NPV)	111.3	164.5	175.0	165.2
Equivalent Annual Cost (EAC)	4.1	6.2	6.6	6.2
Ranking of Options	1	2	4	3
Ranking of Development Options		1	3	2
EAC Margin Development Options		0.4%	-5.9%	0.0%
NPC Switch Value		0.7	(9.8)	9.8

Executive Summary Table 5: Summary of Economic Appraisal Outputs

On the basis of the economic appraisal undertaken:

- Option 1 and option 3 are very close in terms of financial evaluation and therefore the key determinant between the options will be the qualitative assessment and capital affordability
-

Sensitivity testing indicates that:

- There is a small margin between options 1 and 3 but option 2 has a larger NPC switch value as per the table above.

Option 3 is therefore confirmed as the preferred option from a quantitative appraisal perspective.

4.3 Combined Appraisal

The outputs of the Non-Financial and Economic Appraisals have been combined to assess which option offers the best benefit/cost outcome based on the number of benefit points delivered per EAC £000.

Combined Appraisal	Option 0	Option 1	Option 2	Option 3
Weighted Non-Financial Scores	242	390	896	848
EAC Impact (£000s)	4.2	6.2	6.6	6.2
Benefit Points per EAC £000	0.058	0.063	0.136	0.136
Ranking of Development Options	4	3	2	1
Margin %	(57.7%)	(53.8%)	(0.3%)	0.0%

Executive Summary Table 6: Summary of Combined Appraisal Outputs

The output of this option appraisal therefore confirms that Option 3 is marginally preferred over Option 2 and has significantly lower capital requirement.

5.0 PROCUREMENT ROUTE

The preferred procurement route therefore for this scheme is to use the Health Board's Construction Framework.

This procurement route offered the Health Board the benefit of suitably experienced team who are skilled in the delivery of complex health care buildings in accordance with relevant WHBN / WHTM guidelines and statutory legislation whilst taking account of cost, time and quality.

Other than the main works construction contract and associated works and related design team contracts, no other external contracts are being considered within the BJC submission.

It is anticipated that the main building contract will run for approximately 12 months although the start date for this is dependent on the approvals process and securing support for the investments.

6.0 FUNDING AND AFFORDABILITY

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

	£000
Works costs	3,850
Fees	527
Non-works costs	248
Equipment	1,271
Contingency	372
Total Gross	**6,269**
VAT Reclaim	88
Total Gross	**6,181**

Executive Summary Table 7: Capital Costs for the Preferred Option

Year	2020/21	2021/22	2022/23	2023/24	TOTAL
	0	3,049,309	3,131,777	0	6,181,085

Executive Summary Table 8: Phasing of Planned Capital Costs for the Preferred Option

Year	DEL Impairment £m	AME Impairment £m	TOTAL £m
2021/22	0	0	0
2022/23	0	3,387	3,387
2023/24	0	0	0
2024/25	0	0	0

Executive Summary Table 9: Impairment for the Preferred Option

This OBC assumes all capital charges and depreciation will be funded by WG in each of the years as per the above.

6.1 Revenue Costs

The table below shows the additional recurrent revenue costs (excluding capital charges, depreciation and impairment):

		Cost £'000
Endoscopy	Direct Pay Costs	1,862.9
	Non Pay Costs	1,036.7
Clinical Diagnostics	Direct Pay Costs	458.4
	Non Pay Costs	46.8
Capital, Estates and Facilities	Cleaning	50.8
	Estates	38.3
	Waste	4.9
	Security (incl TDSI & CCTV)	3.7
	Energy Combined	75.7
	Water	7.6
	Rates	26.1
Total		**3,611.8**

Executive Summary Table 10: Revenue Costs

6.2 Overall Affordability

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

	£000
Impairment	
WG impairment funding	3,387
Depreciation	
WG Strategic Capital charge funding	236
Other Revenue Costs as funded by WHSSC	0
Other Revenue Costs to be managed by the Health Board	0

Executive Summary Table 11: Overall Affordability

A revenue business case has been prepared and was approved by BCAG at their meeting in June 2021.

6.3 Assumptions That Underpin Affordability

- Funding is anticipated from WG for additional recurrent capital charges and non-recurrent impairment based on actuals;
- It is assumed that there will not be any transition or decant costs;
- All of the additional revenue costs that relate to estates and facilities costs are consistent with other new builds, where rateable values are much higher than for existing estate.
-

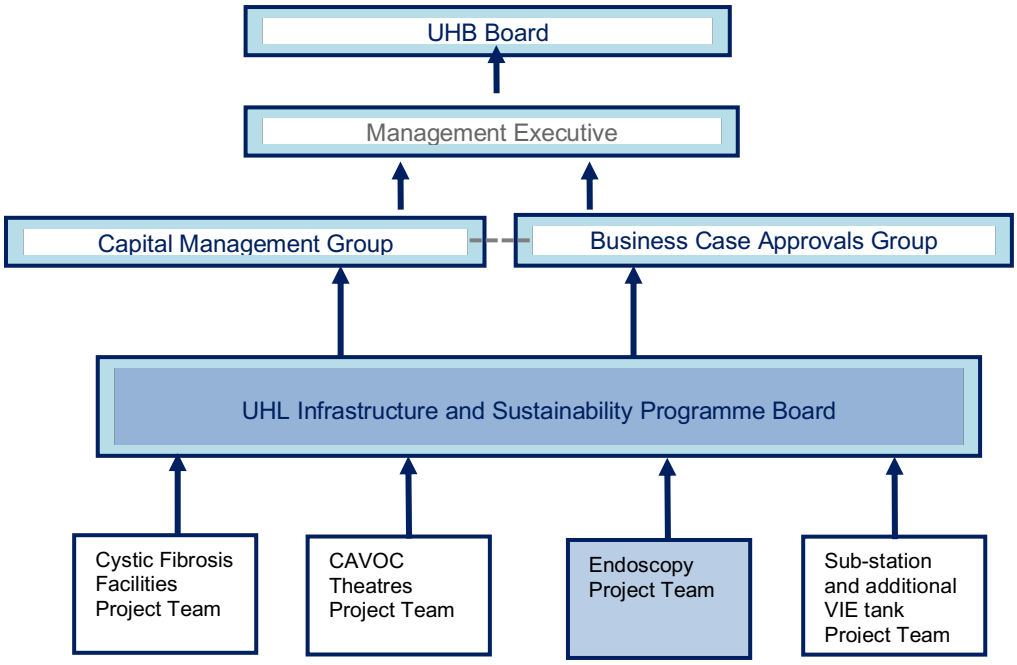
6.4 Project Bank Account

The Health Board can confirm that a Project Bank Account will be prepared at the appropriate stage as the project exceeds the Welsh Government value threshold for the mandatory use of Project Bank Accounts.

7.0 MANAGEMENT ARRANGEMENTS

Robust project management arrangements are vital to ensure the implementation of the overall project and that effective control is maintained over the capital scheme.

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



Executive Summary Figure 2: Project Reporting Structure

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

Milestone Activity	Date
BJC submission to WG	May 2021
WG Approved BJC	July 2021
Design completion and commence construction	September 2021
Construction completion	September 2022
Operational	October 2022

Executive Summary Table 12: Project Plan

Report Title:	**Board Development Programme 2021/2022**							
Meeting:	Board					**Meeting Date:**	27.05.21	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**	
Lead Executive:	**Director of Corporate Governance**							
Report Author (Title):	**Director of Corporate Goverannce**							

Background and current situation:

The purpose of the report is to enable Board Members to discuss and approve the attached Board Development Programme for 2021/2022.

The attached Board Development Programme has been developed for the financial year 2021/2022. The Board Development Programme is a requirement of the UHBs Standing Orders.

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

The Board Development Programme has been designed to support and equip Board Members with the knowledge they need in order deliver their responsibilities as set out within the Annual Plan 2021/2022 and the Health Boards 10 Year Strategy Shaping our Future Wellbeing.

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

The attached Board Development Plan has been developed by the Director of Corporate Governance and has included a number of inputs primarily from Board Member requests, the outputs from Board Members appraisals, requests from outside organisations and other important areas/ priorities identified within the Annual Plan 2021/2022.

It should be noted that this is fluid document and items will be added and or deferred dependent upon other commitments and priorities.

Recommendation:

The Board is asked to:

- **Review** and **approve** the attached Board Development Programme for 2021/22.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x

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

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

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

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

BOARD DEVELOPMENT PROGRAMME 2021-22

1. INTRODUCTION

It is important for Boards to develop a framework of knowledge, skills and competencies that fit the requirements and context of the organisation and can serve as the basis for whole Board and individual Board member appraisal. Alongside whole Board performance evaluation, Board members should undergo an annual appraisal of their individual contribution and performance. This appraisal should focus on the member's contribution as a member of the Corporate Board; in the case of Executive Directors this is distinct from their functional leadership role. The appraisal of the Chief Executive by the Chair is particularly important because the effective performance management of the Chief Executive is critical to the success of the organisation and sets the benchmark for other Executive Directors and Senior Managers.

The pre-requisites of effective and continuous Board development are:

- Chair and Chief Executive commitment
- Board appetite for development
- Good appraisal and personal development planning processes

2. CARDIFF AND VALE UHB CONTEXT

In response to the Covid-19 pandemic the traditional planning rhythm for NHS Wales was paused. Through 20-21 organisations were asked to develop quarterly plans whilst for 2021-22 the direction given from Welsh Government (WG) was that NHS Wales should move to an annual planning cycle.

It is important that the Board is supported to deliver this agenda and provided with opportunities to develop as a team and as individuals, therefore in developing this Board Development Programme the following were considered and link to the Annual Plan for 2021/22:

- Shaping our Future Wellbeing;
- The Cardiff and Vale UHB 2021-22 Annual Plan;
- The Cardiff and Vale University Health Boards Standing Orders;
- Board Assurance Framework;
- Key National developments;
- Areas requested by Board Members; and
- Requests from outside bodies.

(a) Shaping our Future Wellbeing

Cardiff and Vale University health Board's (UHB's) ten-year strategy, *Shaping our Future Wellbeing* states that **Caring for People; Keeping People Well** is why we exist as a UHB, with a vision that **a person's chance of leading a healthy life is the same wherever they live and whoever they are**.

The Strategy is based upon a number of design principles, all of which are aligned with the Principles of Prudent Healthcare introduced by the Welsh Government. It focuses on:

- Empowering the person.
- Home First.
- Delivering outcomes that matter to people.
- Avoiding unwarranted variation and reduce harm and waste.

The UHB's collective ambition for the people of Cardiff and Vale is high and we will continue to push hard to innovate and develop, and to be leaders in Wales.

(b) The Cardiff and Vale UHB 2021-22 Annual Plan

2020/21 was a year like no other as we all tackled the unprecedented global challenge of Covid-19. Like others the pandemic tested our organisation and all our staff in many ways. Whilst the pandemic and the challenges it presented are not behind us, we can now see the light at the end of the tunnel with the recent approval, and current rollout, of two covid-19 vaccines. This has enabled us to develop a plan set against a journey of – *respond, reconstruct and re-design*. The sessions for Board development 2021/22 will support Board Members in their understanding of some of the areas described within the Annual Plan.

(c) The Cardiff and Vale University Health Boards Standing Orders, Standing Financial Instructions, Schedule of Powers and Scheme of Delegated Authorities

LHBs are required by law to develop Standing Orders, which regulate the way in which the proceedings and business of the LHB will be conducted.

Standing Orders, including the Standing Financial Instructions, Schedule of Reservations of Powers and Scheme of Delegated Authorities identify who in the LHB is authorised to do what.

- The documents provides a source of the key rules under which the LHB is managed and governed.
- The regulations which determine the way that the Board operates and is governed are spelt out in the Standing Orders.
- Financial responsibilities and authorities are described in the Standing Financial Instructions and Scheme of Delegated Authorities
- All employees of the LHB need to be aware of their responsibilities and authorities described in these documents.

(d) Board Assurance Framework

The Board Assurance Framework (BAF) is a well embedded document and is

presented to every Board Meeting. It highlights to the Board the key risks to the achievement of Strategic Objectives. The risks for 2021/22 have been identified as

- Workforce
- Financial Sustainability
- Sustainable Primary and Community Care
- Sustainable Culture Change
- Capital Assets (including Estates, IT Infrastructure and Medical Devices)
- Patient Safety
- Wellbeing
- Inequalities
- Inadequate Planned Care Capacity
- Delivery of the 2021/22 Annual Plan

These risks if not properly managed or mitigated could impact upon the delivery of our strategy.

(e) Key National Developments

Key National Developments from Welsh Government and NHS Wales will be presented to Board Development sessions by the relevant Executive Director who will inform the Board of areas of importance and the impact of any national developments on the LHB. These developments may also require formal reporting to the Board and will be timetabled to be presented to the Board when most appropriate.

(f) Areas requested by Board Members

Throughout 2020-21 and through the recent round of Independent Member appraisals, Board Members identified areas and issues that they considered worthy of further exploration at a Board Development Session, these included:

- The NHS Financial system with a focus on Cardiff and Vale and its financial position.
- Charitable Funds and legal duties of Charity Trustee.
- Performance dashboard

(g) Requests from outside bodies

A number of requests are received each year from outside bodies and joint committees, who wish to present to the Board at an informal session, these include:

- The Bevan Commission
- The Emergency Ambulance Services Committee

- NHS Wales Shared Services Partnership
- Welsh Health Specialised Services Committee
- Community Health Council
- WAST
- Digital Health and Care Wales

(h) Other Leadership Development Programmes

Independent Members will also get the opportunity to be involved in wider Leadership and Management Programmes taking place at Cardiff and Vale.

3. BOARD MEMBER INDUCTION PROGRAMME

A Board Member Induction Programme has been developed (see Appendix A) and newly appointed Board Members are currently using the programme for their inductions. The new Induction Programme can be easily customised to each Board Member needs and will be delivered at a pace which suits each individual.

In addition to the Induction Programme for new Board Members induction will also be provided when Independent Members change the Committees they serve upon. This will be done on an individual basis and will be undertaken by the Director of Corporate Governance in conjunction with the Chair of the relevant Committee.

4. DEVELOPMENT OF BOARD MEMBERS AND SUCCESSION PLANNING

(a) Need for flexibility

The Board Development Plan is a fluid document and additional training/ development sessions will be added into the plan throughout the year and as priorities emerge.

(b) Personal Development

All Board members (Executive Directors and Independent Members) participate in an appraisal process on an annual basis. A summary of the key outputs from this process for Executive Directors will be shared at the Remuneration and Terms of Service Committee meeting. In addition to this any collective development needs that have been identified have been included within the development programme for 2021/22.

The identification of individual development needs, including continuing professional development, and implementation of any follow up action is undertaken as part of the appraisal process.

(c) Coaching

All Board members will be encouraged to take up coaching and/or mentoring support this year, in addition to utilising informal networks, and professional support groups.

(d) Academi Wales Programme

Academi Wales deliver a wide range of leadership and management development across the public service in Wales. They specifically undertake:

- Governance and Board Development
- Leadership and Organisation Development
- Talent and Succession Planning

Regular updates on the programme, including podcasts and webinars can be found at https://academiwales.gov.wales/events and learning resources at https://academiwales.gov.wales/Repository.

(e) Shadowing and external learning opportunities

The Board will work with other NHS organisations, inside and outside of Wales, to identify opportunities for shadowing and learning.

(f) Statutory and Mandatory Training

The following statutory and mandatory training sessions should be undertaken by all Board Members. The Director of Corporate Governance will ensure that Board Members are made aware of when training sessions are taking place and will organise the booking of Board Members onto sessions as requested.

- Equality and Diversity
- Infection control
- Safeguarding
- Information Governance
- Health and Safety
- Finance

5. SUCESSION PLANNING

Over the next twelve months a succession plan will be developed by the Executive Director of People and Culture and the Director of Corporate Governance. The plan will be developed and agreed for both Independent Members whose terms of office are coming to an end and for Executive Directors. This will identify high risk areas and will be aligned to Leadership and Management Development Programme currently in place.

(a) Skills Analysis

In support of the succession plan a skills analysis will also be undertaken to identify the full range of skills/qualifications and experiences on the current Board but also to identify where there are any gaps or future gaps which are likely to occur.

Appendix 1
Board Development Programme for 2021-22

Before the commencement of the calendar year dates for a series of Board development sessions to be held on a bi-monthly basis are agreed. The development sessions are structured around the areas identified in paragraph 2 of the plan.

Board Development Session Date	Areas to be covered	Purpose	Executive/IM Lead	Status
29th April 2021	Equalities and Diversity – Nine Protective Characteristics - Race		Len Richards	Session completed 29th April 21
	Youth Board and Children's Rights and Wellbeing		Steve Curry	Session completed 29th April 21
	Management of Clinical Coding across Wales		John Union	Session completed 29th April 21
25th June 2021	Equalities and Diversity – Nine Protective Characteristics -age -disability	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected Characteristics. The session will include what work is taking place within the Health Board aligned to the characteristics	Steve Curry & Michael Imperato Charles Janczewski, Nikki Foreman, Fiona Jenkins	
	Children and Adolescent Mental Health Services	To enable the Board to get an understanding of the breadth of the issues what part the Health Board plays and how other	Steve Curry	

		organisations should support		
	Health and Wellbeing Board Session	Facilitated by a psychologist	Rachel Gidman	
	Performance Dashboard		Michael Imperato & David Thomas	
	Broad aims of Quality, Safety and Patient Experience	To enable the Board to understand the aims and what this means for the Health Board	Ruth Walker and Stuart Walker	
26th August 2021	Equalities and Diversity – Nine Protective Characteristics -gender reassignment -marriage and civil partnership	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected Characteristics. The session will include what work is taking place within the Health Board aligned to the characteristics	Ruth Walker & Susan Elsmore Catherine Phillips	
	Resource Allocation	To enable the Health Board to gain and understanding of how WG is funded and how the Health Board is funded. The session will also provide Members with what the Health Board spends it money on.	Charles Janczewski	
	UHB and RPB Outcomes Framework	To gain and understanding of what aligning and embedding the outcomes frameworks means for the Health Board	Abigail Harris	

	Health Intervention Team		Rachel Gidman	
	Cardiff and Vale Local Public Health Plan	To understand what is within the programme of work and outcome measures prior to review	Fiona Kinghorn	
28th October 2021	Spread and Scale Academy for Wales	To enable the Board to gain an understanding of the work of the Life Science Hub and Bevan Commission	Jonathon Gray	
	Equalities and Diversity – Nine Protective Characteristics - Pregnancy and maternity - Religion or belief	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected Characteristics. The session will include what work is taking place within the Health Board aligned to the characteristics	Catherine Phillips Rachel Gidman & Rhian Thomas	
	Rehabilitation Model	For the Board to gain an understanding of the emerging rehabilitation model	Fiona Jenkins	
	Regional Partnership Board and Locality Based Model of Care	For Board Members to gain an understanding of the integrated locality model.	Abigail Harris	
30th December 2021				
24th February 2022	Equalities and Diversity – Nine Protective Characteristics - Sex	To enable Board Members to gain an understanding of the Equality Act 2010 and the Nine Protected	Fiona Kinghorn & John	

	- Sexual orientation	Characteristics. The session will include what work is taking place within the Health Board aligned to the characteristics	Union Stuart Walker & Gary Baxter	

Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
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Cardiff and Vale University Health Board

Independent Member Induction

Contents

1.0 Introduction

The governance arrangements in Health Boards are unique, with each Health Board comprising a Board of Executive Directors and Independent Members. All have a role to play in the governance of the organisation.

Independent Members have a range of roles to fulfil incorporating legal, oversight and governance responsibilities. They have strategic and leadership responsibilities, stewarding vast public resources, and are expected to act in the best interest of the NHS. It is therefore essential that Independent Members are fully aware of their legal duties, and of the values, vision and behaviours the Health Board seeks to promote among staff, members, patients and the wider public. For this reason it is essential that a Health Board offers and provides a comprehensive induction programme for new Independent Members. This will be complimented by the programme run by Welsh Government for new Independent Board Members. However, the Welsh Government Programme only runs on an annual basis so it will be important for new Independent Members to undertake some form of local induction with their Health Board once they have commenced in post.

2.0 Overall purpose

For an Independent Member to be effective it will be necessary to provide the individual with sufficient information about the Health Board to be able to contribute to discussions in a meaningful manner as soon as possible. It is unrealistic for each and every Independent Member to be fully versed in the issues facing the Health Board at their first board meeting, but each Independent Member should be working towards gaining that comprehensive knowledge. The induction pack is just one method by which necessary information can be imparted.

As individuals absorb information in different ways a number of methods should be used for inducting each Independent Member. These include:

- an induction pack that uses both text and graphics to display contextual and performance data
- site visits to observe the Health Board in action
- meetings with key members of staff, Executive Directors and other individuals
- observing board or committee meetings to gain an overview of the scope of the Health Boards activities
- a buddying/partnering system with a more experienced Independent Member

The time taken to complete an induction will depend on the Health Board its size and complexity, and it may take 12 months in order to cover a full board cycle.
The following outlines all the information about a Health Board a new Independent Member may require in the first months in office. By staggering the approach of when and what kind of information is provided, it is hoped that the new Independent Member will not be overwhelmed by the sheer volume of information to be absorbed.

The objective of induction is to provide a new IM with the information he or she will need to become as effective as possible in their role within the shortest practicable time. The induction process should aim to achieve four things:

- Build an understanding of the nature of the Health Board, its objectives and the communities in which it operates
- Develop the new Independent Members understanding of the role, including legal duties
- Build a link with the Health Boards people – executive directors, staff and users
- Build an understanding of the Health Boards external main relationships.

3.0 Induction design

To ensure that the Independent Member receives the information s/he requires in the most appropriate format it is advisable to consult the new Independent Member before devising the induction. This conversation should inform how the programme should be tailored, in relation to both content and delivery. Previous Independent Member experience and knowledge is of course relevant to the induction design, as the Independent Member may already be aware of the legal and regulatory aspects of the Independent member role in an NHS Health Board. An update of any developments may however, be advisable.

The Director of Corporate Governance, in consultation with the Chair, should prioritise the information to be provided to the Independent Member and schedule the various induction elements over an extended period. Meetings with employees, Executive Directors, advisors, other Independent Members and patients can be arranged over an extended period but ideally this will take place within 6 months. However, Independent Members should see the whole induction plan at the start so s/he has the option to request certain elements earlier, or to have access to certain documents sooner. Vary the delivery of information, and limit the amount of data presented as reading material (whether in hard copy or via a board platform), for example by designating meetings with staff, Executive Directors and fellow Independent Members to cover certain Health Board matters, making use of advisors, other stakeholders, external training courses and organising site visits.

Take account of any relevant training and development programme in place or planned when drawing up the induction programme, so as to complement other activities and avoid any unnecessary duplication. It might be worth thinking about whether some training and development activities could be delivered to the whole board, thereby providing a useful refresher to established Independent Members and developing the relations of the entire board. For example:

- consider asking an existing Independent Member to bring their experience to bear by commenting on the content and design of the draft induction intended for an incoming Independent Member to maximise the time of Independent Members and Executive Directors and staff, the Director of Corporate Governance should consider arranging induction meetings and site visits around existing board, committee and other meetings

- a buddying system may be beneficial to a new Independent Member in order to speed up the IMs understanding of the Health Board's values and softer aspects of the IM board, such as informal behaviours and ways of working. It may also be worthwhile identifying an Executive Director buddy where the new Independent Member will be Chairing a Committee of the Board. The IM should be encouraged to contact the Director of Corporate Governance for any other guidance and information s/he may require.

Equally important to the induction process is receiving feedback from the IM as to the effectiveness of the package provided. Feedback should be sought midway through the process, at the end and about six months afterwards to gain a balanced view of the IMs experience. Any suggestions for improvement should be given due consideration and incorporated into the design of the next induction process.

The expectation is that the induction will be tailored to the needs of the particular Independent Member to avoid repeating information the Independent Member is already well aware of, and that the content will be delivered using a variety of methods, over an extended period.

Many of the topics listed below will be best conveyed by making the Independent Member aware of the source document, while providing a summary of the key points and how they relate to the Health Board, where appropriate.

This list should not be seen as exhaustive.

3.1 Role of the Independent Member

Document	Time Frame
A brief outline of the role of the Independent Member and a summary of his or her responsibilities and continuing obligations	Upon appointment
Code of Governance	Upon appointment
An outline of the role of the Director of Corporate Governance / Board Secretary in supporting the Independent Member	Upon appointment
The Health Boards Standing Orders	Upon appointment
Personal Development Programme	Three to six months
Welsh Government Good Governance Guide Publication	Three to six months

3.2 Board issues

Document	Time Frame
Board structure and schedule of meeting dates	Upon appointment
Scheme of delegations	Upon appointment
The biographical and contact details of other Independent Member and Executive Directors and key employees	Upon appointment
The minutes of the meetings of the last six meetings and agendas for board meetings held in the last three years	Upon appointment

A description of the procedures to be adopted at board meetings. These would normally cover details such as: • when the papers are sent out • normal location of meetings • how long they last • an indication of the routine business transacted • procedure for raising items for consideration • board etiquette policy • domestic arrangements e.g. access, parking, lunch, child care and other expenses, • process for how to send apologies for meetings you cannot attend	Upon appointment
Declarations of Interest Policy and register of interests	Upon appointment
Training in use of Admin Control plus point of contact for issues e.g. password reset	Upon appointment
Corporate calendar which details important dates for the Board, including annual returns, general meetings etc	Upon appointment
Details of relevant Committees, for example Quality, Safety and Experience, Audit, Strategy and Delivery etc. with • Terms of Reference for each Committee, specifications of those responsibilities delegated by the Board to any committees, reporting requirements, • Names of the Independent Members and Executive members serving on any Committees incl. Secretariat • Biographical details of any Independent Members serving on committees	Upon Appointment
Board, committee and individual evaluation processes	Three to six months
Board training and development programme	Three to six months
Most recent Structured Assessment Report	Three to six months
Board composition, Board renewal, succession plans and policy on Independent Member /reappointment	After six months
Details of procedure for resigning or	After six months

removal from office, where appropriate	

3.3 Nature of the Health Board

Document	Time Frame
Copy of the Health Board Strategy – Shaping our Future Wellbeing which includes: Mission Vision Values	Upon appointment
Brief History of the Health Board and the area/demographics it serves.	Upon appointment
How the finances work in a Health Board	Three to six months
Annual Report and Accounts	Three to six months
Annual Quality Statement	Three to six months
Board Assurance Framework	Three to six months
A Healthier Wales	Three to six months
Prosperity for All	Three to six months

3.4 Building a link with the Health Board's people

Document	Time Frame
An organisational chart – including staff and premises	Upon appointment
The contact details of key contacts	Upon appointment
Meetings with Executive Directors, Independent Members and key personnel, where appropriate	Upon appointment
Site visits and programme	Three to six months

3.5 The Health Board's main relationships

Document	Time Frame
Summary of relevant media coverage, of a positive nature or otherwise	Three to six months
List of stakeholders and any agreed engagement plan for each group	Three to six months
Copy of complaints procedure, including a précis of major complaints and incidents resolved in past two years	Three to six months

3.6 Board Committee Induction

Where the Independent Member will be joining a Committee, he or she should be provided with copies of the committee minutes from the preceding 12 months.

Document	Time Frame
Name, role, remit and Terms of Reference of Committee	Upon appointment if Chairing a Committee or three to six months otherwise

Link between Committee policy and the Board's strategic objectives	Three to six months
Members of the Committee, and those regularly invited to attend meetings	Three to six months
Meeting schedule with work plan of forward items or an indication of when routine business is transacted	Three to six months
Main business and financial dynamics and risks	Three to six months
Current issues affecting the committee's business	Upon appointment if Chairing a Committee or three to six months
Technical training on key matters, tailored according to level of expertise	Three to six months

Report Title:	**Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions**						
Meeting:	**UHB Board**				**Meeting Date:**	**27.05.2021**	
Status:	**For Discussion**	**X**	**For Assurance**		**For Approval**	**X**	**For Information**
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Interim Head of Corporate Governance**						

Background and current situation:

The Health Board's Standing Orders (SOs) are based on the model standing orders issued by Welsh Ministers to Local Health Boards. Local Health Boards (LHBs) in Wales must agree standing orders for the regulation of their proceedings and business.

There is a requirement to keep the SO's under review to ensure they remain accurate and current. The Model Standing Orders, Reservations and Delegation of Powers (SO's) were last issued by Welsh Government in September 2019 for Local Health Boards, Trusts, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). They were reviewed by officials in association with representatives of the NHS Wales Board Secretaries and the NHS Wales Directors of Finance group. The revised model documents are issued in accordance the Ministerial direction contained within sections 12(3) (for Local Health Boards) and 19(1) (for NHS Trusts) and 23(1) (Special Health Authorities) of the National Health Service (Wales) Act 2006.

The Minister of Health and Social Services wrote to the Chair of the Board on the 7 April 2021 advising that the Board was required to incorporate and adopt the latest review of the NHS Wales model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions into the Health Board's own standing orders, and that the WHSSC and EASC Standing Orders are to form Schedule 4.1 and 4.2 of the Local Health Board Standing Orders.

The purpose of this report is to request that the Board approve the updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

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

- Cardiff and Vale University Health Board's (UHB's) Standing Orders were last reviewed in in full in February 2019,
- temporary amendments were made to the Standing Orders in July 2020 following the publication of a Welsh Health Circular 2020/11 relating to public appointments in Wales,
- The Audit and Assurance Committee considered the updates made to the CVUHB standing orders Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions on the 13 May 2020, and endorsed the updates for submission to the Board for final approval,
- A summary of the updates made to the Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions is presented at ***Appendix 1*** for approval,
- Once approved by the Board the updated document will be published on the CVUHB website.

Recommendation:

The Board are requested to:

a) **NOTE** and **APPROVE** the updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions for CVUHB.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities		6.	Have a planned care system where demand and capacity are in balance	
2.	Deliver outcomes that matter to people	X	7.	Be a great place to work and learn	
3.	All take responsibility for improving our health and wellbeing	X	8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect	X	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant, click here for more information

Prevention		Long term	X	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

Appendix 1

Updates to Cardiff and Vale UHB'S

Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

May 2021

The Minister of Health and Social Services wrote to the Chair of the Board on the 7 April 2021 advising that the Board was required to incorporate and adopt the latest review of the NHS Wales model Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions into the Health Board's own standing orders, and that the WHSSC and EASC Standing Orders are to form Schedule 4.1 and 4.2 of the Local Health Board Standing Orders.

The table below provides a summary of the updates made:

1.Standing Orders, Reservation and Delegation of Powers

Reference	Update
Miscellaneous	General grammatical updates, updates to web links and references to Welsh Government references.
Statutory Framework	
Page 7 (ii)	HQ Address updated to 2nd Floor, Woodland House, Maes-y-Coed Road Cardiff CF14 4HH.
Page 7 (v)	Paragraph updated to make reference to the requirement for LHB's to make SO's for the regulation of its proceedings and business including provision of the Boards suspension.
Page 8 (vii)	Paragraph moved to (ix)
Page 8 (ix)	Paragraph updated to include paragraph (vii)
Page 9 (xii)	Paragraph updated to reference that NHS bodies includes the NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trusts and, for the purpose of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.
Page 9 (xiv)	Paragraph updated to reference that Part 9 of the Social Services and Well-being (Wales) Act 2014 sets out the arrangements made and provides for LHBs and local authorities to pool funds for the purpose of providing specified services. Web link updated.
Page 9 (xv)	Paragraph moved from Page 11 (xxiii) and inserted on the Well-being of Future Generations (Wales) Act 2015
Page 9 (xvi)	Paragraph updated Welsh Language (Wales) Measure 2011 to include reference to the Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of Local Health Boards. The Local Health Board will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

Reference	Update
Page 9 (xviii)	Paragraph on indemnitees removed as new paragraph added at Page 19, 1.4.4.
NHS Framework	
Page 10 (xx)	**Paragraph updated to confirm that "t**hese include the NHS Values and Standards of Behaviour Framework*; the *'Doing Well, Doing Better: Standards for Health Services in Wales'* (formally the Healthcare Standards) Framework, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems". New web link added.
Page 10 (xxii)	Paragraph deleted and moved to Page 9 (xv)
Cardiff and Vale University Local Health Board's Framework	
Page 11 xxiii	Paragraph updated to refer to the Standing Financial Instructions form Schedule 2.1 of these SOs
Membership of the Local Health Board	
Page 14 1.1.1	Paragraph updated to confirm that the membership of the LHB shall be no more than 24 members
Page 14 1.1.2	Paragraph re-worded to clarify that Officer and non-officer such members shall have full voting rights. Associate Members do not have voting rights.
Page 15 1.1.5	New paragraph added: *"In addition to the eligibility, disqualification, suspension and removal provisions contained within the Constitution Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales."*
Page 15 1.1.6	Paragraph updated: *"A total of 4 associate members may be appointed to the Board. They will attend Board meetings on an ex-officio basis, but will not have any voting rights."*
Tenure of Board members	
Page 16 1.3.1	Paragraph re-worded: Independent Members and Associate Members *"….These members can be reappointed but may not hold office as a member or associate member for the same Board for a total period of more than 8 years."*
Page 16 1.3.2	Reference updated to include: *"An Associate member may be re-appointed if necessary or expedient for the performance of the LHBs functions. If re-appointed they may not hold office as an Associate Member for the same Board for a total period of more than four years. Time served includes time as a Ministerial appointment (if relevant) which need not be consecutive and will still be counted towards the total period even where there is a break in the term. An Independent or Associate Member appointed by the Minister for Health and Social Services who has already served the maximum 8 years as a Ministerial appointment to the same Board will not be eligible for appointment by the Board as an Associate Member."*

Reference	Update
The Role of the LHB Board and responsibilities of individual members	
Page 17 1.4.4	New paragraph added: *"LHBs shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith"."*
Reservation and Delegation of LHB Functions	
Page 19-21 2.0.3 & 2.04	2.0.3 Reference to LHB Joint Duty, and the 2.04 NHS Wales Shared Services deleted as new information now included Page 24, 3.2.2 – 3.25
3.1 Joint Committees	
Page 21 3.2.2 – 3.2.4	Information updated: *3.2.2 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others on its behalf. The Board shall wherever possible determine, in agreement with its partners, that its joint-Committees hold meetings in public unless there are specific, valid reasons for not doing so.* *3.2.3 The Board shall establish, as a minimum, the following joint-Committees:* ▪ *The Welsh Health Specialised Services Committee (WHSSC).* ▪ *The Emergency Ambulance Services Committee* *<u>Joint Committee Standing Orders, terms of reference and operating arrangements</u>* *3.2.4 The Board shall formally approve SOs or terms of reference and operating arrangements for each joint-Committee established. These must establish its governance and ways of working, setting out, as a minimum:* ▪ *The scope of its work (including its purpose and any delegated powers and authority);* ▪ *Membership (including member appointment and removal; role, responsibilities and accountability; and terms and conditions of office) and quorum;* ▪ *Meeting arrangements;* ▪ *Communications;* ▪ *Relationships and accountabilities with others (including the LHB Board its Committees and Advisory Groups);* ▪ *Any budget, financial and accounting*

Reference	Update
	responsibility; ▪ *Secretariat and other support;* ▪ *Training, development and performance; and* ▪ *Reporting and assurance arrangements.* *3.2.5 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the joint-Committee, keeping any such aspects to the minimum necessary. The detailed SOs or terms of reference and operating arrangements for those joint-Committees established by the Board are set out in Schedule 4.*
Page 24 3.5	Joint Committees established by the LHB, deleted as no included at 3.2.2 – 3.2.5.
NHS Wales Shared Services Partnership	
Page 24 4	Paragraph added to outline the work of the NHS Wales Shared Services Partnership. Moved from Page 20-21 2.0.3 & 2.04
4.0 Relationship with the Board	
Page 28 5.8-5.17	Paragraphs updated relating to the: • The Stakeholder Reference Group (SRG) • The Healthcare Professionals' Forum (HPF) • The Local Partnership Forum (LPF)
Working In Partnership	
Page 31 6	New paragraph *"The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. This includes "Partnership Arrangements" established under the direction of Regional Partnership Boards and under which the LHB may carry out any of the specified functions on behalf of the partnership body and may established pooled funds for specified purposes. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working—-implications-for-health-boards-and-NHS-Trusts.pdf"*
Page 32 6.1	Updates to paragraph concerning Community Health Councils (CHC) to confirm legislation
Meetings	
7.2.4 Page 34	Minor update to state that the Annual Plan of Board Business

Reference	Update
	will be published on the LHB's website.
7.25 Page 34	Minor update to confirm that the Annual General Meeting **must include presentation of the Annual Report and audited accounts.**
Values and Standards of Behaviour	
8.6 Page 46	New paragraph inserted concerning Sponsorship: ***"Sponsorship*** 8.0.1 *In addition to gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.* 8.0.2 *All sponsorship must be approved prior to acceptance in accordance with the* ***Values and Standards of Behaviour Framework*** *and relevant procedures. A record of all sponsorship accepted or declined will also be maintained."*
8.7 Page 47	Paragraph on Register of Gifts & Hospitality up[dated to make reference to Sponsorship, now reads Register of Gifts, Hospitality & Sponsorship.
Schedule of Matters Reserved to The Board	
Page 57	The model schedule of matters reserved to the Board has been updated to: • make reference to decisions delegated to the Welsh Health Specialised Services Committee (WHSSC) or Emergency Ambulance Services Committee (EASC), • The list of matters has been re-ordered and re-numbered, see ***Appendix A,*** • Number 6 - Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken now includes the Audit and Assurance Committee as well as the Board
Additional Areas of Responsibility Delegated to Chair, Vice Chair and Independent Members	
Page 63	Updated to reflect membership of the Chair and individual Independent members.

Reference	Update
Delegation of Powers to Committees and Others	
Page 67	Updated to include reference to EASC
Schedule 2.1 Model Standing Financial Instructions for Local Health Boards	
	Updated SFI's included
Schedule 3 Board and Committee Arrangements	
	Terms of Reference for Board and Committee Arrangements updated.
Schedule 4 – Joint Committee Arrangements	
	Terms of Reference for Joint Committee Arrangements updated: • Schedule 4.1 – Welsh Health Services Specialised Services Committee • Schedule 4.2 – Emergency Ambulance Services Committee
Schedule 5 – Advisory Groups	
	Terms of Reference for the Advisory Groups updated: • Schedule 5.1 – Stakeholder Reference Group • Schedule 5.2 – Health Professionals Forum • Schedule 5.3 – Local Partnership Forum
Appendices	
	Appendices updated: • Appendix 1 - Six Principles of Partnership Working • Appendix 2 - Code of Conduct

2.Standing Financial Instructions

Reference	Update
Miscellaneous	The only changes made are: • Inserting UHB name • Changing Director of Workforce and OD to Director of People and Culture • Changing Audit Committee to Audit and Assurance Committee

Appendix A

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs[2] (except for those decisions delegated to the Welsh Health Specialised Services Committee (WHSSC) or Emergency Ambulance Services Committee (EASC).
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: Set out in sections 3-42 below.
3	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the LHB; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Assembly Government requirements

6	NO – Audit & Assurance Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the LHB's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the LHB's Values and Standards of Behaviour framework
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	FULL	STRATEGY & PLANNING	Determine the LHB's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the LHB's key strategies and programmes related to: ▪ Population Health Needs Assessment and Commissioning Plan ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

13	FULL	STRATEGY & PLANNING	Approval of Joint Area Plan prepared under the direction of the Regional Partnership Board and in response to the population assessment
14	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
15	FULL	STRATEGY & PLANNING	Approval of Well-being Plan prepared and agreed by the Public Service Board
16	FULL	STRATEGY & PLANNING	Approve the LHB's Integrated Medium Term Plan, including the balanced Medium-Term Financial Plan
17	FULL	STRATEGY & PLANNING	Approve the LHB's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
18	FULL	OPERATING ARRANGEMENTS	Approve the LHB's framework and strategy for performance management.
19	FULL	STRATEGY & PLANNING	Approve the LHB's framework and strategy for risk and assurance.
20	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
21	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the LHB, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE)
22	FULL	STRATEGY & PLANNING	Approve the LHB's patient, public, staff, partnership and stakeholder engagement and co-production strategies.
23	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the LHB's aims, objectives and priorities

24	FULL	ORGANISATION STRUCTURE & STAFFING	Appointment of officer members of the Board (Chief Executive and Directors) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension officer members in accordance with the provisions of the Regulations and in accordance with Ministerial instructions
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board (Chief Executive and Directors)

Report Title:	**Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act**							
Meeting:	**UHB Board Meeting**					**Meeting Date:**	**27.05.2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	✓	**For Information**	
Lead Executive:	**Executive Nurse Director**							
Report Author (Title):	**Deputy Executive Nurse Director**							

Background and current situation:

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

Section 25E of the Nurse Staffing Levels (Wales) Act (2016) requires Health Boards to submit a Nurse Staffing Levels Assurance Report for the reporting period April 6th 2020 – April 5th 2021.

The report attached at ***Appendix 1*** contains the Annual Assurance Report for 2020-2021 laid out within the schedule of the Nurse Staffing Levels (Wales) Act.

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

The Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act outlines:

- The significant challenges that was experienced through 2020-21 in maintaining and calculating nurse establishments in line with the Act,
- The UHB has continued to implement new ways of working in order to respond to the unprecedented demands experienced throughout the pandemic. This has required an extremely flexible approach to the deployment of nurses during COVID-19,
- In February 2021 the UHB Internal Audit department undertook a formal review of the UHB's compliance with the Nurse Staffing Levels (Wales) Act throughout 2020-2021. The report provided substantial assurance in its compliance with the Act.

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

The Annual Assurance Report:

- Provides the Board with assurance of the progress through 2020-21 in relation to continued calculation, monitoring and maintenance of the Nurse Staffing levels to ensure the discharge of responsibilities under Section 25A,
- The number of wards included in Section 25B&C (outlined in ***Appendix 2***),
- That the Designated Person has discharged their duty in calculating the number of nurses required in adult in-patient medical and surgical wards ensuring the prescribed methodology has been used,
- The process for maintaining nurse staffing levels and managing the risk using all reasonable steps when the numbers fall below the planned roster,
- The impact of not maintaining the nurse staffing levels and any harm that has occurred (two incidences of harm occurred during this period where there is a link to staffing levels),
- The significant changes that took place through 2020-21 due to COVID-19 pandemic.

Recommendation:

The Board is asked to:

- **APPROVE** the **Annual** Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act Report for 2020-2021.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	XX	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact	Not Applicable

Assessment Completed:	

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act 2016	
Health board	Cardiff and Vale University Health Board
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	27 May 2021
Reporting period	6th April 2020 -5th April 2021
Requirements of Section 25A Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels **in any area where nursing services are provided or commissioned, not only adult medical and surgical wards.**	The Nurse Staffing Act (Wales) 2016 states that Health Boards have an overarching responsibility to provide sufficient nurses to care for patients sensitively. This duty applies to all areas that provide nursing services including commissioned services. These considerations are informed by professional judgement and national standards where available. In line with Section 25A of the Act, the Executive Nurse Director has determined that a review of nurse staffing levels across all clinical areas in order to provide assurances that the guiding principles of the Act are considered. This involved robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing levels across their organisation. The process of determining the staffing levels across the Health Board is well established. Wards that are included in 25B&C undertake the bi-annual acuity audit and triangulate that information with their professional judgment of the ward, patient population and staff currently in post and a distinct number of patient outcomes that are generally regarded as being nurse sensitive. In addition, the Executive Nurse Director requests all clinical areas outside of 25B&C to undertake a review of their staffing in line with this timetable to provide assurance of compliance with 25A. The Act requires Health Boards to undertake calculations in May and November each year. However, the first annual calculation in 2020, which was due to be presented to Board in May 2020 was impacted on by the COVID-19 pandemic. A letter received by the Chief Nursing Officer date 24th March 2020, provided Executive Nurse Directors with clarity and assurances in relation to the Covid-19 pandemic. Whilst the Health Board undertook the formal acuity assessment in January 2020, this information was not validated by the All Wales Informatics programme and therefore the nurse staffing levels were calculated solely on professional judgment. An exception paper was subsequently presented to Board in 28th May 2020 providing assurance in the changes to nurse staffing calculation aligned to the service and operations reconfiguration required at the time. Throughout the COVID-19 period, the Health Board has recorded the staffing levels on each ward on a monthly basis to provide assurances that they were being monitored and this information was presented to Board in the Annual Assurance paper in September 2020. Under 25(A) of the Act, staffing levels for all inpatient areas throughout the UHB have been calculated to ensure that they can provide the level of care sensitive to the patient needs. Prior to COVID-19, to ensure that Nurse Staffing levels are maintained, all Clinical Boards had a version of a daily safety briefing whereby senior teams determine staffing requirements and manage risk continually over a 24 hour period. However since the COVID-19 period (March 2020) the Nurse Staffing levels have been managed through the COVID-19 Local Control Centres (LCCs) on a 4 times daily basis through a dynamic risk managed basis using professional judgment. However it should be noted there are exceptions within the Mental Health Clinical Board. The Mental Health Clinical Board management team have been asked to address the gaps in nurse staffing and financial allocation within their IMTP through 2021/22.

