Public Board Meeting

Thu 25 May 2023, 09:30 - 14:55

The All Nations Centre (Muller Hall), CF14 3NY

Agenda

09:30 - 09:32
2 min

1. Welcome & Introductions

Charles Janczewski

09:32 - 09:33
1 min

2. Apologies for Absence

Charles Janczewski

09:33 - 09:34
1 min

3. Declarations of Interest

Charles Janczewski

09:34 - 09:37
3 min

4. Minutes of the Board Meeting held on 30.03.2023

4 Public Board Minutes 30.03.23.pdf (23 pages)

09:37 - 09:40
3 min

5. Action Log - 30.03.2023

5 Public Action Log.pdf (3 pages)

09:40 - 12:35
175 min

6. Items for Review & Assurance

6.1. Patient Story - Paul's Story

15 minutes *Jason Roberts*

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

10 minutes *Charles Janczewski*

6.2 Chair's Report to Public Board - May 2023.pdf (6 pages)

6.3. Chief Executive Report

20 minutes *Suzanne Rankin*

6.3 CEO Report to Board _May 23_Final.pdf (4 pages)

6.4. Board Assurance Framework

10 minutes *James Quance*

6.4 Board Assurance Framework - May 2023 - Covering report.pdf (3 pages)

6.4a Board Assurance Framework - May 2023.pdf (61 pages)

6.5. Chairs Reports from Committees of the Board

10 minutes

6.5.1. Senior Leadership Board

Suzanne Rankin

6.5.1 SLB Chairs Report.pdf (5 pages)

6.5.2. Audit & Assurance Committee: 04.04.23

John Union

6.5.2 Audit Chair's Report 4.4.23.pdf (3 pages)

6.5.3. Quality, Safety & Experience Committee: 11.04.23 (paper) & 09.05.23 (verbal)

Ceri Phillips

6.5.3 QSE Chairs Report.pdf (4 pages)

6.5.4. Finance & Performance Committee: 19.04.23 (paper) & 17.05.23 (verbal)

Michael Imperato

6.5.4 Finance Chair's Report 19.04.23.pdf (2 pages)

6.5.5. Mental Health Legislation & Mental Capacity Act Committee: 02.05.23

Ceri Phillips

6.5.5 MHLMCA Chairs Report 02.05.23.pdf (4 pages)

6.6. Integrated Performance Report:

45 minutes *Fiona Kinghorn / Jason Roberts / Rachel Gidman / Paul Bostock / Catherine Phillips*

- Population Health
- Quality & Safety
- Workforce (People)
- Operational Performance
- Finance

6.6 Integrated Performance Report May 2023.pdf (34 pages)

6.7. Break for Refreshments (10 minutes)

6.8. Six Goals Improvement Programme Presentation

20 minutes *Paul Bostock*

6.8 Six Goals Programme.pdf (13 pages)

6.9. Transforming Access to Medicines (TrAMS)

10 minutes *Meriel Jenney*

6.9 TrAMs cover.pdf (2 pages)
6.9a TrAMs paper for Board.pdf (3 pages)

6.10. Strategic Plan Update

10 minutes *Abigail Harris*

6.10 Planning Update.pdf (5 pages)

6.11. IMTP / Annual Plan Update: Q4 Report

15 minutes *Abigail Harris*

Annex 1 & 2, plus appendices from can be found under the Supporting Documents Folder.

6.11 Board IMTP Q4 Assurance Paper.pdf (4 pages)

12:35 - 14:35
120 min

7. Items for Approval / Ratification

7.1. Anti-Racist Action Plan

10 minutes *Rachel Gidman*

7.1 Anti-racist Action Plan Paper.pdf (3 pages)
7.1a Appendix 1 - CAVUHB Anti-Racist Action Plan.pdf (3 pages)

7.2. Business Cases:

20 minutes: 10 minutes per case

7.2.1. Regional Cataracts Business Case

10 minutes *Abigail Harris*

The Full Business Case can be found under the Supporting Documents Folder

7.2.1 Regional Cataracts Business Case Cover.pdf (7 pages)
7.2.1a Regional Cataracts Business Case Executive Summary.pdf (10 pages)

7.2.2. CAVOC Theatres Outline Business Case

10 minutes *Abigail Harris*

The Full Business Case & Appendices can be found under the Supporting Documents Folder

7.2.2 UHL Orthopaedic Theatres OBC Cover Report.pdf (3 pages)
7.2.2a UHL Theatres OBC Exec Summary v9.pdf (14 pages)

7.3. New Velindre Cancer Centre Full Business Case

10 minutes *Abigail Harris*

Confidential items pertaining to this matter will be discussed in a Private session of the Board meeting immediately before this Public session of the Board meeting.

Appendices for this public item can be located in the Supporting Documents Folder

7.3 nVCC Revised FBC Board - Public Session Final Cover Report.pdf (10 pages)

7.4. Break for Lunch (30 minutes)

7.5. Clinical Consultation Plan for the Welsh Language

5 minutes *Rachel Gidman*

7.5 Clinical Consultation Plan Paper.pdf (3 pages)
7.5a Appendix 1 - Clinical Consultation Plan.pdf (10 pages)

7.6. Cardiff and Vale Regional Partnership Board Joint Area Plan 2023-2028

10 minutes *Abigail Harris*

7.6 CAV RPB Joint Area Plan 2023-2028 Cover Report.pdf (5 pages)
7.6a CAV RPB Joint Area Plan 2023-2028.pdf (27 pages)

7.7. Integrated Annual Plan 2023/2024 Update

10 minutes *Suzanne Rankin / Abigail Harris*

7.7 Integrated Annual Plan Update 25 May 2023.pdf (14 pages)

7.7.1. NHS Planning Toolkit Resubmission

The NHS Planning Toolkit can be found under the Supporting Documents Folder

7.7.1 NHS Planning Toolkit Cover Report Board May 2023.pdf (2 pages)

7.8. Annual Review of Standing Orders and Standing Financial Instructions

5 minutes *James Quance*

7.8 Annual Review of SOs and SFIs May 23.pdf (4 pages)

7.9. Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act (2016)

10 minutes *Jason Roberts*

7.9 Nurse Staffing Levels Cover Report.pdf (3 pages)
7.9a Annual Assurance Report on Compliance with the Nurse Staffing Levels.pdf (22 pages)

7.10. Fire Safety Policy

5 minutes *Rachel Gidman*

7.10 Fire Safety Policy Cover.pdf (2 pages)
7.10a Fire Safety Policy.pdf (9 pages)
7.10b Fire Safety Policy EHIA.pdf (20 pages)
7.10c Fire Safety Policy Statement.pdf (1 pages)
7.10d Fire Safety Management Arrangementsv2.pdf (31 pages)

7.11. Committee / Governance Group Minutes:

5 minutes

1. *Audit & Assurance: 07.02.23 & 04.04.23*
2. *Strategy & Delivery: 24.01.23 & 14.03.23*
3. *Finance: 15.02.23*
4. *