Progress to support for suite of workstreams under the All Wales Nurse Staffing Programme	The Chief Nursing Officer letter of 24th March 2020 specifically referenced the disruption that the Covid pandemic would cause to the ongoing work to extend the Act's second duty to paediatric inpatient wards. In October 2020 Welsh Government advised that the coming into force date for the extension has been postponed provisionally until October 2021. The Nurse Staffing Programme Team and the paediatric workstream have devised a suite of supportive mechanisms to prepare Health Boards for the extension of the second duty of the Act. Following a consultation process during the Autumn of 2020, the Statutory Guidance has been revised to include paediatric inpatients. Within Cardiff & Vale, there are two ward areas that the Act will effect and we are currently recording the nurse staffing levels and patient flow data once a day in line with adult services. A monthly visualizer is received from the nurse staffing programme. In preparation for the first key milestone of undertaking the triangulation calculation for the nurse staff levels in August 2021 we have completed a number of practice triangulation's using our current available data sets. These sessions have been facilitated by the All Wales Paediatric Nurse staffing lead and have included our wards sisters and staff currently working on the wards. The sessions have been very useful in helping identify any gaps in data or knowledge prior to the actual submission date. In addition to this an implementation plan has been developed to ensure the Health Board is on track to meet all the required milestones. As a Health Board we continue to be represented on the All Wales Paediatric Nurse Staffing group which supports the extension of the Act and is in the process of developing operational guidance document to support the extension. Cardiff & Vale UHB continues to be represented on each of the workstream groups within the All Wales Nurse Staffing Programme and is actively contributing to the development of evidence based workforce planning tools in preparation for further extension of the second duty of the Act to other areas in the future. A position paper will be provided to the Executive team prior to formal reporting of paediatrics within the Act.
Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period. • **Adult acute <u>medical</u> inpatient wards** • **Adult acute <u>surgical</u> inpatient wards**	The normal process by which the Board would receive the annual assurance report in 2020 was disrupted by the Covid-19 pandemic. The Chief Nursing Officer for Wales issued a formal letter on the 24 March 2020 to provide Health Boards and Trusts with clarity and assurances around how Covid-19 pressures would disrupt the business as usual processes of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA). In April 2020 guidance and templates were issued to Health Boards/Trusts to enable organisations to evidence the approach taken to determine the staffing levels that are required on their inpatient wards where the required staffing level has been affected during the COVID-19 pandemic. Between March and April 2020, a number of wards under section 25(B) were repurposed for COVID-19 and the Health Board presented a report to Board in May 2020 to provide assurance on how nurse staffing levels were being/to be calculated and maintained during this period. However, as the Health Board progressed to realign and recover services within the unprecedented context, the ward establishments were constantly reviewed to ensure the staffing levels reflect the changing requirements of repurposed wards (for the time period May 2020 to Jan 2021). An exception report was provided to Board in July 2020 which provided information on the revised establishments required going forward, however, it was acknowledged that this position would continue to evolve as the Health Board continued to realign essential services through uncertain times. Due to the significant challenges faced by Health Boards in the management of COVID-19, the Welsh Government left it to the discretion of each Health Board to decide whether to proceed or cease work on the bi-annual recalculation of adult medical and surgical wards. In accordance with the 'Once for Wales' approach Nurse Directors agreed that their organisations would defer the bi-annual audit and subsequent calculations of nurse staffing level until July 2020. This bi-annual calculation audit was subsequently presented to Board in November 2020, following formal sign off of the 25B ward establishments. As the COVID-19 pandemic continued throughout the year, there have been significant repurposing of wards throughout the Health Board in order to respond to the NHS Wales COVID-10 Operating Framework: quarter 2, 2020-2021.Throughout this period, the Health Board has recorded the staffing levels on each ward on a monthly basis to provide assurances that they were being monitored through a professional judgment lens and this information was presented to Board in the Annual Assurance paper in September 2020.

	In October 2020 The Chief Nursing Officer for Wales issued a follow up formal letter providing further clarity, reflecting the changes organisations had been required to make to patient pathways/ designation of wards across their acute sites. This made particular reference to the definition of wards for inclusion/exclusion under Section 25B of the Act, and the expectations upon Health Boards in relation to calculating the nurse staffing levels in such wards. This monthly reporting of staffing levels has continued through to March 2021 and includes which would have been the January 2020 re-calculation period. A decision was made on an All Wales basis that the formal acuity assessment normally carried out in January be cancelled due to the COVID-19 / winter pressures being experienced at the time. Appendix A evidences the rationale, purpose and outcome of recalculation undertaken both within and outside the bi-annual calculation cycle as a result of changes seen to section 25B wards. In light of the fact that no formal calculation has been undertaken in January 2021, the Executive Nurse Director is concerned that we will not have clarity regarding the formally agreed establishments since the bi-annual calculation in November 2020. Therefore an exception report will be shared with Board in June 2021 which will outline the agreed establishment moving forward, through the COVID-19 recovery phase to November 2021, when the bi-annual calculation will be undertaken again.
Using the triangulated approach to calculate the nurse staffing level on section 25B wards	The Nurse Staffing Levels (Wales) Act 2016 requires that all wards included in section 25(B) must calculate the number of Nurses using a triangulated approach utilising three sources of information. The information triangulated is both qualitative and quantitative in nature and must include: • **Professional judgement** – the Clinical Board Nurse Director in conjunction with the Ward Sister/ Charge Nurse and Lead and Senior Nurses should use their knowledge of the clinical area to inform the levels of nurse staffing. The Operational Guidance for the Act provides detailed descriptions defining professional judgment. Included in this description is a suggestion that data on, compliance with mandatory training, vacancy and sickness rates, temporary staffing usage, bed occupancy and student feedback may be of use in supporting this aspect. • **Patient acuity** - use the prescribed evidence-based workforce planning tool to understand the level of acuity and activity that can influence nurse staffing numbers. The tool used to determine the acuity of each patient is the Welsh Levels of Care. • **Quality indicators** – there should be consideration of quality indicators that are particularly sensitive to care provided by a nurse as part of the calculation. To reduce the burden of measurement, quality indicators that have an established data source have been detailed as a minimum data set within the Act and Statutory guidance. The indicators are: • **Patient falls** - any fall that a patient has experienced whilst on the ward; • **Pressure ulcers** - total number of hospital acquired pressure ulcers judged to have developed while a patient on the ward; and • **Medication errors** - any error in the preparation, administration or omission of medication by nursing staff (this includes medication related never events). Under normal circumstances a record of this process is documented for each clinical area using an All Wales Recording Template. These record details of the overall findings of the workforce planning tool, any evidence from the quality indicators for that recording period and a summary of the professional judgement of the team. The areas of responsibility in the sign off the nurse staffing levels in wards where Section 25B&C apply are presented to ensure that the professional opinions across the service are considered. However, as described above, due to the exceptional context of COVID-19, the Health Board has recorded the staffing levels on each ward on a monthly basis to provide assurances that they were being monitored through a professional judgment lens.

Informing patients	The Health Board informs patients of the nurse staffing levels and date of agreement on information boards at the entrance to wards. The All Wales Template is used and this complies with Welsh Language requirements. The staffing levels for that day are displayed inside the ward area. In October 2020 the Health Boards Internal Audit department undertook a formal review of the Health Boards compliance with the Nurse Staffing Levels (Wales) Act throughout 2020-21. Whilst the report outlines that the ability of the Health Board to keep patients informed of the staffing levels were significantly impacted by the Covid-19 pandemic, it also provided substantial assurance in the Health Boards overall compliance with the Act.

Section 25E (2a) Extent to which the nurse staffing levels are maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

The extent to which the nurse staffing levels have been maintained	**Period covered**	**Required establishment (WTE) of S25B wards at the beginning of the annual reporting period. (April)**		**Required establishment (WTE) of S25B wards calculated during first cycle (May)**		**WTE of required establishment of S25B wards funded following first (May) calculation cycle**		**Required establishment (WTE) of S25B wards calculated during second cycle (Nov)**		**WTE of required establishment of S25B wards funded following second (Nov) calculation cycle**	
	Year	**RN:** 1028	**HCSW:** 452	**RN:** 1028	**HCSW:** 452	**RN:** 1028	**HCSW:** 452	**RN:** 1084	**HCSW:** 540	**RN:** 1084	**HCSW:** 540
	It is clearly referenced that during the COVID-19 period of 2020-2021, the Health Board experienced unparalleled challenges to the maintenance of nurse staffing levels across a wide range of clinical areas. It is therefore acknowledged that the number of wards under section 25B is likely to have changed during the reporting period. For more details of individual wards and their calculated nurse staffing levels, refer to the annual assurance reports, in the hyperlinks above. The Board should be assured that any non-recurrent increase in establishments as a result of professional judgment has been met by non-recurrent COVID-19 funding. As outlined earlier, in order to provide assurances to the Board that nurse staffing levels have been professionally calculated and align to the financial envelope, a further paper will be presented in June 2021 following formal sign off in the absence of the January to May calculation.										
Extent to which the nurse staffing levels are maintained within Section 25B wards	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, it was identified that there was no consistent solution to extracting all of the data explicitly required under section 25E, and health boards were using a variety of e-rostering and reporting systems. During the reporting period 2019/20, all health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme to develop a consistent approach to capturing quantitative data on a daily basis (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board. For the 2018/9 and 2019/20 annual reports, this health board - together with all other health boards/trusts in Wales - provided narrative to describe the extent to which the nurse staffing levels have been maintained in order to meet its statutory reporting requirement under Section 25E of the Act. For 2020/21 it was anticipated that this section of the Annual report would contain quantitative data, if at least for a part of the year. During the reporting period 2020/21 all health boards/trusts in Wales had planned to implement and use the NWIS delivered enhancements to the NHS Wales Health and Care Monitoring System (HCMS). In light of this development, on 1st July 2020, organisations have had access to a consistent approach to capturing quantitative data on a daily basis to enable each organisation to demonstrate the extent to which the nurse staffing levels across the health board have been maintained in areas which are covered by Section 25B/C of the Act. Unfortunately, due to the evolving nature of the COVID-19 pandemic and the significant impact upon normal everyday operational delivery the Health Boards ability to capture this data has been limited.										

	Looking forward, NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. It is anticipated that during the next reporting period (2021-2024) a once for Wales informatics system will be developed and will support Health Boards/Trusts in meeting the reporting requirements of the Act and the Once for Wales approach will ensure consistency. Discussions continue on a national basis to identify the national system and the Nurse Staffing Programme team is working with providers to ensure the system is able to support NHS Wales in collating the data required to inform the reporting requirements
Process for maintaining the nurse staffing level	The monitoring of nurse staffing levels is the responsibility of all nurses and operational leads throughout the system and the Health Board continually encourages staff to raise any concerns they have regarding nurse staffing levels. Within the time frame of this Annual report (6 April 2020 – 5 April 2021) the normal mechanism for maintaining the nurse staffing levels has been significantly disrupted by the COVID-19 pandemic, however under section 25(A) Staffing levels for all inpatient wards across the Health Board have been calculated to ensure that they can provide the level of care required for the patients within each area. This has been an evolving dynamic process reflecting the challenging operational context, which has been reviewed daily. As a result of moving away from a once daily critical staffing meeting prior to COVID-19, the Health Board implemented a revised approach to maintain the scrutiny of nurse staffing to include: • Formation of the Nurse staffing Hub aligned to the COVID-19 operational Centre / Local Command Centre (LCC) • A Director of Nursing was deployed to the Nurse Staffing Hub to oversee the deployed nurse staffing and staffing requests to assess and balance the risk across the Health Boards. • The Senior Nurse on call rota was enhanced to provide senior nurse cover between the hours of 1600 – 2000 hours each day to cover the transition from day to night cover. • Clinical Boards undertake a morning huddle where nurse staffing if discussed and the information provided to the Nurse Staffing Hub and reviewed four times per day. In order to support this, the Health Board have implemented new ways of working to meet the unprecedented demands that the Health Boards has been experiencing. This has required an extremely flexible approach to the deployment of nursing teams across the Health Boards to ensure the correct repurposed clinical areas are maintained in line with the changing demands for COVID-19.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels					
Patients harmed with reference to quality indicators and complaints (*) which are classified as serious incidents and reported centrally NOTE: (*) complaints refers to those complaints made under complaints regulations (Putting	**1) Total number of closed serious incidents/complaints during last reporting period**	**2) Total number of closed serious incidents/complaints during current reporting period.**	**3) Total number of serious incidents/complaints not closed and to be reported on/during the next reporting period**	**4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods (**)**	**5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor**

Things Right (PTR)					
Hospital acquired pressure damage (grade 3, 4 and unstageable).	31	4	0	↓ 27	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	11	23	7	↑ 12	2
Medication related never events.	0	0	1	1	0
Complaints about nursing care	0	0	0		0
NOTE (**): In relation to the data presented in Column 4 above, direct comparison between the numbers of closed SI's/Complaints reported during 2019/20 and the number reported in 2020/21 should not be made due to the significant changes in the number/size/patient pathway etc of wards classified under Section 25B during 2020/21 as a result of operational changes made during the Covid-19 pandemic period.					
Section 25E (2c) Actions taken if the nurse staffing level is not maintained					
Actions taken when the nurse staffing level was not maintained	Throughout the time frame for this report, consideration has also been given to the continuing review and adjustments to the planned rosters at varying levels of escalation in line with the pandemic response and the Health Boards ability to maintain the correct staffing levels. It was recognised that the nurse staffing levels at times of increasing escalation within both the COVID-19 and the non-COVID wards meant significantly different nurse staffing level than have previously been agreed within this Health Board. It is reasonable to assume that even though the agreed staffing levels were reported on a monthly basis, these levels changed within the challenging operational context on a day today, hour by hour basis. The issues relating to deviated staffing levels were often complex and multifaceted (i.e. increased absence, repurposing of wards, increased critical care demand etc). As described above, the Nursing Hub aligned to the 4 times a day Local Command Centres assumed responsibility for the continual assessment of nurse staffing levels. The ability for this process to escalate within the Health Board was aligned to the escalation plan set out in the Operational Framework included in the Act. To maintain operational services within unprecedented times, any significant changes to the nurse staffing levels across the clinical areas would be adopted only after key triggers have been reached and the move to them would be agreed through the pandemic response command structure, and would include the Executive Nurse Director leading the decision making process. For any incidents (above) where the failure to meet staffing levels were considered to be a factor, these incidents are reported to Welsh Government as part the normal reporting procedure. Within the organisation, all injurious falls are investigated using the Root Cause Analysis principles and reported to the MDT falls delivery group for lessons learned.				

Conclusion & Recommendations	
	The report outlines the unprecedented challenges that the Health Board has faced through the pandemic and the subsequent disruption to the schedule for the Nurse Staffing Levels (Wales) Act. However the report outlines the work that has continued through this time and provides assurance to the Health Board that Nurse Staffing levels have continued to be calculated and monitored through 2020-21.

Summary of Required Establishment

Appendix 2

Health board/trust:	Name: Cardiff & Vale UHB	
Period reviewed:	Start Date: April 2020	End Date: April 2021
Number of wards where section 25B applies:	**Medical:**	**Surgical:**
	23	20

To be completed f EVERY wards where section 25B applies

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment**

Medical

Ward	**Required Establishment at the start of the reporting period (as at April 6th 2020)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?***	**Required Establishment at the end of the reporting period (as of April 5th 2021)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?***	**Biannual calculation cycle reviews, and reasons for any changes made**			**Any reviews outside of biannual calculation, if yes, reasons for any changes made**		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
Heul	28.85	22.74	Yes	29.43	22.74	Yes	Yes	No		No	No	
A6S	16.24	11.37	Yes	0	0	No	Yes	No		No	No	A6S stroke moved to C4 May 20
C4	0	0	No	16.24	11.37	Yes	Yes	No		No	No	C4 opened as stroke ward May 20
B7	32.26	17.06	Yes	32.27	17.06	Yes	Yes	No		No	No	
A7	32.26	19.44	Yes	0	0	No	Yes	No		No	No	A7 Gastro moved to A6 May 20
A6	0	0	No	32.26	19.44	Yes	Yes	No		No	No	A6 opened as gastro ward May 20
A7COVID	0	0	No	27.6	19.9	Yes	Yes	Yes	Opened May 20- funded from COVID expenditure	No	No	

C6	32.26	20.71	Yes	27.6	19.9	Yes	Yes	Yes	Establishments reduced as now non-covid ward	No	No	
A1L	22.93	8.54	Yes	16.63	17.06	Yes	Yes	Yes	Establishments reduced when A1L changed from Surgery to Medicine	No	No	
A1	30.69	17.06	Yes	30.85	17.06	Yes	Yes	No		No	No	
C5	0	0	No	27.6	19.09	Yes	Yes	No		Yes	Yes	C5 changed to Medicine (from surgery) in Oct 20
LSW	0	0	No	37.6	34.6	Yes	No	No		Yes	Yes	Ward opened up to support winter and COVID
LSWGFA	0	0	No	26.00	31.2	Yes	No	No		Yes	Yes	Ward opened up to support winter and COVID
LSWGFB	0	0	No	26.00	32.2	Yes	No	No		Yes	Yes	Ward opened up to support winter and COVID
CFU	12.11	2.78	Yes	12.11	2.78	Yes	Yes	No		No	No	
E6	20.9	17.06	Yes	19.48	18.48	Yes	Yes	No		No	No	
E4	20.9	17.06	Yes	20.09	17.06	Yes	Yes	No		No	No	
E7	0	0	No	20.09	17.06	Yes	Yes	No	Changed to 25b ward in May 20	No	No	
E8	0	0	No	20.09	17.06	Yes	Yes	No	Changed to 25b ward in June 20	No	No	
W1	20.44	13.89	Yes	0	0	No	Yes	No	W1 transferred to surgery May20	No	No	
E2	20.9	17.06	Yes	20.9	17.06	Yes	Yes	Yes	Funded from COVID expenditure	No	No	
W6	20.09	14.21	Yes	0	0	No	No	No				W6 changed to Specialist ward Oct 20
W2	0	0	No	20.09	14.21	Yes	Yes	Yes	W2 opened as Medicine Oct 20	No	No	

Specialist												
W6	0	0	Yes	20.09	14.21	Yes	Yes	No		Yes	Yes	C5 moved to W6 incorporating Bethan Oct ✓
C5	28.63	18.68	Yes	0	0	No	Yes	No		Yes	Yes	C5 moved to W6 Oct ✓
A4PT	0	0	No	24.2	19.9	Yes	No	No		Yes	Yes	Poly trauma service opened Sep 20 ✓
A4N	0	0	No	15.57	8.33	Yes	Yes	Yes	Medical speciality managed by SpCB	No	No	✓
T4	0	0	No	38.37	8.53	Yes	No	No		Yes	yes	Closed in Ap 20 for COVID. Reopened Aug 20 ✓
B4H	39.13	15.99	Yes	39.13	15.99	Yes	Yes	No		No	No	✓
C3CCU	28.82	5.69	Yes	34.21	9.8	Yes	Yes	No		No	No	✓
B1	29.89	10.56	Yes	29.89	10.56	Yes	Yes	No		No	No	✓
B5	29.89	18.32	Yes	29.89	18.32	Yes	Yes	No		No	No	✓
B4N	30.66	19.9	Yes	30.66	19.99	Yes	Yes	No		No	No	✓
T5	29.81	13.33	Yes	29.81	13.33	Yes	Yes	No		No	No	✓
ITU	240.93	22.5	Yes	240.93	22.50	Yes	Yes	No		No	No	✓

Surgical

Ward	Required Establishment at the start of the reporting period (as at April 6th 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (as of April 5th 2021)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
DUTH	22.93	11.37	Yes	22.93	11.37	Yes	Yes	No		No	No	✓
A2	33.89	15.48	Yes	29.43	17.06	Yes	Yes	Yes	Bed numbers and Establishment reduced in July 20 - move to green speciality	No	No	✓
B2V	16.48	8.53	Yes	16.48	8.53	Yes	Yes	No		No	No	✓
CAVOC	38.49	14.21	Yes	24.69	14.21	Yes	Yes	No		Yes	Yes	Establishment reduced as ward closed for COVID and reopening April 21 ✓
W4	15.21	11.37	Yes	7.80	4.50	Yes	Yes	Yes	W4 (trauma) moved to W3 June 20. West 4 changed to breast	No	No	✓
W3	0	0	Yes	14.15	11.37	Yes	Yes	yes	W3 (breast) changed to trauma ward June 2020	No	No	✓
W1	0	0	Yes	20.76	20.34	Yes	Yes	Yes	Closed as a medical ward for COVID Ap20 and B6 moved into W1. Reduced establishment in line with reduced bed numbers	No	No	✓

B6	0	0	No	30.58	16.22	Yes	Yes	Yes	B6 (frailty) moved to W1 during COVID. B6 changed to H&N / urology	No	No	✓
A3L	19.32	14.21	Yes	0	0	Yes	Yes	Yes	A3L closed during COVID May 20 moved to A5S	No	No	✓
A5S	0	0	Yes	16.13	8.53	Yes	Yes	Yes	A5S opened May 20 from A3L reduced establishment in line with reduced beds	No	No	✓
SSSU	36.13	13.23	Yes	21.8	11.94	Yes	Yes	Yes	Establishment reduced in line with reduced beds	No	No	✓
SAU	23.74	11.25	Yes	23.74	11.25	Yes	Yes	No		No	No	✓
C7	52.17	28.43	Yes	30.58	16.22	Yes	Yes	Yes	Changed to red AGP ward Apr 20. Establishment reduced as changed to amber ward	No	No	✓ No establishment
B2N	0	0	No	20.09	11.37	Yes	Yes	Yes	Changed to surgical admissions June 20	No	No	✓
A5N	0	0	No	19.32	14.21	Yes	Yes	Yes	A5N closed due to COVID and reopened to Spinal May 20	No	No	✓

Report Title:	Broad Street Clinic, Barry - Barry Gateway Regeneration								
Meeting:	UHB Board						**Meeting Date:**	27 May 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	Executive Director of Planning								
Report Author (Title):	Director of Capital Estates & Facilities								

Background and current situation:

The UHB Broad Street Clinic, is located on a prominent site as you enter Barry Town Centre from its junction with Dockview Road. The Vale of Glamorgan Council (VoGC have developed a proposal for the regeneration of this gateway, designed to improve the entrance to the town centre, which includes redevelopment of the Gladstone Bridge Compound site (currently in VoGC ownership) and the Broad Street Clinic site.

The Local Authority approached the UHB with its vision at an early stage and have worked in partnership to progress the proposals which would be funded in the main by the Welsh Government Regeneration budget.

The proposal is to develop two landmark buildings delivering new affordable residential apartments and replacement of Broad Street Clinic subject to statutory consents and funding.

Whilst the re-provision of Broad Street Clinic was not considered a priority for the UHB at this time, the opportunity to have a new facility within the development would be of significant benefit to the patients within this area

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

- The PCIC Clinical Board have identified the need to retain a facility within the area of the proposed development,
- The existing facility does not meet current HBN/HTM (Health Building Notes/Health Technical Memoranda) or DDA (Disability Discrimination Act 1995) requirements and the fabric of the building is deteriorating and is not conducive with delivering community clinical services,
- The Regeneration Project provides an opportunity to develop a modern fit for purpose environment for the benefit of patients and staff,
- There are no significant financial implications associated with being part of the regeneration project.

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

The Broad Street clinic is a two storey 1960's facility currently used to provide locality services within Primary and Community Care.

It is the permanent base for one of two District nursing teams within Barry, and provides a **number of community clinics** including Podiatry, Abdominal Aortic Aneurysm (AAA), Sexual

health services, Continence, wound services, Child and Adolescent Mental Health Services (CAMHS), Speech and Language therapy, Audiology and Eye clinics.

The utilisation of these premises has remained consistently high, and its town centre location with easy transport links has ensured that despite the fabric of building being poor, the clinics run from this location are well used, indicative that this location is beneficial to the population it serves.

The District nurses use these premises as a base, and to offer clinic appointments to those who can attend. This is essential to be able to be continued, especially in light of the **additional accommodation** proposed for this area.

It remains clear that it is imperative that primary and community services are offered from this base in the future to **serve the growing population** within and around the Town Centre and Docks area, and that this location offers the most accessible base.

It has been advised that the premises at Broad Street Clinic do not currently meet the access requirements in terms of DDA requirements. Also that the fabric of the building is no longer fit for purpose in delivering community clinical services in an appropriate environment (security and infection control aspects).

This proposed scheme will enable the Vale Locality to deliver services in an appropriate environment and to continue to meet the needs of the population in this area and across the Central Vale Cluster.

The Vale Locality team are cognisant that to date there has been no engagement with the community regarding the clinic, and hence this is proposed to be a **like for like replacement**, with no change proposed to space or service provision. The Clinic would remain in the vicinity with a move to an adjacent location, therefore there is no negative impact on the community of such a proposed move.

Approval to proceed with this scheme would allow, subject to the appropriate engagement and consultation, an **extension or change** to the services provided at this location in the overall plan for Shaping our Future Wellbeing in the Community within the Vale Locality. However, there would be a commitment to retain a presence at this location for primary and community health care provision with this investment in facilities fit for purpose and service delivery.

The proposal is for the site currently owned by the UHB to be declared surplus and aquired by the Vale of Glamorgan Council via the Welsh Government Land Transfer Protocol. The Land Transfer protocol requires a joint appointment of a surveyor to determine the value of the site. The capital receipt realised would then be invested into the 'fit out' of the new clinic area provided as part of the new development on the Gladstone Bridge site which is the first phase of the regeneration project.

Within the attached report (***Appendix 1***), dated 11th March 2021, details of the project including the estimated costs, funding arrangements and land transaction proposal are identified. The report recognises that the Health Board have no capital funding beyond the capital receipt to invest in the project.

The proposal would be that the UHB would have a long lease at a peppercorn rent for a period of 99 years. Service charges would be applicable but it is envisgaed that these costs would be similar to those currently associated with the Broad Street Clinic. The new development would also include car parking spaces of a similar number of those at Broad Street Clinic.

Recommendation:

The Board is asked to:

- **SUPPORT** the partnership working with the Vale of Glamorgan Council in relation to the Barry Town Centre Regeneration Project ,
- **APPROVE** the declaration of Broad Street Clinic site as surplus, subject to formal agreements between both parties on the re-provision of the clinic in the Gladstone Bridge development,
- **APPROVE** the investment of the capital receipt associated with the disposal of the Broad Street Clinic site for the 'fit out' of the new clinic provided as part of the proposed development.

Shaping our Future Wellbeing Strategic Objectives
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities	√	6.	Have a planned care system where demand and capacity are in balance	√
2.	Deliver outcomes that matter to people	√	7.	Be a great place to work and learn	√
3.	All take responsibility for improving our health and wellbeing		8.	Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	√
4.	Offer services that deliver the population health our citizens are entitled to expect	√	9.	Reduce harm, waste and variation sustainably making best use of the resources available to us	√
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10.	Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention	√	Long term	√	Integration	√	Collaboration	√	Involvement	√

Equality and Health Impact Assessment Completed:	Not Applicable Trust and integrity / Ymddiriedaeth ac uniondeb Personal responsibility / Cyfrifoldeb personol

BARRY TOWN CENTRE GATEWAY REGENERATION PROJECT

PROPOSED REDEVELOPMENT OF BROAD ST CLINIC SITE & GLADSTONE RD BRIDGE COMPOUND SITE

A Paper Prepared for

Cardiff & Vale University Health Board

VALE of GLAMORGAN
BRO MORGANNWG

Date: 11th March 2021

1. Purpose

1.1. The purpose of this paper is to summarise the **vision** put forward by the Vale of Glamorgan Council (The Council) to facilitate the regeneration of the western gateway of Barry Town Centre (identified in **Figure 1**) in order to deliver a landmark development of new affordable homes and health facilities. The Council is **keen to collaborate** with Cardiff & Vale University Health Board and the Welsh Government to deliver this ambitious project.

1.2. The Council's **Barry Regeneration Project Board** has recently confirmed its ongoing in principle support for this exciting project, subject to Cabinet approval. A report is presently being prepared for submission to **Cabinet** to provide the executive approval for the project subject to funding and statutory consents.

2. The Project (subject to Cabinet approval, contract, and statutory consents)

2.1.The aims of the Council's Barry Town Centre Gateway Regeneration project are to deliver a range of **new affordable homes**, integrated with **health facilities,** commercial and other uses; safeguard and create new jobs and bring back into economic use several undeveloped and underutilised sites at the western end of Barry town centre. This will help boost the town centre, improving it as a sustainable place for living, working, and shopping.

2.3. The focus of this Paper is on the **Gladstone Road Bridge Compound Site** and the **Broad Street Clinic Site**, identified in **Figure 2:**

i. **Gladstone Road Bridge Compound Development Site** - is a vacant area of undeveloped land (measuring approximately 0.7 acres (0.28 Hectares). The Council owns the freehold interest in the land; and

ii. **Broad Street Clinic Site** - measures approximately 0.42 acres (0.17 Hectares) and comprises a two-storey detached Clinic property and car park for approximately 30 cars. The freehold interest of the site is owned by the Cardiff & Vale University Health Board.

Indicative Master Plan Vision

2.4.The Council's Master Plan vision (subject to Cabinet approval and statutory consents) is to redevelop both sites to deliver a coordinated pair of high-quality contemporary landmark buildings comprising a mix of new affordable homes together with new accommodation within the redevelopment for the Broad St Clinic (similar floorspace – circa 520 Sq M).

2.5. A preliminary master plan vision and artists impression is provided by **Figure 3**, subject to statutory consents and funding. (**IMPORTANT** – The drawings in Figure 3 are only indicative artist's impressions of one possible master planned proposal for redeveloping the two sites. The final scheme design proposal would be prepared in due course, subject to statutory consents and therefore determined by the separate statutory planning process and associated community consultation).

2.6. It is intended to deliver the project in two phases:

- **PHASE 1** – firstly, the **Gladstone Road Bridge Compound Site** (Site B in Figure 2) would be redeveloped to deliver a new five to six storey affordable **older persons residential** block of circa 46 no. older persons apartments and circa 520 Sq M replacement accommodation for the **Clinic;** and

- **PHASE 2** – secondly, the **Broad Street Clinic Site** (Site A in Figure 2) would be **demolished and cleared,** and the site redeveloped with a **new three to four storey affordable residential block** of circa 34 no. affordable apartments (mix of 1 and 2 bed). Prior to this phase commencing, the Broad St Clinic would have relocated to the new Clinic space created during **Phase 1**.

Estimated Capital Cost and Funding

2.7. The Council (via its Housing Services department), would facilitate the redevelopment, which is estimated to cost in the region of **£13.4 Million**. The project is estimated to have a **funding gap of £3.025 Million** (of which circa £1.3 Million is attributed to the capital cost of the new accommodation for the Clinic use). The Council proposes submitting **grant applications to the Welsh Government** to fill the funding gap e.g. **Transforming Towns grants programme and Integrated Care Fund.**

2.8. The Council understands **Cardiff and Vale University Health Board have no funds** presently available to help deliver the project. Please note paragraph 3.2. below.

3. Land Transaction Proposal

3.1. To achieve project delivery, subject to Cabinet approval and contract, the Council proposes the :

i. **freehold purchase of the Broad St Clinic Site by the Council from Cardiff & Vale University Health Board by virtue of a Public Sector Land Transfer.** In accordance with the Public Sector land transfer process the Council would acquire the land , subject to a jointly commissioned land valuation; and

ii. **disposal of 520 Sq M of floorspace within the new redevelopment for the Clinic to Cardiff & Vale University Health Board,** by virtue of a long lease at a peppercorn rental. The long lease for the Clinic would be disposed of to the UHB at nil consideration.

3.2. The Council (and its Project Board) require a **commitment from Cardiff & Vale University Health Board to invest all the capital receipt** (that would have been paid to the health board by the Council to purchase the freehold interest of the Broad St Clinic site) **back into the regeneration project**. The Council had originally

suggested this sum of money be used by the Health Board towards the cost of the proposed long lease for the new accommodation for the Clinic. However, it is understood from the health board's Director of Capital, Estates and Facilities that the Premium will be a capital source of funding and could only be used by the health board towards the **capital cost of fitting out the new accommodation for the Clinic**.

Local Need for the Broad St Clinic Use

3.3. The Council understands that there is a need to **retain the Broad Street Clinic** in this locality and regards this health use as an important part of the mixed use vision for this gateway regeneration project.

3.4 The Vale Locality Manager/Head of Adults Social Care has been party to the discussions re the Council's proposals for regeneration in this vicinity. It has remained clear that Broad Street Clinic pre-pandemic has been a **well utilised facility** providing the locality services within primary and community care.

3.5 It is the permanent base for one of two District nursing teams within Barry, and provides a **number of community clinics** including Podiatry, Abdominal Aortic Aneurysm (AAA), Sexual health services, Continence, wound services, Child and Adolescent Mental Health Services (CAMHS), Speech and Language therapy, Audiology and Eye clinics.

3.6 The utilisation of these premises has remained consistently high, and its town centre location with easy transport links has ensured that despite the fabric of building being poor, the clinics run from this location are well used, indicative that this location is beneficial to the population it serves.

3.7 The District nurses use these premises as a base, and to offer clinic appointments to those who can attend. This is essential to be able to be continued, especially in light of the **additional accommodation** proposed for this area.

3.8 It remains clear that it is imperative that primary and community services are offered from this base in the future to **serve the growing population** within and around the Town Centre and Docks area, and that this location offers the most accessible base.

3.9 It has been advised that the premises at Broad Street Clinic do not currently meet the access requirements in terms of DDA requirements. Also that the fabric of the building is no longer fit for purpose in delivering community clinical services in an appropriate environment (security and infection control aspects).

3.10 This proposed scheme will enable the Vale Locality to deliver services in an appropriate environment and to continue to meet the needs of the population in this area and across the Central Vale Cluster.

3.11 The Vale Locality team are cognisant that to date there has been no engagement with the community regarding the clinic, and hence this is proposed to be a **like for like replacement**, with no change proposed to space or service

provision. The Clinic would remain in the vicinity with a move to an adjacent location, therefore there is no negative impact on the community of such a proposed move.

3.12 Should the 'in principle' agreement for this scheme be given, subject to the appropriate engagement and consultation, an **extension or change** to the services provided at this location may be considered in the overall plan for Shaping our Future Wellbeing in the Community within the Vale Locality. However, there would be a commitment to retain a presence at this location for primary and community health care provision with this investment in facilities fit for purpose and service delivery.

4. Conclusions

4.1. As stated, the Council's **Barry Regeneration Project Board** is in principle supportive of Barry Town Centre Gateway Regeneration Project, , subject to Cabinet approval, contract, and statutory consents. A report regarding the project will be submitted to the Council's **Cabinet** soon. The Council is keen to work in collaboration and hopes Cardiff & Vale University Health Board will confirm its formal in principle support for this ambitious project as outlined in this summary paper.

Attachments: Figures 1 to 3.

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Service Contact – PCIC:

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Vale Locality Manager/Head of Adults Social Care
Cardiff and Vale UHB/The Vale of Glamorgan Council
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Figure 1: Barry Town Centre Gateway Regeneration Project (Gladstone Road Regeneration Area)

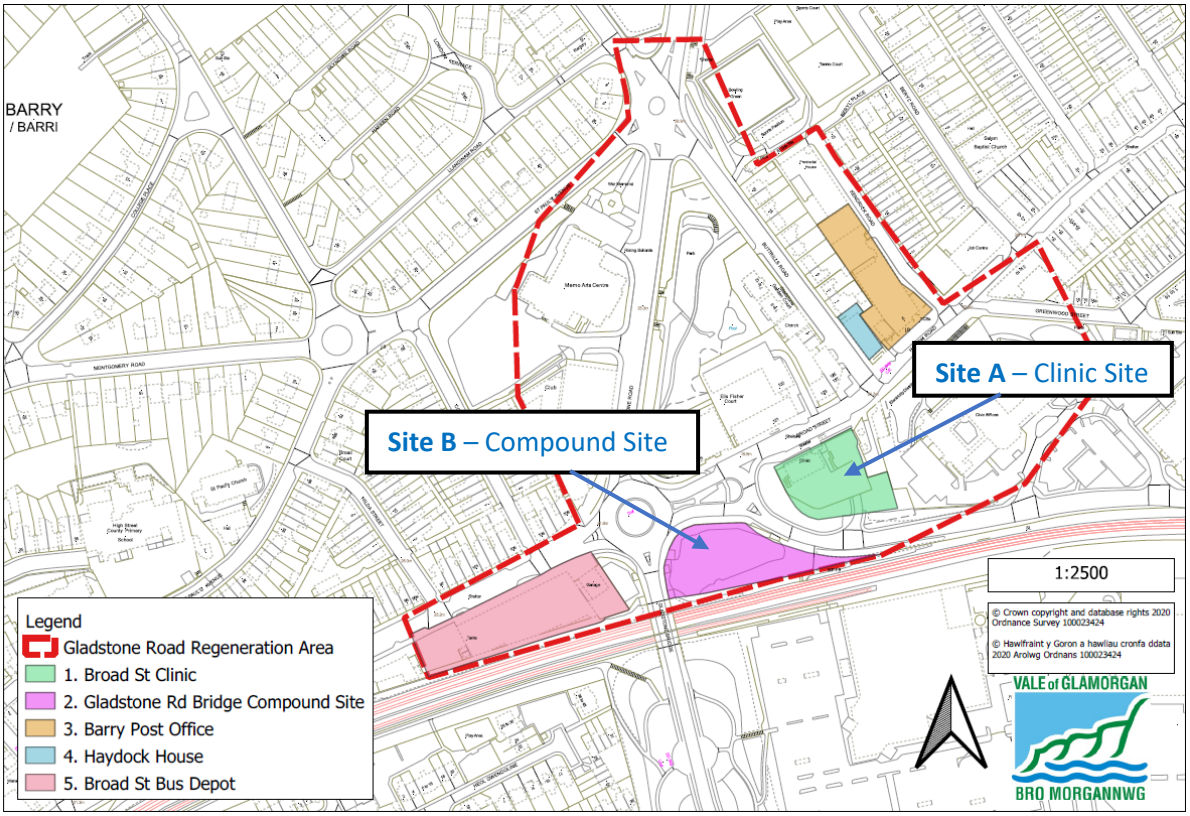
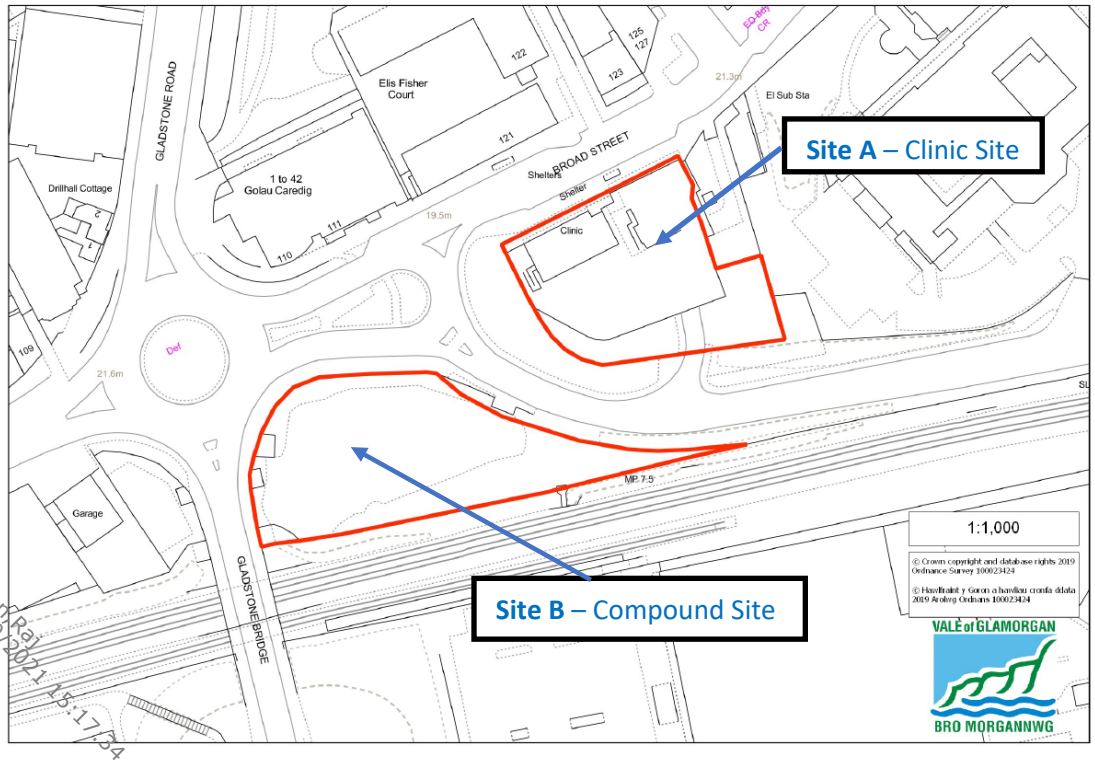


Figure 2: Site Boundaries (Compound and Clinic Sites)



Broad St Clinic

Gladstone Road Bridge Compound Site

Figure 3: Artist's Impression

IMPORTANT – The drawings in Figure 3 are only indicative artist's impressions of one possible master planned proposal for redeveloping the two sites. The final scheme design proposal would be prepared in due course, subject to statutory consents and therefore determined by the separate statutory planning process and associated community consultation.

CONFIRMED MINUTES OF THE COVID-19 BOARD GOVERNANCE GROUP HELD ON WEDNESDAY 11th FEBRUARY 2021 at 1.00pm VIA MS TEAMS/EXECUTIVE HEADQUARTERS, WOODLAND HOUSE MAES Y COED ROAD, HEATH, CARDIFF CF14 4HH

Present:

Charles Janczewski	CJ	Chair
John Union	JU	Independent Member - Finance
Dr Rhian Thomas	RT	Independent Member - Capital and Estates
Sara Moseley	SM	Independent Member - Third Voluntary Sector
Akmal Hanuk	AH	Independent Member – Local Community
Gary Baxter	GB	Independent Member University
Eileen Brandreth	EB	Independent Member – Information Communication &Technology

In attendance:

Nicola Foreman	NF	Director of Corporate Governance
Caroline Evans	CE	Secretariat

Apologies:

Michael Imperato	MI	Interim Vice Chair
Susan Elsmore	SE	Independent Member – Local Authority

CV19BGG: 21/02/11/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting of the COVID 19 Board Governance Group and it was confirmed that the meeting was quorate. He informed the group that Item 6.2 had been withdrawn from the Agenda as it would be presented at the forthcoming Private session of the Board and requested that any questions or queries relating to DHH WRU sponsors losses be raised at that meeting.	**ACTION**
CV19BGG: 21/02/11/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted from Michael Imperato and Susan Elsmore.	
CV19BGG: 21/02/11/003	**MINUTES OF THE MEETING HELD ON** The minutes of the meeting held on the 14th January 2021 were reviewed by the Covid 19 Board Governance Group (BGG) and were approved as a true and accurate record. There were no matters arising.	
CV19BGG: 21/02/11/004	**ACTION LOG FROM THE MEETING HELD ON 14th JANUARY 2021**	

	The DCG provided an update on the Action Log. She referred to: **Action CV19BGG: 20/12/16/006 Chairs Actions** - that a front sheet with a summary would accompany any future Chairs Actions but it had not yet been developed by procurement department and will follow up **CV19BGG: 21/01/14/005 DHH** - that the Corporate Governance Department were currently in the process of recruiting an Archivist to carry out work reviewing the records and that a timeline would be produced. **CV19BGG: 21/01/14/005 Draft Exit Agreement Cardiff Blues –** that Ed Hunt had reported back to the Solicitor but that an updated agreement had not yet been received.	
CV19BGG: 21/02/11/005	**COVID-19 GENERAL UPDATE** The Chair provided the group with a brief overview of the situation. He reported that infection rates were reducing and that the rate for Cardiff was currently 98.1 per 100k over a seven day rolling period, 119.8 for the Vale and 176 within the over 60's where there was a slight increase due to an outbreak in a Vale Care Home. The positivity rates were currently 8.7% in Cardiff and 10% in the Vale. That the hospital situation remained largely unchanged, admissions were falling but bed capacity was still high and the length of stay was becoming longer with an average of 15 days. The situation within critical care was much improved although they were still under pressure. The Chair stated that the Health Board was now trying to focus on recovery and look at the associated planning processes although a cautious approach was being taken. He reported a similar situation within Primary Care and although it was easing slightly, as GP's embarked on the vaccination process, their regular work had been pushed back which had resulted in a significant increase in their overall workload. Optometry, Pharmacy and Dental were in reasonable order.	

	He reported that 95,802 vaccines had been delivered to date but highlighted that there were certain factors that affected the percentages. He referred to the 100%+ achievement of rolling out the vaccine within Health and Social Care and that the private sector front line staff and WAST staff had not been factored in to the denominator figures which caused slight distortion. The Chair stated that the Health board were on track to deliver cohorts 1-4 by 15th February and that there were now mass vaccination centres operating in Splott, Pentwyn and as from this week, Holm View in Barry. He added that the Satellite sites at UHW and UHL had not been heavily used. He reported that the delivery of the vaccine to care homes was now complete with the exception of those where there had been outbreaks and that there were currently five mobile teams in operation but this would be expanded to 20 teams to complete delivery to the housebound patients within these cohorts. He explained that the vaccine supply levels were likely to dip due to production issues with the Pfizer vaccine and demands from EU countries but that these issues were being addressed and that it was expected that normal supplies would be resume from Mid-March. He reported that the Health Board were considering trying to accelerate the vaccination programme further. Following a question from EB requesting information regarding the statistics on wastage of the vaccine, the Chair clarified that there had been minimal wastage and the First Minister had confirmed this whilst on a visit to the Pentwyn vaccination centre last week.	
CV19BGG: 21/02/11/006	**CHAIRS ACTION** NF presented a Chair's Action to the group for approval. She explained that it related to a mobile MRI scanner that would be supplied inclusive of a full staffing compliment. This additional facility was aimed at reducing the backlog of the MRI waiting list which would take approximately seven months. She invited the group to ask questions. Following a question from RT regarding why the staff turnover in radiology was so high, NF agreed to clarify this with Steve Curry. JU queried if it had been passed through the tender process and NF stated that it was a direct award but agreed to clarify this with Steve Curry and feedback to the group.	**ACTION NF** **ACTION NF**

	The Chair stated that we were fortunate to have this opportunity and that it was a good investment, enabling the Health Board to get back on track. **Resolved that:** The Board Governance Group approved the_total cost of £554k for MRI capacity during 21/22.	
CV19BGG: 21/02/11/007	**DECISIONS LOG FROM MANAGEMENT EXECUTIVES** The DCG presented the Decision Log to the group for noting and explained to the group that there were two decisions, one of which required sign off for the MRI Scanner and that this had been approved. There were no queries.	
CV19BGG: 21/02/11/008	**ANY OTHER BUSINESS** The Chair informed the group that David Edwards, the new Independent Member for ICT would be starting with the Health Board on the 1st April and that he would be replacing Eileen Brandreth. He also reported that Mike Jones had been appointed as the new Independent Member for Trade Union as from the 1st March. They were both welcomed to their new role. The Chair stated that he would be undertaking a review of the committee membership.	
CV19BGG: 21/02/11/009	**DATE AND TIME OF NEXT MEETING** 11th March 2021 – 9.30am Via MS Teams	

Confirmed Minutes of the Public Audit and Assurance Committee
Held on Tuesday 9th February 2021 09:00am – 12:30am
Via MS Teams

Chair		
John Union	JU	Independent Member – Finance
Present:		
Eileen Brandreth	EB	Independent Member – ICT
In Attendance:		
Anthony Veale	AV	Audit Wales
Charles Janczewski	CJ	UHB Chair
Chris Lewis	CL	Interim Director of Finance
Darren Griffith	DG	Audit Wales
Ian Virgil	IV	Head of Internal Audit
Mark Jones	MJ	Audit Wales
Michael Imperato	MI	UHB Vice Chair & Independent Member - Legal
Nicola Foreman	NF	Director of Corporate Governance
Nigel Price	NP	Local Counter Fraud Specialist
Steve Curry	SC	Chief Operating Officer
Wendy Wright	WW	Deputy Head of Internal Audit
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Interim Executive Director of Workforce & OD

AAC 21/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the public meeting.	**ACTION**
AAC 21/02/002	**Apologies for Absence** Apologies for absence were noted. Nigel Price Local Counter Fraud Specialist (LCS) mentioned he would be attending in place of Craig Greenstock, Counter Fraud Manager, for the foreseeable future as he was away from work on sick leave.	
AAC 21/02/003	**Declarations of Interest** There were no declarations of interest.	
AAC 21/02/004	**Items for Information and Noting - Internal Audit reports for information** **1. Mental Health Outpatient Clinic Cancellations** The CC informed the committee that a slight adjustment would be made to the agenda order so the committee could discuss the Mental Health Outpatient Clinic Cancellations with the Chief Operating Officer (COO) present at the meeting.	

The Head of Internal Audit (HIA) stated that the report was their final report from an audit looking at the management of outpatient clinic cancellations within the Mental Health clinical board. The audit looked at, amongst other things, whether there was a consistent documented procedure in place for managing cancellations, whether there were appropriate justifications for cancelled outpatient appointments, the processes for booking and replacing of appointments and the wider reporting and monitoring of those cancellations within the clinical board.

The HIA confirmed that the report provided limited assurance of the operational controls in place. The key reasons for this were:

- The lack of monthly reporting of cancellations within the clinical board
- The absence of a system for monitoring incidents where outpatients clinics were being cancelled
- In regards to PARIS, a lack of detailed recordings within the system highlighting the justifications for cancellations was noted
- Processes in place across the clinical board were inconsistent. In the two directorates they had focused on there were different systems in operation that resulted in a lack of any consistent or written procedures being in place.

The HIA stated that the bulk of report reflected on findings and areas of good practices and the action plan at appendix A provided the full detail of each of the issues that had been highlighted with management responses to address those issues.

The CC noted the two high & three medium management responses that were included and highlight that the bulk of the responses were scheduled to be completed by 21st April 2021.

The COO thanked the CC for the opportunity to contribute his views in the meeting and the HIA for his report. He said that the report sets out management response to five areas of concern two high & three medium rated.

In regards to the two high rated areas and the written guidance, the COO met with the clinical board twice and the information & reporting teams to discuss this as there were a few nuances in the background which the COO would discuss further. He stated essentially there was no real reason why the Health Boards overall rules for cancellations could not apply in Mental Health with some nuances. It was agreed that the Mental Health Clinical Board would be adopting Health Board guidance immediately but due to the nature of some of the appointments and the models of care in Mental Health, (a mix of community, primary and secondary care services) there maybe changes in how cancellations are systematically recorded those going forward. Nevertheless the general principles would apply.

The COO then spoke about recommendation number five in regards to performance reporting and how this was expected to be in place by April. There was some work to be done around PARIS and he highlighted that some of the information in Mental Health was coming through Biz and some through PARIS which reflected the transformation work in that area

to move to a more community based model through the 8 CMHT's., He added that they had committed to ensuring performance would be reported through that model.

The COO then discussed the three medium recommendations:

1) Finding 2 – Lack of Evidence to support Cancellations – this was being worked on. In regards to the PARIS system the individual managing the system had been on sick leave but a replacement had been sourced to continue that work and it was expected that the management response plans would be achieved..
2) Finding 3 – Authorisation of clinic cancellations - the Clinical Director and Deputy Clinical Board Director had made contact with all clinical teams to ensure that cancellation of clinics are signed off by the respective Clinical Director. The COO mentioned that he noted from the report rebooking of patients was happening in a timely manner but commented that it was important to record those events systematically.
3) Finding 4 - PARIS is used inconsistently between Mental Health
4) Directorates - In regards to Mental Health services for older people it was noted that staff were not consistently using the systems available to them. The COO confirmed that on a locality basis, the southern localities had moved from manual to system recording from the 21st January, Northern localities would move across in February.

The COO spoke about how things would operate moving forward. Work was underway with partners across the Health Board, including Lightfoot whom they have partnered with to join up information streams to understand whole system pathways for service users. Lightfoot's ability to use the existing information systems, pull out information and present it in a pathway specific form has afforded the opportunity to deal with the Biz vs PARIS information. The COO added that the mental health clinical board were working with Lightfoot on opportunities like this going forward so that the issues identified in the report were apparent sooner rather than later. The COO mentioned that his last conversation with the clinical board was on the 08/02/2021 and he felt assured that they had accepted the report and recognised the urgency of the required actions.

Independent Member – ICT (IM-ICT) was pleased to see the prompt action taken to the report but was concerned about the impact on patients of cancellations. She noted the reasons for patient cancellations were recorded but that the reasons for clinical cancellations were not. She queried whether clinical reasons for cancellations could also be included.. She also noted that the audit excluded CAMHS outpatients and suggested that the application of process improvements should be applied to CAHMS patients as well.

The COO confirmed that the drop down box method of recording cancellations did not allow for a lot of detail but he agreed this could be dealt with more appropriately and was hoping to receive some feedback

	on this.. In response to the second query the COO answered that the remit agreed was around Adult and older persons services to which the HIA reinforced. The meeting was then resumed in its original order.	
AAC 21/02/005	**Minutes of the Committee meeting held on 17th November 2020** The CC reviewed the minutes from the 17th November 2020 **Resolved that:** (a) The Committee approved the minutes of the meeting held on 17th November 2020 as a true and accurate record.	
AAC 21/02/006	**Action Log following the Meeting held on 17th November 2020** The Committee reviewed the action log and the following updates were provided: • Completed actions were noted • **AAC 20/09/008** – update to be brought to the April meeting • **AAC 20/04/005 and AAC 20/11/023** – The HIA confirmed that he had met with the Executive Medical Director and that there was an expectation that the Follow up report would be brought to the committee by April / May • **AAC 19/12/012** – The item was deferred from this meeting and would be brought to a future meeting • **AAC 20/11/021** – The Director of Corporate Governance (DCG) stated that the item had come to the previous committee meeting and went to the January Board for approval. The Action was now complete. • **AAC 20/11/010 + AAC 20/11/013** – IM-ICT confirmed that these reports would go to DHIC for noting and information. • **AAC 20/11/011** – DCG stated that this will be taken to the March S+D meeting **Resolved that:** (a) The Committee reviewed and noted the action log and the updates provided.	
AAC 21/02/007	**Any Other Urgent Business** There were no items raised.	
AAC 21/02/008	**Internal Audit Progress and Tracking Reports** The HIA stated that this was the usual report that came to the committee detailing progress made against the internal audit plan for the year. He highlighted section 2 that detailed the audits planned to be delivered in February of which 9 weren't finalised in time due to difficulties in progressing work in the prevailing climate. Section **2.1** of the report provided reasons for each delay.	

	Section 3 of the report detailed the 3 reports that have been finalised since the last committee meeting. The mental Health report was discussed earlier in meeting and the other 2 reports summaries were provided at section 6.Full copies of the reports were available as part of the meeting agenda at item 9.1. The HIA confirmed that the: • Specialist CB report – Patient Assessment and Provision of Equipment by ALAS – this received a substantial assurance rating and there was nothing that he wanted to bring to the attention to the committee regarding this. • The Asbestos Management report received a reasonable assurance rating with positive outcomes and a few medium priority recommendations around compliance with contractors signing in and out of UHW premises. Section 4 of the report addressed delivery of the Audit Plan. He stated that over the last few meetings updates were given of the adjustments that had been made to the plan due to the ongoing pandemic. He had therefore provided an update on the 2021 plan and his proposed timings for the production of an annual report and opinion. Section 5 of the report provided an update on work undertaken to validate completion of recommendations within the Health Boards Internal Audit recommendations tracker. The purposed of the exercise was to provide assurance to the committee that the management responses detailed within the tracker were accurate and that actions listed as completed and been undertaken.. Since the previous meeting he had taken a sample of responses from the 2018/19 recommendations and the outcomes confirmed that the information recorded in the tracker was accurate and backed up by evidence. The HIA stated that this provided the committee with assurance that the information within the tracker was accurate. The CC commented that this provides good assurance to the committee and thanked the HIA for his work. The DCG commented that the work undertaken by the HIA gave good reassurance to the committee and to members of her team that the information being provided was accurate. Section 6 of the report confirmed that he had begun planning for the 2021/22 internal audit plan, a draft of which would be shared at a management executive meeting in March for approval and subsequently come to the Audit committee in April for formal sign off. The HIA commented that the Appendix area provided detail of all audits within the plan and their present status. He stated that and appendices B and C provide information on current responses to the audit reports they had finalised. Of the 10 finalised to date, 8 had been responded to by management within the agreed timescales. **Resolved that:**	

	a) The Committee considered the Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports. b) The Committee approved the proposed amendments to the Internal Audit Plan for 2020/21	
AAC 21/02/009	**Internal Audit Plan to Complete 2020/2021** The HIA stated that the report was for information rather than approval and to provide more detail on the adjustments made to the plan for the year and the potential impact on the HIA's opinion for the year. He highlighted that due to the fact he anticipated delivering fewer audits than in 2019/20 it had been agreed with the Board Secretaries Group to remove the formal use of the domain approach to arrive at the Head of Internal Audit Annual Opinion for Health Boards in 2020/21. The HIA then highlighted the key areas that Internal Audit would look to gain assurance over as part of the work throughout the year. • Governance And Risk Management – in the audit plan they have a detailed piece of work looking at this process. The HIA is happy they have sufficient coverage over the governance and risk management side of things in this area to form an opinion for the year. The HIA added that the piece of work done around Covid governance arrangements within the Health Board had provided additional assurance on the governance processes and changes that were made during the pandemic and he felt that this gave invaluable resource to feed into the HIA opinion for the year. • Controlled Activity within Health Board – The HIA stated that the key assurance they get in this area comes from the actual internal audit work and advisory work that they had undertaken in the various departments and clinical boards. He added that it is in this area that they had seen impact on the level of number audits they were planning to undertake. The HIA informed the committee that at the time of producing the report in December there were 17 complete on going audits and a further 14 reviews that they were still planning to start and complete before the end of the year. The HIA advised that he had discussed those further 14 reports with each of the lead executives to confirm that they were happy for the work to go forward and engage in and he provided assurance that the work should be able to start and completed for inclusion in the opinion for the year. • The HIA added that there were 4 further reviews identified that could not be completed (the reasons for this were detailed within the report).He added that in the majority of cases where reports could not proceed this was because the reviews would be in areas of Health Board that were significantly impacted by the pandemic and staff were not available engage in the proposed Audits.	

	The HIA informed the committee that his team planned to deliver 31 audits as part of the year's plan, which compared to 39 from previous year. He stated that although there was a reduction it still demonstrated that they were getting good coverage across the Health Board. The HIA concluded that given all the considerations into account and where they were within the plan, he still intended to deliver a full HIA Opinion for the year which was very positive for the Health Board and would be the ideal outcome. The CC commented that the paper was welcomed by the committee and that he felt it was very timely as it set out clearly where the Health Board was and provided assurance that Internal Audit would complete the work outlined and provide an end of year opinion. The Interim Director of Finance (IDF) queried entries on page 8 of the report in relation to Financial Governance & Management and 2 reports expected from shared services. He asked if they would form part of the HIA's opinion of controls in place for the Health Board. The HIA confirmed that they undertake audit work on services provided by NWSSP around payroll and accounts payable. He said every year they do work on these areas and they do feed into the HIA Opinion to give assurance on those processes that are being undertaken for the Health Board. He added in normal years' work done on those systems is an overall piece of work covering the services provided for all the trusts and Health Boards in Wales, for this year they have increased testing in those pieces of work and undertaken more specific tests on transactions for individual Health Boards to be able to give a more detailed assurance and report for the individual Health Board. The IDF asked if the HIA would bring back the report to the Audit committee from those areas. The HIA stated that he would need to confirm whether this would be a specific report or an additional item within the annual report with NWSSP colleagues but advised that there will be a level of assurance for the Health Board in that area. He also confirmed that Internal Audit had sufficient resource to carry out the work in the remaining months. **Resolved that:** a) The Committee noted the Internal Audit Plan to Complete 2020/2021	
AAC 21/02/010 Khan Raj 05/20/2021 15:17:34	**Audit Wales Update** Anthony Veale – Audit Wales (AV-AW) firstly discussed the letter sent by the AGW to the Health Board and to other Chief Executives in Wales. He said that it sets the context on how Audit Wales will conduct its work against the backdrop of the pandemic, he feels within the letter are a few important messages that the committee should hear: • Against the backdrop of the pressures that the Health Board is under currently they will adjust focus and timing of their work as	

	Audit Wales recognises that it is a difficult time but will continue to be agile, work in partnership and maintain the audit focus. AV-AW continued to discuss the Audit Wales update and stated that it can be taken as read by the committee and asked Darren Griffiths – Audit Wales (DG-AW) to highlight key areas from the report. DG-AW highlighted the approach undertaken for structured assessment work for that year. He stated that they are planning to take the work in 2 phases: • Phase 1 – Health Board Operational Planning Arrangements • Phase 2 – Corporate Governance And Financial Management Arrangements DG-AW stated that Phase 1 is well underway and that they had to adjust and adapt their approach due to Covid and remote working. He added that they are hoping to provide initial feedback to Health Board the following month verbally and would look to commence Phase 2 soon afterwards being mindful of the circumstances under which the Health Board are operating under. He then provided an update on the GPX programme. They were hosting a Covid learning week from 8th March to 13th March. This would be to showcase positive practice in public sector demonstrating how public bodies reacted to the pandemic and there would be sessions that were relevant to NHS bodies which would be available on their website. The IDF queried the work on the structured assessment looking at the timing and asked if it is mainly an exercise in looking back as opposed looking forward. DG-AW confirmed that the IDF was correct and that they are looking at Q3/Q4 operational plans and looking at the arrangements the Health Board has in place for producing that plan. He said that this would be a retrospective look on how this plan was pulled together to provide feedback before formalising a 2021/22 plan. **Resolved that:** (a) The Committee noted the Audit Wales update.	
AAC 21/02/011 Khan Raj 05/20/2021 15:17:34	**Doing it Differently, Doing it Right? Governance in the NHS During the COVID-19 Crisis** The CC asked AV-AW if any further comments were required for the report. AV-AW was happy for the committee to take the report as read.	

	The CC confirmed with committee members that they had, had the opportunity to read the report and no further queries were raised **Resolved that:** a) The Committee noted the Audit Wales update	
AAC 21/02/012	**Follow-up of Operating Theatres** The CC asked AV-AW if any further comments were required for the report. AV-AW was happy for the committee to take the report as read. The CC confirmed with committee members that they had, had the opportunity to read the report and no further queries were raised **Resolved that:** a) The Committee noted the Audit Wales update	
AAC 21/02/013	**Declarations of Interest and Gifts and Hospitality Tracking Report** The DCG advised that the report was shared for members to review. Since the previous meeting a further 705 declarations had been received in addition another 400 had been received since the report had been written. Of those declarations received and recorded: • 144 declared an interest – identified 3 potential conflicts – 2 relate to other employment and other one was procurement issues • returns • 11 gifts declared up to November 2020 The CC asked of that 1100 what is the total number we could get back or is it only 8a or above? The DCG answered that they chase all staff annually but chase Band 8a and above more robustly to ensure that declarations from decision makers are recorded. She added that if people withhold information we won't know, as long as they chase and receive information there is less chance of breach as people would have been made aware of the policy. **Resolved that:** a) The Committee noted the ongoing work being undertaken within Standards of Behaviour. b) The Committee noted the update in relation to the Declarations of Interest, Gifts, Hospitality & Sponsorship Register.	

AAC 21/02/014	**Regulatory Compliance Tracking Report** The DCG confirmed that there had not been a lot of activity in this area due to the external agencies that undertake inspections being unable to attend in the usual way. She made the committee aware that since November 2020 only 3 further inspections had taken place. The DCG highlighted the list of upcoming inspections in the following quarter and advised that it was still uncertain whether these inspections would be undertaken in the prevailing climate. **Resolved that:** a) The Committee Noted the inspections which had taken place since the last meeting of the Audit Committee in November 2020 and their respective outcomes. b) The Committee noted the continuing development of the Legislative and Regulatory Compliance Tracker.	
AAC 21/02/015	**Internal Audit Tracking Report** The DCG stated that this report concerned internal audit recommendations that had been made between 2017/18 and 2018/19 with additional entries for 2021/22 added to the report added for the first time. She highlighted that they have been reduced from 111 to 110 but 19 recommendations were added meaning that 20 had completed since the previous meeting. She mentioned that these were followed up with the executive colleagues between each committee meeting to ensure that recommendations and actions against them are continually monitored. The DCG added that those recommendations which were listed as completed would be taken off for the next meeting but were displayed for reporting purposes similar to an action log. The CC queried whether it was difficult chasing the 2017/18 recommendations because of their age. The DCG responded that she had asked her team to meet the individuals rather than the executive leads for those recommendations so that action could be taken for them to be completed or for confirmation to be given that they had been superseded by another. It was identified that there were a number of actions that could potentially be removed once team members had the opportunity to liaise with operational leads. The HIA mentioned that he would look to meet with the DCG and her teams to agree a process of reducing outstanding areas. IM-ICT queried if any of the outstanding audits were high priority and whether management in the areas couldn't complete these due to lack of resource, or they had made a decision that the action was no longer necessary. She also asked whether a mechanism was available to close the action with those conclusions.	

	The DCG stated that would be her plan and was why she wanted her team to go out and meet the individuals responsible for the recommendations so they have a clear understanding as to why recommendations hadn't been completed. This would allow colleagues to report back with clear commentary on the status of recommendations. The DCG added that for the next meeting she would bring back a clearer and updated position on these recommendations with specific narrative around them to demonstrate that the DCG and her team had spoken with the individuals concerned as well as seeing the reasons why. From this the Committee could sign off or keep them on the tracker depending on the responses received. IM-ICT suggested that the persons responsible are accepting the risk in delaying these actions and that the clinical boards responsible are condoning a different appetite for risk. She felt that there needs to be a firm statement and acknowledged by Audit on any subsequent review. **Resolved that:** a) The Committee Noted the tracking report which was now in place for tracking audit recommendations made by Internal Audit. b) The Committee Noted that progress would be seen over coming months in the number of recommendations which were completed/closed	**NF**
AAC 21/02/016	**Audit Wales Tracking Report** The DCG advised that the report tracked progress against recommendations made by Audit Wales in the same manner that internal audit recommendations were tracked and discussed in the previous item. Since the previous meeting 3 recommendations had been added • 2 in relation to the effectiveness in Counter Fraud Arrangements • 1 in relation to the Structured Assessment 2020 She highlighted that the tracker demonstrated that 3 recommendations had been completed since November and a further 12 recommendations had been partially completed. 8 had no actions recorded against them however the DCG informed the committee that this didn't mean that nothing had been happening, rather it was the case that her team had received no response to requests for updates. She stated some of this work has been impacted by Covid-19. **Resolved that:** a) The Committee noted the progress which had been made in relation to the completion of WAO recommendations. b) Committee noted the continuing development of the WAO Recommendation Tracker.	
AAC 21/02/017	**Final Accounts Timetable and Plans** The IDF stated that the purpose of the report was to provide members an opportunity to comment on the draft timetable for the production of the	

Health Board's annual report. The IDF reminded the committee that the annual report and accounts came in 3 parts

- Performance report
- Accountability Report
- Financial Statements

The IDF highlighted that the previous year the Health Boards accounts received a 'qualified with limitation of scope' opinion as Audit Wales were unable to sufficiently evidence the inventory balances due to remote work and Covid. He stated that the same was likely to apply for the accounts going forward for 2021 and he informed the committee that they are highly likely to end up with a qualified set of accounts due to limitation of scope.

The CC queried if this would be for all UHB's in Wales or all public bodies.

The IDF responded that there were very few who have a materiality threshold which warrants this and due to the nature of C&V UHB and the type of services the Health Board provides the stock is about 1% of the UHB turnover.

AV-AW commented that this is the cut-off point that if stock balances are greater than materiality which is set relatively consistently across public sector bodies. Once it goes above that threshold auditing standards mandate Audit Wales to attend an audit committee because of the circumstances they can't therefore have a qualification.

The IDF referred to appendix 1 and the draft timetable which set the following key dates:

- 30th April – Draft Accounts
- 7th May - Draft of whole suite of reports need to be submitted for consideration
- 10th June - Special Audit meeting which includes a special Board Meeting on 11th June to submit to Welsh Government for consideration.

The IDF mentioned that the Audit Committee Workshop which goes through the detail of major judgment and estimates which takes a review of accounts and all major supporting documentation needs to be arranged after they submit draft accounts in May (after the 7th).
The IDF added that for 2021 they will be reverting back to a normal timescale as the previous year it was elongated by an extra month. He also commented that the audits and preparation of accounts worked well remotely so lessons would have been learned from that experience. He mentioned that it would still be a pressurised time period for both Audit wales, the DCG teams and his own team to complete the Annual Statement.

Resolved that:

	a) The Committee reviewed and noted the proposed timetable and approach for the Annual Report 2020-21.	
AAC 21/02/018	**Review Committee Terms of Reference** The DCG confirmed that it was an annual requirement that the Committee review it's terms of reference. She added that the TOR's and work plan for all committees would be submitted to the Board at the end of March. She highlighted that very few changes had been made from the previous year's terms of reference. **Resolved that:** a) The Committee approve the changes to the Terms of Reference for the Audit and Assurance Committee and b) The Committee recommended the changes to the Board for approval.	
AAC 21/02/019	**Audit Committee Annual Report** The DCG stated that the report provides a summary of the work undertaken by the committee over the course of the financial year and provides assurance to the committee that it is doing what it should be in line with its TOR. **Resolved that:** a) The Committee reviewed the draft Annual Report 2020/21 of the Audit and Assurance Committee b) The Committee recommended the Annual Report to the Board for approval.	
AAC 21/02/020	**Annual Work Plan** The DCG stated that the work plan is prepared and approved to ensure that the committee gets through the work it is supposed to, in alignment with the Terms Of Reference, during the next financial year. **Resolved that:** a) The Committee reviewed the Work Plan 2021/22 b) The Committee approved the Work Plan 2021/22 c) The Committee recommended approval to the Board	
AAC 21/02/021	**Audit Wales 2021 Audit Plan 139 – 144** AV-AW – reminded members that the plan sets out who they are, what they will do, and how much it will cost. He stated that their work is defined in two strands 1. Audit of the accounts 2. Performance Audit works Mark Jones – Audit Wales (MJ-AW) spoke in regards to the NHS Finance Wales Act 2014 which is about the rolling 3 year revenue	

	resource limit and capital resource limit which is very relevant to the regularity opinion of the annual accounts. He mentioned that the health board have qualified their accounts for the last 4 years in this area because on a 3 year rolling basis there has always been a deficit, which was likely to continue in the 2021 accounts because in 2018/19 the Health Board had a £9.8 Million deficit which was still within that 3 year period. He provided the example of the Health Board needing to make a surplus of £9.8 Million to not have this 3 year deficit. AV-AW highlighted that one thing that was not included in the plan was the Audit fee which was due to the fact that their fee scheme had not been approved but was expected at the end of the month. He stated that he would confirm to the committee and Health Board what the estimate fee would be once available.	
AAC 21/02/022	**Items for Information and Noting - Internal Audit reports for information** The Committee received the following 3 reports: 1. Pre-Employment Checks – Reasonable assurance 2. Surgery CB – Theatres Directorate Sickness Absence Management – Reasonable assurance 3. Regional Partnership Board – Reasonable assurance **Resolved that:** (a) The Committee noted the Internal Audit reports.	
AAC 21/02/023	**Items to bring to the attention of the Board / Committees** There were no items to be brought to the attention of the Board / Committees.	
AAC 21/02/024	**Review of the Meeting** The CC thanked everyone for their attendance and contribution to the meeting.	
AAC 21/02/025	**Date and Time of Next Meeting** To note the date, time and venue of the next Committee meeting: **Tuesday 6th April 2021 at 9.00am**	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE
HELD ON 24th FEBRUARY 2021
VIRTUAL MEETING via TEAMS

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
John Union	JU	Independent Member - Finance
Charles Janczewski	CJ	Board Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Andrew Gough	AG	Assistant Director of Finance
Chris Lewis	CL	Interim Director of Finance
Nicola Foreman	NF	Director of Corporate Governance
Steve Curry	SC	Chief Operating Officer

In Attendance:

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Len Richards	LR	Chief Executive
Ruth Walker	RW	Executive Nurse Director

FC 21/02/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 21/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 21/02/003	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	
FC 21/02/004	**MINUTES OF THE COMMITTEE MEETING HELD ON 27th JANUARY 2021**	

	The minutes of the meeting held on 27th January 2021 were reviewed and confirmed to be an accurate record. **Resolved – that:** The minutes of the meeting held on 27th January 2021 were approved by the Committee as an accurate record.	
FC 21/02/005	**ACTION LOG FOLLOWING THE LAST MEETING** **There were no outstanding actions**. **Resolved – that**: The Finance Committee **noted** that there were no outstanding actions.	
FC 21/02/006	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 21/02/007	**FINANCIAL PERFORMANCE MONTH 10** The Assistant Director of Finance summarised the key points within the Month 10 Finance Report and highlighted material changes from the previous month. The Committee was informed that at month 10, the UHB had reported a year to date underspend of £0.208m following an in month operational overspend of £0.095m. The reported position included net expenditure of £124.492m arising from the management of COVID 19 which was offset by an equal amount of Welsh Government COVID 19 funding. Six of the eight measures on the Finance Dashboard were RAG rated green. Two measures remained RAG rated red namely: the reduction in the underlying deficit to £4m and the delivery of the recurrent £25m 3% devolved savings target. Progress against the 2 measures had been impeded by the COVID pandemic and this had adversely affected the underlying deficit brought forward to the 2021/22 Financial plan. Moving onto performance against income, pay and non pay budgets the Committee was informed that the position at month 10 represented a progression of the trends established in the first 9 months of the year. At month 10 the year end forecast of net expenditure due to COVID 19 in 2020/21 was £161.947m and this was offset by confirmed additional COVID 19 funding of £161.947m. With the exception of the COVID allocations to cover the cost of vaccination and TTP, all additional COVID related allocations were now assumed to be fixed. Allocations for TTP and Vaccinations were expected to be finalised at month 11 based on spend to date and the forecast for the remaining month of the year. In reply to a query from the Finance Committee Chair (RT) the Interim Director of Finance confirmed that the UHB was expecting Welsh Government to recover any over funding of Tracing costs at month 11.	

	The UHB Chair (CJ) asked whether Welsh Government would provide cover for the TTP and vaccination costs which were programmed to roll into 2021/22 and the Interim Director of Finance indicated that this had not yet been confirmed as it was subject to a further budget round within Welsh Government. It was noted that the forecast of net expenditure due to COVID 19 in 2020/21 included the cost estimate of the additional annual leave accrual that was expected to arise in 2020/21 which was estimated at £8.798m. **The actual additional annual leave provision would not be known until the sample data, upon which the accrual will be based, is collected and costed at month 12**. Turning to Clinical Board performance it was highlighted that there were material operational overspends in the Women & Children and in the Medicine Clinical Board. The UHB Chair noted that the Clinical Boards which were reporting significant operational overspends in year had also reported similar overspends in previous years. The Chief Operating Officer informed the committee that performance within the Medicine Clinical Board was sensitive to pressures associated with the provision of unscheduled care and that there was also a challenge in separetely identifying COVID and non COVID service costs in year. The Interim Director of Finance added that in 2020/21 the UHB had focussed on overall financial performance and that the empasiss on performance at Clinical Board level was expected to increase as the UHB moved into the new year. The Finance Committee Chair (RT) indicated that Clinical Board Financial Performance would be reviewed by the Committee in 2021/22 with an expecation that remedial action would be taken where there was a reported material overspend. In this context the UHB Chair (CJ) indicated that the Finance Committee would also need assurance that the UHB was allocating appropriate budgets and supporting the Clinical Boards to deliver within the established budgets. The Chair added that the UHB also needed to understand why some Clinical Boards were able to operate within delegated budgets whilst some could not. There were no signicant concerns around the UHBs balance sheet and the UHB remained on track to meet is PSPP, Cash and Capital Expenditure targets. In conclusion, the Assistant Director of Finance highlighted that at month 10, the key revenue financial risk is managing the impact of COVID 19 within the additional resources provided. **Resolved – that:** The Finance Committee **noted** the month 10 financial impact of COVID 19 which is assessed at £124.492m; The Finance Committee **noted** the additional Welsh Government funding of £124.492m assumed within the month 10 position;	

	The Finance Committee **noted** the month 10 reported financial position being a surplus of £0.208m; The Finance Committee **noted** the breakeven position which assumes additional Welsh Government funding of £161.947m to manage the impact of COVID 19 in line with quarter 3&4 planning assumptions; The Finance Committee **noted** the risks that are being managed on the capital programme; The Finance Committee **noted** the revised forecast 2020/21 carry forward Underlying Deficit is £25.3m and the risks identified that, if not managed, could increase this.	
FC 21/02/008	**FINANCE RISK REGISTER** The Assistant Director of Finance (AG) presented the Finance Risk register. The two remaining extreme risks were noted as being: **Fin01/20** – Reducing underlying deficit from £11.5m to £4.0m in line with IMTP submission. **Fin03/20** – Delivery of £29.0m (3.5%) CIP The Finance Committee noted that the COVID-19 financial plan risk (FIN10/20) including Surge capacity was shown in an appendix as a sub-set to the main risk register. The Assistant Director of Finance indicated that all risks had been reviewed in month. The Committee was asked to agree to the removal of the 2 risks below where Optimum controls were in place. • FIN04/20 – Winter Pressures. Optimum controls were in place and there was an expenditure plan in place against the approved Urgent and Emergency Care funding. This was now a low risk. • FIN09/20 – Cardiac Outsourcing. Optimum controls are in place and this was now unlikely to have an impact on the 2020/21 financial plan and was now a low risk. **Resolved - that:** The Finance Committee **noted** the risks highlighted in the 2020/21 risk register. The Finance Committee **agreed** that risks FIN08/20 and FIN09/20 could be removed from the risk register.	

	The Finance Committee **noted** the risks highlighted in the Surge Capacity sub set risk register.	
FC 21/02/009	**FINANCIAL PLAN 2021/22** The Assistant Director of Finance introduced a presentation on the 2021/22 Annual Plan – Draft Financial Framework and re-emphasised the following points: • The UHB received the initial allocation letter for 2021/22 on the 22nd December 2020 and this is to be used to develop plans to deliver against the priorities set out in the NHS Planning Framework. • **The initial allocation does not include funding to address the increase in planned underlying deficit due to Covid-19.** • At this stage, the allocation letter does not include funding to cover the ongoing response to Covid-19. • Resource planning assumptions for Covid-19 will be issued separately. • Subject to further Covid-19 funding, there is an expectation that the UHB will operate within the funds set out in this allocation. • Additional funding for key priorities will be allocated as appropriate when costs are identified. It was highlighted that the UHB intended to base an approvable annual plan on the following three parts: 1. **Core Financial Plan : Delivering in-year financial balance and maintaining the current level of underlying deficit** 2. Continuation of non-recurrent response to COVID 19. 3. Covid-19 recovery (service) The Committee was reminded of the UHBs 2020/23 3 year plan which was submitted to Welsh Government before the pandemic. This plan delivered a break even position each year over the 3 year period based on the delivery of £25m of recurrent savings in 2020/21. Delivery of the plan would of left the UHB with an underlying deficit (ULD) of £4m at the beginning of 2021/22 and would of eliminated the ULD by the start of 2022/23 The presentation noted there was a projected £21.3m shortfall against the recurrent savings plan in 2020/21 and this was treated as a cost of COVID 19. However, the UHB **has not yet received confirmation of how the £21.3m increase in the underlying deficit due to Covid-19 is to be treated in the 2021/22 financial plan.** Consequently the UHB's financial position moving into 2021/22 is £21.3m worse than originally planned and as a result of this the Finance Committee was informed that the draft 2021/22 Financial Plan includes a planned deficit of £21.3m as follows: Khan Raj 05/20/2021 15:17:34	

	2021/22 Plan £m	2022/23 Plan £m
Prior Year Plan	(4.0)	(21.3)
Adjustment for non recurrent items in previous year (note 1)	(21.3)	(4.0)
b/f underlying deficit	**(25.3)**	**(25.3)**
Net Allocation Uplift (including LTA inflation) (note 2)	19.4	
Draft Cost Pressures Assessment (note 3)	(27.4)	
Investments	(4.0)	
Recurrent Cost Improvement Plans 1.5% (note 4)	12.0	
Non Recurrent Cost Improvement Plans 0.5% (note 5)	4.0	
Planned Surplus/(Deficit) 2021/22	**(21.3)**	

Notes

1. Non delivery of recurrent CIP due to Covid-19
2. Core 2% uplift less top-slice for paramedic banding and 111 service
3. Capped approach to cost pressures - further refinement required
4. assumes 1.5% recurrent CIP target 2021/22 (1.25% devolved/0.25% corporate)
5. assumes 0..5% non recurrent CIP target 2021/22 (0.25% devolved/ 0.25% corporate)

The Finance Committee was advised that the **Savings requirement had increased from 1.5% to 2% (1.5% recurrent / 0.5% non recurrent) in order to deliver in year financial balance. The key driver for the increase was a more granular assessment of cost pressures and it was noted that cost pressures had been capped in order to produce an approvable plan.**

The delivery of an in year financial balance would require an additional 2.7% savings target (£21.3m), which was not considered to be achievable during a pandemic. In addition, an increase in assessed cost pressures or planned investments would require an additional savings requirement. The Plan also assumed that Clinical Boards would manage brought forward / in year operational pressures and it was noted that if additional funding was allocated to Clinical Boards to cover the 2020/21 operational position that this would require an increase in the savings target applied to all Clinical Boards.

The £19.4m 2021/22 Core Allocation uplift was detailed as follows: Allocation Uplift 2% (includes first 1% of wage award) £13.9m; Mental Health Uplift £2.1m: Top sliced allocations (£1.1m);Invest to Save repayments (£0.6m); and LTA income uplift £5.1m

The plan included £27.4m of funding for cost pressures in 2020/21 as follows: Cost Growth £9.4m (including pay inflation, non pay inflation & CHC/FNC inflation); Demand/Service growth £15.9m (including NICE & New High Cost Drugs, Continuing Heath Care, Prescribing, Velindre Cancer Centre, Specialist Services, Ring Fenced Services, EASC & LTA inflation; Other Cost Pressures £2.1m (including Welsh Risk Pool & Local Cost Pressures).

In response to a query from the Finance Committee Chair (RT) it was confirmed that the Core plan assumed that income recovery in respect of services provided to neighbouring Health Boards and other income streams would be maintained in 2021/22.

The presentation noted that Welsh Government had requested a financial assessment of the UHB's continuing Covid-19 response so that both the core financial plan and net Covid 19 impact could be quantified. Specific cost information is required around TTP; Mass Vaccination; Surge capacity / Field Hospitals; Cleaning Standards ;Other Covid-19 related expenditure; Non delivery of 21/22 planned savings; Planned operational Expenditure reductions; and Slippage on planned investments. No financial assessment of the cost of Coved -19 recovery was required at this stage.

The risks and opportunities identified alongside the Financial Plan were outlined as

- Risks
  - Deficit plan (awaiting clarification from WG as to how this is handled)
  - Commitments against proposed £4.0m investment reserve
  - Cost pressure assessment
  - Clinical Board CIP delivery
  - Management of operational position
  - Cost of continued Covid-19 response
  - Continuation of Block Contracts
- Opportunities
  - Covid-19 response funding
  - Covid-19 impact on cost growth
  - Covid-19 recovery funding

Finally, the Committee was advised of the timetable and process for the submission of the IMTP/Financial Plan. Following further discussion at Management Executive Meetings and engagement meetings with Welsh Government and the Finance Delivery Unit on March 3rd, the financial plan would be brought back for discussion at the Finance Committee Meeting on the 17th March 2021 so that Financial Plan recommendations could be agreed for Board approval. This would enable formal sign off by the Board at its meeting on the 25th March 2021 before formal submission of the plan to Welsh Government by the 31st March 2021.

Comments and queries were received as follows:

- The UHB Chair (CJ) asked for clarification of the plan to deliver in-year financial balance whilst maintaining the current level of underlying deficit and whether this would lead to a break-even position in 2021/22. In reply the Interim Director of Finance confirmed that the current underlying deficit (ULD) would not deteriorate if the plan was delivered and the ULD would be held at circa £25.3m. However in the absence of additional Welsh Government funding to cover the £21.3m increase in the planned underlying deficit brought forward to 2021/22 it was noted that the UHB would report a deficit of £21.3m at the end of 2021/22 if the plan was delivered. There was still uncertainty around the provision of additional funding to cover the increase in the planned deficit and in response to a further query from the Finance Committee Chair the Interim Director of Finance confirmed that the increase in the planned level of ULD moving

	onto 2021/22 had arisen as a result of constraints on the progress of recurrent savings schemes during the pandemic. • The Independent Member – Finance (JU) asked whether the impact of the increase in the underlying deficit carried forward to 2021/22 would extend beyond 2021/22 and the Interim Director of Finance confirmed that if additional coverage was not provided by Welsh Government that this would be the case. • The Executive Director of Strategic Planning confirmed that the formal IMTP process had not been reinstated and that the UHB would again be subject to a 1 year operational plan in 2021/22. • The Finance Committee Chair (RT) asked whether the UHB could go beyond the 1.5% recurrent savings target proposed for 2021/22 in light of initial plans to deliver a 3% recurrent savings in 2020/21. In response the Chief Operating Officer indicated that the UHB faced a considerable challenge to reinstate pre Covid levels of service as the pandemic passed and that the delivery of savings in excess of the planned 1.5% recurrent target would be difficult and may dis-engage the service. The Interim Director of Finance added that the UHB's capacity to deliver savings schemes was still expected to be limited in the early part of 2021/22 as a result of the continuing impact of the pandemic. • The Interim Director of Finance indicated that the forecast of net COVID costs in 2021/22 was dependent on a number of variables and it was expected that Welsh Government would initially focus on the forecast for the first quarter of 2021/22. **Resolved – that**: The Finance Committee **noted** the presentation.	
FC 21/02/010	**FINANCE COMMITTEE – TERMS OF REFERENCE** The Director of Corporate Governance indicated that the Finance Committee Terms of Reference (TOR) were last reviewed in February 2020 and approved by the Board in March 2020. The Committee was asked to review the TOR and consider any changes to the TOR. **<u>Comments were received as follows:</u>** The UHB Board Chair (CJ) advised that all references to Chairman should be changed to Chair. In addition the UHB Board Chair (CJ) indicated that the section on Members should read as follows: Chair: Independent member of the Board Members: A minimum of **2** other Independent members of the Board. Further to this it was noted that under the section on Member Appointments the reference to the Committee being chaired by the Independent Member for	

	Finance should be amended to "The Committee will be chaired by an Independent Member and supported by a Vice Chair who shall also be an Independent Member." **Resolved – that:** The Finance Committee **approved** the Terms of Reference for the Finance Committee subject to the amendments for the comments received. The Finance Committee **recommended** the amended Terms of Reference to the Board for approval.	
	FINANCE COMMITTEE – ANNUAL WORKPLAN The 2020/21 Workplan for the Finance Committee was introduced by the Director of Corporate Governance to provide members of the Finance Committee with the opportunity to review the Work Plan for 2021/22 prior to presentation to the Board for approval. The Finance Committee considered the draft workplan and agreed that the future scheduling of some of the development areas could be switched with agreement of the Finance Committee. **Resolved – that:** The Finance Committee **reviewed** and **approved** the 2020/21 Work Plan; The Finance Committee **recommended** approval of the workplan to the Board.	
FC 21/02/011	**MONTH 10 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 21/02/012	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 21/02/013	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday 17th March 1.30pm; Virtual Meeting via Teams**	

CONFIRMED MINUTES OF THE MEETING OF THE FINANCE COMMITTEE
HELD ON 24th MARCH 2021
VIRTUAL MEETING via TEAMS

Present:

Dr Rhian Thomas	RT	Chair, Independent Member – Capital and Estates
John Union	JU	Independent Member - Finance
Abigail Harris	AH	Executive Director of Strategic Planning
Catherine Phillips	CP	Executive Director of Finance
Chris Lewis	CL	Deputy Director of Finance
Len Richards	LR	Chief Executive
Nicola Foreman	NF	Director of Corporate Governance
Ruth Walker	RW	Executive Nurse Director

In Attendance:

Secretariat:

Paul Emmerson	PE	Finance Manager

Apologies:

Andrew Gough	AG	Assistant Director of Finance
Charles Janczewski	CJ	Board Chair
Rachel Gidman	RG	Director of Workforce and Organisational Development
Steve Curry	SC	Chief Operating Officer

FC 21/03/007	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting.	**ACTION**
FC 21/03/008	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
FC 21/03/009	**DECLARATIONS OF INTEREST** The Chair invited members to declare any interests in proceedings on the Agenda. None were declared.	

FC 21/03/010	**MINUTES OF THE COMMITTEE MEETING HELD ON 27th JANUARY 2021** The minutes of the meeting held on 24th February 2021 were reviewed and confirmed to be an accurate record. **Resolved – that:** The minutes of the meeting held on 24th February 2021 were approved by the Committee as an accurate record.	
FC 21/03/011	**ACTION LOG FOLLOWING THE LAST MEETING** There were no outstanding actions. **Resolved – that**: The Finance Committee **noted** that there were no outstanding actions.	
FC 21/03/012	**CHAIRS ACTION SINCE THE LAST MEETING** There had been no Chairs action taken since the last meeting.	
FC 21/03/013	**FINANCIAL PERFORMANCE MONTH 11** The Deputy Director of Finance summarised the key points within the Month 11 Finance Report. The UHB had reported a year to date underspend of £0.502m. The reported position included net expenditure of £135.826m arising from the management of COVID 19 which was offset by an equal amount of Welsh Government COVID 19 funding. Six of the eight measures on the Finance Dashboard were RAG rated green. Two measures remained RAG rated red namely: the reduction in the underlying deficit to £4m and the delivery of the recurrent £25m 3% devolved savings target. Progress against the 2 measures was still impeded by the COVID pandemic and this had adversely affected the underlying deficit brought forward to the 2021/22 Financial plan. Moving onto performance against income, pay and non pay budgets the Committee was informed that the UHB had reported an in month operational underspend of £0.294m and that trends were broadly in line with the first 10 months of the year. At month 11 the year end forecast of net expenditure due to COVID 19 in 2020/21 was £161.179m and this was offset by confirmed additional COVID 19 funding of £161.179m. The key assumptions informing additional COVID allocations were unchanged in month and the key area of uncertainty was the cost estimate of the additional annual leave accrual which would be based upon the level of untaken annual leave carried forward from 2020/21. In response to a query from the Independent Member – Finance (JU), the Deputy Director of Finance confirmed that work was ongoing to assess the financial accrual required in	

	respect of untaken annual leave and that the collection of data to inform the accrual was continuing. Turning to Clinical Board performance it was highlighted that the operational overspends in the Women & Children and in the Medicine Clinical Boards had both improved in month, although cumulative material overspends were still reported by both Boards. The Finance Committee Chair (RT) asked if the operational overspend reported by both Clinical Boards was expected to continue in the new financial year and whether the position required further scrutiny by the Finance committee. In response, the Deputy Director of Finance advised that during the pandemic, the focus had been on the overall UHB position. However, when the UHB emerged from the direct impact of the pandemic it was expected that the focus would shift and that Clinical Board performance may require further scrutiny if significant overspends were reported. The Committee was asked to note that the UHB had received a significant amount of additional capital allocations in later part of the year which in turn required additional operational attention on capital spending plans at the end of year to ensure that the UHB maximised the use of its available capital resource. In this context the Independent Member – Finance (JU) asked for assurance that the UHB had a robust structure and process in place to manage its capital expenditure as it moved towards year end. The Deputy Director of Finance confirmed that the UHBs Capital Management Group monitored capital spend on a scheme by schemes basis and that agreed virements were actioned to ensure that the capital allocation was utilised. The UHB had also developed a prioritized list of additional capital expenditure that could be actioned if further Welsh Government Capital funding was provided. There were no signicant concerns around the UHBs balance sheet and the UHB remained on track to meet is PSPP and Cash targets. In conclusion, the Deputy Director of Finance highlighted that at month 11, the key revenue financial risk remained managing the impact of COVID 19 within the additional resources provided. **Resolved – that:** The Finance Committee **noted** the month 11 financial impact of COVID 19 which is assessed at £135.826m; The Finance Committee **noted** the additional Welsh Government funding of £135.826m assumed within the month 11 position; The Finance Committee **noted** the month 11 reported financial position being a surplus of £0.502m; The Finance Committee **noted** the breakeven position which assumes additional Welsh Government funding of £161.179m to manage the impact of COVID 19 in line with quarter 3&4 planning assumptions;	

	The Finance Committee **noted** the revised forecast 2020/21 carry forward Underlying Deficit is £25.3m and the risks identified that, if not managed, could increase this.	
FC 21/03/014	**FINANCE RISK REGISTER** The Deputy Director of Finance presented the Finance Risk register. The two remaining extreme risks were noted as being: **Fin01/20** – Reducing underlying deficit from £11.5m to £4.0m in line with IMTP submission. **Fin03/20** – Delivery of £29.0m (3.5%) CIP The Finance Committee noted that the COVID-19 financial plan risk (FIN10/20) including Surge capacity was shown in an appendix as a sub-set to the main risk register. The Deputy Director of Finance indicated that all risks had been reviewed in month. The Committee was asked to agree to the removal of the 1 risk below where Optimum controls were in place. • FIN06/20 – Nursing Position. Whilst there were pressures against nursing budgets which would continue into 2021/22 the position would not impact on the delivery of the 2020/21 financial plan. Therefore the risk was reported as low and the Committee was requested to approve removal of the risk from the risk register. The Independent Member – Finance (JU) asked whether the 2021/22 risk Register would be presented at the next Finance Committee and the Finance Committee Chair (RT) asked whether a separate register was still required for the Surge capacity. In response the Deputy Director of Finance indicated that the 2021/22 register was expected to be presented to the next Committee meeting and that it was not expected that the surge capacity would continue to be included as a sub set risk register. Referring to the inclusion of the nursing position on the Risk Register the Chief Executive indicated that budgets were set in accordance with Nursing standards and that controls on additional deployment of nursing input were in place. The Executive Nurse Director added that funding was now allocated in respect of Birth Rate plus and that there had been some success in the recruitment of additional nurses. In this context, it was suggested that the nursing position should be reported by exception in 2021/22 and should necessarily be included on the risk register if the absence of new risks emerging around nursing. Khan Raj 05/20/2021 15:17:34	

	Resolved - that: The Finance Committee **noted** the risks highlighted in the 2020/21 risk register. The Finance Committee **agreed** that risks FIN06/20 could be removed from the risk register. The Finance Committee **noted** the risks highlighted in the Surge Capacity sub set risk register.	
FC 21/03/015	**FINANCE COMMITTEE – ANNUAL REPORT** A paper summarising how the Finance Committee has met its Terms of Reference during the financial year was introduced by the Director of Corporate Governance. The Finance Committee considered and agreed the report**.** **Resolved – that:** The Finance Committee **recommended** the report for Board **approval** subject to an amendment to reflect attendance at the February meeting.	
FC 21/03/016	**MONTH 11 FINANCIAL MONITORING RETURNS** These were noted for information.	
FC 21/03/017	**ITEMS TO BRING TO THE ATTENTION OF THE BOARD** There were no items to being to the attention of the Board.	
FC 21/03/018	**DATE OF THE NEXT MEETING OF THE COMMITTEE** **Wednesday 28th April 2.00pm; Virtual Meeting via Teams**	

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 16th February 2021 at 09.00am
Via MS Teams

Chair:		
Susan Elsmore	SE	Independent Member – Local Authority
Present:		
Gary Baxter	GB	Independent Member – University
Michael Imperato	MI	Independent Member – Legal
In Attendance		
Stephen Allen	SA	Chief Officer – Community Health Council
Guy Blackshaw	GB	Clinical Board Director - Specialist
Steve Curry	SC	Chief Operating Officer
Lisa Dunsford	LD	Director of Operations – PCIC
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Nicola Foreman	NF	Director of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies & Health Science
Ann Jones	AJ	Patient Safety & Quality Assurance
Fiona Kinghorn	FK	Executive Director of Public Health
Rajesh Krishnan	RK	Assistant Medical Director (Patient Safety and Clinical Governance)
Claire Main	CM	Interim Director of Nursing – Specialist Services
Hywel Pullen	HP	Assistant Director of Finance
Ruth Walker	RW	Executive Nurse Director
Stuart Walker	SW	Executive Medical Director
Joy Whitlock	JW	Head of Quality and Safety
Catherine Wood	CW	Interim Director of Operations – Specialist Services
Observer		
Annie Burrin	AB	Patient Safety Team
Emily Howell	EH	Audit Wales
Secretariat		
Nathan Saunders	NS	Corporate Governance Officer
Apologies		
Abigail Harris	AH	Executive Director of Strategic Planning
Christopher Lewis	CL	Interim Executive Director of Finance
Tracey Meredith	TM	Vale Locality Integrated Manager

QSE 21/02/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the first QSE Committee meeting of 2021.	**Action**
QSE 21/02/002	**Apologies for Absence** Apologies for absence were noted. The Chief Operating Officer (COO) advised the CC that he would need to leave the meeting at 10am to chair the COVID response meeting.	

QSE 21/02/003	**Declarations of Interest** The Executive Director of Therapies & Health Science declared that she sits on board of Cwm Taf Morgannwg University Health Board.	
QSE 21/02/004	**Minutes of the Committee Meeting held on 15th December 2020** The minutes of the meeting held on 15th December 2020 were reviewed. **Resolved that:** a) The minutes of the meeting held on 15th December 2020 be approved as a true and accurate record.	
QSE 21/02/005	**Action Log following the Meeting held on 15th December 2020** The Executive Nurse Director (END) advised the Committee that item QSE 19/12/014 had been stood down because of work being started on the perfect ward. She noted that a report would be brought to September's meeting and the Action Log would be updated.	**NS**
QSE 21/02/006	**Chair's Action taken since last meeting** No chairs actions had been taken since the previous meeting.	
QSE 21/02/007	**Specialist Clinical Board Assurance Report** The Interim Director of Operations – Specialist Services (IDOSS) presented to the Committee. The presentation was intended to highlight how the team had delivered on the patient safety agenda and to show what the clinical board had been doing. The Specialist Clinical Board had taken a safe response to the pandemic and wanted to focus on what had been learnt, achieved and enabled despite COVID and not just in terms of what had been done to develop the patient safety agenda but also how it was done. She added that the Specialist Services clinical board had worked to key principles which were assumed in everyday practice but which they had made very clear and explicit. These were: 1) Symbiotic Relationship between leadership culture and patient safety. 2) Servant Leadership model. 3) Patient Experience. 4) Staff engagement –staff are the biggest asset. 5) Performance 6) Innovation – Clinically driven changes. The IDOSS advised the Committee that the team wanted to be become leaders in their field. Their work would be underpinned by financial integrity, the use of data to understand, demonstrate and prove change and to provide a focus on operational excellence. The IDOSS highlighted the following achievements.	

1) Clinical innovation – This had enabled the UHB to become the second unit in the UK to undertake hepatitis C transplantation for both kidney and pancreas patients, the first unit in the UK to have undertaken Normothermic Perfusion, enabled the delivery of CAR-T therapy and the UHB was a pilot site for Catheter Directed Therapies.

2) Quality Improvement – They had implemented a Blood Count Analyser in the Haematology Day Unit, implemented a support care programme, started work on a STEP UP programme and had started work on a Patient at Risk Team (PART)

3) They had achieved a reduction in All Key HCA Metrics – reduced across the board using data to improve performance and sharing successes.

The Clinical Board Director – Specialist (CBDS) and the Interim Director of Nursing – Specialist Services (IDNSS) then shared operational examples of how the Specialist service were delivering on the principles mentioned as well some of the nascent actions in place that they wanted to implement over the following year.

The CBDS advised the Committee that Cardiac surgery were going through a journey and one of the headlines was that before COVID-19 hit, the service was carrying significant risk with long waiting times associated with high morbidity and mortality. He added that it was relatively clear from the onset of Covid UK that having major surgery and contracting COVID-19 perioperatively was a bad combination and that the mortality rate would have been approximately 50%.

The CBDS advised that it was important that changes made were Clinician led and that after much deliberation, the decision was made to move services to Llandough Hospital (UHL) where a green pathway was instigated. He noted that it had been a huge success and that the data spoke for itself.

He added that there had been no COVID-19 deaths via the green zone and that initially it was thought that the move to UHL was the “least worst” option but had realised that it was a successful move.

The CBDS advised the Committee that it had taken just 3 weeks between the decision to move to UHL and starting to deliver the service at UHL. He added that the waiting list had gone down by 50% and that by the end of March they were hopeful that there would be less than 100 patients on the list which Surgeons had deemed a stable waiting list.

The CBDS advised the Committee that a significant reduction in cancellations was noted and that the team appeared to be more stable and morale had increased.

He noted to the Committee that during the initial stages they had put as much work into one theatre at UHL as they had been in 2 theatres at UHW and productivity was excellent.

	The CBDS advised the Committee that the Green Zone had been really positive which enabled the team to restore confidence in their own service and in the public. The CBDS advised the Committee that with Cardiology being based at UHW, it made sense that at some point, the cardiac surgical services would need to be repatriated to UHW but hoped that it could be done with some of the changes implemented to make the service of the very best quality. He added that with the expansion of ITU into C3 North and South, the cardiologists had noted that they did not want that space back and wanted everything to be on the first floor at UHW which made sense and what they hoped to achieve was to continue the good work undertaken to support cardiac surgical services, cardiology and ITU which would deliver the appropriate spaces. The Interim Director of Nursing – Specialist Services (IDNSS) presented on the Major Trauma Service. She advised the Committee that the service was designed to go live in April 2020 but due to COVID it was delayed. She added that during that time the polytrauma unit was repurposed as the Coronary Care Unit (CCU) and although they had pulled together a team ready to deliver the Major Trauma Service those staff members were kept in their existing employment or redeployed to support other units. The IDNSS advised the Committee that a decision was then made for the Major Trauma Service to go live in September 2020 which brought a number of challenges. She advised the Committee that the advantage of the Dragon's Heart Hospital was taken and a lot of simulation training was performed there through online platforms. The IDNSS advised the Committee that all of the policies had to be revisited which involved cross collaboration with other Health Boards and other directorates within the UHB to make sure everybody would be aware of the impact of the service. The IDNSS commented that the impact of going live was significant and was an unknown quantity in the context of what patients would come into the service given the public restrictions in place. The IDNSS advised the Committee that 262 patients had gone through the service up until December 2020 of which 93 had been involved in serious vehicle incidents and a mixture of falls predominantly from Cardiff and Vale but also from Cwm Taf Morgannwg UHB and Aneurin Bevan UHB. She added that they had tested all of the pathways that were implemented through the Major Trauma Service and brought together the Health Boards and repatriated the patients either back to their home (155 patients) or back to local specialist areas for rehabilitation and follow up care.	

The IDNSS advised the Committee that an important key focus was that they had kept the team together despite not having an initial base which proved beneficial in their Key Performance Metrics.

The IDNSS advised the Committee that they had focussed on the MTC service and had worked closely with a specific MDT approach. She added that the important thing was to link with the community service to help support.

The IDNSS advised the Committee that it had been a testament to starting a brand new service in a short space of time and that they were currently working on the 2nd phase of the business case which was driven by the team coming together and wanting to deliver this service.

The IDNSS advised the Committee that Critical Care was a well-established service within Specialist Services and the information provided to the Committee had been worked to recognise that whilst there were 35 beds in the system the team had been working towards 50 level 3 beds for a number of years.

The IDNSS advised the Committee that one of the most significant pieces of work within Critical Care was that the unit went from reporting zero Datix incident reports to being one of the highest reporters and had developed an open and trusting culture.

The teams focus was on the patient at risk team recognising early on the patients who were deteriorating.

The team were piloting a high intensity rehabilitation area where patients are stepped down from Critical Care to ensure that they could get the therapy they needed to reduce their length of stay and get them home.

It had been identified that access to space and expansion was possible and that the team would need to focus on the important things within the MDT about driving critical services.

The IDNSS advised the Committee that the Haematology Service was being looked at as a new project which included:

1) Accreditation of JACIE – The current service did not meet the clinical needs for accreditation.
2) Meeting the needs of the future population.
3) Collaboration with Medicine, Specialist Services and Velindre.
4) Planning and Capital Involvement.

The IDOSS advised the Committee that clinically led services worked well and that they had adopted a mature risk based approach to performance management which had enabled progression and transformation in relation to the patient safety agenda.

She added that they had asked one of the teams recently how they had felt after a performance review and their answer was that they felt excited which was a real demonstration in the team's belief. She noted that transformation was motivating and the team were keen to do more.

The CC complimented the team and noted that it was a comprehensive and coherent presentation which highlighted the team's ambition.

The Executive Director of Therapies & Health Science (EDTHS) noted that she was really assured by the attention given to the presentation.

The EDTHS noted that there had not been information provided around Artificial Limb and Appliance Service (ALAS) and wanted to advise the Committee that the Welsh Health Specialised Services Committee (WHSSC) would be funding micro-processor knees which would make a huge difference to the quality of care given to amputees.

The EDTHS also advised the Committee that Paul Rogers had been appointed as one of her Assistant Director of Therapies & Health Science (ADTHS) and asked that the ADTHS would have a good link with Specialist Services.

The Independent Member – University (IMU) asked:

1) In relation to the Critical Care environment, the IMU was unsure of the deficiency in bed numbers identified in 2014 and if it had been addressed.

The IDNSS responded that they were still working in the surge capacity so were working with in excess of 50 beds. They were working closely with estates to get a more robust layout for the 50 beds.

2) The IMU noted that isolation facilities remained a significant risk. He asked what was being doing to address that risk.

The IDNSS responded that they had been working alongside IP&C colleagues about how they would cohort and segregate patients.

3) What was the status of CAR-T therapy during COVID-19 and what were the plans for scale up of CAR-T therapy in post COVID-19 era?

The IDOSS responded that CAR-T therapies had progressed as per pre-pandemic levels throughout all of 2020 and that they had developed a green pathway which enabled the safe delivery of the CAR-T programme.

The IDOSS added that new NICE indications for increasing the scope of CAR-T therapies which were being planned which fitted in with the new haematology model presented.

The CBDS advised the Committee that CAR-T was on the verge of an explosion and that the latest information he had received suggested that they were considering treatment of multiple myeloma which would be an enormous expansion.

He added that within the new post anaesthetic care unit (PACU), where all green pathway surgical patients go, there had been talk of an area being established for CAR-T therapies.

	The Assistant Director of Patient Safety and Quality (ADPSQ) advised the Committee that she could provide assurance that she would attend the QSE meetings with the specialist clinical board and that in April, she would be bringing the Quality and Safety framework for the next 5 years to the Committee. The END advised the Specialist Service Team that they should be proud of what they had been able to maintain during COVID-19 and how they had moved the service forward and decreased mortality which demonstrated really good learning. The END advised the Committee that she could not let the opportunity pass to commend the Specialist Service team for their work around IP&C and the improvements they had made. The END what advice the team would give to colleagues elsewhere in the UHB about improving incident reporting. The IDNSS responded that the reporting side more work was needed to get the information out. She added that what they had learnt was how to pull together themes from the reports and report those back. From that they could develop a quality improvement programme and take an MDT approach. The Independent Member – Legal (IML) advised the Committee that at every meeting there was talk of pressure damage and asked if there was a timeline to the Specialist approach to this and whether something could be reported to the QSE Committee to understand how to approach the problem. The END responded that the QSE Committee were due to have a paper on pressure damage at the next meeting. The IDNSS responded that within specialist services and critical care they were working through the understanding and the huge amount of data around pressure damage. She added that they would look back over the previous 12 months and would need to balance what had happened to get a full context of what was happening to patients and how to look at targeted interventions. The CC asked the Specialist Team how staff morale was. The IDOSS responded that staff were tired but morale was good. She added that there were specific wellbeing pieces in place and there was a strong sense of comradery within the team. **Resolved that:** a) The Committee noted the progress made by the Clinical Board to date. b) The Committee noted the approach being taken by the Clinical Board. c) The Committee approved the content of the report and the assurance given by the Specialist Services Clinical Board.	**CE** **NS**

QSE 21/02/008	**Quality Indicators Report** The Assistant Director of Patient Safety and Quality (ADPSQ) advised the Committee that the Quality Indicators Report was still a work in progress and noted that there was more to be done on the dashboards. The ADPSQ highlighted some of the key areas within the report, including: 1) The number of Serious Incidents had reduced 2) Clinical Board – Increased closures were noted 3) Pressure Ulcer damage 4) Never events – Since May 2020, there had been 6 which was higher than normal. The events were under investigation and a detailed view would be brought to the April meeting. The ADPSQ advised that there were some concerning trends around stroke data. She added that the data which provided most concern was patients getting to the stroke unit within 4 hours which had reduced to 17%. This would be discussed in detail at a future clinical effectiveness meeting. The ADPSQ advised the Committee that the Mortality Data for level 1 reviews compliance was improving and noted that there was a well-functioning mortality group chaired by Dr Krishnan. The ADPSQ advised the committee that in regards to IP&C, they were performing well. The EDTHS advised the Committee that she had an update on the stroke position. She noted that the UHB performed better than other Health Boards and that it needed to be recognised that the impact of COVID-19 had dictated the data and that the stroke team had been outreaching to other wards. The EDTHS advised the Committee that she was assured around the quality of care and that we were doing the very best we could during this time. The Chief Officer – Community Health Council (COCHC) noted to the ADPSQ that the graphs around inpatient falls appeared to be going up and asked if this was due to an increase in falls or was it the way the data was being presented. The ADPSQ responded that she needed to look closely at the data and would monitor that over time. She added that Annie Burrin had joined the Patient Safety Team recently who would be undertaking focused work to support falls prevention in the UHB. The COCHS asked the ADPSQ if the nutrition scores going down was a good thing. The ADPSQ responded that the scores should be as high as possible so the data would need to be looked at. The END added that if a patient assessment was undertaken on admission, the nutrition score would remain absent throughout the patient's stay so	

	during the COVID-19 period they probably would not have done as well on admission. The CC asked that in terms of the dental never events were there aspects of clinical supervision that the Committee needed to be concerned about. The ADPSQ responded that they had taken a thematic review of dental surgery and supervision was a recurring theme. She added that as part of the past work around never events, dental had linked up with centres of excellence from England and had agreed that when appropriate, somebody would come in and have a look at the processes in place in an external review process would be undertaken. The Executive Medical Director (EMD) responded that dental wrong tooth extraction was the biggest single never event in UK. He added that dental extraction was the only operation undertaken by students in health board so there was always a risk. The EMD advised the Committee that when there are complex dental issues it required attention to detail at every step which was way in excess of any other area. He noted that the key would be to take the learning from such events and utilise the external review process referred to by the ADPSQ. **Resolved that:** a) The Quality, Safety and Experience Committee noted the contents of the Quality Indicators report and the actions being taken forward to address areas for improvement.	
QSE 21/02/009	**Exception Reports and Impact of Covid-19 on Patient Safety** A verbal update was provided by the END. The END advised the Committee that her time was focused on 4 main things. 1) Keeping going 2) Managing the ongoing COVID-19 pandemic 3) Ensuring we understand the demand for reopening activities such as surgery 4) The General Q&S agenda. The END advised the Committee that what was seen in COVID-19 was a general slow down into the summer of patients presenting with COVID-19, but gains in hospital acquired COVID. She advised that there had been a peak in hospital acquired COVID during January 2021, particularly at UHL. To address that concern teams had undertaken the following actions: • Increased lateral flow testing of staff.	

- Tested patients 3 days post admission in amber areas.
- Continued with point of care testing in EU
- Refreshed the communication plan across the UHB with a particular attention to staff behaviour.
- Asked Gwen Low, Consultant in Public Health, to provide a fresh look at the work they were currently undertaking.
- Increased focus on core IP&C and cleaning standards
- Maintained the good working between the IP&C team and the Local Command Centres.

The END advised the Committee that they knew the increase in hospital acquired infections related to geography and environment but it had was also been about patients testing negative on arrival and then positive during their stay.

The END advised the Committee that individual behaviours played a big part in this. She gave examples of car sharing, sitting together at lunch and not wearing masks.

The END advised the Committee that it was important from an assurance perspective to note that the team were looking at the things within the Health Board's own control such as staff behaviour.

The END advised the Committee that discussions had been had around lateral flow testing and the retesting of patients 3 days into their stay. It was agreed that this approach would be taken forward.

The END advised the Committee that colleagues had revisited the link between the operations meeting and the IP&C meeting and that the Executive Director of Public Health had also been invited to attend.

The CC noted that certain actions were within the control of the UHB and asked for an example of what was not in the control of the UHB.

The EMD responded on behalf of the END that that the key issue for the UHB was community incidents and that when talking about transmission in hospital by staff or visitors, the chance of those staff/visitors outside of work having COVID depended entirely on the community incident.

The EMD advised the Committee that as Community incidents drop so should the transmissions.

The EMD advised the Committee that the number of asymptomatic staff they had identified had been tiny.

The EMD advised the Committee that there had been good therapeutic advances in relation to COVID-19 which had a direct knock on effect of the number of patients who were escalated to AGPs and Critical Care.

The EMD advised the Committee that the clear ongoing issue was workforce wellbeing. He added that a new wellbeing survey would be shared at the operational meeting on Thursday 18th February.

Resolved that:

	a) The Quality, Safety and Experience Committee noted the verbal update on Exception Reports and the Impact of Covid-19 on Patient Safety.	
QSE 21/02/010	**Progress on Mass Vaccination** The Director of Operations – PCIC (DOP) gave the Committee an overview of the Mass Vaccination work. The DOP advised the Committee that the majority of vaccines were being delivered through 3 mass vaccination centres. 1) Splott, which had opened in December 2020 2) Pentwyn Leisure Centre 3) Holm View in Barry She advised the Committee that in January hubs were established at UHW and UHL, and there had been mobile teams going out to care homes and more recently, to the patients who were housebound. The DOP shared the following figures with the Committee: Total vaccinations: 111,658 Total for groups 1-4: 96,503 (89%) Group 1: care home staff and residents: 81% Group 2: people 80+: 87% Group 2: frontline health and care staff: 98% Group 3: people 75-79: 88% Group 4: people 70-74: 90% Group 4: clinically extremely vulnerable: 74% The DOP advised the Committee that there were also a small number of people who had declined the vaccine or did not turn up to an appointment. The DOP advised the Committee that they had also been vaccinating patients in hospital and had patients in the lakeside wing, Barry Hospital, Rookwood Hospital and St. Davids Hospital had been vaccinated. The DOP advised the Committee that they had started some clinics at UHL for people who may have had allergic reactions. The DOP advised the Committee that there was a reduced vaccine that week and that teams would be focusing on 2nd doses. The DOP advised the Committee that the Patient experience team had undertaken a snapshot survey and received 68 responses. 97% were very satisfied and 3% satisfied with the work at the vaccination centres, which was a positive response. The DOP advised the Committee that in relation to incidents – there had been 16 to date. A small number of people had fainted and had adverse reactions.	

The DOP advised the Committee that there would be a formal review by (Health Inspectorate Wales) HIW and that they would be visiting 2 mass vaccination sites in March 2021. A self-evaluation report would be also be required which could be shared in the future.

The Executive Director of Public Health (EDPH) advised the Committee that some work had been undertaken around what could be done if there was a larger amount of the vaccine and whether Cardiff and Vale would be able to become a mass vaccination area. She added that the biggest challenge was the supply of vaccine and talks were ongoing with Welsh Government (WG) around this.

The EDPH advised the Committee than an analysis on the BAME community had started which was not complete as ethnicity data was only completed on 49% of those who had had the vaccine.

The CC noted to the Committee that the Imam's in various mosques had held meetings around the BAME community uptake on the vaccine.

The Assistant Director of Patient Experience advised the Committee that they had been looking at the seldom heard groups and were writing a strategy to take to the board. She added that they were working with local authorities around that and that it was a fast moving action.

The END advised the Committee that the focus would be on something that was bespoke for those communities and in regards to the traveller community, the vaccinations would have to travel to them.

The IMU asked about the sustainability of mass vaccination when looking forward to the prospect of a winter booster programme.

The DOP responded that in terms of workforce it was challenging. There had been a lot of offers for help but it had been challenging. She added that in an ideal world, longer shifts needed to be covered but staff had been reluctant to cover long shifts.

The DOP advised the Committee that in terms of planning for ongoing immunisation, they had been working on the 2 vaccines for priority groups and they could employ people on a more permanent basis if there was a booster programme.

The END added that the training programme was "quite something" and they would revisit that develop a more pragmatic approach.

The COCHC offered his help with communications within the community.

The EDPH responded to the COCHC and suggested that the Head of Communications could get involved in the discussions around communication and that there was a regional incident management team that met each week.

Resolved that:

	The Quality, Safety and Experience Committee noted the update on Mass Vaccination progress.	
QSE 21/02/011	**Board Assurance Framework – Patient Safety** The DCG advised the Committee that the report should be taken as read and reminded Committee members that the framework was shared for review before providing assurance to the board. **Resolved that:** a) The Quality, Safety and Experience Committee reviewed the Board Assurance Framework risk in relation to Patient Safety to enable the Committee to provide further assurance to the Board when the Framework was reviewed in its entirety at the March Board meeting.	
QSE 21/02/012	**HIW Activity and Reports Update** The ADPSQ advised the Committee that it was a short report and that the HIW had stepped down their activity during COVID-19. She added that since the last report, HIW had quality checked MEAU at UHL and an improvement plan had been submitted. The ADPSQ advised the Committee that they were still communicating with the HIW in terms of the maternity review and that an update would be brought to the next QSE Committee meeting. The ADPSQ advised the Committee that HIW would be attending the mass vaccination centres in March 2021 and they had also started a thematic review of mental health crisis prevention in the community. **Resolved that:** a) The Quality, Safety and Experience Committee noted the level of HIW activity across a broad range of services and agreed that the appropriate processes were in place to address and monitor the recommendations.	
QSE 21/02/013	**Health Care Standards Self-Assessment Plan and Progress** The ADPSQ advised the Committee that every year a self-assessment was undertaken against Health Care Standards, however due to the pressures of 2020, a full assessment was not carried out. She advised the Committee that progress updates had been provided to the Committee on improvement plans. She advised the Committee that a self-assessment would be undertaken in 2021 against 17 of the standards. She suggested that, with permission of the Committee, she would work with the specialist groups until the end of April to submit SBARs and would bring a paper back to the June Committee.	

	Resolved that: a) The QSE Committee noted and agreed the proposed approach to the 2021 Health and Care Standards self-assessment**.**	
QSE 21/02/014	**Terms of Reference** The DCG advised the Committee that the Terms of Reference (ToR) feed into the end of year arrangements and are reported through to the annual report and she was keen to get them in this year as they were not in last year's report. The DCG advised the Committee that Audit Wales had delayed and slowed down their quality review due to ongoing pressures relating to Covid 19. The DCG advised the Committee that the ToR had been brought for the Committee approval. The EMD advised the Committee that he was unsure if the Organ Donor Committee would report to QSE but that the possibility had been left open in the ToR. He added that he did not think the Learning Committee would report to QSE and thought it was the outcomes that would be provided. The END advised the Committee that she agreed that the outcomes of the Learning Committee should be reported to QSE. **Resolved that:** a) The Quality, Safety and Experience Committee approved the Terms of Reference and recommended them for approval to the Board on 25th March 2021.	
QSE 21/02/015	**Work Plan** The DCG advised the Committee that the Work Plan had been drafted broadly and that it reflected what was in the ToR. **Resolved that:** a) The Committee reviewed and approved the Committee Work Plan for 2021/22 and recommended approval to the Board on 25th March 2021.	
QSE 21/02/016	**Committee Annual Report** The DCG advised the Committee that the Committee annual report provided a summary of all the work undertaken by the committee during the year. The CC commented that Committee Members should endeavour to improve their attendance figure of 73%. The DCG responded that work was being undertaken around who would sit on which Committee which would be taken to Board in March.	

	Resolved that: a) The Committee reviewed the draft Annual Report 2020/21 of the Quality, Safety and Experience Committee and recommended the Annual Report go to the Board for approval.	
QSE 21/02/017	**Policies and Procedures** The DCG advised the Committee that not all policies came to the Committee for approval. She added that at each meeting the Committee would be provided with a list of policies for ratification and that due diligence regarding prior approval of the documents would have been undertaken The DCG advised the Committee that ratification was needed for the following policies: 1) Ultrasound Risk Management Policy and Procedure. 2) Use of Antimicrobial Agents Policy. 3) Blood Component Transfusion Policy and Procedure. 4) New Procedure Policy. **Resolved that:** a) The Quality, Safety and Experience Committee ratified the Policies/Procedures listed following their approval by appropriate quality and safety sub groups of the UHB.	
QSE 21/02/018	**Board of Community Health Councils in Wales Report - Feeling forgotten? Hearing from people waiting for NHS care and treatment during the coronavirus pandemic** The COCHC advised the Committee that it would be helpful to have a discussion with somebody from the UHB around this. It was suggested that the Chief Operating Officer (COO) would be the best person to discuss this with. **Resolved that:** a) The Committee agreed to provide a continued commitment to ongoing communication with people regarding service delivery.	
QSE 21/02/019 Khan Raj 05/20/2021 15:17:34	**Minutes from Clinical Board QSE Sub Committees: Exceptional Items to be raised by Assistant Director Patient Safety & Quality.** a) Children & Women's Clinical Board minutes – 24/11/20 b) Specialist Clinical Board minutes – 30/10/20 c) CD&T Clinical Board minutes – 11/11/20 d) Surgery Clinical Board minutes 17/11/20 f) Medicine Clinical Board Minutes – Unconfirmed	

	Resolved that: a) The minutes of each of the sub committees were noted approved as a true and accurate record.	
QSE 21/02/020	**Items to bring to the attention of the Board / Committee** No items were noted.	
QSE 21/02/022	**Any Other Business** No other business was noted	
QSE 21/02/023	**Review of the Meeting** The CC commented that she liked to give ample time to presenters as this provided the Committee with good quality presentations.	
QSE 21/02/024	**Date & Time of Next Meeting:** Tuesday 13th April 2021 at 9am. Via MS Teams	

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

Chair:		
Michael Imperato	MI	Committee Chair
Members:		
Sara Moseley	SM	Committee Vice Chair & Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Estates
In attendance:		
Abigail Harris	AH	Executive Director of Strategic Planning
Caroline Bird	CB	Deputy Chief Operating Officer
Ceri Dallimore	CD	Principal Informatics Analyst
Dan Crossland	DC	Transformation and Innovation Lead Occupational Therapy
David Thomas	DT	Director of Digital Health Intelligence
Fiona Kinghorn	FK	Executive Director of Public Health
Lee Davies	LD	Operational Planning Director
Neil Jones	NJ	Consultant Community Addictions Unit
Nicola Foreman	NF	Director of Corporate Governance
Rachel Gidman	MD	Interim Executive Director of Workforce & Organisational Development
Scott Mclean	SM	Director of Operations – Children & Women
Stuart Walker	SW	Executive Medical Director
Secretariat		
Raj Khan	RK	Corporate Governance Officer
Apologies:		
Gary Baxter	GB	Independent Member – University
Steve Curry	SC	Chief Operating Officer

S&D 21/03/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	**Action**
S&D 21/03/002	**Apologies for Absence** Apologies for absence were noted.	
S&D 21/03/003	**Declarations of Interest** Independent Member – Third Sector (IM-TS) declared an interest as the Director of Mind Cymru	
S&D 21/03/004	**Minutes of the Committee Meeting held on 12th January 2021** The Committee reviewed the minutes of the meeting held on 12th January 2021. Executive Director of Public Health stated in relation to S & D 21/01/014: Healthy eating standards:	

	Paragraph 1, should say 'where 75% of the food and drink consists of healthier options' not 'could be' **Resolved that:** (a) The Committee approved the minutes of the meeting held on 12th January 2021 as a true and accurate record pending the update.	
S&D 21/03/005	**Action Log following the Meeting held on 12th January 2021** The Committee reviewed the action log and the following comments and updates were made: **S&D 15/09/007 - Strategic Equality Plan – Action Plan –** the Interim Executive Director of Workforce & Organisational Development (EDWOD) stated she would follow up with the Equalities Manager to bring this back to the next meeting The Director of Corporate Governance (DCG) and Director of Digital Health Intelligence (DDHI) confirmed that the integrated performance report would be taken to the May Board meeting. The remaining actions were confirmed to be completed or on the agenda for the meeting. **Resolved that:** (a) The Committee noted the Action Log.	
S&D 21/03/006	**Chair's Action taken following the meeting held on 12th January 2021** The CC and IM-TS met with the Equalities Manager and had followed up with him regarding the Equality, Inclusion and Human Rights Policy. The CC as part of the Wales Vice-chairs meeting had met with Eluned Morgan - Mental Health Minister who had stated that her focus was on CAHMS and the CC confirmed that it was opportune that the committee was focusing on the topic today. The CC highlighted the Mental Health Minister's interest in the Welsh Language Strategy and that she would want Health Boards to capture and measure developments and improvements in Welsh language. The Interim Executive Director of Workforce & Organisational Development (EDWOD) reassured the CC that this was happening and that there was an Equality & Welsh Language Group from which they monitor outcomes. She offered to bring this back to a future committee meeting to which the CC agreed.	RG

S&D 21/03/007	**Employment Policies for Approval** **(a) Job Planning Procedure** The Executive Medical Director (EMD) stated that this had taken a year, which included a 5–6-month negotiation with BMA, which did not result in a consensus result although many of the recommendations were considered. The EMD confirmed that the procedure was there to support the implementation of a uniform, fair, equitable, and transparent job planning process for all consultants. The EMD added that this came out of the need to properly job plan all senior medical staff and an internal audit saying they had limited assurance on their job planning processes. The EMD stated that it was partly written from fresh, partly taken from an older version, and partly taken from a Hywel Dda equivalent. He had circulated to all other health boards at their request as they wanted to utilise it themselves. The EMD advised that the procedure had come to the committee for sign off and he felt that it was a good piece of work with many keen to get the process started. He mentioned that they had started uploading job plans electronically a few weeks previously which had increased to 20% of all plans. IM-TS queried if there was anything that needed to be highlighted in terms of risk The EMD highlighted that the biggest risk was the balance of job plan in the delivery of direct critical care (DCC) and supporting professional activities (SPA). The EMD stated that in the English contracts, it says consultants will have on average 7.5 DCC and 2.5 SPA but the Welsh contract says typically consultants will have 7 DCC and 3 SPA. He highlighted that it says “typically” which was a deliberate obfuscation in the contract due to Welsh Government and BMA not agreeing. He advised that the way people were interpreting this was on the basis that they had an entitlement to 3 SPA’s which was not what the procedure said. All new Welsh job plans have to get Royal College approval and have to have 3 SPAs. **Resolved that:** (a) the committee **APPROVED** the Job Planning Procedure	
S&D 21/03/008 Khan Raj 05/20/2021 15:17:34	**Research & Delivery Strategy 2021-2024** The EMD reminded members that he brought the 3 year strategy to the committee the previous year for sign off. Since then, a number of things had changed i.e. Covid, research response & learning, UHW2 and additional thinking about what a learning healthcare system means. Another change he highlighted was the ongoing relationship with Cardiff	

	University and how this was getting stronger. The EMD stated that all these things made them think that they needed to refresh the strategy already rather than wait another 3 years. **Resolved that:** **(a)** the committee **NOTED** the contents of the re-written strategy, and **APPROVED** its contents and the direction of travel of the Health Board's R+D services.	
S&D 21/03/009	**Terms of Reference** The DCG stated that the paper could be taken as read by the committee and she highlighted that there had been very few changes. The DCG highlighted one addition which was the socio economic duty which needed to be reported on within the committee. The CC confirmed that requirement to report on the Socio Economic Duty would commence on the 31st March 2021. The IM-TS queried the EHIA, under 2.8, and whether it adequately covered equalities more broadly in the context of the strategy in relation to our population and workforce. She also queried, under item 4, job planning and sharing information. She felt that some items sat more appropriately with other committees and felt that the chairs of committees needed to have assurance that work was being picked up elsewhere once referred. The DCG agreed with the IM-TS and advised that the committee should cover equalities as it was responsible for reporting on the work the Health Board had undertaken for equalities and diversity. The DCG agreed to make changes to the TOR. **Resolved that: following pending changes** (a) **APPROVE** the changes to the Terms of Reference for the Strategy and Delivery Committee and (b) **RECOMMEND** the changes to the Board for approval.	
S&D 21/03/009	**Work Plan 2021-22** The DCG stated that the work plan reflected the routine business of the committee. She advised that under the SOFW strategy she aimed to bring in work with Q5 that had been looked at an executive level to ensure that the committee were sighted on progress. There were also a number of programs that the Health Board would focus on over the following 2 months and the DCG confirmed that she would list those in the work plan to ensure that the committee did not lose sight of progress. The Executive Director of Strategic Planning confirmed that it was her intention is to regularly bring to S&D committee a flash report on where programmes were in terms of delivery and to provide an in depth look at one or two programmes at each committee meeting.	

	The EDSP stated she will work with the DCG to ensure they have a rolling programme. **Resolved that:** (a) The Committee **REVIEWED** the Work Plan 2021/22; (b) The Committee **APPROVED** the Work Plan 2021/22; **(c)** The Committee **RECOMMENDED** approval of the Work Plan to the Board.	**AH**
S&D 21/03/010	**Committee Annual Report** The DCG advised that the report was a backwards look at the committees work over the year. She mentioned that it feeds into the overall annual report and annual governance statement and was shared to demonstrate what the committee should have done under its Terms of reference which is why the report is signed off by the chair. The report provides a review of year and what has taken place where and when. She added that the only thing missing from the report was the strategic focus placed on key areas, i.e elective surgery, primary care, Mental Health, etc. at recent meetings. It was noted that these items would need to be captured, prior to Board approval, and pulled to the front of report to make it more obvious to those reading the report that this has been undertaken. **Resolved that: Following pending changes** a) The Committee **REVIEWED** the draft Annual Report 2020/21 of the Strategy & Delivery Committee **b)** The Committee **RECOMMEND** the Annual Report to the Board for approval.	**NF**
S&D 21/03/011	**Mental Health Strategy Presentation to include Adult, Children and Neurodevelopmental.** The Director of Operations – Children & Women (DO-CW) provided a presentation to the committee He reminded the committee of the targets set in each area **Primary Mental Health (PMH)** Assessment • 80% of Children & Young People (CYP) to be assessed within 28 days of referral Intervention • 80% of CYP to have an intervention within 28 days of assessment **Specialist CAMHS (SCAMHS)** Assessment • 80% of CYP to be assessed within 28 days of referral Intervention • No formal target currently, though there is talk of a target being introduced for CYP psychological therapies • 90% of CYP identified as requiring a Care & Treatment Plan (CTP) have one in-place and within review date **Neurodevelopment (ND)**	

Assessment

- 80% of newly referred patients should be seen & assessed within 26 weeks of referral

The DO-CW then provided information which showed the trended analysis of PMH referrals pre and during Covid as well as pre and post school opening during Covid highlighting that there was an 80% rise of referrals once schools opened back up. He also highlighted the waiting times throughout.

In terms of compliance he stated that from May – October they were above the target performance thresholds but had since taken a significant drop since schools had re-opened, highlighting C&V were not alone in that position compared to the rest of Wales

The DO-CW stated that based on what they knew, the team has the capacity to get back to a recovered position as demonstrated within the presentation and he was hopeful to deliver on the improved performance position in Q1 of the new financial year and sustain it into Q2

He then went onto display the same trended analysis for Specialist CAHMS highlighting the average referrals in the pre Covid days being 140 a month, which then dipped during Covid to half of that but similarly seeing significant rises once schools opened back up.

He highlighted that the waiting list length had risen from 15 weeks to 25 weeks

The DO-CW said in summary:

- PMH & SCAMHS services across Wales were experiencing similar increases in demand for PMH, SCAMHS and Crisis
- Flow through services has been slower as a result of:
  - difficulties in engaging patients in remote appointments, and
  - increasing complexity of initial presentations
  - Increased numbers of Young People referred for eating disorders
  - Ongoing challenges with recruitment to vacancies
- What would happen to Demand following release of the 2nd lockdown was uncertain
- The already pressured service was suffering increasing pressure from external bodies, often about individual cases. This detracted from clinical/operational work and presented a potential governance risk
- Lay media publicity describing “tsunamis” or “epidemics” of “Mental Health issues” for young people following the pandemic may:
  - ‘Pathologise’ what is essentially a normal distress reaction to abnormal circumstances
  - Worsen the over-medicalisation of social and emotional distress in our dealings with public sector partners

The DO-CW then discussed Neurodevelopment stating that committee members would hear more frequently about the Neurodevelopment targets.

In terms of performance C&V compared to the rest of Wales the Health Board see 1 of 4 referred to the service within the 26 week target.

In terms of referrals pre Covid they spiked above the average and dropped significantly during Covid and then rose above the average once schools re-opened.

In terms of waiting list times, children and young people waiting figures in March recorded 327 people waiting over 26 weeks but that had risen to 550 and rising. He stated that he could not assure the committee that those times would be brought down.

The DO-CW showed the Annual ND Waiting List vs the Annual capacity highlighting that the teams were working against a backlog highlighting that Transformation work was underpinned by a realisation that the "Dr only" model would lead to further deterioration in ND waiting times.
He stated that:

- School closures have a very significant impact on ND assessment times: the majority of assessment time is spent in school
- Community Pediatricians have seen a significant upsurge in Safeguarding and Children Looked After work, therefore further diminishing capacity for ND assessments
- Welsh Government Delivery Unit were supporting our Demand/Capacity modelling and Process Mapping
- The Health Board was working with the National ND Strategy Team supporting work on a proof-of-concept digital tool (called 'Do It') which would streamline information capture and assessment for professionals and make the process much more accessible for CYP and their families
- 20-25% of the population have Neurodiverse traits:'pathologising'/over-medicalising these and creating a dependency on health services was unsustainable

The Transformation and Innovation Lead, Occupational Therapy (TIL) continued the presentation reminding the committee that the team had predicted that following falling Covid cases there would be an increase in mental Health referrals.

The TIL presented data from the National Care Commissioning Unit (NCCU) which showed across Wales referral rates were slightly below that of the expected level from 2019/20 but with an expected projection of it increasing from January 2021.

He highlighted that in C&V the largest area was the community and that they had seen a return to normal levels, although there were concerns that there were higher emergency and urgent referrals but upon review they were equivocal with the 2019/20 rates. He added that what they had noticed was whilst inpatient acute admissions had fallen by 8% in Wales, formal Mental Health Act admissions had risen by 11%.

The TIL highlighted a slide which was presented to the Board in June 2020 which outlined their strategic direction and intent, which was something they were able to maintain.

	The TIL spoke about the recovery college in relation to empowerment, he reminded the committee that it holds lived experience and clinical expertise with equal parity. He advised that everything in the recovery college was co-produced and everything had to abide by its 3 principles: -Hope -Control -Opportunity Every Course was developed from scratch by a peer tutor with lived experience of recovery and a professional tutor who was usually a clinician. The students were also people with lived experiences of mental health challenges. The TIL then spoke about empowerment in action: • There were no referral in courses, people had the choice to choose what course they attend • Students shaped the curriculum • Holding lived experience with equal parity – the college is run by a peer lead. There are health staff within the college but the vast majority of staff are people who have had lived experience. The CC thanked the team for the presentation and confirmed that would like to discuss the way forward offline as the position seemed to be one which they were firefighting and that the issues were ones that may be bigger national issues. **Resolved that:** **a)** The Committee **NOTED** the update	
S&D 21/03/012	**Strategy & Delivery Dashboard Demo** Director of Digital Health Intelligence (DDHI) and the Principal Informatics Analyst (PIA) provided a demo of the Strategy & Delivery Dashboard. The DDHI informed the committee that he had met with the Chief Operating Officer (COO), EDSP, and the CC to discuss how to develop the dashboard in a more meaningful and useful way. The PIA provided a demo of Dashboard looking at scheduled and unscheduled care, the DDHI commented that he would like the committee to consider whether: - The format was correct - How it complimented the performance report that was presented separately Independent Member – Estates (IM-E) queried whether the right metrics were being measured and how would the dashboard be used to get the best value from it. The PIA responded that the dashboard was still in test mode but would be available within the business intelligence system as a dashboard for anyone to view. The DDHI added that it would be available to independent members and in response to the query about the correct metrics being measured, he advised that this would be part of a wider piece of work as	

	the teams were seeing things in the performance report which hadn't been mapped out yet but there were still opportunities to adjust the system. The EMD whether the accuracy of the dashboard would depend on how it was being used. He suggested that if dashboard was used to measure operational performance, then some of those metrics would be key but if a BAF dashboard was used there was potential to consider other metrics for Quality & Safety as there are a number of those metrics which would overlap. He also queried where the data would come from. If the system was used operationally in the clinical boards daily then it needed to be completely up to date live data but if it was looked at in a Board meeting to look at performance over the year then different timeframes would be needed. The EMD commented that there was a need to define the: - Purpose - Metric - How it's should be presented - Source of data - Narrative of the data presented The CC agreed with the points made by the EMD and he acknowledged the work taken to get to the Dashboard to the current position. He commended the DDHI and his team. The CC asked the DDHI to meet outside the meeting to discuss how to carry the work forward, the MD also asked to meet the DDHI to discuss this work. **Resolved that:** **a)** The Committee **NOTED** the update and demo of the Dashboard	**DT**
S&D 21/03/012	**Partnership Planning update to include:** **(a) Work of the Regional Partnership Board** **(b) White Paper on Social Services** **A - Work of the Regional Partnership Board** The EDSP confirmed that the update was shared for noting as it provided a brief overview of the work done in relation to Health and social care under the RPB. It showed that there were a number of streams of work and services funded through non recurrent money which ended in the new financial year. She added that the update highlighted that a good programme of work had been set out for the year including: - development of the outcomes framework - regrouping the work of the RPB (Starting Well, Living Well, Ageing Well) The EDSP informed the committee that the RPB had learnt that there was some funding to continue what was invested as winter capacity over and above normal intermediate health and social care services.	

	She added work was being undertaken around engagement on how best engage with communities and that would inform their thinking going forward. **B - White Paper on Social Services** The EDSP shared with the committee what was included within the white paper that was out for consultation. She commented that it was produced following quite a detailed stock take and assessment of the state of affairs in social care but was not made a public document. She felt that it described a situation where over time various reforms of social care had resulted in a situation where progress had been made in some but the service area had not seen the pace of change that had been anticipated. She highlighted 4 key changes detailed in the White Paper: - A national framework for commissioning care and support for children and adults would be developed to rebalance the market with the aim of improving services - A 'National Office' for social care would be established to develop and deliver the national framework - The RPB would be established as corporate legal entities. Re-shaped RPB's, with functions to employ staff and hold budgets, would be expected to undertake significant joint commissioning and more direct market shaping - Current planning and reporting arrangements would be consolidated, and those arrangements would be a better basis to evidence accountability to local and regional partners, as well as Welsh Ministers in respect of any national resources allocated to RPB's The EDSP highlighted what was talked about in terms of what rebalancing means - Away from complexity, towards simplification - Away from price, towards quality and social value - Away from reactive commissioning, towards managing the market - Away from task-based practice, towards outcome-based practice - Away from organisational focus, towards more effective partnership She added that the UHB, RPB and NHS Wales responses to the white paper would be lodged by the 6th April 2021 **Resolved that:** **a)** The Committee **NOTED** the update on the Regional Partnership Board for information. **b)** The Committee **NOTED** the update on White Paper on Social Services	
S&D 21/03/013	**Elective Treatment Strategy Update – Verbal** The Deputy Chief Operating Officer (DCOO) shared a verbal update with the committee. At the time of the meeting there 280k open pathways with	

	patients waiting a lot longer and the Health Board's response needed to be more significant and not just about services returning back to normal. She advised that the issue was wider than just elective treatment as it included the whole of planned care. Operational teams continued to refine their approach but 3 key principles continued to underpin the strategy - Clinically led and designed - Data driven - Risk orientated The DCOO stated that the operational teams approach was currently in 3 facets – Risk, need, value – establishing what is high value care, how to prioritize patients based on clinical urgency rather than time – Efficiency - how to get back to pre Covid levels – Capacity – how to transform capacity to manage the backlog The DCOO added that there would be some capital schemes for expansion of infrastructure, theatres, endoscopy suites, etc. but in the interim the teams would need to utilise as much capacity as possible. She concluded that plans were being finalised in draft for inclusion in the annual plans but behind that would sit a more detailed plan. She stated that plans would be submitted at the end of March, with conversations with Welsh Government around funding and she suggested that an update be brought back to a future committee meeting **Resolved that:** **a)** The Committee **NOTED** the update on the Elective Treatment Strategy	**SC**
S&D 21/03/014	**Performance Reports** **(a) Organisation Key Performance Indicators** The DCOO confirmed that the paper could be taken as read and highlighted the impact of Covid and how the second wave was different from the first i.e. higher level of Covid admissions, twice the occupancy level – 277 in the first wave as opposed to 560, etc. She stated throughout the pandemic the Health Board had been able to maintain essential services and highlighted: – Single cancer pathway – came into effect 1st December, replacing the previous 2 measures of the urgent suspect & non urgent suspected cancer targets – Actions being taken in terms of recovery were being done in 2 planning horizons 1. To remain Covid ready & plan in 4-6 week cycles and look at how to rebalance footprints to reflect the transition from Covid to non Covid activity 2. 6 month / 12 month / 5 year recovery plan being looked at in the annual plan The CC queried how would what's happening in primary care be captured.	

	The DCOO responded that this was reflect in the Board reports to a degree but to the committee via the Covid update report and the performance report **(b) Workforce Key Performance Indicators** The EDWOD highlighted that an additional paper was added to share graphs to provide clarity to the figures in the report. Sickness rates were going down, the pay bill was reducing and turnover rates were in a healthy position. The Job planning which the EMD referenced earlier in the meeting would be taken off the graph as it was not being put on ESR and would be placed on another system called allocate. In regards to Fire, statutory, mandatory training and appraisals, she stated that a good uptake on training had been seen based off value based appraisal returns. The EDWOD wanted to highlight that through the wellbeing groups staff were reporting that they felt as though they hadn't had a breather as we moved to the next phase of Covid/lockdown and the ambitions for the future. She stated that it was the intent of the team to reflect back on the 23rd March 2020 when it was the first lockdown and to thank staff but to be mindful of the struggles staff were still facing. The CC highlighted the voluntary resignation trends rising to which the EDWOD responded that they needed to look at the exit questionnaires to understand the reasons behind this. The CC stated that the next committee meeting would look at workforce and the way forward for workforce and staff wellbeing. **Resolved that:** **a)** The Committee **NOTED** the year to date position against key organisational performance indicators for 2020-21but in the context of current Covid operating challenges. **b)** The Committee **NOTED** and **DISCUSSED** the contents of the report	**RG**

S&D 21/03/015	**Board Assurance Framework** **(a) Capital Assets** The DCG reminded the committee that each of the risks within the BAF was allocated to a lead committee for assurance and scrutiny and that the S&D committee had 7 of the 9 risks listed. The DCG commented that The Capital Assets risk covered IT, Medical devices, and actual assets. She highlighted that an additional £1 million was received from Welsh Government and it was agreed the funds would be spent on medical devices and the bulk of it on IT infrastructure. The DCG advised that this did not mean this risk was fully mitigated as going forward this risk would be carried in to the following financial year. IM-E queried whether submission of the UHW2 business case would impact on existing OBC's and given the existing demand on Welsh Government whether they would be affected or postponed. The EDSP responded to confirm that if there was a new site for UHW2 this would deal with a massive amount of backlog in terms of estates maintenance at UHW. She advised that the Health Board must ensure that the budget for maintenance going forward is the right size as there has never been any review on spend for estates, maintenance, or equipment as it usually rolls forward each year. The CC asked what assurance would be given to the Board around this risk. The DCG confirmed that it was about making sure the actions in place to manage the risk were taking place and that this would continue to be monitored. **Resolved that:** a) The Committee **REVIEWED** the attached risk in relation to Capital Assets to enable the Committee to provide further assurance to the Board when the Board Assurance Framework is reviewed in its entirety.	
S&D 21/03/017	**Shaping Our Future Wellbeing Ten Year Strategy Delivery Programme Including Key Milestones & Metrics** The EDSP and CC agreed that the item would be deferred to the next meeting	**AH**
S&D 21/03/018	**People & Culture** The EDWOD shared a good news story and asked for support to promote the kick-start programme. As a corporate platinum health standards organisation the EDWOD stated that the programme was something that C&V should be doing and highlighted that C&V would be the first health board in Wales to become a direct employer. The EDWOD confirmed that this was an exciting opportunity as it leads on the inclusion agenda and she highlighted: • 50 places were available with an opportunity to apply for more	

	• 17 were starting in corporate areas • The programme was fully funded by Welsh Government The EDPH stated that the programme was a great piece of work and added that good employment opportunities contributed to good emotional mental health and she was really supportive of the programme. **Resolved that:** a) The Committee **NOTED** the UHB's successful application to become a Kickstart direct employer The Committee **NOTED** that by March 2021 placements would commence in Cardiff and Vale UHB supported by an Inclusion Manager. The committee members would **PROMOTE** the scheme for employment opportunities.	
S&D 21/03/019	**Review of the Meeting** The CC thanked everyone for their contribution during the meeting. All committee members confirmed it was a good meeting with an appropriate level of Independent Member challenge and scrutiny.	
S&D 21/03/020	**Date & Time of next Meeting** **Date & Time of Next Meeting:** Tuesday 11th May 2021 at 09:00am Via MS Teams	

Confirmed Minutes of the
Mental Health and Capacity Legislation Committee
Held on 19th January 2021 – 10am.
Via MS Teams

Chair:

Sara Moseley	SM / CC	Interim Chair and Independent Member – Third Sector
Present:		
Eileen Brandreth	EB	Independent Member - ICT
Michael Imperato	MI	Independent Member - Legal
In Attendance:		
Julia Barrell	JB	Mental Capacity Act Manager
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Daniel Crossland	DC	Transformations and Innovation Lead
Aaron Fowler	AF	Head of Risk and Regulation
Neil Jones	NJ	Consultant - Community Addictions Unit (CAU)
Robert Kidd	RK	Consultant Clinical and Forensic Psychologist
Amanda Morgan	AM	Service User
Sian Rowlands	SR	Head of Corporate Governance
Matthew Russell	MR	Social Worker CMHT
Ruth Walker	RW	Executive Nurse Director
Sunni Webb	SW	Mental Health Act Manager
Ian Wile	IW	Head of Operations, Mental Health
Linda Woodley	LW	Local Authority Representative
Secretariat:		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Steve Curry	SC	Chief Operating Officer
Nicola Foreman	NF	Director of Corporate Governance
Scott McLean	SMc	Director of Operations – Mental Health

MHCL 21/01/001	**Welcome & Introductions** The CC welcomed everybody to the meeting and thanked the Committee in advance for the brevity they would bring to the meeting. Apologies were raised to the Service User for the delay in board papers being sent and assurance was given that the delay would not happen again.	**ACTION**
MHCL 21/01/002	**Apologies for Absence** Apologies for Absence were noted from Steve Curry, Nicola Foreman and Scott McLean.	
MHCL 21/01/003	**Declarations of Interest** The CC declared an interest in the meeting as the Director of Mind Cymru and advised the Committee that a letter had been sent by Mind Cymru that related to ethnicity monitoring for people detained under the Mental Health Act.	

MHCL 21/01/004	**Minutes of the Committee Meeting held on 20th October 2020** The Committee reviewed the minutes from the meeting held on 20th October 2020. Resolved that: a) The CC noted a clarification regarding point: *"MHCL 20/10/009 - The Committee noted that further work needed to be undertaken to progress the audit outcomes by the next meeting"* The CC advised the Committee that it was not on the agenda and asked that it be on the agenda for the next meeting. b) The CC noted point: *"MHCL 20/10/010 - The CC asked what learning had taken place in preparation for the next COVID-19 wave."* The CC noted that the population was in the midst of the second wave of the pandemic and asked the Head of Operations, Mental Health (HOMH) for an update on specific COVID-19 related issues that would affect the subject matter of the meeting. The update was noted in Any Other Urgent Business.	
MHCL 21/01/005	**Action Log – 20th October 2020** The Executive Nurse Director (END) advised the Committee that work had commenced on action MHCL 20/10/009 and that time would be spent at the meeting to provide clarity on what the Committee needed. The CC advised the Committee that action MHCL 20/10/13 could be closed as membership of the Committee would be looked at once revisions of the Terms of Reference had been agreed. The CC advised the Committee that action MHCL 20/10/14 needed to be updated and it was agreed that a date for an update to be provided would be agreed offline.	**NS / NF**
MHCL 21/01//006	**Chair's Action taken since last meeting** The CC advised that she had met with the Director of Corporate Governance (DCG), the END and the Chief Operating Officer (COO) and had looked at the minutes and brought a suggested revision to the meeting. No other actions had been taken	

MHCL 21/01/007	**Any Other Urgent Business Agreed with the Chair** The CC asked the HOMH to update the Committee around the prevailing COVID-19 situation within Mental Health. The HOMH advised the Committee that the administration of the Mental Health Act had “moved mountains” which had enabled the appropriate remote work that was needed. The HOMH advised the Committee that the Mental Health Act Manager (MHAM) had looked at putting sound proofing into some of the ward areas. The MHAM responded that the work would start over the following weeks and would ensure that patients had the appropriate facilities in place and she advised the Committee that all hearings were taking place remotely and that no patients had attended the Mental Health Act office. The HOMH advised the Committee that they had authorised temporary administrative support for the team. The HOMH advised the Committee that they had continued to run as an essential service and the approach during the 2nd wave had been to put a resource ring in place around inpatients, the community specialist services and primary care. The HOMH advised the Committee that COVID-19 activity had affected inpatient areas and the team had right-sized the service to fit the staffing profile that had been available. The HOMH advised the Committee that the Transformations and Innovation Lead (TIL) and himself had conducted an audit that looked at referral activity into Mental Health. The audit showed that capacity was around the same or above what it was pre-COVID-19. The HOMH noted to the Committee that Primary Care were getting, on average, 2500 referrals per month across all Primary Care services and that some services had struggled with staff loss through COVID-19. The HOMH advised the Committee that full use of the third sector had been utilised and that the responsiveness and flexibility to demand had been magnificent. The CC asked the HOMH to extend the Committee’s thanks to all staff. The END advised the Committee that from a clinical perspective in relation to Infection Prevention &Control (IP&C) the Mental Health Service had managed a number of outbreaks and she had been extremely impressed by the work they had undertaken.	

	The Consultant Clinical and Forensic Psychologist (CCFP) advised the Committee that whilst operating under COVID-19 there had been no delays with section 62 as Second Opinion Appointed Doctors (SOAD) were working remotely.	
MHCL 21/01/008	**Patient Story** No patient story presented was shared at the meeting. It was agreed that efforts would be made to ensure that stories were shared at future meetings.	
MHCL 21/01//009	**Mental Capacity Act** **Mental Capacity Act Monitoring Report:** The CC asked the report authors if there was anything that they wanted to draw to the Committee's attention. The CC advised the Committee that the paper highlighted a drop in the use of the Independent Mental Capacity Advocates (IMCA) service and asked if this was due to restrictions on contact. The END responded that there had been some feedback from the IMCAs around the flexibility of letting them on site and she acknowledged that it had been difficult to get the position right but she had not received any concerns. The Independent Member - ICT (IMI) noted that IMCAs had had varied experiences in gaining access to patients on wards and asked if there was any intention to issue guidance to make it clear what the position should be. The END responded that guidance had not been issued because it was felt that the situation had settled. She confirmed that she would be happy to issue guidance depending on what was happening in given clinical area at any one time. The Mental Capacity Act Manager (MCAM) advised the Committee that overall the IMCA service was doing as much as they could remotely but on some occasions there had been a need to see the patient. The IMI noted that there had been a significant drop in referrals and asked if that was because the need had disappeared and how that would be interpreted. The END advised the Committee that there had been some challenges around availability. The MCAM advised the Committee that the main drop was the use in IMCAs as the relevant person's representative under DoLs. The IMI asked who would make the referral.	

	The MCAM responded that the DoLs supervisory body function would appoint and that if there was nobody else appropriate to appoint to the position of relevant person's representative then the referral would be made to IMCA. The CC advised the Committee that this item would be kept under review because making sure that people are represented properly was really important and that the matter would be discussed at the next meeting to track the position. The CC advised the Committee that there was a persistent issue with low compliance with staff training and noted that it should be added onto the risk register. The END responded that the issue needed to be addressed and a plan would need to be put in but advised the Committee that the release of staff was difficult especially at the time of the meeting. She confirmed that she would bring a proposal as to what that training would look like, what opportunities were available and how medical staff would access the training. The CC advised the Committee that it would be brought to a meeting later in the year when capacity would be better.	**RW** **NS**
MHCL 21/01/010	**DoLs Report – Verbal Update** The END invited the Committee to share what information should be brought to the Committee in regards to DoLs. The CCFP advised the Committee that he would want to see a figure on the number of section 49 reports because it felt like the Organisation was asked to do those but that there was not a sense of how many there are or where they are. The Head of Risk and Regulation (HRR) advised the Committee that the MCAM and he monitored the section 49 requests that came in and that they acted as a point of contact and reference to assist colleagues. He advised the Committee that it was unknown whether all colleagues were reporting s.49 requests to him or the MCAM. The MCAM added that not all section 49 reports would be about mental capacity issues and that sometimes they could concern clinical issues rather than anything to do with mental capacity. The END advised the Committee that one of the greatest challenges was how many DoLS orders the organisation managed, where did they occur and whether there was a process in place to understand how the system was measured. The END advised the Committee that it would be good to know where DoLS predominantly originated because there were places that they had been expected, like locked wards, but they had not been received.	

	The END advised the Committee that there was quite a lot of information to process and that legislation would need to be looked at to be clear about what was required and what would be reported into the Committee. The CC advised the Committee that the introduction in the paper was really good and clear and she agreed with the END's assessment of what the Committee should be looking at and proposed that a course of action was taken. The CC advised the END that she would be happy for the END to go away and come back with clear recommendations for the Committee. The END responded that she would propose separating the report and providing a separate one on DoLs and a separate one on the Mental Health Act. The MCAM responded that DoLs was part of the Mental Capacity Act and that because it was about depriving people of their liberties, it was important to discuss and she added that the COVID-19 practice for DoLS suggested that their use needed to be reported within the organisation. The IMI asked if there were any insights on how other health boards reported on DoLS and whether there was any best practice that could be identified. The END responded that there were people reporting DoLS in a more robust way compared to Cardiff and Vale UHB and that the Health Board could learn from others". The END concluded that there would be new legislation coming into force in the near future but that a date was not set. She advised that she would not be comfortable as lead to wait until that legislation was in place to fully report so it was her intention to report on plans in the interim. The CC responded that the new legislation would be in place in 2022. The CC thanked the END and MCAM for their work.	
MHCL 21/01/011	**Mental Health Act** **Mental Health Act Monitoring Exception Report** The MHAM advised the Committee that the team had met with the Police in regards to ethnicity monitoring. She noted that she was confident that an improvement in the data would be seen moving forward and in particular the data for between October and December. The MHAM advised the Committee that discussions were continuing around the time that the clock began ticking under the MHA for patients within Accident & Emergency (A&E) and she confirmed that	

	the team had been in discussion with Richard Jones (of Blake Morgan Solicitors) on the topic to finalise a stance. The CC advised the Committee that an answer on the ticking clock in A&E would need to be found and asked the HOMH to take that to the crisis care concordat meeting to push for an answer. The Independent Member - Legal (IML) asked if an independent counsels advice around A&E would be useful. The CC responded that to fix the A&E issues, clear national guidance would be needed and it would be important to get the position right. The IML advised the Committee that the ethnicity data seemed to be emerging too slowly which had a great significance given the impact of COVID-19 which appeared to effect ethnic minorities more. The CC responded that the ethnicity data was not just required in relation to Sections 135 and 136 of the Mental Health Act, it was also needed in relation to the use of the Mental Health Act across the board. She added that it was not just the responsibility of the police, it was the health board's responsibility to capture the data which would be within the organisation's control. The CC advised the Committee that the UHB should be position itself to be on top of these issues before the new Mental Health Act came into force. The MHAM commented on the ethnicity data and advised that there had been a blip with the electronic form which had been corrected and was live on PARIS for the data to be recorded.	
MHCL 21/01/012	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.** The HOMH advised the Committee that the report covered all 4 parts of the measure and that part 1A drew attention to pre-COVID-19 activity numbers which had now been reached and exceeded in terms of referrals. Given staff losses and high volume activity it had not taken much to breach and a lot of the activity around the 28 day referral to assessment had occurred over the course of the previous week. The HOMH advised the Committee that compliance had reduced dramatically when capacity did not reach demand. The HOMH advised the Committee that 3 extra staff had been employed who would specifically provide assessment services and would commence their roles in the coming months. The HOMH advised the Committee that at the time of the meeting, people were being booked into the service at 37 to 38 days instead of the 28 day target which meant that 100's of service users were waiting. The HOMH advised the Committee that the Director of Operations – Mental Health (DOMH) had asked him to bring the CAMHS position to	

	the Committee and he advised that there had been a high level of referrals and Interruption with staffing numbers due to COVID-19. He noted that CAMHS was, at the time of the meeting, non-compliant and the team were taking on extra staff to help reset the trajectories. The IMI asked why there were no figures in the report for CAMHS in relation to part 1A. The HOMH responded that he was not sure why the data was not included in the report and confirmed that he had received figures from the DOMH earlier that day and advised the Committee that compliance was around 56% in December. The IMI advised the Committee that CAMHS figures always appeared to be missing from Committee and asked the CC to advise the DOMH that the figures should be a standing item on future agendas. The CC responded that the Committee would need to write to the directorate to impress upon them that the requirement to report was mandatory. The IML responded that he had been in email correspondence with the DOMH that day about CAMHS and confirmed that he would convey the position to him later that week. The CC responded that she wanted it in writing as well and that assurance could not be provided without seeing what was going on and that there was a need to have the position on the record. The CC advised the Committee that the report mentioned the National Assembly for Wales which was wrong as the body was now called the Senedd. The CC advised the Committee that in terms of part 1A of the report there was a massive increase in the number of people waiting and she shared her hope that the impact of the measures put in place would find their way through in time. The CC advised the Committee that she welcomed the continued focus on care and treatment plan quality and completions. The HOMH advised the Committee that part 1A of the report was symptomatic of broader pressures within Primary Care and that the Mental Health service would be investing in tier 0 capacity with the third sector and would also support GPs to ensure that they refer into the appropriate areas. The HOMH advised the Committee that care and treatment planning was the heartbeat of the therapeutic relationship for mental health and that compliance with part 2 of the report was very good. It was the first time that the service had hit 90% in a long time.	

	Resolved that: a) The Mental Health and Capacity Legislation Committee noted the content of the report and the work undertaken by the Mental Health Clinical Board.	
MHCL 21/01/013	**Items to bring to the attention of the Committee for Noting / Information** **Feedback on Committee Training Session & Review** The Head of Corporate Governance (HCG) advised the Committee that the paper was for noting. **Resolved that:** a) The Committee noted the summary of the second Committee training session.	
MHCL 21/01/014	**a) Hospital Managers Power of Discharge Minutes** The Chair of the Powers of Discharge sub-Committee (CPDSC) advised the Committee that there was nothing to raise and that the minutes were shared for information. The CPDSC advised the Committee to note that the service were now providing 3 person hearings and had dropped the 4th member. **b) Mental Health Legislation and Governance Group Minutes** The CCFP advised the Committee that there had been positive things noted about the way the service had adapted to working virtually. He also added that: - he needed to pursue the issue of reading the rights to CTO clients in adult Q&S. - there had been progress in working relationships with the CAMHS teams. - the service had met with various people from the emergency unit about the use of the Mental Health Act for patients presenting at UHW. - information regarding the UK Governments reform of the Mental Health Act would need to be brought to the Committee. The CC advised the Committee that a briefing on the content and focus of the white paper would be added to the agenda for the next meeting.	

	The CCFP asked the Committee whether in terms of the detention of people with learning disabilities, how that have a knock on effect with DoLs.	
MHCL 21/01/015	**Corporate Risk Register** **Corporate Risk Register – Mental Health Clinical Board Risks** The CC advised the Committee that items discussed that day and recommended for inclusion within the Corporate Risk Register, DoLS Training and CAMHS reports would not sit on the Corporate Risk Register and should instead be noted as actions. The HRR advised the Committee that he had worked with the HOMH to refine the Mental Health Clinical Board's extreme risks which would be reported at that month's Board meeting and were shared at the meeting for further scrutiny and assurance that appropriate mitigating action would be taken. THE HOMH specifically discussed the risk relating to conveyancing of Service Users in and out of community settings. Problems with WAST waiting times had led to the HOMH and his team seeking alternative conveyancing options with the St. Johns Ambulance Service who had provided a similar contract to Cwm Taf University Health Board. The HOMH advised the Committee that St. Johns Ambulance could provide a service at short notice and had a vehicle and staff available should approval be given for proposals. The Local Authority Representative (LAR) confirmed support for the proposal. She noted concern that an incident could occur when individuals were detained who should be in hospital settings but had been left in the community for a significant waiting periods. She noted that a national solution had been discussed with WG over a year ago. The IML advised the Committee that this had been a concern pre-COVID-19 and asked the HOMH how much of the proposal would be a "sticking plaster" and whether there would be scope to move to a longer term solution. The HOMH responded that he was looking for a long term solution and advised the Committee that he could not see the operational side of WAST changing anytime soon which was why he had looked at St. Johns ambulance as a medium to long term resolution. The HOMH advised the Committee that he would take the issue to the Chief Operating Officer (COO) and report back to the Committee. The CC advised the Committee that the risk outlined was not a downward trend risk and that the retention of the severity of that risk in terms of safety, dignity and care would need to be on the Board's radar.	

	The LAR reiterated that the risk had been ongoing since 2017 and that it was not just a COVID-19 related issue and advised that the position worsened because WAST were not responding. The HRR advised the Committee that the downward trend shown to the Committee was not intended to suggest the risk had reduced in terms of severity and that it was the score that had reduced following a rescoring using the risk management scoring matrix correctly. The CC responded that upon looking at the risk register it did not capture the mitigating actions so it was difficult to evaluate. The HRR responded that the team would continue to work with the HOMH and increase the detail in the action section of the risk register. The IMI asked what the foundation was for WAST saying that they would not transport an unwell person. The HOMH responded that WASTs stance was that an unwell person with mental health problems was not in immediate danger in comparison with someone with physical health problems. The IMI asked if the Committee were formally pushing back on that stance. The CC responded that as a committee the concern should be escalated and noted that the committee's position could be put in writing to compel commissioners of the service to take action. The CC asked the HOMH to speak with the COO and to come back to with a proposal which could be taken forward under Chairs Action.	
MHCL 20/10/016	**Items for Approval Ratification** **Terms of Reference** The CC advised the Committee that discussions had been had around membership of the Committee and welcomed the Committee's input and thoughts. The END advised the Committee that when the function of the Committee was explored it had become clear that it was a Committee about providing assurance to the board in relation to the application of the Mental Health legislation which included the Mental Health Act and DoLs and that it was not a wider Committee than that. The END advised the Committee that it was time to narrow down and be very clear about the focus of the Committee and who should be "around the table" as well as the accountable officers for the areas of responsibility brought to the Committee. She advised that it was important to bring in colleagues as when important.	

	The CCFP advised that it would be helpful to have colleagues from the Local Authorities (LA) attend the Committee meetings. The CC responded that in relation to that aspect of the work consideration was needed for LA input. Amanda Morgan (Service User) asked about the role of service users and carers within the Committee and their value within the forum. The CC responded that the discussion that had happened previously was that certainly in relation to patient stories that the focus would be on people's experience of the legislation to enable a rounded view of the impact of the legislation. The CC advised the Committee that more thought would need to be given to the role of Service Users and Carers within the Committee. The IMI added that there was a real issue between making sure the Committee was open to hearing those most affected by legislation and avoiding anecdotal and operational matters. She thought that a balance needed to be struck between the need to be open to listening to the views of those who use the service and the need to gain assurance that the Health Board was complying with its legislative responsibilities. The Service User advised the Committee that, as the voice of a carer, it was unclear on how much value was being added to the vast majority of the Committee agenda and that there had been a constant battle about whether they had been a part of the committee or not. The CC responded that rather than having Service Users and Carers as part of the substantive Committee, they could be brought when different aspects were looked to assess how the legislation was affecting individuals. The END advised the Committee that the conversation had been really helpful and that information could be gathered from Service Users that would help and inform the Committee. The CC advised the Committee that Primary Care input was missing and that it would be useful to understand what was going on from the Primary Care perspective. **Work Plan and Committee Annual Report 2020/21** It was agreed that the Committee Work Plan and Annual Report would be brought to the next MHCLC meeting.	**NF / NS**
MHCL 20/10/017	**Review of the Meeting** The IMI advised the Committee that this was her last meeting and thanked the Committee for their support.	

	The CC thanked the IMI for her input and noted that she had looked at things thoroughly. The CC noted that the timings for this Committee should be the same from this point. 1 hour and 30 minutes.	
MHCL 20/10/018	**Date & Time of next Committee Meeting** 20th April 2021 9am – 10.30am	

MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON TUESDAY 26 JANUARY 2021 CONDUCTED VIA MICROSOFT TEAMS

Present:	
Sam Austin	Llamau (Chair)
Frank Beamish	Volunteer
Mark Cadman	WAST
Janice Charles	Vale of Glamorgan Council
Jason Evans	South Wales Fire and Rescue
Iona Gordon	Cardiff Council
Shayne Hembrow	Wales and West Housing Association
Tom Hurlock-Norton	Carers Trust
Duncan Innes	Cardiff Third Sector Council
Zoe King	Diverse Cymru
Tim Morgan	South Wales Police
Linda Pritchard	Glamorgan Voluntary Services
Geoffrey Simpson	One Voice Wales
Siva Sivapalan	Third Sector, Older Persons
Lani Tucker	Glamorgan Voluntary Services
In Attendance:	
Aaron Fowler	Head of Risk and Regulation, UHB
Ed Hunt	Programme Director, UHW2, UHB (item 21/07 only)
Luke Fox	Senior Media Officer, UHB (item 21/09 only)
Abigail Harris	Executive Director of Strategic Planning, UHB
Vicky Le Grys	Programme Director, Strategic Clinical Redesign, UHB (item 21/08 only)
Jess Mannings	Community Health Council
Wendy Orrey	Community Health Council
Rachel Wallbank	COVID Rehabilitation Team Lead, UHB (item 21/09 only)
Keithley Wilkinson	Equality Manager, UHB
Apologies:	
Paula Martyn	Independent Care Sector
Secretariat:	Gareth Lloyd, UHB

SRG 21/01 WELCOME AND INTRODUCTIONS

The Chair welcomed and introduced Duncan Innes and Tom Hurlock-Norton who had replaced Sarah Capstick and Amy Faulkner respectively as members of the SRG.

SRG 21/02 APOLOGIES FOR ABSENCE

The SRG **NOTED** the apologies.

It was **NOTED** that although not members of the SRG, apologies had been received from Nikki Foreman, Angela Hughes and Anne Wei.

SRG 21/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 21/04 MINUTES AND MATTERS ARISING FROM STAKEHOLDER REFERENCE GROUP MEETING HELD ON 24 NOVEMBER 2020

The SRG **RECEIVED** and **APPROVED** the minutes of the SRG meeting held on.24 November 2020.

Re-admission Rates
Abigail Harris informed the SRG that the UHB's re-admission rates for medical patients over the age of 65 for the period April 2018 to December 2020 had been around 15%. These figures include all re-admissions whether for the same condition or for a different condition to the original admission. The UHB was not an outlier on its re-admission rates. The Nuffield Trust suggests an anticipated re-admission rate of just under 15% and the Royal College of Physicians a re-admission rate of 15%.

SRG 21/05 FEEDBACK FROM BOARD

Aaron Fowler informed the SRG that in addition to the regular bi-monthly UHB Board meetings there were now hour and a half meetings during the intervening months. He then drew the SRG's attention to some specific items discussed at the UHB Board meetings held on 26 November and 17 December 2020.

November

- Revised nurse staffing levels
- The UHB's response to the climate emergency
- Mass Vaccination Plan
- The UHB's Quarters 3 and 4 Service Delivery Plan
- The Regional Partnership Board Winter Protection Plan

- Revised governance arrangements. These new arrangements had been introduced to improve transparency rather than to address problems.

December

- General Update on the COVID-19 pandemic
- Retrospective agreement of the costs associated with Dragon's Heart Hospital

A link to the papers for these meetings would be sent to the SRG.

Action: Gareth Lloyd

SRG 21/06 UPDATE ON UHB'S QUARTERS 3 AND 4 SERVICE DELIVERY PLAN

Abigail Harris informed the SRG that the UHB was tracking slightly above the worst case scenario described in its Quarters 3 and 4 Delivery Plan. The significant second peak of C-19 cases had been made even more challenging by the new Kent variant. Prior to Christmas, the UHB had taken the decision to step back some non-urgent elective activity. The UHB had' however been able to continue to undertake all urgent cancer work and indeed had offered to support neighbouring Health Boards by treating some of their cancer patients. The UHB had increased the number of Critical Care beds from 32 to 60 and has plans for a further increase if required. Increased non Critical Care capacity had also been secured from the independent sector.

The SRG was informed that the UHB had not experienced as much 'winter' activity e.g. influenza, as in many previous years. This could be due in part to the measures introduced to reduce the transmission of C-19. The C-19 infection rates were beginning to reduce although regrettably, it was unlikely that the peak in C-19 deaths had been reached.

Approximately 42,000 individuals had already been vaccinated against C-19 in Cardiff and the Vale. It was anticipated that all care home residents would have been vaccinated in the coming days with the exception of those in homes where there were C-19 outbreaks. The UHB was on track to vaccinate all individuals in the top four priority groups by mid-February dependent on the supply of vaccines being as anticipated. The UHB was working with local authority partners to see how the vaccine could be rolled out to individuals over the age of 18 who were not within the top 9 priority groups. Consideration might have to be given to creating much larger mass vaccination centres and offering vaccines 24/7.

The SRG was informed that the Welsh Ambulance Services NHS Trust (WAST) had also been much busier during the second wave than during the first. Its disposition rate remained good and it was still able to respond flexibly to the changing needs of Health Boards despite the difficulties created by C-19 related staff absences.

AH confirmed that all GP practices in Cardiff and the Vale had received doses of the vaccine and supply was not considered a big problem. The way that practices were managing the vaccination process did however differ with some working together in clusters. Mobile units to deliver the vaccines to the housebound were also in operation.

The SRG raised a number of concerns/questions

- Is take up of the vaccine amongst different groups such as the Black and Minority Ethnic community, being monitored? AH explained that the UHB was working closely with community leaders and would be tracking the vaccination rates to see if they identified any issues with take up amongst certain communities.
- Is there was any reason why care home staff could not be vaccinated at the same time as the residents? Abigail Harris suggested that this would be down to the individual care home management.
- Are there any plans for community pharmacies to participate in the vaccination programme? Abigail Harris explained that this was being considered as part of the national discussions on the roll out to those not in the nine priority groups.
- Will there be sufficient the supply of vaccine to ensure that people receive their second doses within the required timescales. Abigail Harris re-assured the SRG that this had been factored into the UHB's vaccine capacity planning. She acknowledged that there were concerns about the 12 week gap between vaccinations but explained that this was the advice of the Joint Committee on Vaccination and Immunisation (JCVI). NHS Wales was using the new Welsh Immunisation (data) System which identifies who has had which vaccine and when they are due to receive their second. Some individuals are already being booked in for their second vaccine between 10 and 11 weeks after their first vaccine.

SRG 21/07 UHB SUSTAINABILITY PLAN

The SRG received a presentation from Ed Hunt on the UHB's draft Sustainability Action Plan (SAP), a copy of which had been circulated in advance of the meeting.

Climate change is the single biggest issue facing humanity and Cardiff is predicted to be heavily impacted as we move towards the end of the century. The UHB has a strong track record of reducing its environmental footprint and has a number of projects planned to make further improvements.

A working group was established to develop the SAP. The group decided to adopt the four pillars advocated by the Centre for Sustainable Development which are: prevention; patient self-care; lean service delivery; and low carbon alternatives. A proposed set of actions has also been identified which are grouped under eight themes:

- Energy
- Waste food
- Water
- Procurement
- People
- Built environment, green infrastructure biodiversity
- Transport
- Clinical.

The proposed sustainability targets were then shared with the SRG.

The SRG raised a number of questions and made several observations.

- The objective of reducing the number of cars on the UHB's sites and increasing the use of active travel is welcomed but will present a challenge as people are generally reluctant to forgo the convenience of their own cars. The SRG was informed that the park and ride service had been a great success with large numbers using the service. A significant number of outpatient consultations are now conducted 'virtually' and this has also reduced the numbers of people who need to access UHB sites. The UHB hopes that about 50% of outpatient consultations will be 'virtual' after the pandemic.
- One of the reasons why people are reluctant to cycle is that they are concerned about bike security.
- All items sold in the UHB's retail outlets should be recyclable. The SRG was informed that the UHB hoped to significantly reduce the number of plastic water bottles on its sites and the Health Charity had funded the installation of water fountains.
- How is the UHB dealing with the significant increase in 'sharps' waste created by the mass vaccination programme? The SRG was informed that this waste is incinerated and the UHB would look to ensure that as much heat as possible is recovered through the incineration process.
- A huge amount of litter is created by disposable face masks, cups etc. The SRG was informed that UHB staff were encouraged to recycle wherever possible. The UHB was also looking at possible options for

resterilizing some personal protective equipment although this was at a very early stage.

The SRG was informed that Abigail Harris and Len Richards would be meeting with representatives from Cardiff local Authority to discuss the UHB's role in the Council's One Planet Cardiff strategy. The UHB was also working with Vale of Glamorgan Public Services Board on its Climate Change Charter.

The SRG was asked how patients should be engaged/consulted on regarding the SAP. It was agreed that it would be appropriate to engage/consult when there's service change proposed such as the Shaping Our Clinical Services Programme.

SRG 21/08 SHAPING OUR CLINICAL SERVICES

The SRG received a presentation from Vicky Le Grys on the draft questions that it was proposed would be used during the Shaping Our Clinical Services engagement process, the timeline for which had been agreed with the Community Health Council.

The draft questions were as follows:

- Do you agree with the case for change we have set out including both challenges and opportunities? Have we missed anything?
- Do you agree that in order to meet some of the challenges and take advantage of opportunities we have set out that there is a need to transform some of our clinical services?
- Are you supportive of the principles we have set out in section (x) for Emergency and Urgent Care, Elective Care, Specialised Care?
- Is there anything else we should consider when transforming the way in which we deliver Emergency and Urgent Care, Elective Care, Specialised Care, what haven't we thought of?
- In your view what are most important aspects of your healthcare: distance I have to travel, seeing the right specialist that it is timely, that it provides the best outcome for me, that it is delivered close to home where possible, or other?
- If the way you receive your care changes in the future, what are the most important things we need to consider in order to limit any negative impacts on your family/care givers?
- When we are looking at the design of our hospitals for the future, what features would make your visit or stay better?
- How can we help you to ensure that more of our services can be delivered at home?
- How would you feel about receiving some of your care with modern technology (e.g. virtual appointments from either home or a community facility)?

The SRG enquired how Shaping Our Clinical Services (SOCS) integrated with the UHB's Shaping Our Future Wellbeing (SOFW) Strategy. Abigail Harris explained that the UHB had taken stock of SOFW last year to see if it needed to be revised or accelerated. The UHB had concluded that the underlying principles remained appropriate but that the following programmes of work should be accelerated

- SOCS
- UHW2
- The Locality Service Model and integration with Health and Social Care (driven through the Regional Partnership Board)
- Rehabilitation Programme
- Outpatient Modernisation (to include changing way that secondary care clinicians support their colleagues in primary care and using digital technologies to reduce the number of traditional outpatient clinics)
- Primary Care reform e.g. groups of practices coming together to provide certain services.

The SRG noted that consideration would have to be given as to how to engage with the traditionally hard to reach groups. Vicky Le Grys explained that the UHB's Communications team were developing a robust communications plan and Anne Wei was looking specifically at how the UHB could should engage with these hard to reach groups.

The SRG suggested that there should be a focus on health promotion and encouraging people to take more responsibility for their own health and wellbeing and making good lifestyle choices.

SRG 21/09 KEEPING ME WELL WEBSITE

Rachel Wallbank and Luke Fox explained the background to the UHB's 'Keeping Me Well Website', a link to which had been circulated to the SRG in advance of the meeting.

The website has been developed as a rehabilitation, therapist led, first-line intervention to support self-management and recovery strategies for the identified four populations of those affected by C-19:

1) those individuals recovering from COVID;
2) those awaiting paused care who may as a consequence have a deterioration in their functioning;
3) those individuals who haven't accessed care and maybe at risk of deterioration of function; and
4) those individuals who are vulnerable and may be shielding, where isolation may cause increased risk of reduced activity/deconditioning and significant risk of reduction in mental and physical wellbeing.

The SRG was informed that circa 10% of C-19 patents develop enduring symptoms sometimes described as long COVID, Their pathway to recovery should be via supported self-care. Initial data from the Kings Colle London App suggests that 'long COVID is more prevalent amongst the mid-40s to mid-50s age group and mainly amongst women with co-morbidities. Anecdotally most of those with Long COVID do not appear to have been hospitalized.

The SRG was then asked the following specific questions:

- Do you think we have covered those populations mentioned? What have we missed?
- The site needs to be accessible to all including those marginalised by difficulties accessing digital resources. Any suggestions on how we tackle this?
- Is the site easy to navigate? Are the pages easy to read? Is the language accessible?

The SRG made several observations.

- The website is extremely helpful
- Consideration should be given to how those with sight loss can access the resources. Luke Fox explained that software to assist those with sight loss was being considered.
- Are there opportunities to share the website with other Health Boards? Luke Fox reported that he was aware that some other Health Boards had directed their populations to the website.
- Consideration could be given to imparting some of the information via telephone calls.
- The third sector could be used to get the information out to hard to reach communities.
- Consideration could be given to including a simple diagram that explains what resources are available for specific symptoms.
- It would be helpful to have data on website usage.
- There should be a section where users can leave comments. Rachel Wallbank confirmed that there would be a section at the end of the website asking for patient feedback.

SRG 21/10 NEXT MEETING OF SRG

Microsoft Teams meeting, 9.30am-12pm Tuesday 23 March 2021.

CONFIRMED MINUTES OF THE HEALTH AND SAFETY COMMITTEE HELD ON 5th JANUARY 9:00AM
VIA MS TEAMS

Chair:		
Akmal Hanuk	AH	Independent Member – Local Community (Committee Chair)
In Attendance:		
Rachael Daniel	RD	Interim Head of Health and Safety
Martin Driscoll		Executive Director of Workforce & Organisational Development
Stuart Egan	SE	Staff Safety Representative
Nicola Foreman	NF	Director of Corporate Governance
Michael Imperato		Independent Member – Legal
Geoff Walsh	GW	Director of Estates, Capital and Facilities
Secretariat:		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Janice Aspinall	JA	Staff Safety Representative
Fiona Jenkins	FJ	Director of Therapies and Health Sciences
Fiona Kinghorn	FK	Executive Director of Public Health Wales

HS 21/01/001	**Welcome & Introductions** The Committee Chair (CC) noted that the meeting was not quorate. The Director of Corporate Governance (DCG) advised the Committee that if any decisions needed to be made, they would go to the Board.	**Action**
HS 21/01/002	**Apologies for Absence** Apologies for absence were noted.	
HS 21/01/003	**Declarations of Interest** There were no declarations of interest.	
HS 21/01/004	**Minutes of the Committee Meeting held on 24th November 2020** The Committee reviewed the minutes of the meeting held on 24th November 2020. **Resolved – that:** (a) The Committee approved the minutes of the meeting held on 24th November 2020 as a true and accurate record.	

HS 21/01/005	**Action Log following the Meeting held on 24th November 2020** The CC noted that the Actions in progress would be discussed at the meeting with the exception of **HSC: 19/10/009: HSE Inspection** The Interim Head of Health and Safety (IHHS) advised the Committee that no date had been set for the Health and Safety Executive (HSE) inspection and that due to COVID-19 the inspection had fallen off the HSE agenda.	
HS 21/01/006	**Chair's Action taken since last meeting** No Chair's Action were noted.	
HS 21/01/007	**Health and Safety Policies Schedule** The IHHS advised the Committee that at the last Health and Safety meeting she had noted to the Committee that a number of policies were out of date and needed review. She also advised that there would be a 12 to 18 month extension due to the ongoing COVID-19 pandemic The IHHS advised the Committee that she had added an extra column to the schedule to note when the review date should be. The IHHS gave the Committee assurance that the policies that had not been reviewed did not have any major content that required change and that the policies remained valid. The CC asked that in regards to the current COVID-19 situation, was the Health Board exposed to any areas where it needed a new policy or needed to update one. The IHHS responded that the team were looking at a policy around Protective Personal Equipment (PPE) and that work was ongoing. The CC asked if this policy was a new one or if it would be added onto an existing policy. The IHHS responded that it was a new policy and that a draft should be completed by the next Health and Safety Committee meeting being held in March 2021. The CC noted to the Committee that it was an important area of risk, specifically in regards to the pandemic and that it should be taken up as a priority. The IHHS responded that we do not have a policy in place at present but there were a number of documents in the background in relation to standard operating procedures and that the policy would formalise the position. The CC asked how the documents were being communicated. The IHHS responded that it varied and specific departments received relevant information based on their requirements. An example being that any service requiring airhoods would receive that information but services not using them would not.	

	The IHHS advised the Committee that information could also be obtained on the COVID website and Health and Safety website. The IHHS confirmed that there was also a PPE cell meeting for clinicians to receive information and updates. The CC advised the Committee that he was cautious a PPE Policy was not in place but confirmed that if members were assured by the IHHS's comments then the meeting could continue. The Executive Director of Workforce & Organisational Development (EDWOD) asked if Cardiff and Vale University Health Board were in the same position as other Health Boards in Wales and asked if they had policies in place already. The IHHS responded that there was an intention for an All Wales approach and to share as much information as possible so that Health Board's were not reinventing the wheel. The IHHS confirmed that she would query the position with other Health Boards to compare. The CC confirmed that this would be beneficial. **Resolved:** a) The Committee noted the contents of the report.	
HS 21/01/008	**Priority Improvement Plan – Verbal Update.** The IHHS advised the Committee that the Priority Improvement Plan (PIP) needed a complete overhaul and that this would be done in conjunction with the new Head of Health and Safety who was due to start in February. The IHHS noted that the PIP would be in line with the risk register and would be fully reviewed to look at where the organisation would be when coming out of the COVID-19 pandemic. The CC asked if it was an internal appointment for the new Head of Health and Safety. The EDWOD responded that it was an external appointment –and that a recruitment consultant was used. He noted that the new recruit was currently the Head of Health and Safety for BOC and was an Engineer by background. The Independent Member – Legal (IML) asked when the new Head of Health and Safety would attend their first Health and Safety Committee Meeting. The IHHS responded that the first meeting would be 30th March 2021. The IML noted that the new Head of Health and Safety would have been in post for 2 months by then and asked what the Committee would be expecting them to have ticked off by their first meeting.	

	The EDWOD responded that the anticipation was that they would hit the ground running. He noted that the IHHS and he had prepared a full induction programme and that the new recruit would be meeting members of the Committee. The CC advised the Committee that it was important to give the new recruit a good briefing in terms of where the Health Board was in relation to Health and Safety and to use their experience and knowledge. The CC advised the Committee that we hold an agenda item for them at the next meeting for an overview in line with the new Head of Health and Safety's initial findings. **Resolved:** a) The Committee noted the Priority Improvement Plan	**RD**
HS 21/01/009	**Fire Enforcement Report** The Director of Estates, Capital and Facilities (DECF) advised the Committee that there had been no activity in terms of audits from the enforcing authority as they had been preoccupied during the COVID-19 pandemic. The DECF noted to the Committee that there had been a decrease in unwanted fire signals and advised the Committee that there had been a reduction in fire activity across all sites. The DECF advised the Committee that in regards to fire training there was online training available but unfortunately there was a statutory obligation for clinical teams to have face to face training on an annual basis. This was a significant issue at the time of the meeting but had been an issue prior to COVID-19 due to staffing levels. The DECF advised the Committee that staff were under enormous pressures and it proved difficult to get close to the required target of staff undertaking face to face training. The DECF felt that it needed to be noted that the Health Board was not compliant on this issue. The DECF advised the Committee that additional staff had been brought in which included ex fire safety officers who would be manning the helideck at the University Hospital of Wales (UHW) and would provide cover for the Lakeside Wing. The IML asked how the management of Health and Safety areas was going in regards to the new Lakeside Wing. The DECF responded that he had had meetings with Executives about how to move forward with fire safety in that area. He advised the Committee that they had adopted the same approach as the Dragon Heart Hospital (DHH). This would provide cover from ex fire service officers who would be able to fight fires rather than just assist with evacuation.	

The DECF advised the Committee that a lot of clinical staff were needed to evacuate a ward and that it would not be possible with current staffing levels which is why ex fire service officers had been brought in.

The DECF advised the Committee that there had been pressures on Portering and Security services who were part of the firefighting team. A number of staff had been in self-isolation, shielding and reduced numbers in those areas necessitated bringing in support from Cardiff airport in relation to the staffing of the helideck.

The EDWOD advised the Committee that he hoped that the Lakeside Wing would not need to be at full capacity

The CC thanked the DECF for his hard work and raised two areas of concern.

1) Face to face training was a statutory requirement. The CC asked if there was a way to mitigate that and he commented that the fact the organisation was not compliant was worrying.

The DECF responded that it was not a problem for his team as they had the capacity to train. The pressure was due to staffing levels.

The DECF advised the Committee that it would be difficult taking staff out of areas where there were already staff members self-isolating, shielding or off sick. The pressures on Nursing and Medical were equally as bad.

The DECF advised the Committee that a large recruitment drive had occurred with Human Resources supporting.

2) The length of training.

The DECF responded that the training took a few hours.

The EDWOD responded that he had and his team had looked at options to undertake training offline and how to engage with the Health and Safety Executive (HSE). He advised the Committee that an offer of remote training was something that could be done because other areas of the UK such as law courts were managing to provide courses such as the Speed Awareness Course virtually.

The EDWOD advised the Committee that the United Kingdom had recognised the position and this is why the Health Board needed to liaise with the HSE. He advised that this would be rolled out in 2021 and that by that stage the organisation should be meeting the statutory requirements.

The CC advised the Committee that he would be keen to keep this item on the agenda moving forward and to monitor progress at future Committee meetings.

Resolved:

a) The Committee considered the on-going efforts to meet the requirements of fire safety enforcement action.

HS 21/01/010	**Enforcement Agencies Report** The IHHS advised the Committee that since the last meeting there had been 1 new correspondence from the HSE in relation to a steam boiler in University Hospital Llandough (UHL). It was examined by a competent person and found to have 1 defect. The Health Board responded accordingly to the HSE and there had been no correspondence since so it was assumed that the case was closed. The IHHS advised the Committee that there had been 2 updates for noting since the last meeting. 1) HSE were investigating the death of a member of staff who had tested positive for Covid-19. Since the report had come out a formal update had been provided from HSE and who noted that it was not RIDDOR reportable so they did not consider it a work related death. This item is closed. 2) Communication from the HSE on the 11th November 2020 in relation to face fit testing practices in a Nursing Home. A meeting took place with the IPC Department on 20th November 2020 to address the concerns raised by the HSE. The IHHS advised the Committee that the Health Board had received a Notification of Contravention in respect of Face Fit Test reports and that the report used by the Health Board did not contain all the information required by HSE guidance. This was rectified and the correct form is now used. The IHHS advised the Committee that the Health and Safety team took on face fitting at the beginning of the COVID-19 pandemic and that since then the team's main role was taken over by fit testing. This was being undertaken 5 days a week. The IHHS advised the Committee that Clinical Boards (CB) should be doing fit testing and that there was a plan in place for this albeit, it was a lengthy process. The Intention was that the Health and Safety department would pick up any exceptions and the rest of the fit testing would be taken up by CBs. It was noted that during more challenging times CB's could not release staff so the Health and Safety team were undertaking more fit testing centrally. The CC asked the IML if he was aware of any background information regarding the death of a staff member. The IHHS responded that the investigation had looked at the timeline of where the staff member was working and 14 days prior to that. The investigation looked at the patients on the ward at the time and their COVID-19 status and had looked at PPE requirements at the time and if there had been any breaches. What the investigation found was that all correct procedures had been in place. The IML asked if any other Health Board's in Wales had been investigated in similar situations.	

	The IHHS responded that as far as she was aware, no other Health Board had been investigated. She noted that the HSE were asked to investigate by the coroner. The Staff Safety Representative (SSR) advised the Committee that he was concerned by the Health Board not reporting staff who had fallen victim to COVID-19. He noted that teams were well aware of outbreaks in wards and in mental health for example where Staff had contracted COVID-19 and had not reported anything under RIDDOR. The SSR advised the Committee that such incidents should be reported and that there would clearly be cases for people looking for compensation who had fallen ill by going to work. The IHHS responded that the HSE treated outbreaks very differently to the Health Board and that they did not look at those outbreaks under RIDDOR and needed very clear evidence that the infection was work related. At the time of the meeting it remained very difficult to prove transmission at work because COVID-19 was very prevalent in the community. The CC advised the Committee that he took assurance from what the IHHS had shared. The CC commented that there were a number of areas to learn from which it was important for the committee to be aware of. The CC noted that resources were stretched and had been insufficient to enable a full review of some of the key areas on the agenda. The CC asked what the cause of this was, what were the constraints and how were plans to resolve the issues to be implemented. He added that if there was a resource issue it should be discussed and then presented to Board. The IHHS responded that the Health and Safety department were taking on things that had not been in their remit previously and that meant the normal day to day role of the Health and Safety team was not always being followed up. The Health and Safety team had an advisory team and a training team and that as of the previous day there were 4 members off work with COVID-19 from the training team. The EDWOD advised the Committee that there were similar stories across the organisation from clinical departments who had been taking down services or finance, HR, Procurement etc who were struggling with numbers. The EDWOD shared that the things that the Health Board wanted to do were on hold and he advised the Committee that it would not be helpful to detail what was not being done. He hoped that the Committee recognised the position and realised that staff were doing the best they could. The SRR advised the Committee that the people left behind were taking up the slack and were prioritising the work. The CC agreed that it was a very difficult time and he stressed that the point he tried to raise was that in terms of the UHB's priorities, the Health	

	and Safety Committee should clearly set the priority items in relation to COVID-19 and winter pressures. **Resolved:** a) The Committee noted the contents of the report.	
HS 21/01/011	**Committee Terms of Reference & Work Plan for 2021-22** The DCG advised the Committee that there were very few changes for the next financial year and advised the Committee that the Deputy Chief Operating Officer (DCOO) had been added to the work plan as it was intended that she would be the Executive Lead who would be taking over from the EDWOD when he left the Organisation. The DCG advised the Committee that the Committee was currently under review as to whether it should remain a Committee of the Board and noted that if it did not remain it would likely report into the Quality, Safety and Experience Committee or the Strategy and Delivery Committee and the Terms of Reference would require amendment to take that into account. The DCG advised the Committee that there was no statutory requirement for it to be a Committee of the Board but that discussions were ongoing so it would continue to report to the Board. **Resolved:** a) The Committee noted and agreed the Terms of Reference and Work Plan update.	
HS 21/01/012	**Sub Committee Minutes:** **i. Operational Health and Safety Group –** The EDWOD advised the Committee that there was nothing to raise and that the papers should be taken as read.	
HS 21/01/013	**Self-assessment of Committee Effectiveness & Forward Action Plan** The DCG advised the Committee to be aware that the self-assessments had been to all other Committees of the board and that it was slightly delayed in coming to this Committee. The DCG advised that another self-assessment of the Committee was due in April. The DCG advised that the report was shared for noting and that she would pick up any actions with the CC directly and make sure that the committee were on track to complete the effectiveness reviews and forward action plans. **Resolved:**	

	a) The Committee noted the results of the Committee's self-assessment Effectiveness Review for 2019-20. b) The Committee approved the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.	
HS 21/01/014	**Environmental Health Inspection Report – Verbal Update** The IHHS advised the Committee that Environmental Health were not prioritising inspections and that there had not been any inspections since the last meeting. There was no indication of when inspections would recommence. The CC asked if everything was still being done as it should be had inspections continued. The DECF responded that they were still doing what should be done and had appointed an Environmental Health Officer who would start the following week and would be undertaking internal audits and making sure that nothing fell by the wayside. The CC asked for an update at the next Committee meeting. **Resolved:** a) The Committee noted the Environmental Health Inspection Report	**GW**
HS 21/01/015	**Items to bring to the attention of the Board/Committee** No items were referred to the Board or other Committees.	
HS 21/01/016	**Review of the Meeting** The CC welcomed comments from the Committee. The IML commended the CC for moving through the agenda quickly. The CC asked to reiterate his thanks to the executive members and their teams.	
HS 21/01/017	**Date and time of next Meeting** **30th March 2021 – 9am** **MS Teams**	

GIG CYMRU NHS WALES | Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 10 NOVEMBER 2020 AT 09:30HOURS VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner
Judith Paget	Chief Executive, Aneurin Bevan ABUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
Carol Shillabeer	Chief Executive, Powys PTHB
In Attendance:	
Steve Ham	Chief Executive Officer, Velindre NHS Trust
Hannah Evans	Director of Transformation, Swansea Bay SBUHB
Gavin Macdonald	Interim Chief Operating Officer, Betsi Cadwaladr UHB
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Assistant Director of Quality and Patient Experience
Ricky Thomas	Head of Informatics, National Collaborative Commissioning Unit (NCCU)
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust
Shane Mills	Director of Nursing and Quality, National Collaborative Commissioning Unit

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 20/86	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to he virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee. Paul Mears was welcomed to his first meeting.	Chair
EASC 20/87	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Gill Harris, Tracy Myhill, Tracey Cooper and Gwenan Roberts.	Chair
EASC 20/88	**DECLARATIONS OF INTERESTS** There were no additional interests to those already declared.	Chair

EASC 20/89	**MINUTES OF THE MEETING HELD ON 8 SEPTEMBER 2020** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 8 September 2020. Members **RESOLVED** to: • **APPROVE** the Minutes of the meeting held on 8 September 2020.	Chair
EASC 20/90	**ACTION LOG** Members **RECEIVED** the action log and **NOTED** specific progress as follows: **EASC 20/45 & 20/57 Learning Lessons of working during a pandemic** To be received at the next meeting (added to the Forward Look). **EASC 20/57 Unscheduled Care Dashboard** Stephen Harrhy updated Members by explaining that progress had been made in the work to develop the Unscheduled Care Dashboard. Specification has been developed following work with health boards which would be circulated (added to the Action Log) and external funding had been confirmed. A tender process would soon commence. **EASC 20/57 Healthcare Inspectorate Wales (HIW) Report** The report has been circulated. **EASC 20/60 Governance Update** A report would be received at the next meeting (added to the Forward Look). **EASC 20/70 CASC as Co-Chair Task and Finish Group** Members noted the ongoing work with the Fire and Rescue Services in relation to their work as first responders. Stephen Harrhy agreed to provide an update on the work at the next meeting (added to the Action Log). **EASC 20/73 EASC allocation letters for Major Trauma Services and Critical Care Transfer Services** Stephen Harrhy confirmed that the allocation letters had been received for Major Trauma and Critical Care Transfer Services from the Welsh Government and discussions had commenced with providers. Information related to potential slippage would be included in the next finance report.	CEO WAST CASC Completed Ctte Sec CASC CASC & Director of Finance

	EASC 20/74 Serious Adverse Incidents (SAIs) In relation to the benchmarking information requested, Jason Killens confirmed that the National Quality Group of UK Ambulance Services are developing a snapshot across all Ambulance Services in the UK which will be shared when received. Members **RESOLVED** to: • **NOTE** the Action Log.	CEO WAST
EASC 20/91	**MATTERS ARISING** There were no matters arising.	
EASC 20/92	**CHAIR'S REPORT** The Chair's report was received. Members **RESOLVED** to: • **NOTE** the Chair's report.	
Part 2. ITEMS FOR DISCUSSION		**ACTION**
EASC 20/93	**CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT** The Chief Ambulance Services Commissioner's (CASC) report was received. In presenting the report, Stephen Harrhy highlighted the following key items: • Ministerial Ambulance Availability Taskforce Members noted that letters were in the process of being sent to the Taskforce Members outlining the approach being taken and the plans for the production of the Interim Report which would be submitted to the Minister at the end of the year. The Taskforce would be asked to critique the key documents and reviews which have been completed on ambulance services. The aim will be to update the EAS Joint Committee and its sub groups as often as practicable (Added to the Action Log). • Ambulance Quality Indicators (AQI) Members noted that the AQIs were now being published again following the pause due to the pandemic and they were backdated to cover the whole year. • Emergency Medical Retrieval and Transfer Service (EMRTS) Capital funding was being sought to support the service direction, particularly for 24/7 working and additional vehicle requirements. Some revenue slippage has been utilised to lease vehicles which would then need to be resolved in 2021. No issues were raised by Members concerning this approach.	CASC CASC / Director of Finance

	• Non-Emergency Patient Transport Service (NEPTS) Members noted that the timescales for transfers had been brought forward for Aneurin Bevan, Betsi Cadwaladr and Cwm Taf Morgannwg University Health Boards and Powys Teaching Health Board, with the expectation that all transfers would be completed by mid-2021 Stephen Harrhy thanked the health boards for their support in moving forward the agreed collective approach. • Revising EASC Integrated Medium Term Plan The EASC IMTP was discussed at the EASC Management Group and a summary had been provided to Members to ensure that the revised priorities were supported. WAST explained that they welcomed the new approach and were working closely with the EASC Team on the detail. The key deliverables were clarified in order to lead to a balanced approach. No issues were raised by Members to this approach. • Ministerial Ambulance Availability Taskforce Further progress had been made on arrangements for the Taskforce. An interim report was planned for submission before the end of the year. The report would be shared with Members and would be discussed in detail at the meeting in January 2021 (Added to the Action Log). • Beyond the Call Shane Mills was invited to present the findings of the work commissioned by the Welsh Government through the Mental Health Crisis Care Concordat – National Review of Access to Emergency Services for those experiencing mental health and or welfare concerns, report title 'Beyond the Call'. Members noted the importance of language and how mental health services were described. Mental health was referred to as those with a diagnosed mental health disorder and welfare concerns such as social issues and housing, which has an impact on mental health. The review would be published in November and would be shared widely in the system. Members noted the barriers to access to services which were compounded by mental health, including the stigma attached to it. The review involved all agencies across health and social care and also wider public services such as the police and fire and rescue services. Opportunities were highlighted such as the 111 service as well as a range of other "in hours" and "out of hours" services.	CASC

	The Review recommended further work to enhance the 111 service in Wales which has also been supported by the 111 service board. The Review captured the missed opportunities, supported by data, although this was more difficult in social care. The role of the Police within mental health was also captured and this constituted 9-15% of their daily calls. A bespoke data collection was created and 10,000 calls used which were broken down into 17 index areas. The Review was also supported by an expert reference group. Shane Mills gave an overview of the findings of the data and the inter-connectedness in terms of how and when people accessed services. Members noted the breakdown of information by gender and age, type of caller (self-callers or public), time spent on the phone and the overall time spent. There were 10 recommendations made by the Review which included ensuring real time data and effective multiagency collaboration. Members noted other areas of ongoing work included an access review with MIND and also a conveyance review. Carol Shillabeer added the key drivers in terms of the work identified by the Police and it was important to work closely with them to develop the Review, which has led to a generally better understanding with the Police. In terms of services across Wales there is variability in provision but work to streamline the model in Wales, and potentially a once for Wales approach, can be progressed. Members discussed the prevalence of mental health demands during the pandemic and whether a once for Wales approach could be achieved and how to simplify access for people. Jason Killens also shared WAST's findings that having mental health practitioners in the call centres had been very well received during the pandemic. The link between drug and alcohol use was discussed and it was confirmed that a strong relationship had been identified in the Review. Members were keen to have actions to take forward in each area to ensure that the findings of the review were acted on. Members noted that the Review would be formally presented to the Minister with responsibility for Mental Health services and Mental Health Crisis Care Concordat. The recommendations had been discussed with the 111 service board and further opportunities would be progressed. Mental health practitioners would be available in the WAST control centres over the winter. Khan Raj 05/20/2021 15:17:34	

	Members noted that further work to clarify the next steps and the governance routes would take place and further information would be shared at the NHS Wales CEO group. Shane Mills was warmly thanked for the helpful presentation and he agreed to share the final version of the document with Members (Added to the Action Log). • Commissioning Intentions Members noted a more streamlined approach would be taken and this had been discussed at the EASC Management Group. The approach would take account of the emerging context and a further iteration would be taken to the EASC Management Group for further development before being presented at the next EASC meeting (Added to the Forward Look). The Chair thanked Stephen Harrhy for his report and Members **RESOLVED** to: • **NOTE** the Chief Ambulance Services Commissioner's report	Carol Shillabeer Ctte Sec CASC
EASC 20/94	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) PROVIDER REPORT** The update report from the Welsh Ambulance Services NHS Trust (WAST) was received. Members noted: • Covid Pandemic Abstractions had risen, slightly less than the peak of the first wave and had triggered the tactical approach to production. This included using staff from 3 Fire and Rescue Services on a regular basis to support production for the front line. Jason Killens offered to bring forward the lessons learned from the first wave to the next meeting (added to the Action Log). • Health and Safety Executive (HSE) Members noted the update which related to the wearing of personal protective equipment (PPE). As a result policies had been updated and the dialogue with the HSE had been helpful with a number of meetings held. Progress was being made and the approach by WAST had been appropriately adjusted. • Clinical Indicators / Clinical Outcomes Jason Killens gave an overview of the work related to the electronic case card (moving away from the digital pen). A supplier has been identified and capital funding secured for implementation towards the end of next year. This would enable a greater understanding related to outcomes and over time this will allow informed adjustments to the service.	CEO WAST

	Members noted that there was a training requirement, some could be undertaken on line and some would also need to be face to face. Some modifications and testing would be also required. The issues of interoperability with emergency department systems was also raised and Members were assured that this was a function of the system. This would happen in a phased way and linking to the Welsh Clinical Portal and other different systems across NHS Wales in due course. • Non-Emergency Patient Transport Services (NEPTS) In keeping with the requirement for social distancing this was having an impact on the service because vehicles were restricted in the number of patients they could accommodate. This issue was being discussed at the NEPTS Delivery Assurance Group. • Emergency Medical Services Demand and Capacity Review Members were reminded that the staff growth had been planned for a further 136WTE this year and good progress had been made with the expectation that this target would be met by the end of year. This was having a positive impact in the unit hours of production (UHP) which was very encouraging. Members asked: In terms of production hours and the impact of the investment in line with the Demand and Capacity Review Members asked regarding the forecasting and the impact over the winter months. Members noted that 100% of the rosters equated to 119,000-120,000 hours. The figures in October were similar to earlier in the year due to various reasons. The forecasting into the winter used various scenarios including normal winter demand and high levels of Covid. The aim would be to get to 107% of roster fills (113% would be the maximum fill due to vehicle availability). In terms of the urgent care system and the inter-operability opportunities, Members noted that the unscheduled care dashboard work was currently at the tender process stage and further information would be available in due course (Added to the Action Log). Members **RESOLVED** to: • **NOTE** the WAST provider report.	NEPTS DAG CASC

EASC 20/95	**FOCUS ON – SYSTEM PRESSURES** Stephen Harrhy introduced the session and provided some context in relation to the purpose of the session. A presentation had been shared with Members which concentrated on the commissioner perspective on planning and securing sufficient ambulance services for the population of Wales within the context of severe system pressures. In terms of the WAST Demand Management Plan (WAST DMP) at level 5 or 6 Members noted that this would mean that WAST would not be able to send a resource to any caller. This was felt to be an extreme position and that every opportunity should be taken to try and avoid such occurrences. The aim of the session was to: • Ensure ambulance availability - actions to take over handover delays and WAST actions to maximise resources available • Understand the impact of escalation across the system as a whole – on both health boards and WAST. • How health boards and WAST work together and the regional solution • Align escalation plans with Covid learning • Capacity for alternatives for demand management • Find the tolerances • Identify actions to take. Members agreed to this approach. Ross Whitehead gave the presentation, again highlighting the commissioner perspective to plan and secure sufficient ambulance services for Wales. On a few occasions recently, the WAST DMP had been triggered and these system pressures challenged the ability of the Committee to meet with its statutory obligation. Members noted that WAST had undertaken modelling forecasts in line with the expectations of the Welsh Government in relation to the impact of the pandemic and many forecasts indicated that WAST would not reach the 65% performance target for red calls. An overview of incident demand, attended scene, attended hospital and lost hours was provided. Members noted the specific impact of the pandemic on service provision as well as the data and the actions already taken in terms of recruitment, establishing the Operational Delivery Unit, the doubling of handover delays since August and the WAST DMP level 6 triggered on more than one occasion.	

	Members noted the modelling and scenario plans for worst case, most likely in high covid levels and most likely in low covid levels. In terms of the collective position and the actions required to deliver the statutory requirements this winter, Members noted the key areas of efficiencies, investment and additionality opportunities for the operational delivery unit and handover delays. The modelling that had been undertaken had assumed 90% of the handover delays experienced in 2019. Members discussed the ongoing system pressures, and in particular for health boards, with regard to handover delays at emergency departments. Stephen Harrhy also confirmed that the work undertaken by Improvement Cymru would also inform the process going forward. Members supported the requirements to maximise the availability of ambulances this winter, the need to have a focus on reducing harm and improving quality and patient outcomes and the need to act in a proactive way starting from a Health Board footprint but to engage collectively on a regional basis where this was **needed by exception**. Members committed particularly to the following actions: **Ambulance Resource –** Central funding has been provided to support WAST to staff rosters up to the fleet maximum of 113%. Funding for this would come centrally from the winter protection fund and WAST should maximise available resource with immediate effect. Stephen Harrhy agreed to circulate a report on securing additional NEPTS capacity as part of the Q3 and Q4 winter protection plan (Added to the Action Log). **Resource Efficiency** – Members agreed that WAST should effectively target this additional resource to times of the day, dates and regions where there was currently a mismatch between demand and capacity. **Safe cohorting of patients / patient offload Department (POD) staffing and operating model** – Members recognised the role that the safe cohorting of patients would have this winter in enabling the timely release of ambulances and Stephen Harrhy agreed to work with WAST and the relevant health boards to find a solution to staffing and agreeing the operating model for these areas for this winter (Added to the Action Log).	CASC CASC

	Operational Delivery Unit (ODU) – Members recognised the role of the ODU in supporting system level information flow and recognised it needed to develop further to support the system. Members agreed that Health Boards should proactively maximise their own capacity prior to requiring regional support. Stephen Harrhy agreed to continue to work with the Chief Operating Officers (COOs) on this to agree scope and responsibilities and to develop the operating model for the ODU (Added to the Action Log).	Health Boards CASC
	Information – Members recognised the opportunities that were currently available for sharing information between WAST and Health Boards and the additional opportunities that an expanded unscheduled care dashboard and 'signals for noise' present us with. Jason Killens agreed to review and enhance the data provided regularly to Health Boards with a focus on a range of the Ambulance Quality Indicators (AQIs) (Added to the Action Log), Stephen Harrhy agreed to work with the NHS Wales Informatics Service (NWIS) to provide an immediate Business Intelligence based solution and to move forward the on-going procurement of a dashboard and supporting data infrastructure to have a single view in health boards and WAST (Added to Action Log).	CEO WAST CASC
	Handover Levels – Members discussed the importance of minimising patient handover lost hours and the requirement to maintain levels **below 150 hours per day** as any level above this would be challenging from a resource availability perspective (Added to the Action Log). Members also discussed the importance of turning vehicles around quickly and adopting a 'no tolerance' approach to delays over 1 hour.	Health Boards and WAST
	Escalation – Members agreed that a standardised approach to escalation (and the level within organisations) with a focus on proactive actions, quality improvement and harm reduction would be necessary and helpful for providing clarity on responsibilities and actions at all levels of escalation, both at Health Board level and in WAST. Stephen Harrhy agreed to take this work forward and would circulate a draft proactive proposal to Members (Added to the Action Log).	CASC
	Post Production Lost Hours – Members agreed that quick progress was required on the understanding and reduction of post-production lost hours particularly those associated with rest breaks. Members discussed the need to provide WAST with support and cover for this, recognising that it would be a challenging ask.	

	Jason Killens agreed to respond to Stephen Harrhy on this issue and clarify his thoughts on potential ways forward (and learn from other services and reviews) which would be shared with all Members (added to the Action Log). Members **RESOLVED** to: • **NOTE** the presentation and action the areas agreed above.	CASC & CEO WAST
Part 3. ITEMS FOR APPROVAL OR ENDORSEMENT		**ACTION**
EASC 20/96	**FINANCE REPORT** The EASC Finance Report was received. Members noted the stable position. Further work would be undertaken to include critical care and for the Emergency Medical Retrieval and Transfer Service. Work continued to monitor the additional funding provided for additional staff in WAST, out of hospital care and winter planning. Members **RESOLVED** to: • **APPROVE** and **NOTE** the report.	Director of Finance
EASC 20/97	**EASC SUB GROUP MINUTES** Members received the confirmed minutes of the EASC Sub Groups as follows: • EASC Management Group - 27 Aug 2020 • NEPTS Delivery Assurance Group – 18 Aug and 29 Sept 2020 • EMRTS Delivery Assurance Group – 16 June 2020. Members **RESOLVED** to: • **APPROVE** the confirmed minutes as above.	CASC
EASC 20/98	**EASC GOVERNANCE INCLUDING THE RISK REGISTER** The EASC Governance report was received. In presenting the report Stephen Harrhy explained that two risks had been escalated on the risk register namely the performance in the red and amber categories. Members **RESOLVED** to: • **APPROVE** the risk register • **NOTE** the governance report and the requirement for the effectiveness survey. Khan Raj 05/20/2021 15:17:34	CASC

EASC 20/99	**FORWARD PLAN OF BUSINESS** The forward plan of business was received. Members noted that further work was required on the Emergency Medical Service (EMS) Framework. Further work would take place outside of the meeting to suggest the next Focus on topic. Following discussion, Members **RESOLVED** to: • **APPROVE** the Forward Plan.	Chair
Part 4. OTHER MATTERS		**ACTION**
EASC 20/100	**ANY OTHER BUSINESS** One further item of business was raised at the meeting. Jason Killens suggested that the NEPTS Delivery Assurance Group could discuss discharge planning across the winter. Ross Whitehead suggested as time was a major factor in this matter as well as access to providers and offered to write to WAST with some proposals which was agreed by Members.	CASC

DATE AND TIME OF NEXT MEETING		
EASC 20/101	A meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 9 March 2021 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

Khan Raj
05/20/2021 15:17:34

LOCAL PARTNERSHIP FORUM MEETING

Wednesday 16 December 2020 at 10am, via Teams

Present	
Mike Jones	Chair of Staff Representatives/UNISON (co-Chair)
Rachel Gidman	AD of OD(co-Chair)
Martin Driscoll	Exec Director of Workforce and OD (part of meeting)
Julie Cassley	Deputy Director of WOD
Fiona Jenkins	Exec Director of Therapies and Health Sciences
Fiona Kinghorn	Exec Director of Public Health (part of meeting)
Andrew Crook	Head of Workforce Governance
Len Richards	Chief Executive (part of meeting)
Fiona Salter	RCN
Rhian Wright	RCN
Abigail Harris	Executive Director of Strategic Planning
Chris Lewis	Interim Director of Finance
Steve Gauci	UNISON
Rebecca Christy	BDA
Jonathan Strachan-Taylor	GMB
Joe Monks	UNISON
Lianne Morse	Head of HR Operations
Zoe Morgan	CSP
Nicola Foreman	Director of Corporate Governance
Peter Hewin	BAOT/UNISON
Ceri Dolan	RCN
Stuart Egan	UNISON
Caroline Bird	Deputy COO
Mat Thomas	UNISON
Dawn Ward	BAOT/UNISON
Ruth Walker	Executive Nurse Director (part of meeting)
Apologies	
Pauline Williams	RCN
Secretariat	
Rachel Pressley	Workforce Governance Manager

LPF 21/001 WELCOME AND APOLOGIES

Mr Jones welcomed everyone to the meeting and apologies for absence were noted.

Mr Jones noted that was Mr Driscoll's last LPF meeting and wished him the best for the future. Mr Richards agreed, thanking Mr Driscoll for his work over the last three years, not least for the way he and Mr Jones had worked together. He noted that Rachel Gidman would be acting as Interim WOD Director from 1 March 2021.

LPF 21/002 Declarations of Interest

Dr Jenkins declared that she also sits of the Board of Cwm Taf Morgannwg Health Board.

LPF 21/003 MINUTES OF THE PREVIOUS MEETINGS

The minutes of the meetings held on 10 December 2020 and 16 December 2020 were agreed to be accurate records.

LPF 21/004 ACTION LOG

The Action Log was noted.

LPF 21/005 MASS VACCINATION PROGRAMME

Mrs Kinghorn advised the Forum that she was the strategic lead for the Mass Vaccination Programme and Mrs Walker was the operational lead.

The programme was going well and was on schedule to have delivered the first vaccine to the first 4 priority groups by the middle of February. An overarching dashboard had been developed and would be shared with the Forum, though there some areas which still needed to be refined including the figures for care homes. It was known that some people would refuse the vaccine, but so far the uptake had been very encouraging.

The mass vaccination centres in Barry and Pentwyn were now open in addition to the one in Splott and any teething problems around issues such as parking were being ironed out with the Local Authorities.

Work was taking place with partners in the BAME Community and within other seldom heard groups e.g. the homeless to encourage uptake.

Mrs Kinghorn noted that there would be a dip number of vaccinations delivered over the next couple of weeks due to a reduction in supply of the Astra-Zeneca vaccine, but it would then significantly increase. Pfizer supplies would be used primarily for individuals who were due to receive their second dose.

Mrs Walker asked members of the Forum to pass on her thanks to staff. She acknowledged that there are had been some initial issues around training but the programme had been refreshed to overcome these.

Mrs Kinghorn advised that Jonathon Grey, Director of Transformation, was working with the Local Authorities to see how the programme could be scaled up to vaccinate as much of the under 60s population as possible in a quicker way. Mr Richards indicated that this proposal had been well received and there would be a meeting the following day to discuss it, however, it would require agreement with Welsh Government, especially in relation to vaccine supply.

Mr Hewin said that while he understood the decision to extend the period between the first and second dose from 3 to 12 weeks had not been a Health Board decision, staff were very concerned about it. He asked if it was possible to ensure that everyone had a second dose within 12 weeks. Mrs Kinghorn advised that the second dose would be booked at the same time as the first one, and WG was keeping sufficient supplies of the Pfizer vaccine back to ensure that there was enough. The Astra-Zeneca supply was being managed locally but she anticipated that there would be plenty.

Miss Ward asked what the strategy for communicating and dealing with staff who opted out of immunisation was. Mrs Kinghorn reminded the Forum that vaccination was not mandatory but that she hoped staff would want to take the opportunity to protect themselves, their families and their community. However, while we cannot force people to be immunised it was important to encourage it and to send a strong message around transmission rates. Mrs Walker agreed that it was not mandatory but reminded the Forum that staff groups who were registered and regulated had a code of conduct which required them to protect. She emphasised the importance of educating where concerns were raised and said that she hoped we wouldn't have to take any further action.

Mr Egan asked for a clear message to be sent to non-front line staff so that they knew when they would be offered the vaccine. He stated that although they were not front line, they do work in our hospitals and use shared areas e.g. concourse.

Mrs Wright advised that she had worked a shift at the Splott centre the previous week and had been very impressed, but she had been unable to book on for another shift despite trying. Mrs Walker acknowledged that there were some logistical issues within the team that were being worked though, but for now Mrs Wright should send her an email which she would share at the daily huddle.

Miss Salter asked for clarification about potential action against registrants who declined the vaccine. Mrs Walker re-iterated that she had said she hoped this would *not* happen, and that the key thing was understanding why individuals were refusing it and what support they needed in order to find solutions.

Mrs Kinghorn finished by reminding the Forum that the vaccine was not a panacea and that it was important to continue with social distancing, hand washing and PPE/face coverings.

LPF 21/006 HEALTH AND WELLBEING UPDATE

Mrs Gidman provided the Forum with an update on Health and Wellbeing topics. She emphasised how important this was, stating that it cannot just be strategic, but that staff need to feel the changes , noting that the evidence shows health and wellbeing of staff impacts on patient care.

Key points to note included:

- The Staff Haven at the Lakeside Wing (LSW) is now open and plans are in place for Havens in UHL and a second in UHW in the near future. There are also plans to introduce a 'click and deliver' service for staff to order refreshments
- Employee Wellbeing Service waiting times are low - employees can be seen quickly in all areas except the trauma pathway which currently is funded for only 1 session and plans are in place to increase this service
- Wellbeing sessions are being held twice a week to support Managers
- The Health and Wellbeing lead is visiting ward areas to see staff and discuss wellbeing

Mr Hewin welcomed Mrs Gidman's update but stated that from a staff side perspective compassionate leadership was the bedrock of wellbeing. He noted that the Respect and Resolution Policy was due to be published soon (replacing the Dignity at Work Process and Grievance Policy) and suggested that it might be useful to have a future discussion about this.

Miss Ward supported the overall strategy but reminded the Forum of the need to be mindful of agile workers and to be creative to ensure that were also supported.

LPF 21/007 OPERATIONAL UPDATE

Ms Bird reminded the Forum that this wave felt very different to the previous one. She advised that EU admissions had not gone down and planned care waiting lists had been maintained as much as possible.

The number of covid patients had decreased but was still in the region 200 inpatient cases and additional capacity remained open. The ITU position had improved but was not back to normal levels. Planned care had also recovered but, again, was not back to the pre-covid position and we were still using Spire and St Joe's and an external company for endoscopies.

Ms Bird emphasised that the staff were doing a phenomenal job. She said the situation was more complex than ever before and it was necessary to plan and work with a great deal of uncertainty. Ms Bird agreed with comments made earlier about the importance of employee health and wellbeing.

The biggest challenge is now Planned Care, with waiting lists aging (ie people waiting longer) and the immediate task is to recover where elective work has been stopped e.g. orthopaedics and theatres. It is therefore necessary to consider when is the right time to return people to their usual place of work.

Ms Bird said that we need to support our existing workforce and increase our workforce, and work with HEIW and WG on our recovery plan. She recognised that Mental Health and PCIC have their own sets of challenges and suggested that perhaps a future update could focus on these.
Action: Ms Bird

Mr Hewin thanked Ms Bird for specifically mentioning Mental Health and said that he would really welcome that focus. He said that IT remained one of the biggest challenges to both innovation and health and wellbeing and he had been pleased to see a published plan. However, he asked if there was any scope to increase the technical support available as he knew they were working to capacity and there was now an issue with getting laptops configured.

Miss Ward asked how robust the connection between operational delivery and the public health strategy was, specifically in relation to staff returning to their usual place of work. Ms Bird indicated that at the current time we are planning in short horizons given the uncertainties – so we are planning for the next 2 weeks and modelling for the next 4-6 weeks after that but that whenever possible they are trying to give staff as much notice as possible.

LPF 21/008 RECRUITMENT AND THE WORKFORCE HUB

The Forum received a presentation from Mrs Morse on recruitment and workforce activity which has taken place in the Hub over the last 10 months or so.

Mrs Morse advised that during the first wave business as usual had stopped within HR Operations and temporary recruitment was brought in-house. At that time there was no opportunity to plan and processes were developed as they went along. It was a high pressured, busy time and approximately 1000 additional temporary staff were recruited.

After the first wave processes were reviewed as the team prepared for the second wave. Subsequent changes have meant that this time business as usual has continued alongside the recruitment activity, processes have been mapped out and made virtual, and strong links have been made with the other Hubs.

Since September 2020 a further 1000+ temporary staff (excluding nurses and doctors) have been recruited. In addition, a significant number of Bank staff have been offered fixed term contracts and there have been deployments both within the UHB and with other NHS Organisations using the mutual aid principles.

Mrs Morse gave assurances that safe and efficient governance processes are in place but by working this way we have been able to do things differently e.g. advertising on social media, telephone interviews etc and noted that by being in control we had been able to fix things quickly when they went wrong.

Ms Ward asked how this learning would be taken forward and used in the future. Mrs Morse advised that there is a need to have a discussion, both internally and with shared services, about the processes and how they can be streamlined. Mr Richards agreed with this, stating that he believed we now needed to embed and continue the fantastic work that had been done, but this would require discussion and negotiation.

LPF 21/009 CHIEF EXECUTIVES REPORT

Mr Richards advised the Forum of the following points:

- There were more COVID patients at that time than there had been at any point during the first wave. There was a debt of gratitude to staff for the commitment and ownership of the situation. We were now starting to think about what recovery means, and a recovery plan is being developed especially around planned care. The UHB is actively engaged in developing a business case across the whole system with the ultimate goal of replacing UHW.
- A digital plan is in place for the roll out of O365 and distribution of new equipment but it is apparent that the infrastructure is strained by the demand for virtual meetings etc. Significant digital investment across all sites is necessary and this has started, but this does fall under the same category of money as capital estates and capital equipment.
- The new Executive Director of Finance, Catherine Phillips, is due to start with the UHB on 1 March. Mr Lewis was thanked for everything he has done as Interim Director, and it was noted that this had been recognised by WG.

Miss Ward said that she understood that the trade off for investing in digital technology would be that we wouldn't require as many buildings, but re-iterated the importance of including the community and agile workers in any planning as much of the thinking seemed to be site based. Mr Richards agreed, noting that within SOFW the aim is for people to live longer, healthier lives in their community which means that we need to enable staff to work in the community. We have adopted virtual clinical interactions now but are still only scratching the surface of what digital technology can do to allow us to deliver care in the community, prison etc without having to return to an office to input it onto a computer.

LPF 21/010 IMTP

Mrs Harris reminded the Forum that the usual 3 year planning process had been suspended due to the ongoing uncertainties and that the requirement for 2021/22 was an annual plan. However, despite being an annual plan it is very much routed in the SOFW principals.

The plan needed to focus on and addresses the five ministerial priorities of:

- Reducing health inequalities
- Prevention
- Access to care
- Primary and community care
- Mental health and well-being

The context in which the plans are developed remains the 'four harms' associated with covid and many of the changes introduced over the last year are to be embedded and built upon. The plan consists of three key areas – service, workforce and finance.

Mrs Harris suggested that it might be appropriate to have a discussion at the next meeting about the continued focus on the delivery of the strategy over the next 5 years.

LPF 21/011 FINANCE REPORT

Mr Lewis provided an update on the financial position up to 31 December 2020. He noted that there was a slight underspend in month 9 and a breakeven forecast thanks to WG support with covid related costs.

LPF 21/012 WOD PERFORMANCE KPI REPORT

The Local Partnership Forum noted the WOD KPI report. It was agreed that a more detailed discussion on absence figures would take place at Workforce Partnership Group the following week
Action: Mrs Gidman

Mrs Gidman noted the decreasing compliance rates for mandatory training and stated that the risks associated with this, especially around fire, could not be ignored.

LPF 21/013 PATIENT QUALITY, SAFETY AND EXPERIENCE REPORT

The Local Partnership Forum noted the Patient Quality, Safety and Experience Report.

It was noted that the definition of a hospital acquired infection had not been confirmed yet.

LPF 21/014 ITEMS FOR BOARD

There were no specific items which the LPF wanted to be brought to the attention of the Board.

LPF 21/015 ANY OTHER BUSINESS

There was no other business raised.

LPF 21/016 FUTURE MEETING ARRANGEMENTS

The next meeting will be held on Thursday 22 April 2021 at 10 am with a staff representatives pre-meeting at 9am. The meeting will be held remotely.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE
JOINT COMMITTEE MEETING – MAY 2021

The Welsh Health Specialised Services Committee held its latest public meeting on 11 May 2021. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

The papers for the meeting are available at:
https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

Minutes of Previous Meetings
The minutes of the meeting of 9 March 2021 were taken as read and approved.

Action log & matters arising
Members noted there were no outstanding actions or matters arising.

Chair's Report
The Chair's Report referred members to the forthcoming early retirement of Kevin Smith, Committee Secretary, on 31 May, and his return part time for around five weeks from 7 June, and the appointment of his successor, Jacqueline Evans, from 1 June 2021.

The Report also referred members to the Chair's Actions taken to approve the appointment of Professor Ian Wells as an Independent Member of the Joint Committee with effect from 1 May 2021 for an initial term of two years.

In addition, the Chair reported that Emrys Elias had tendered his resignation with effect from 31 May 2021 and that a nomination had been received for a successor, whose appointment would be dealt with later in the week by Chair's Action.

Members (1) noted the contents of the report; (2) ratified the appointment of Jacqueline Evans as Committee Secretary with effect from 1 June 2021; and (3) ratify the Chair's Action appointing Prof Ian Wells.

Managing Director's Report
The Managing Director's report, including updates on:

- Opening of the interim Mother & Baby Unit at Tonna Hospital;
- The south Wales Thoracic Surgery Strategic Outline Case (SOC);
- The PET Programme Business Case;
- The status of the audit of the 2020-21 Accounts;
- De-escalation the SBUHB TAVI service from level 3 to level 2;
- Removal of the CVUHB Paediatric Intensive Care service from escalation; and
- Removal of the SBUHB Soft Tissue Sarcoma service from escalation,

was taken as read.

It was agreed that SBUHB would circulate the Thoracic Surgery SOC to members.

South Wales Major Trauma Network (SWMTN) Update
Members received a presentation on the work of the SWTN from its opening in September 2020 to March 2021, which included a summary of the Delivery Assurance Group report. Members noted the content of the presentation and discussed elements of it in detail.

A further update will be provided to the Joint Committee meeting in six months' time.

Neonatal Transport Service for South and Mid Wales
Members received a paper that proposed a project structure and governance assurance framework as requested following Joint Committee's decision regarding the establishment of an Operational Delivery Network Transport Service for mid, west and south Wales in April 2021. It was noted that the proposed structure borrowed many features from the SWMTN model, which was regarded as exemplary.

Members noted (1) the proposed project management process and associated timeline; and (2) the draft commissioner assurance process, recognising that this would be subject to further discussion in the 'In Committee' section of the meeting and with the programme team.

Revised Risk Management Strategy
Members received a paper that presented the revised Risk Management Strategy (RMS) for WHSSC for approval and shared the latest version of the Corporate Risk Register for information.

Members (1) approved the revised Risk Management Strategy; (2) noted the latest version of the Corporate Risk Register; and (3) noted that further work is on-going to develop risk reporting in line with the RMS.

Activity Reports for Months 11 and 12 2020-21
Members received papers that highlighted the scale of the decrease in activity levels during the COVID-19 period, and whether there are any signs of recovery in specialised services activity. These activity decreases are shown in the context of the potential risk re patient harms and of the loss of value from nationally agreed financial block contract arrangements.

The Month 12 report been restructured from previous format to deal with specialties/areas on an all-Wales basis and would be developed further based on feedback received.

Members noted the information presented in the reports.

Financial Performance Report – Month 12 2020-21
Members received a paper the purpose of which was to provide the final outturn for the financial year. The financial position at was an under spend of £12.03m after making prudent provisions.

The under spend relates mainly to months 1-12 under spend on the pass through elements of NHS Wales provider SLA's, NHS England anticipated underperformance against agreed block contracts where provider activity is forecast at >20% below agreed baseline and Q1 – Q4 2020-21 development slippage. Owing to uncertainty regarding the pace of activity, recovery and timing of information flows from NHS England providers, WHSSC has adopted a prudent approach to providing for expenditure reductions that may arise from under-performance.

Members noted the content of the report.

Other reports
Members also took as read the update reports from the following joint Sub-committees and Advisory Groups:

- Management Group;
- All Wales Individual Patient Funding Request Panel;
- Quality & Patient Safety Committee; and
- Integrated Governance Committee

Standing Orders (SOs) and Standing Financial Instructions (SFIs)
The Committee Secretary reported that revised Model SOs and SFIs had recently been received from Welsh Government and that work was underway to review the WHSSC SOs and SFIs to propose any necessary changes. It was agreed that these would be the subject of a Chair's Action.

Report Title:	**Corporate Risk Register**								
Meeting:	Public Board Meeting						**Meeting Date:**	27th May 2021	
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**	✓	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The Corporate Risk Register has been developed to enable the Board to have an overview of the key operational risks from the Clinical Boards and Corporate Directorates. The Corporate Risk Register includes those risks which are rated 15 (out of 25) and above.

The Board now has oversight of strategic risks via the Board Assurance Framework and extreme Operational Risks (Corporate Risk Register) for the Health Board.

The Corporate Risk Register Summary is attached at ***Appendix 1***. The detail of each risk listed is also discussed and reviewed at the appropriate committees of the Board. Following March's Board meeting all entries linked to Mental Health, were discussed at April's Mental Health Capacity and Legislation Committee for further scrutiny and assurance.

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

The Risk and Regulation Team ("the Team") continue to work alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management Strategy and Procedure.

The Team continue deliver a programme of education and training to risk leads within Clinical Boards and Corporate Directorates and host weekly virtual Risk Management training sessions to Health Board Staff generally

Alongside that programme of training the Risk and Regulation team to deliver bespoke training sessions to meet the individual needs of Clinical Boards/Corporate Directorates, to ensure that a consistent approach to the recording of risk and risk appetite is adopted across the Health Board.

As those sessions have gathered pace and the uptake in attendance from risk leads has increased the number of risks reported by some Clinical Boards and directorates has increased significantly. In particular the Team has now received top level Risk Registers from the Children and Women Clinical Board and Capital Estates and Facilities directorate for the first time. The Medicine and Primary Community and Intermediate Care Clinical Boards have also, following post training reviews of their Risk Registers submitted significantly more detailed and comprehensive registers for inclusion within the Corporate Risk Register.

Whilst it is encouraging to note the increase in engagement the additional risk have not, on this occasion, been automatically included within the Corporate Risk Register. A further review of the risks presented will need to be undertaken to ensure that there is a consistency of approach, scoring and methodology for each risk prior to being added to the register.

The Team intends to undertake this task prior to the July's Board meeting so that the Health Board are cited on the key extreme operational risks faced by the Health Board as at June 2021. Thereafter the Board will continue to be appraised of the key risk facing the Health Board at each Board meeting as they present themselves the month prior to each meeting.

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

There are currently 24 Extreme Risks (risks rated 15 and above) on the Corporate Risk Register as the table below shows. This represents a decrease of 1 Extreme Risk entry since March's Board meeting which is reflected in the addition of two new risks (risks 9 and 19) and the removal of three entries (risks 25 to 27). The scores allocated to all current recorded risks have remained stagnant since March 2021.

It is the Risk and Regulation teams' intention to ensure that the Corporate Risk Register is a dynamic document that helps to mitigate risk and put in place actions to remove or manage risk in a timely manner. With that in mind the Team will continue to meet with risk leads and Clinical Board directorates to provide support and guidance on the management and treatment of risk. By way of an example, the Team met with the Medicine Clinical Board nursing risk leads in April. The output from those meetings has seen an increase in the number of risks reported by the Medicine Clinical Board which will need to be reviewed prior to the next Board meeting.

On this occasion no extreme risks have been returned by the Mental Health Clinical Board or the Emergency Planning, Human Resources/Workforce and Finance Corporate Directorates. The Risk and Regulation Team are now also in discussion with the Health Board's Health and Safety team (who have historically managed risk internally) and it is hoped that Extreme Health and Safety risks will be recorded on the Corporate Risk Register following completion of an Audit of the existing systems.

Assuming that scores do not increase prior to the next board meeting a total of 3 entries (those shaded grey) will be removed from the Corporate Risk Register prior to May's Board meeting.

The present position is as follows:

March 2021	May 2021
7 risks rated 15 (extreme risk) 8 risks rated 16 (extreme risk) 10 risks rated 20 (extreme risk)	6 risks rated 15 (extreme risk) 10 risks rated 16 (extreme risk) 8 Risks rated 20 (extreme risk)

Over the course of time, as the impact of Covid-19 reduces and with further scrutiny and review of risks, it is hoped that these risks should reduce either in number or rating. It should also be noted that the register, despite being over scored in some areas, does provide the Board with an indication of the risks that the organisation is dealing with operationally. Each risk can also be linked back to the Strategic Risks detailed upon the BAF.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The programme of education and training that is being implemented by the Risk and Regulation team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

RECOMMENDATION

The Board is asked to:

- **NOTE** the Corporate Risk Register and the work which is now progressing.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	x
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	Not Applicable

CORPORATE RISK REGISTER SUMMARY MAY 2021

Risk Ref	Risk (for more detail see individual risk entries)	Clinical Board / Corporate Directorate	Link to BAF	Initial Risk Score	Risk Score Mar 20	Risk Score May 21	Trend	Target Risk Score
1	Risk of patient and staff harm due to inadequate social distancing.	Medicine	Patient Safety	5x5=25	5x4=20	5x4=20	→	5x2=10
2	Risk of patient harm due to patients remaining on ambulances longer than agreed time frames	Medicine	Patient Safety	5x5=25	5x4=20	5x4=20	→	5x2=10
3	Risk of serious incidents due to delayed cancer diagnosis	Medicine	Patient Safety/Planned Care Capacity	4x5=20	4x5=20	4x5=20	→	4x3=12
4	Risk of patient harm and sub-optimal patient experience due to a lack of sufficient workforce capacity and resilience to deliver consistent and high quality service delivery at times of high demand	PCIC	Workforce/Planned Care Capacity	4x5=20	4x5=20	4x5=20	→	4x2=10
5	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient nursing workforce	Specialist Services	Patient Safety/Planned Care Capacity	5x5=25	5x4=20	5x4=20	→	5x2=10
6	Risk that patients will not receive care in a suitable environment due to a number of facility shortcomings.	Specialist Services	Patient Safety/Capital Assets	5x5=25	5x5=25	5x4=20	→	5x2=10
7	Risk of increased rates of cross infection and compromised delivery of medical and nursing care due to facility issues	Specialist Services	Patient Safety/Capital Assets	5x5=25	5x4=20	5x4=20	→	5x2=10
8	Cardiothoracic - Risk to patient harm due to clinical area relocations and reduced footprints	Specialist Services	Patient Safety	5x5=25	5x4=20	5x4=20	→	5x2=10
9	Inreased risk of anaphylaxis in Allergy patients due to increased waiting times following an increase in referalls from neighbouring Health Boards	Specialist Services	Patient Safety	4x4=16		4x4=16	→	4x2=8
10	Risk of breakdown of complex care packages leading to hospital admission , patient flow issues and impact upon patients and their families	PCIC	Sustainable Primary and Community Care	4x5=20	4x4=16	4x4=16	→	4x3=12
11	Covid-19	PCIC	Test Trace and Protect	4x5=20	4x4=16	4x4=16		4x3=12
12	Risk that patients will not receive access to emergency caredue to reduced theatre capacity for Major Trauma	Specialist Services	Patient Safety/Capital Assets	4x4=16	4x4=16	4x4=16	→	4x2=8
13	Risk of Data Protection Legislation breaches due to out of date Information Governance Data policies and procedures.	Digital Health Intelligence	Patient Safety	4x4=16	4x4=16	4x4=16	→	5x2=10
14	Risk of patient harm due to failure to provide timely access to surgery.	Surgery	Patient Safety/Planned Care Capacity	4X5=20	4x4=16	4x4=16	→	4x3=12
15	Risk of partient harm and sub-optimal patient experience due to a backlog of Diagnostics and Therapies services.	CD&T	Patient Safety	4x5=20	4x4=16	4x4=16	→	4x3=12
16	Risk of patient harm and suboptimal patient experience due to aged and outdated estate in some areas making delivery of safe and sustainable healthcare difficult	CD&T	Capital Assets	4x5=20	4x4=16	4x4=16	→	4x3=12
17	Risk to patient safety, quality of service and compliance with national standards/best practice due to suboptimal IT provision	CD&T	Capital Assets	4x5=20	4x4=16	4x4=16	→	4x3=12
18	Risk of patient and/or staff harm due to non compliance with All Wales Staffing Act	Medicine	Workforce	4x5=20	4x4=16	4x4=16		5x2=10
19	Risk of patient harm due to failure to adhere to Point of Care Testing guidance.	CD&T	Patient Safety	5x4=20		5x3=15	→	5x2=10
20	Risk of patient harm due to GP Practicies becoming unsuitable in the current climate.	PCIC	Sustainable Primary and Community Care	5x4=20	5x3=15	5x3=15	→	5x2=10
21	Risk to patient safety causing serious incidents due to patients not being reviewed within the Critical Care Department in a timely manner due to insufficient medical workforce	Specialist Services	Workforce	5x5=25	5x3=15	5x3=15	→	5x2=10
22	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to lack of bed capacity	Specialist Services	Patient Safety	5x5=25	5x4=20	5x3=15		5x2=10
23	Risk to patient safety due to different approaches to Chemotherapy prescription for TYA Cancer patients between sites.	Specialist Services	Patient Safety	5x4=20	5x3=15	5x3=15	→	5x1=5
24	Risk of safety to patients on the cardiac waiting list due to failure to meet the RTT 36 week wait	Specialist Services	Patient Safety/Planned Care Capacity	5x4=20	5x3=15	5x3=15		5x2=10
25	Risk to the health and wellbeing of a minor inpatient following admission to adult mental health services	Mental Health and Capacity Legislation Committee	Patient Safety	5x5=25	5x5=25			5x1=5
26	The opening underlying deficit in 20/21 is planned to be £11.5m. The IMTP planned c/f underlying deficit in 2021/22 is £4m.	Finance Committee	Financial Sustainability	5x5=25	5x4=20			5x2=10
27	Deliver 3.5% cip (£29m)	Finance Committee	Financial Sustainability	5x4=20	5x4=20			5x2=10

Report Title:	**Finance Committee Chairs Report**								
Meeting:	Board Meeting						**Meeting Date:**	27/05/2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Catherine Phillips, Executive Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the 24th March 2021.

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

With the operation imperative being managing the impact of COVID-19, the initial financial focus was on justifying additional expenditure incurred in dealing with the pandemic. Welsh Government (WG) has now set out the resources available to support the COVID-19 response and there is an expectation that NHS bodies will manage within these resources to deliver their original planned position, which for the UHB is a break even position by the end of 2020/2021.

How the UHB recovers from the pandemic is also key and in this context the UHB needs to avoid adding recurrent expenditure to its underlying position and to embed the many transformation changes that have been delivered at pace.

Assessment and Risk Implications

Financial Performance Month 11

The report updated the Committee on the UHB's financial plan.

The UHB developed plans at pace for managing COVID-19 including the deferral of elective work and an increase to available bed capacity to manage surges in activity.

The WG amended the monthly financial monitoring returns to capture and monitor net costs due to COVID-19 that were over and above LHB plans. The financial position reported to WG for month 11 was an underspend of £0.502m as summarised in table 1 below:

Table 1: Month 11 Financial Position 2020/20 21

	Month 1 £m	Month 2 £m	Month 3 £m	Month 4 £m	Month 5 £m	Month 6 £m	Month 7 £m	Month 8 £m	Month 9 £m	Month 10 £m	Month 11 £m	Total £m
COVID 19 Additional Expenditure	38.438	17.290	5.330	6.565	10.597	7.939	8.561	8.776	12.453	12.114	10.859	138.922
COVID 19 Non Delivery of Savings Plans	2.118	2.150	2.056	2.094	1.752	(1.704)	1.960	1.946	1.368	2.579	2.001	18.320
COVID 19 Reductions in Planned Expenditure	(2.522)	(4.241)	(2.921)	(1.626)	(1.885)	(0.965)	(1.230)	(0.299)	(1.234)	(1.418)	(1.428)	(19.769)
COVID 19 Release of Planned Investments	0.000	(0.168)	(0.679)	(0.089)	(0.244)	(0.142)	0.044	(0.142)	(0.031)	(0.098)	(0.098)	(1.647)
Net Expenditure Due To COVID 19	38.034	15.030	3.786	6.944	10.220	5.129	9.335	10.281	12.556	13.177	11.334	135.826
Operational position (Surplus) / Deficit	0.191	(0.048)	(0.204)	0.244	(0.361)	(0.094)	(0.091)	(0.099)	0.158	0.095	(0.294)	(0.502)
Welsh Government COVID 19 funding received			(11.016)	(0.306)	(34.950)	(32.871)	(9.335)	(10.281)	(12.556)	(13.177)	(11.334)	(135.826)
Financial Position (Surplus) / Deficit	38.225	14.982	(7.434)	6.882	(25.091)	(27.836)	(0.091)	(0.099)	0.158	0.095	(0.294)	(0.502)

The table shows that in February, the in month net expenditure of £11.334m as a consequence of COVID-19 was matched by an equal amount of additional WG funding.

The additional COVID-19 expenditure in the 11 months to the end of February was £138.922m. Within this, the costs of the Dragon's Heart Hospital (DHH) were significant, especially the set up costs which allowed for significant expansion. At month 11 costs of £54.033m related to the DHH. There were also £84.889m of other COVID-19 related additional expenditure.

COVID-19 was also adversley impacting on the UHB savings programme with underachievment of £18.320m against the month 11. Further improvement was not anticipated until the COVID-19 pandemic passed.

Elective work had been significantly curtailed during the first 11 months of the year as part of the UHB response to COVID-19 and this had led to a £19.769m reduction in planned expenditure.

The UHB had also seen slippage as a commissioner of £1.647m on the Welsh Health Specialised Services Committee (WHSSC) commissioning plan due to the impact of COVID-19.

The net expenditure due to COVID-19 at the end of February was £135.826m and this was matched by an equal amount of additional WG COVID-19 funding. The UHB also had a small operating underspend of £0.502m leading to a net reported surplus at month 11.

Whilst the UHB expected the non COVID-19 related operational position to remain broadly balanced as the year progressed, the additional costs arising from plans to manage COVID-19 were expected to continue. The month 11 forecast of net expenditure due to COVID-19 in 2020/2021 was £161.179m and this was offset by additional COVID-19 funding of £161.179m as summarised in table 2 below:

Table 2 : Summary of Forecast COVID-19 Net Expenditure

	Cumulative Month 11 £m	Forecast Year-End Position £m
COVID 19 Additional Expenditure	138.922	163.936
COVID 19 Non Delivery of Savings Plans	18.320	20.370
COVID 19 Reductions in Planned Expenditure	(19.769)	(20.685)
Total Release/Repurposing Of Planned Investments/Development Initiatives	(1.647)	(2.443)
Net Expenditure Due To COVID 19	**135.826**	**161.179**
Operational position (Surplus) / Deficit	(0.502)	0.000
Welsh Government COVID funding received / assumed	(135.826)	(161.179)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**	**(0.000)**

The forecast additional WG funding was based upon the resource assumptions set out in the NHS Wales Operating Framework 2020/2021 for Q3 and Q4.

Within the forecast the DHH costs were assessed at £58.0m with a further £2.4m capital costs.

It was noted that the forecast was based on a number of variable assumptions and assumed WG funding to help meet the additional costs arising from COVID-19.

The forecast year end underlying deficit was £25.3m which was £21.3m more than the planned £4m identified in the submitted Integrated Medium-Term Plan (IMTP) as a result of the slippage against savings schemes.

Risk Register

The 2020/2021 Finance Risk register was presented to the Committee.

It was highlighted that 2 of the risks identified on the 2020/2021 Risk Register were still categorised as extreme risks (Red) namely:

- Reduction in the £11.5m underlying deficit c/f to 2020/2021 to the IMTP planned £4m c/f underlying deficit in 2021/2022,
- Delivery of the 3.5% CIP (£29m).

The Committee agreed to the removal of the 1 risk below where the risk to the delivery of the financial plan was assessed to be low:

- FIN06/20 – Nursing Position.

Finance Committee - Annual Report

The Finance Committee reviewed and approved the 2020/2021 Annual Report of the Finance Committee.

Recommendation:

The Board is asked to:

- **NOTE** the report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Finance Committee Chairs Report**								
Meeting:	Board Meeting						**Meeting Date:**	27/05/2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Catherine Phillips, Executive Director of Finance**								
Report Author (Title):	**Dr Rhian Thomas, Chair of Finance Committee**								

Background and current situation:

To provide the Board with a summary of key issues discussed at the Finance Committee held on the 28th April 2021.

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

With the operation imperative being managing the impact of COVID-19, the initial financial focus was on justifying additional expenditure incurred in dealing with the pandemic. Welsh Government (WG) set out the resources available to support the COVID-19 response with an expectation that NHS bodies would manage within these resources to deliver their original planned position, which for the UHB was a break even position by the end of 2020/2021.

The UHB's provisional year end revenue outturn is a surplus of £0.090m which is broadly in line with the break-even position previously forecast. The UHB also reported that it stayed within its Capital Resource limit and achieved its creditor payment compliance target. These are all provisional at this stage and will be subject to External Audit scrutiny. The year-end reported position is however, not expected to materially change.

Assessment and Risk Implications

Financial Performance Month 12

The report updated the Committee on the UHB's financial plan.

The UHB developed plans at pace for managing COVID-19 including the deferral of elective work and an increase to available bed capacity to manage surges in activity.

The WG amended the monthly financial monitoring returns to capture and monitor net costs due to COVID-19 that were over and above LHB plans. The financial position reported to WG for month 12 was an underspend of £0.090m as summarised in table 1 below:

Table 1: Month 12 Financial Position 2020/2021

	Month 1 £m	Month 2 £m	Month 3 £m	Month 4 £m	Month 5 £m	Month 6 £m	Month 7 £m	Month 8 £m	Month 9 £m	Month 10 £m	Month 11 £m	Month 12 £m	Total £m
COVID 19 Additional Expenditure	38.438	17.290	5.330	6.565	10.597	7.939	8.561	8.776	12.453	12.114	10.859	40.283	179.205
COVID 19 Non Delivery of Savings Plans	2.118	2.150	2.056	2.094	1.752	(1.704)	1.960	1.946	1.368	2.579	2.001	2.020	20.340
COVID 19 Reductions in Planned Expenditure	(2.522)	(4.241)	(2.921)	(1.626)	(1.885)	(0.965)	(1.230)	(0.299)	(1.234)	(1.418)	(1.428)	(1.054)	(20.823)
COVID 19 Release of Planned Investments	0.000	(0.168)	(0.679)	(0.089)	(0.244)	(0.142)	0.044	(0.142)	(0.031)	(0.098)	(0.098)	(0.955)	(2.602)
Net Expenditure Due To COVID 19	38.034	15.030	3.786	6.944	10.220	5.129	9.335	10.281	12.556	13.177	11.334	40.294	176.120
Operational position (Surplus) / Deficit	0.191	(0.048)	(0.204)	0.244	(0.361)	(0.094)	(0.091)	(0.099)	0.158	0.095	(0.294)	0.412	(0.090)
Welsh Government COVID 19 funding received			(11.016)	(0.306)	(34.950)	(32.871)	(9.335)	(10.281)	(12.556)	(13.177)	(11.334)	(40.294)	(176.120)
Financial Position (Surplus) / Deficit	38.225	14.982	(7.434)	6.882	(25.091)	(27.836)	(0.091)	(0.099)	0.158	0.095	(0.294)	0.412	(0.090)

The table shows that in March, the in month net expenditure of £40.294m as a consequence of COVID-19 was matched by an equal amount of additional Welsh Government funding.

The COVID-19 related expenditure reported in month 12 included additional pay costs of circa £26.7m in relation to untaken annual leave, carried over training grade doctors study leave and the NHS bonus payment.

The additional COVID-19 expenditure in the 12 months to the end of March was £179.205m. Within this, the costs of the Dragon's Heart Hospital were significant, especially the set up costs which allowed for significant expansion. At month 12 costs of £55.422m related to the Dragon's Heart Hospital (DHH). There were also £123.783m of other COVID 19 related additional expenditure.

COVID-19 was also adversley impacting on the UHB savings programme with underachievment of £20.340m against the month 12. Further improvement was not anticipated until the COVID-19 pandemic passed.

Elective work had been significantly curtailed during the first 12 months of the year as part of the UHB response to COVID-19 and this had led to a £20.823m reduction in planned expenditure.

The UHB has also seen slippage of £2.602m on the Welsh Health Specialsied Services (WHSSC) commissioning plan and other investments due to the impact of COVID-19.

The net expenditure due to COVID-19 at the end of March was £176.120m and this was matched by an equal amount of additional Welsh Government COVID-19 funding. The UHB also had a small operating underspend of £0.090m leading to a net reported surplus at month 12.

The COVID-19 year-end position was breakeven following receipt/confirmation of £176.120m WG funding as summarised in table 2 below:

Table 2 : Summary of COVID-19 Net Expenditure

	Year-End Position £m
COVID 19 Additional Expenditure	179.205
COVID 19 Non Delivery of Savings Plans	20.340
COVID 19 Reductions in Planned Expenditure	(20.823)
COVID 19 Release/Repurposing of Planned Investments/Development Initiatives	(2.602)
Net Expenditure Due To COVID 19	**176.120**
Welsh Government COVID funding received	(176.120)
Net COVID 19 Forecast Position (Surplus) / Deficit £m	**0.000**

The UHB delivered its planned breakeven year end position based upon the resource assumptions set out in NHS Wales Operating Framework 2020/2021 for Q3 and Q4.

The assessed year end underlying deficit was £25.3m which was £21.3m more than the planned £4m identified in the submitted Integrated Medium-Term Plan (IMTP) as a result of the slippage against savings schemes.

Deep Dive – Resource Allocations and Funding

The Finance Committee received a presentation on resource allocations and funding which considered the following:

- How the Welsh Government is funded,
- Funding from Welsh Government (including the new allocation formula & the UHBs assessed share of NHS Funding),
- Cross Border flows and LTAs,
- How the UHB spends its resources.

Recommendation:

The Board is asked to:

- **NOTE** the report.

Shaping our Future Wellbeing Strategic Objectives

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1.	Reduce health inequalities	6.	Have a planned care system where demand and capacity are in balance
2.	Deliver outcomes that matter to people	7.	Be a great place to work and learn
3.	All take responsibility for improving our health and wellbeing	8.	Work better together with partners to deliver care and support across care

			sectors, making best use of our people and technology	
4.	Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5.	Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	**X**	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**Audit & Assurance Committee – Chair's Report**									
Meeting:	**Board Meeting**							**Meeting Date:**	**27/05/2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**	
Lead Executive:	**Chair, Audit & Assurance Committee**									
Report Author (Title):	**Corporate Governance Officer**									

SITUATION

To provide the Board with a summary of key issues discussed at the Audit & Assurance Committee held on 6th April 2021.

Internal Audit Progress and Tracking Reports

The Internal Audit Progress and Tracking Reports were received and the Head of Internal Audit (HIA) provided the Committee with the current position regarding the work to be undertaken by the Audit & Assurance Service as part of the delivery of the approved 2020/2021 Internal Audit plan.

The HIA advised that it was recognised that there had been a delay throughout the year in progressing with delivery of the plan due to delays in being able to meet with Health Board managers and staff due to the ongoing effects of the COVID-19 pandemic. The Committee noted that:

- the internal audit team had received information from the IM&T team and that work would be progressed and finalised to be included in the annual report. This would be brought to the audit committee workshop on the 13 May 2021,
- discussions had commenced with the Medical Director concerning the Consultant Job Planning Follow-up audit and a start date of April 2021 had been agreed. The Medical Director had wanted to move the start from March to April to ensure it was appropriate to carry out the follow-up. The HIA advised the Committee that the outcome would be submitted to the May 2021 meeting.

The CC asked the HIA if all of the delayed assignments would be included in the final annual report. The HIA confirmed that they would be included.

The HIA advised the Committee that 8 internal audit reports had been finalised since the last meeting and that each of the reports provided a positive outcome with 4 substantial assurance assessment ratings, and 4 reasonable assurance assessment ratings.

The Committee noted that the Compliance with the Nurse Staffing Levels Act (Wales) 2016 report provided substantial assurance around the processes that Cardiff and Value University Health Board (CVUHB) had put in place during the COVID-19 pandemic which was to continue monitoring and reporting compliance with the provisions of the Act.

The HIA reminded the Committee that the internal audit report for the Lakeside Wing had been circulated to members in February 2021, and that the report had been formally submitted and a reasonable assurance rating had been given. The Committee noted that despite significant time pressures, robust governance arrangements had been applied to the project with no evidence of reduced controls in key areas such as the establishment of a sound project structure, assignment and operation of responsibilities, reporting or project decision making.

The Committee noted that there was one additional adjustment that required the Committee's approval which was a planned piece of work on the post contract audit of the costs of the Dragon's Heart Hospital (DHH). The Interim Director of Finance (IDF) had requested the work be undertaken following work that been undertaken by KPMG.

Audit Wales Update

The Committee noted that:

- In accordance with the Welsh Government's (WG's) timetable Audit Wales would review the draft Performance Report and the draft Accountability Report once they were submitted on the 7 May 2021, and that the Financial statements would be reviewed once they had been submitted on the 30 April 2021,
- On the 10 June 2021 the Audit & Assurance Committee and the Board would consider and approve the audited accounts, performance report and the accountability report alongside the audit report, prior to the document being submitted to WG in readiness for the 11 June 2021 deadline,
- Audit Wales had completed work on the Assessment of Progress against previous ICT recommendations and Test, Trace and Protect (TTP) in Wales in April 2021,
- Audit Wales were currently undertaking work on the Structured Assessment 2020 – supplementary outputs, Orthopaedic Services Follow up, Quality Governance and Phase 1 of the Structured assessment 2021 – operational planning,
- Work was being undertaken to review the COVID-19 vaccination rollout - A high level overview of the administration planning and the rollout approach of all vaccinations in Wales. The aim of the review was to provide assurance on the efficiency of the rollout and to identify success factors and any barriers,
- Planned work that had not yet commenced included review of unscheduled care and a follow up on radiology services,
- Between 8 and 12 March 2021, Audit Wales had held an online week of learning, good practice and ideas linked to the COVID-19 learning project "Making Sense of a Crisis: Learning from the CVOID-19 Pandemic". The learning resources produced were available on the Audit Wales website.

Report of the Auditor General on Test, Trace, and Protect (TTP) in Wales

The Audit Wales Manager (AWM) advised the Committee that the report set out the main findings of Audit Wales' review of how public services were responding to the challenges of delivering TTP services in Wales.

The Committee noted that:

- the service was developed largely from scratch and at pace and it was suggested that the service needed to continue to evolve alongside the mass vaccination programme to effectively manage virus rates,
- The report gave a high-level overview of what had been, and continued to be a rapidly evolving programme,

- The evidence base for the report included document reviews, interviews with staff in Health Boards, Local Authorities, the NHS Wales Informatics Service (NWIS), Public Health Wales (PHW) and the WG between September and December 2020, and an analysis of key metrics that showed how well the TTP programme had been performing,
- the report on Personal Protective Equipment (PPE) would be published next week and would be brought to the next Audit Committee meeting for consideration.

Assessment of progress against previous ICT recommendations
The report providing an assessment of progress against previous ICT recommendations was received and the Committee noted that the report presented the findings of the progress made by CVUHB against recommendations that had arisen from previous reviews concerning information governance and information technology.

2021-2022 Fee Letter
The Audit Wales Audit fee outturn for the past year and the fee estimate for the year ahead letter was received and the AWFM advised the Committee when the Audit Committee had considered the audit plan in February 2021, the fee was unable to be added as the information was not available as it was being considered by the Senedd's Finance Committee.

The Committee noted that the letter set out the fee for the year ahead and that the fee estimate for 2021 was 2.6% higher than last year's fee estimate and 1.3% lower than last year's actual fee. Going forward, Audit Wales would be providing all Health Board's in Wales with a separate fee for estimates for financial work on the Health Board's account and its Charitable Fund.

Review the System of Assurance
The report providing an update on the review of the system of assurance was received and the DCG advised the Committee that it had been recognised that the existing assurance tools in place could be further developed into a more comprehensive Assurance Framework.

The Committee noted that developing an Assurance Framework for the Board would further improve the governance of the Health Board and support the achievement of the Health Boards Strategic objectives.

The DCG advised that an assurance mapping exercise would be undertaken to give CVUHB a more systematic review and give the Board an element of further assurance in terms of the different levels including management assurance, internal assurance and external review.

The DCG advised that the Board Assurance Framework (BAF) tool was well integrated and that an internal audit assessment had given positive assurance on that.

Draft Accountability Report 2020-2021
The draft Accountability Report 2020-2021 was received and the DCG advised the Committee that the document was a very early draft which was being brought to Committee for assurance, and that the gaps in information within the document would be updated as the information became available in April and May 2021, and that it was a work in progress.

Declarations of Interest, Gifts, Hospitality & Sponsorship
The update report on Declarations of Interest, Gifts, Hospitality and Sponsorship was received and the DCG advised that the Committee had previously agreed that an update on Declarations

of Interest, Gifts, Hospitality and Sponsorship would be provided to each Audit Committee for information and that the report provided an up to date position for the Financial Year 2020/2021.

Legislative and Regulatory Tracker Report
The Legislative and Regulatory Tracker report was received and the DCG advised the Committee that the report tracked compliance across the organisation and that it included inspections that had been undertaken.

The DCG advised that three new entries had been added since the February 2021 meeting:

1) A focused inspection of the Splott Mass Vaccination Centre was undertaken on the 1 March 2021,
2) A virtual interview was undertaken on the 18 March 2021 with staff at the Hazel Ward at Hafan y Coed,
3) A virtual interview was undertaken on the 10 March 2021 with staff at Ward E12, Hafan y Coed,

The DCG advised the Committee that 3 further inspections were due to take place:

1) Health Inspectorate Wales (HIW) were scheduled to undertake an inspection of the Teenage Cancer Trust on the 31 March 2021,
2) UKAS were scheduled to undertake inspections at the Haematology and Phlebotomy departments between the 20 and 22 April 2021,
3) The Welsh Scientific Advisory Committee were scheduled to undertake inspections at the Audiology department on the 1 June 2021.

Internal Audit Tracking Report
The Internal Audit Tracking Report was received and the DCG advised the Committee that recommendations made by Internal Audit had reduced from 110 individual recommendations to 106 during the period February to April 2021.

The Committee noted that a further 14 recommendations had been added for the current financial year, and that 8 internal audits had been added to the tracker equating to 30 reports in total. These would be added to the tracker once they had been considered by the Committee.

Outstanding Audit Recommendations Update – 2017/2018
The DCG gave an update on the outstanding internal recommendations for the year 2017/2018 and put forward proposals for their management going forward.

The EDF asked the DCG if the outstanding audit recommendations for 2018/2019 and 2019/2020 would be completed over the next period, the DCG advised that she would review them and agree timescales for completion.

Audit Wales Tracking Report
The DCG advised the Committee that the report gave assurance on the implementation of recommendations which had been made by Audit Wales by means of an external audit recommendation tracking report.

The CC queried the total number of outstanding actions and the DCG confirmed that there were 21, and that the total of 25 on the tracker included the actions that had been completed for completeness. The completed actions would be removed from the document after the meeting.

Counter Fraud Annual Plan 2021-2022
The Counter Fraud Annual Plan 2021-2022 was received and the Local Counter Fraud Specialist (LCFS) advised the Committee that the new plan outlined the planned NHS Counter Fraud work for period April 2021 to 31 March 2022. He advised that the plan was fundamentally the same as the existing approved plan.

The EDF advised the Committee that she would let the CC know when the plan was signed off.

Self-assessment of Effectiveness - Verbal
The update on the self-assessment of effectiveness was received and the DCG advised the Committee that to ensure effective governance Committees of the Board were required to undertake a self-assessment of their effectiveness on an annual basis, in accordance with the provisions of the Health Board's Standing Orders. The DCG advised that the results of the surveys should be available by the next committee meeting.

Induction Support for Committee Members - Verbal
The verbal update on the Induction Support for Committee Members was received and the DCG advised that the composition of the Committee membership had not been approved by the Board, and it had been suggested that that this committee include the Independent Member – ICT and the Vice Chair within the membership.

The Committee noted that there was an opportunity for new members to have an induction on the Audit and Assurance Committee, and to spend time with the CC and familiarise themselves with the standing Audit and Assurance agenda items on a regular basis.

Clinical Audit Plan
The Clinical Audit Plan 2021-2022 report was received and the EMD advised the Committee that the purpose of the report was to inform them of the proposed tier 1 and tier 2 (national and local) audit plans for each Clinical Board in 2021/2022.

- In February 2018 the committee agreed an approach to categorise clinical audits into three tiers, to support a prudent and targeted approach:
    - Tier 1 - Mandatory National Clinical Audits,
    - Tier 2 - All other national audits and local clinical audits undertaken to address the patient safety and quality agenda,
    - Tier 3 - Local clinical audits undertaken for any other reason including revalidation and CPD purposes.
- The Clinical Boards and Clinical Audit Leads had developed a 2021/2022 Clinical Audit Plan incorporating all Tier 1 and anticipated Tier 2 audits. There was not an expectation that Tier 3 audits would be included in the clinical audit plans, however the requirement to register and have approved all audits and to report and escalate the results remained imperative.

Internal Audit Plan 2021/2022

The Internal Audit plan 2021-2022 was received and the HIA advised that following an extensive planning process and in accordance with the requirements of the Public Sector Internal Audit Standards, the plan set out a risk-based plan of work for the year 2021/2022.

Internal Audit reports for information:

The following Internal audit reports were received:

1. UHW Surge Hospital - Lakeside Wing,
2. Compliance with the Nurse Staffing Levels Act (Wales) 2016,
3. Claims Reimbursement,
4. Charitable Funds,
5. Tentacle IT System Follow-up,
6. Integrated Health Pathways,
7. UHB Core Financial Systems,
8. Risk Management.

Recommendation:

The Board is asked to:

- **NOTE** the report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Quality, Safety & Experience Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**27/05/2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair - Quality, Safety & Experience Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Quality, Safety & Experience Committee held on 13th April 2021.

Children & Women's Clinical Board (CWCB) Assurance Report

The Clinical Board report gave an update on the continued progress made regarding the Quality, Safety and Patient Experience Agenda despite the significant challenges of the past year.

It was highlighted that as the Clinical Board emerged from the second wave of the pandemic the level of emotional well-being support that would be required for children and young people was a concern.

It was noted that the Children & Women's Clinical Board (CWCB) had followed the quality framework cycle of quality planning, quality control and assurance, and quality improvement and had wanted to move into the quality improvement area and would use data collected during the quality control and assurance cycle to achieve this.

The Committee was shown the figures of how the Clinical Board were performing compared to 12 to 18 months ago:

- Child immunisations had worsened which was thought to be due to parent's reluctance to bring their child for a vaccine and due to school closures,
- Staff flu vaccine uptake had increased by 11% compared to the previous year,
- Safeguarding training had improved and was at 75% compared to the Health Board average of 63%,
- Healthcare Acquired Infection rates had improved and there was a 50% reduction in C-Difficile infections and E-Coli bacteraemias,
- Vaginal/Non-interventional childbirth had worsened. Caesarean section, instrumental delivery and induction of labour rates had all increased,
- R&D had improved. A new C&W R&D group had been established.
- Timely Access to care pre-covid19 had improved with significant improvements in RTT, Cancer and Tier-1 Primary Mental Health.

- Timely Access to care peri/post covid19 had worsened with a significant deterioration in RTT, Tier-1 Primary Mental Health and others.
- Concerns response times had worsened with increasing volume and complexity as well as decreased capacity.
- Staff absence had improved with a decrease to 4.3% from 5.2%.
- Staff appraisal had worsened and reduced to 38% from 50%.

The worries of the clinical board teams were also presented to the Committee:

- Timely access in Benign Gynaecology, numerous Community Children's Services (Immunisations, Continence, Children Looked After, Neurodevelopment, Primary Mental Health, CAMHS including eating disorders, Paediatric Surgery and Paediatric Endoscopy.
- Estates infrastructure in the Obstetrics and Gynaecology block at UHW.
- Children and Young people in crisis.
- Commissioning arrangements and infrastructure in Neonates.
- Absence of resourcing for population growth and universal Children's services.
- Multiple small clinical specialities with poor resilience.

The DOCW suggested that a number of plans would be put forward which included;

- A Community Children's Services Covid-19 response plan.
- Attempting to maintain the Youth Board.
- Securing infrastructure for, and exploring the redesign of Benign Gynaecology services.
- Development of Clinical effectiveness strategy for the clinical board in line with the Cardiff and Vale University Health Board (CVUHB) strategy.
- Transforming inpatient care for Children and Young People with mental illness.
- Contributing to the WHSS National Strategy for Specialist Children's Services.

To move forward with the plans, it was suggested that the Board would need to support the clinical board in influencing external stakeholders and partners and that urgent short-term and other medium-term Estates work would be required in the Obstetrics and Gynaecology block at UHW.

It was noted that maternity services would now look back at the RCOG report and noted that there were 2 red areas that had been addressed quickly:

- Consultant cover.
- Antenatal and postnatal ward rounds.

The Committee was advised that a local IP&C team had been established and was led by a consultant and met on a monthly basis to review practice.

It was noted that a new MRSA working party had been developed to look at increased incidents on neonatal screening.

The Committee noted that:

- the birth rate was decreasing; however, the acuity of care was increasing and also home births was less than 1% of total births,

- there was a national drop in birth rate and that more women were getting pregnant with underlying comorbidities,
- the medical engagement in quality and safety processes through the maternity department was probably the highest across the Clinical Board and they had a risk lead and protected time in their job plans for undertaking assessments of concerns and complaints.

Quality Indicators Report

The Committee had agreed a set of key indicators at the June 2020 meeting and the aim was to bring those indicators as a progress report into the Committee.

The Committee was advised that data was available right from the frontline and that every charge nurse and Multi-Disciplinary Team (MDT) had access to the data at ward level, and that the data would be extended to the community and Lightfoot would be utilised in an attempt to integrate some of their data into the pathway to make the data more live.

The Committee was advised that the Stroke indicators had deteriorated to 17% but had since increased to 40% and that it was compliant against the 4 hour target.

It was noted that the National falls group was re-establishing itself and also a new appointment had been made to CVUHBs quality team who would monitor falls within CVUHB.

Exception Reports

The Committee was advised of unprecendented challenges in CVUHB over the last 12 to 18 months including;

- 60 ward closures from 17 April 2020 to 23rd February 2021,
- Approximately:
  - 8,000 bed days lost to date740 patients,
  - 740 patient with labratory confirmed COVID-19 associated with incidents or outbreaks,
  - 370 staff with labratory confirmed COVID-19 and possible links to incidents or outbreaks.

It was noted that the A1N-MDU at THE University Hospital of Wales (UHW) had the highest number of deaths and that in comparison with other Welsh University Health Boards (UHBs), CVUHB was “middle of the road” and trending with other UHBs. However in January and February of 2021, CVUHB had seen a significant spike in cases.

The Commitee was advised of the mortality rates from November 2020 to January 2021:

- 25% Mortality rate from Hospital Acquired COVID-19,
- 44% of inpatient COVID-19 deaths were hospital acquired,
- 89% of those deaths were linked to an outbreak,
- November to December 2020 there were 45 HCA COVID-19 deaths,
- January to April 2021 there were 176 HCA COVID-19 deaths.

Themes were identified that drove the data to the levels presented. Some of the themes included:

- Patients testing negative and becoming psoitive up to 5 days into admission,
- Patients having multiple moves during their hospital stay,
- Staff behaviours,
- Issues with documentation.

It was noted that some of the actions that had been taken were:

- Continuation of regular communications to staff regarding social distancing, Personal Protective Equipment (PPE) and not coming into work when sympomatic,
- Retesting patients in amber areas 72 hours after admission and then every 5 days therafter,
- A daily Infection, Prevention & Control (IP&C) Cell and a fortnightly PPE Cell,
- Commenced early discussions with the laboratory to plan for a potential third wave.

Impact of COVID-19 on Patient Safety

The Committee was advised that hospital visiting had been restarted and was being undertaken carefully to ensure that all risks were balanced.

It was noted that over 300,000 people had been vaccinated and that CVUHB were currently inviting priority group 10 for vaccinations, and that over 80% of groups 1 to 7 had been vaccinated. This was ahead of the plan by 2 weeks.

It was noted that the Did Not Attend (DNA) rate was the biggest challenge and had been significantly high in the previous week due to the issues around the AstraZeneca vaccine, however since opening up to allow more people to book appointments themselves, the DNA rates had slightly decreased over a 24 hour period.

Health Inspectorate Wales (HIW) – Activity Update and Primary Care Update

The Committee was advised that Health Inspectorate Wales (HIW) had scaled down their inspection work during the pandemic and in October 2020, HIW had informed CVUHB of a planned programme of quality checks from November 2020 to January 2021.

It was noted that there had been once focused inspection at the Mass Vaccination Centres and 2 tier 1 quality checks. One tier 1 quality check had been undertaken on East 12 at the University Hospital Llandough (UHL) which had been positive, with just one ongoing issue concerning environmental risk assessments which the patient safety team were hoping could now be reinstated.

Themes and Trends in Never Events

The Committee was advised that since April 2015 there had been 34 Never Events reported by CVUHB. The highest number per year was 7 and the lowest was 3.

It was noted that wrong site surgery was the most commonly reported never event with 8 incidents being reported which included wrong site anaesthetic blocks and dental extractions.

Half of the Never Events had occurred at the UHW and the 8 wrong site surgery Never Events were reported by the Surgery Clinical Board, half of which had occurred in the Dental Hospital.

In terms of themes and trends, the most recurring theme identified related to staff factors which had been seen particularly in the dental arena and a meeting was held with Cardiff University to improve the level of supervision for dental trainees.

The Committee was advised that the development of a Human Factors Framework and Training Strategy would be an important element of the revised QSE Framework for the next 5 years. Embedding a Human Factors and Systems based approach to safety would support the reduction of Serious Incidents (SI's) and Never Events.

Gosport Review

The Committee received an update on the Gosport report concerning deaths caused by excessive opiate usage at the Gosport War Memorial Hospital, which originally been presented to the Committee in 2019. The Committee noted that there was an outstanding action relating to building a clinical audit of anticipatory prescribing into the national audit of end of life care, and that an update on all outstanding issues would be brought to the Committee meeting in June 2021.

Draft Quality, Safety and Experience Framework (Presentation)

The Committee was advised that for strategic context, key documents would be needed to shape the thinking around the QSE framework which included;

- Welsh Government's "A healthier Wales: long term plan for health and social care", 2018,
- NHS Patient Safety Strategy 2019 (2021),
- Worl Health Organization (WHO) Global Patient Safety Action Plan 2021-2030

Eight themes had been identified for CVUHB to base the QSE framework on:

- Safety Culture
- Leadership and Prioritisation
- Patient experience and involvement
- Patient safety learning and communication
- Staff engagement and involvement
- Data and Insight
- Professionalism
- Quality Governance

It was noted that when the framework is brought to the Committee in June it would include an implementation plan setting out what was achievable in year one, year two etc.

Board Assurance Framework (BAF) – Patient Safety

The Director of Corporate Governance (DCG) advised the Committee that the Board Assurance Framework (BAF) had been presented to the board and was brought to the QSE Committee to allow assurance to the board that it had been discussed.

Thromboprophylaxis Policy

The Thromboprophylaxis Policy was received and approved.

Swab, Instrument and Sharps Count Policy and Procedure

The Swab, Instrument and Sharps Count Policy and Procedure was received and approved.

Minutes from Clinical Board QSE Sub Committees

The Committee was advised that the Clinical Boards (CB) had managed to keep their Quality and Safety meetings wholly in place throughout the COVID-19 pandemic, and that items of importance could be found in the QSE Committee meeting minutes.

Recommendation:

The Board is asked to:

- **NOTE** this report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Mental Health Capacity and Legislation Committee Chair's Report**								
Meeting:	**UHB Board**					**Meeting Date:**	**27.05.2021**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Corporate Governance Officer**								

Background and current situation:

The Mental Health Capacity and Legislation Committee held its last meeting on 20 April 2021. This report provides the Board with a summary of the key issues discussed at that meeting.

KEY ISSUES TO BRING TO THE ATTENTION OF THE BOARD:

A Patient Story - Sectioned Under the Mental Health Act

The patient story provided information of a patient who had been sectioned under the Mental Health Act in Cardiff and Vale University Health Board's (CVUHB) inpatient facilities and her experience.

The Mental Capacity Act Monitoring Report & Deprivation of Liberty Safeguards (DoLS) Report

It was noted that CVUHB had received a letter from the Welsh Government (WG) to inform the implementation of the Liberty Protection Safeguards (LPS) which are planned to come into force in April 2022.

It was noted that a set of key indicators had been agreed which would provide the Mental Health Capacity and Legislation Committee with a trajectory over a period of time which included the number of DoLS applications, and the number that were completed.

It was noted that there was a lack of understanding and acknowledgement from professionals across the Health Board in relation to Court of Protection processes and requirements which had been identified as a training need. Relevant training would be provided for staff in the next two months as well as the provision of suitable guidance to support staff with difficult clinical decision making.

It was noted that each of the Clinical Boards had a Quality and Safety Governance arrangement which enabled them to monitor the level of training in this area.

Mental Health Act Monitoring Exception Report

The Mental Health Act Monitoring Exception Report was received, and the Mental Health Act Manager (MHAM) advised that the Mental Health team were still awaiting a response from legal

advisors regarding the section 136 issues concerning when the clock started ticking in the Accident and Emergency (A&E) department, and that the issue remained unresolved. The Committee noted that a further legal opinion had been sought and that the Mental Health Clinical Board were awaiting the response. It was agreed that the newly appointed Vice Chair would raise this issue at a national level as it effect all Local Health Boards and has remained unresolved for a considerable time.

The Committee was advised that the number of Children and Adolescent Mental Health Services (CAMHS) section 136 referrals had increased and that there were no repeat presentations, therefore each assessment was in relation to a different child.

The Committee noted that the outcome of those assessments was 86% being admitted to hospital.

It was noted that the Mental Health service who deal with adolescents had seen a marked increase in demand and that Covid-19 had done a lot with the unsettling of this age group. It was noted that a joint funded project lead would be looked at to explore good practice in this area and to try and get into the agenda to make some improvements.

The Committee was advised that the team had been in discussion with the Mental Health Tribunal (MHT) and had met with the Vice President to express concerns that had been raised in relation to how the tribunals were being conducted via telephone only, and questions had been raised as to whether this affected a person's right to a fair trial. The MHT had been in contact with Teams across NHS Wales to identify what equipment was currently in use, and to consider the options of finding a resolution as not all teams had access to digital devices.

It was noted that fundamentally defective applications continued to ensure effective communication between the Local Authority and UHB and promote Mental Health Act training across the UHB.

ACTION: Committee to receive an update from the Vice Chair on progress regarding the s136 waiting time issue.

Reforming the Mental Health Act

The Committee was advised that the consultation with staff concerning reforming the Mental Health Act (MHA) had lasted over a month and that it went to the Local Authority (LA) staff via the integrated teams but noted the responses were from CVUHB and not the LA.

The MHA review looked at the legislation and the practice and implementation of the legislation,. This latter element of recommendations relates largely to practice in England. It was was noted that all consultation responses received from Wales would be referred to the Welsh Government and would form part of their considerations when responding to the UK Government.

It was noted that it would be a little while before a proper assessment could be undertaken on the impact of any changes to the legislation on the Health Board. The Committee agreed that the proposals were a step in the right direction in terms of the modernisation of services but that there would need to be support to implement changes.

Mental Health Measure Monitoring Including Care and Treatment Plans Update Report

The Committee were advised that the service had been through an exceptionally busy period and it was still challenging to deliver the requirements of the Mental Health Measure.

It was noted that Part 1a of the measure – 28 day referral to assessment compliance target of 80% was particularly challenging.

In the context of Covid-19 it was noted that the service had started to see the surge in demand for Mental Health service with 150 referrals in March 2021.

It was noted that the main third sector providers had seen the highest number of referrals in February 2021 and that they were almost at 500 a month between them.

It was noted that a significant uptake in referrals had been seen and they were fearful that once schools reopened, another increase would be seen.

It was noted that there was increasing demand and increased capacity due to the effects of COVID-19 and some tier 0 work with education would be needed which had received around £600k of funding which would be looked at moving forward.

The Committee was advised that assurance could not be provided around the compliance and the decision as to how the Board is alerted needed to be taken.

It was noted that the issues would need to be escalated through the Chairs Report and the actions needed to be reviewed and reported to Board when back on track.

Information relating to children and adolescents were missing from the papers and reports. The Chair of the Board and of the Committee reiterated the need to consistently provide these in the future. This undertaking was provided and will be monitored.

It was noted that the Committee was unable to provide assurance in relation to Child and Adolescent Mental Health in relation to the Measure because information had not been presented.

Corporate Risk Register – Mental Health Clinical Board Risks

The Committee were advised that there were 2 risks with scores over 15 relevant to the Mental Health Clinical Board.

The risks remained stagnant since March's Board meeting however it was anticipated that both entries would be de-escalated at May's Board meeting following the successful implementation of appropriate controls for each risk.

The Committee Work Plan

The Committee were advised that the work plan reflected what was in the Terms of Reference which were approved at the last Committee meeting.

It was noted that the Patient Story needed to be added as a standing item and that the Mental Health Updates would be discussed at future agenda setting meetings.

Committee Annual Report 2019/2020

The Committee Annual Report 2020/2021 was ratified following a Chairs Action was taken to allow the Committee Annual Report to be presented to the Board meeting in March 2021.

RECOMMENDATION

The Board is asked to:

- **NOTE** the contents of the report.

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant, click here for more information

Prevention		Long term		Integration		Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable

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Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	9 March 2021

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/meetings-and-papers/
Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee. The meeting scheduled to take place in January 2021 was cancelled due to operational pressures related to the pandemic.

CHIEF AMBULANCE SERVICES COMMISSIONER'S REPORT

Stephen Harrhy presented an update on the following areas:

- Ongoing work with the Fire and Rescue Services (as potential first responders)
- Safe cohorting of patients to help reduce handover delays at emergency departments
- The progress developing a dashboard to help health boards better plan their services working in real time with the ambulance service
- The work of the Ministerial Ambulance Availability Taskforce, the interim report had been submitted to the Minister for Health and Social Care
- Emergency Medical Retrieval and Transfer Service (EMRTS) - Members were notified that accessing capital funding had been an issue for the service in terms of their expansion plans and this had now been resolved.
- Non-Emergency Patient Transport Service (NEPTS) - Members noted that the roll out was almost complete; the final two health boards would soon complete the transfer and the CASC thanked the Members for their support in progressing this matter.
- Emergency Medical Services Framework - Members noted that the EMS Framework had been refreshed. The version produced was less technical than previous iterations but continued to link to the care standards and core requirements but was more focused on outcome and outputs, a change which was welcomed by the Members. There were no specific issues to raise and the framework had been discussed at the EASC Management Group. The Framework was approved by the Committee.

PROVIDER ISSUES

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:

- Covid pandemic, escalation levels at WAST and also learning lessons
- Red performance remained below the target
- Serious adverse incidents

- Handover delays had increased leading to unacceptable waits for ambulances
- Update on the use of personal protective equipment and the Health and Safety Executive
- Progress on the Operational Delivery Unit at WAST and linking with Chief Operating Officers
- The Demand Management Plan at WAST had increased to level 5 and this meant that people in communities who would have normally received an ambulance response being left to make their own arrangements.

FOCUS ON - EASC ANNUAL PLAN AND COMMISSIONING INTENTIONS

Members noted the intention to focus on three areas in alignment with health boards' resetting:

1. Focus on commissioned services
2. Transformational work programmes
3. Develop the commissioning cycle more fully.

Members noted that the Annual Plan and Commissioning Intentions had been discussed at the EASC Management Group and the guiding principles agreed included:

- Intentions will be at the strategic level and will be extant for a minimum of 3 years
- Collaborative priorities ie WAST, HBs and EASC Team will be agreed annually for each intention
- They will focus on delivery and outcomes
- Each intention will have annually agreed aims, product or indicator or a combination of these.
- They will recognise the challenges of resetting in post-Covid environment and the opportunities to fast track service transformation
- They will not replace or override extant requirements within the commissioning framework or statutory targets or requirements.

For emergency medical services the commissioning intentions included:

- seizing the opportunities afforded by the Welsh Clinical Response Model and the 5 Step EMS Ambulance Pathway.
- optimising the availability and flexibility of front line resources to meet demand.
- maximising productivity from resources and demonstrate continuous improvement.
- developing a value-based approach to service commissioning and delivery which enables an equitable, sustainable and transparent use of resources to achieve better outcomes for patients.
- collaborating to reduce and prevent harm, and improve quality of service and outcomes for patients.
- collaboratively developing and delivering services that allow the ambulance service to contribute to the wider health system.

Members asked about the 111 Service Programme and Contact First plans; the Committee was not currently responsible for commissioning these services under the Statutory Establishment Order for the EAS Joint Committee. Members were aware of the increasing symbiosis of the 999 service and the 111 Service Programme. The 111 Service Programme Board was also considering the right governance arrangements to avoid duplication.

Members noted the current position that the 111 Service reported through its Programme Board and the Contact First reported through to the National Programme for Urgent and Emergency Care. Members felt it would be helpful that the processes could be simplified and noted that the EASC Joint Committee could provide strong governance for these services.

The EMRT service had been allocated funding to establish the Critical Care Service (£1.7m) as well as funding to support the Major Trauma Network.

WELSH AMBULANCE SERVICES NHS TRUST (WAST) DRAFT INTEGRATED MEDIUM TERM PLAN (IMTP)

The draft WAST IMTP was received. In presenting the plan, Jason Killens highlighted the overarching (current draft) summary position including:

- The plan built on previous plans
- Recognises the EMS 999 service and also the front end of the 111 service (through the programme board)
- Recognised that this was a 3 year plan although Welsh Government only asked for an annual plan
- Demand and Capacity review investment and efficiencies to be made; increasing hear and treat rate

Next 12 months

- Call handling (111 roll out – BCUHB in June and CVUHB will be the last health board to come on line)
- Implement new SALUS system – national system for 111 in the summer (Plans for CVUHB could be brought forward after the new system is implemented if required)
- More call handlers and clinicians and investing in senior clinicians in 111 to develop options for patients
- Digital options and offers to be developed – including video assessments with clinical staff (begin to defray as much activity with a digital offer)
- WAST expect 111 and 999 services to come together as a clinical service and work through how this may look in the future
- Demand and capacity – appointing a further 127 staff to close relief gap and concurrently the efficiency work – will involve changing rosters
- Electronic patient clinical record; will improve data collection and accessibility and connection of data sets which will inform decision making
- Respiratory and other pathways
- NEPTS – national footprint for the first time

Additional offers could include (if commissioned)

- Recruit a further 50 paramedics
- More staff through advanced practice (20 in September)
- Implement 'Beyond the Call,' responding with specialist clinicians and a level 2 full service nationally.

Members noted that additional information would be developed to provide a sense of what might be achieved on performance into the final version of the IMTP. The model for rural areas was also of interest to Members and further work would take place to discuss improving services.

Members **RESOLVED** to:

- **SUPPORT** the draft WAST IMTP.
- **APPROVE** the Chair and CASC sign off the plan at the appropriate time before submission to the Welsh Government.

FINANCE REPORT

The EASC Finance Report was received. Members noted the stable position, 100% balanced plan. There were no anticipated difficulties to complete the finance report at year end.

Members **RESOLVED** to: **APPROVE** and **NOTE** the report.

EASC GOVERNANCE INCLUDING THE RISK REGISTER

The EASC Governance report was received.

Members noted:

- The temporary changes to the model Standing Orders in line with the Welsh Health Circular 2020/11 would revert to the original Standing Orders on 31 March 2021.
- The EASC Directions and Regulations
- The Risk Register which had been received at the EASC Management Group
- The EASC Sub Group membership had been clarified for all health boards
- Plans to improve public access to Committee meetings in line with health boards.

Members **RESOLVED** to:

- **APPROVE** the Model Standing Orders for EASC noting the changes following the completion of the Welsh Health Circular 2020/011 on 31 March 2021
- **APPROVE** the risk register.

Key risks and issues/matters of concern and any mitigating actions
• Increasing handover delays • Red performance not meeting the target - risk register amended to demonstrate deterioration in performance • Decreasing Amber performance - risk register amended to demonstrate deterioration in performance • WAST Demand Management plan at level 6 • Next 'Focus on' session – a modern ambulance service
Matters requiring Board level consideration and/or approval
• None
Forward Work Programme
Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**11 May 2021**			

Report Title:	**Health & Safety Committee – Chair's Report**								
Meeting:	**Board Meeting**						**Meeting Date:**	**27/05/2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**X**	
Lead Executive:	**Chair Health & Safety Committee**								
Report Author (Title):	**Corporate Governance Officer**								

SITUATION

To provide the Board with a summary of key issues discussed at the Health & Safety Committee held on the 30 March 2021.

Health & Safety Overview

The Committee were introduced to the new Head of Health and Safety (HHS) who provided them with an overview of Health and Safety.

It was noted that there were some areas in Cardiff and Vale University Health Board (CVUHB) to be improved upon and that improved value could be achieved.

e-Datix was a suggested area that could provide improved value by providing instant investigation.
It was noted that the immediate cause of an incident, the controls that were not present or utilised had to be identified to improve.

It was identified that a standard audit system where the Organisation could proactively identify shortcomings, assign appropriate actions and communicate those would also provide improved value.

The Committee was advised that out of 12 RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reports in January 2021, only one was due to a specified injury and the remaining 11 were a result of 7 day absenteeism.

It was noted that a Health and Safety review had commenced on Monday 29 March and that it was sponsored at an Executive Director level with the full support of the Chief Executive Officer (CEO).

Assurance was provided that the outputs from the Health and Safety review would update the Health and Safety risk register as well as other risk registers.

Enforcement Agencies Report

The Committee was advised of 2 Health & Safety executive (HSE) updates since the last Health & Safety (H&S) Committee meeting:

1) CVUHB had received a notice of contravention from the HSE in relation to fit testing in a nursing home. An action plan was provided to them and HSE were very satisfied with the action that was taken. HSE had officially closed the notice, however CVUHB actions were continuing in respect of fit testing across the organisation.

2) The HSE were working closely with the Her Majesty's Coroner in relation to CVUHB staff deaths due to COVID-19. The HSE had fully investigated the event and had concluded that the death was not RIDDOR reportable as they did not consider it to be a work related exposure to coronavirus.

It was noted that CVUHB had been advised to review all risk assessments in line with the new COVID-19 variants.

Lone worker Devices Report

The Committee were advised the use of lone worker devices had decreased during the COVID-19 pandemic and it was noted that training would be given to increase the use.

It was noted that some lone worker devices could be allocated to vulnerable staff affected by domestic abuse or stalking if required, and that training would be provided to those staff members on using the devices.

The Committee were advised that communication from the Health and Safety department would be provided to staff each month which would include information including incident statistics, RIDDOR reports and lone worker usage.

It was suggested that the statistics on the use of lone working devices should be a standing item on the Health and Safety Committee agenda.

Regulatory and Review Body Tracking Report

The Committee were advised that the report was brought to the Committee bi-annually however there had not been any environmental health inspections due to the ongoing COVID-19 pandemic.

Training Requirements and Compliance

The Committee were advised that the Health and Safety team were now able to offer more training courses due to a drop off in COVID-19 work.

The Health and Safety team had worked with the Leading, Educating and Developing (LED) team on the Electronic Staff Record (ESR), and work had progressed on ensuring that ESR had the correct competencies matched to staff and that the courses were recorded correctly.

The Committee was advised by the Head of Health and Safety that he wanted to enforce the Link Worker system whereby once staff were trained , they could then cascade the training to other staff.

It was noted that a Health and Safety dashboard would be made available to demonstrate compliance statistics and that it would be relevant to individual Clinical Boards.

The Committee were advised the not all staff had access to computers to undertake mandatory training and the Committee Chair (CC) suggested that the LED should develop a strategy to ensure computer access for those staff as nothing should be preventing staff from receiving training.

Health and Safety Policy Update

The Committee noted that health & safety policy update had not been finalised and that an update would be provided to a future meeting.

The Committee noted that the existing statement of intent would be developed and strengthened and a one page standalone statement of intent would be produced outlining CVUHB's commitment to managing health and safety effectively. The document would be supported by a detailed charter which would be signed by each Executive Director and cascaded broadly to all staff and patients to raise awareness of the commitment to health & safety.

Environmental Health Update

The Committee was advised that no environmental health inspections had been carried out at the time of writing the report but it was noted that they had started to engage again as COVID-19 restrictions were being lifted.

It was also noted that an inspection had taken place in the food processing unit however feedback had not yet been received.

An Environmental Officer had been appointed and had started undertaking work to review key areas of environmental health.

Fire Enforcement and Management Compliance Report

The Committee were advised that unwanted fire signals had increased as a direct result of more activity on CVUHB sites.

It was noted that UHW has the largest number of devices in the Health Board and that some of the devices needed to be changed. CVUHB had been awarded £173K to address the replacement of devices in the tower block at UHW and had also secured monies for fire compartmentation work to be done at community sites.

The Committee was advised that NHS Wales had a compliance target of 85% and that fire safety training compliance needed to be improved in CVUHB, and that significant falls had been seen in training compliance during COVID-19 despite the training being available electronically.

It was noted that:

- face to face training would be reintroduced over the next couple of months which should improve compliance, fire safety training was mandated and it was suggested that executive challenges be provided to Clinical Board to increase compliance,
- the communications team would be providing a promotional piece that explained that fire safety was a statutory requirement and it was noted that ward managers could be held accountable for that training,

- a new HHS would present a monthly report on health and safety issues to the Management Executive (ME) meeting so that performance and compliance could be monitored,
- the Board would receive assurance through the overall workforce dashboard which outlined compliance statistics, the minutes of the Health and Safety Committee and the Committee Chairs report.

Recommendation:

The Board is asked to:

- **NOTE** the report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Stakeholder Reference Group Report**								
Meeting:	**UHB Board**						**Meeting Date:**	**27th May 2021**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**X**
Lead Executive:	**Abigail Harris**								
Report Author	**Sam Austin, Chair of Stakeholder Reference Group**								

SITUATION

The following report provides Board with a summary of the key issues discussed at the Stakeholder Reference Group (SRG) meeting held on 23 March 2021.

REPORT

BACKGROUND

This is a report provided to the Board by the Chair of the UHB SRG.

ASSESSMENT

The SRG considered the following.

Shaping Our Future Clinical Services

The SRG received a presentation from Nav Masani and Vicky Le Grys. The SRG welcomed the direction of travel being described but asked whether the backlog of activity and tired workforce created by the pandemic might make it difficult to move forward with transformational changes to the way services are provided. They were informed that this did present a challenge but it was clear that the UHB could not simply revert to providing services in the same way that they had been provided prior to the pandemic. There must instead be greater emphasis on prevention and early intervention and improved clinical pathways. Staff were certainly exhausted but it had been encouraging that they had come forward in large number to engage in clinical workshops on the future of clinical services.

The SRG suggested that if UHL was further developed car parking facilities and access to UHL would have to be improved. Active travel must be encouraged and cycle parking needs to be improved.

The SRG raised concerns that some people, frequently with serious conditions, were presenting too late to primary care. Access to a wide range of different practitioners, not just GPs, must be improved.

Concern was raised that the elderly have less access to technology and could therefore be disadvantaged by some of the proposed changes. The SRG was reassured that face to face consultations would remain available for those who preferred it or who could not access or use the technology. Health inequality is an issue and the UHB must be mindful of the recently published Race Equality Action Plan. The SRG was assured that an Equality Health Impact Assessment had been undertaken and would continue to be updated throughout the programme. It was vitally important to engage with all communities and a comprehensive engagement programme had been devised.

It was agreed that members of the SRG would help publicise the engagement process within their organisations and networks and encourage people to participate.

South East Wales Vascular Services Engagement

The SRG received a presentation from Vicky Le Grys. The SRG was informed that Vascular services in South East Wales are provided from UHW, Grange University Hospital and Royal Glamorgan Hospital. At present, however, there is an urgent temporary arrangement in place for Cwm Taf residents. The service in Cwm Taf UHB became undeliverable at the end of 2020 and these patients were currently being seen in either Aneurin Bevan UHB or Cardiff and Vale UHB. There were many challenges facing Vascular services which make it difficult to provide them from all the hospitals that currently provide them and clinicians have therefore been discussing how Vascular services could be reconfigured. They have reached a collective agreement that the best way to provide Vascular services would be via a hub and spoke model. This would mean all major Vascular operations would be done in one hospital but patients

would still attend their local hospital for work/advice prior to their operation and for rehabilitation after their operation. This model would make the best use of skill and staff and would result in better outcomes for patients. A number of things were considered when identifying where the 'hub' should be including the need for a range of other services to be on the same site such as Major Trauma services. Taking these requirements into account, UHW is considered the 'best fit' for the 'hub'. 'Spoke' hospitals will be retained at Royal Gwent Hospital, Grange University Hospital, Royal Glamorgan Hospital and UHL.

The SRG enquired whether population size had been the main reason for selecting UHW as the Hub and whether if there were more people in South East Wales there be more than one Hub? They were informed that one hub was required as this would then provide the critical mass of operations required to enable clinicians to develop and maintain their skills. UHW had been selected due to the other specialties on the site. The SRG also enquired whether recruitment was an issue and they were informed that the finite number of Vascular surgeons had driven the development of Hub and Spoke models for Vascular services across the UK including the other parts of Wales.

Members of the SRG agreed to publicise the engagement process within their organisations and networks and encourage people to participate.

@ Home Locality Based Integrated Care Model
The SRG received a brief presentation from Cath Doman on the development of an @ home locality-based integrated care model. The model is based on keeping people well, healthy, independent and at home. This will require an extensive range of support and expertise. Specialist care and support e.g. hospital care and specialist children's services must be there when required but the default position must be to provide care in peoples' homes or as close to it as possible.

The SRG welcomed the @ home concept. It noted that education/information and early intervention would be key to the success of the model. The SRG enquired about integrated health and social care budgets. They were informed that although there were a lot of pots of funding available to the Regional Partnership Board this was separate funding and did not challenge the traditional 'siloing' of budgets and moving forward there was a need to consider where resources should be brought together.
The SRG enquired what the UHB was doing with regards to falls prevention. Cath Doman explained that falls were a huge factor in long term disability. Primary care colleagues were aware of the signals that could indicate that individuals might be at increased risk of falls and early intervention is key. If someone does fall admission to hospital might not necessarily be the best course of action and instead there needs to be support to allow them to remain at home safely.

It was agreed that Cath Doman would return to a future meeting of the SRG to provide more detail of the development of the model.

RECOMMENDATION
The Board is asked to:

- **NOTE** this report.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	✓
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care	✓

		sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	✓	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	✓
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓
Equality and Health Impact Assessment Completed:	Not Applicable								

Report Title:	**Local Partnership Forum Report**								
Meeting:	UHB Board						**Meeting Date:**	May 2021	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	Executive Director of People and Culture								
Report Author (Title):	Workforce Governance Manager								

Background and current situation:

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of Workforce and OD. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum usually meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

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

This report provides Board with a summary of the key issues discussed at the meeting held on 22 April 2021

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

- The Forum received a presentation from Victoria Legrys, Programme Director, on Shaping Our Future Clinical Services. Ms Legrys had previously met with the Forum prior to the formal launch of the engagement process. This was now complete and an analysis of the feedback had begun.

- The Deputy Chief Executive updated the Forum on the following:
  - A Programme Business Case had been submitted to Welsh Government (WG) for UHW2 asking for endorsement. If approved, this would allow us to proceed to the Strategic Outline Case stage.
  - The Annual Plan had been submitted to WG. This set out the approach to be taken over the next year in regards to: our response to the pandemic; short and medium term recovery plans; and links with the longer term strategy

- The Deputy Director of Operations for Mental Health Clinical Board, was in attendance to provide a joint presentation on the Covid-19 Response and recovery in Mental Health with Peter Hewin (lead rep for MHCB). As a Clinical Board they tried to prepare for this to ensure readiness for an expected increase in demand while also keeping momentum around their transformation agenda and keeping safe. 4 priority areas were identified as staff and team resilience, outpatient models and locality working, effective home working and co-production (including the use of peers with experience of mental health conditions and services). A number of challenges were also identified including activity and demand, but also new ways of working and positive risk taking.

- A new All-Wales Respect and Resolution Policy has been developed which supersedes both the Dignity at Work Process and Grievance Policy. It has been approved at an All-Wales level and is going through local ratification processes ahead of the official launch date of 1 June 2021. The new Policy builds upon an approach started with the Maximising Attendance at Work Policy which recognises that treating people fairly doesn't mean treating everyone the same. It requires us all to make sure we approach difficult workplace issues with the aim of resolving them at an early stage and without formal policy and processes being invoked. The Policy is ACAS approved and includes tools and flowcharts to support staff and managers find solutions earlier. There will also be an All-Wales mediation network and training delivered in partnership with staff representatives.

- LPF received the Finance Report, Workforce KPI Report and Patient Safety, Quality and Experience Report for February 2021.

Recommendation:

The Board is asked to:

- **NOTE** the contents of this report

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	X	Involvement	
Equality and Health Impact Assessment Completed:	Not applicable								

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Mrs Margaret Foster, Chair
Lead Executive	Mr Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	18 March 2021

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Managing Director's Report – the main issues noted were:

- **Welsh Risk Pool** - the 2020/21 £121m DEL forecast includes significant additional risk since December due to the current national lockdown. Cases which would have otherwise continued to settlement are being delayed into the next financial year. The potential risk to the outturn has been quantified at £6m and mitigating steps are being taken to see what other appropriate action can be taken to reduce any changes to the forecast outturn. The risk-sharing agreement has been frozen as at the end of January at the agreed figure of £13.779m and this has been communicated to Directors of Finance.
- **SSPC Membership** - The Minister is currently updating the regulations to enable both Health Education and Improvement Wales, and Digital Health & Care Wales, to become full voting members of the Shared Services Partnership Committee. As part of this process, Welsh Government have taken the opportunity to review the Shared Services element of the Velindre NHS Trust Establishment Order to ensure that it appropriately covers all the services provided and offered by NWSSP. Their findings were that the Order remains appropriate, and in accord with the definition of what NWSSP were established to do.
- **TRAMS** - Committee Members were written to at the start of February to confirm their **APPROVAL** to support the TRAMs proposal and specifically to fund a small and non-recurring revenue gap in years 3 and 4 of the project through a first call on NWSSP savings. Positive confirmation of support was received from all NHS organisations on this proposal, including a number who have committed to use their share of any NWSSP savings even though they do not directly benefit from the TRAMS business case. Feedback is currently awaited from the Minister's Office with regard to endorsement of the Programme Business Case following the positive Capital Infrastructure Investment Board meeting on the 28th January.

Items Requiring SSPC Approval

Annual Plan – Since presenting the Plan to the January SSPC, the Director of Planning, Performance, and Informatics has met individually with Committee members to discuss the indicative plan and confirm key priorities for 2021-22. The Touchpoint meeting with the Welsh Government Planning team on 2 March was followed by a further meeting with the Finance Delivery Unit on 8 March. Both were extremely positive. The key aspects of the plan, and the associated financial implications and requirements, were presented to the Committee. The plan is ambitious but proportionate and financially balanced. The plan seeks to:

1. Support the NHS in reducing the four harms of COVID19, including the vaccination campaign.
2. Continue to deliver the basics well, with a strong focus on end user experience.
3. Review processes and tailor services to customer priorities as they restart areas such as planned care.
4. Implement a number of 'Once for Wales' solutions that deliver service improvement and transformation.
5. Apply learning from the pandemic and embed new efficient and sustainable ways of working across the organisation.
6. Put the voice, health, and wellbeing of our staff at the heart of our plans.

The Plan was supported by Committee members in particular highlighting the potential impact and support NWSSP could have with regard to the foundational economy and the decarbonisation agenda. The Committee **APPROVED** the plan.

Laundry Services - Sufficient progress has been made with three out of the five existing laundries to allow the TUPE transfer process to conclude on 1st April. A number of appointments have been made to strengthen the management structures within NWSSP to oversee the transfer and subsequent operation of the laundry service going forward as well as ensuring the next phase of the laundry development is taken forward in a timely manner. The financial positions have largely been agreed with ABUHB, BCUHB and Swansea Bay for the three laundries transferring on 1 April. The transfer will mean customers who currently have their laundry service provided by one of these laundries will continue to receive the same service "as is" with no anticipated change in delivery arrangements or cost attributed to that service at the present moment. A draft Service Level Agreement has been documented for the provision of this service which was **APPROVED** by the Committee and which will be reviewed after the end of the first quarter of operation together with the development of additional KPIs.

Temporary Medicines Unit - The Committee **APPROVED** the extension of the associated TMU SLA and Technical Agreements, up to March 2023.

Scan4Safety- The Scan4Safety Business Case was presented by the NWSSP Director of Procurement and the Programme Manager. This had previously been reviewed by the Committee in January. In addition, it had been taken to DoFs in February and was going back to DoFs on 19th March. The benefits of the initiative were reiterated and were fully supported by the Committee. The Committee **APPROVED** the Full Business Case for submission to Welsh Government subject

to endorsement of the revised funding arrangements by DOFs on 19th March 2021.

NHS Wales Mediation Network – The Committee were asked to consider a request to fund the costs associated with the development of a new Mediation Network for NHS Wales. The development of the Network is seen to be an integral part of the wider work to address concerns relating to bullying and harassment arising from Staff Survey feedback, setting a framework for improved working relationships and encouraging respect and early resolution of grievances and dignity at work matters. The Committee **APPROVED** the request to fund the 2021/22 costs (approx. £60k) from a call on savings within NWSSP.

Digital Workforce Systems Scheduling – The Committee received a proposal relating to the adoption of a Once for Wales e-scheduling system contract for District Nursing and other Community-based staff at its January 2021 meeting. The required approach was endorsed in the January meeting and the Committee were now being asked to **NOTE** the award of a two-year contract for this system with effect from 31 March 2021.

Finance, Workforce and Governance Updates

Project Management Office Update – The Committee reviewed and noted the programme and projects monthly summary report, which highlighted the team's current progress and position on the schemes being managed.

Finance and Workforce Report - As at the end of M10 the year-end forecast remains at a break-even position. The final ESR recharges for 2020/21 have now been confirmed to UHBs/Trusts and the recharge invoices raised in February following the previously noted risk in respect of this. The previously communicated risk associated with the CTES SIP Fund has been reduced and £0.368m of funds will be returned to UHBs/Trusts in 2020/21.

Corporate Risk Register – there is now one red risk on the register, relating to the replacement of the NHAIS system which is due to go live on 1 July. Two former red risks, relating to the implications of BREXIT and the replacement of the Ophthalmology Payments system have now been reduced to an amber rating.

Finance Monitoring Reports – the Committee were provided with the monitoring returns for Months 9, 10 and 11 for information.

Matters requiring Board/Committee level consideration and/or approval

- The Board is asked to **NOTE** the work of the SSPC and ensure where appropriate that Officers support the related work streams.

Matters referred to other Committees

N/A

Date of next meeting	20 May 2021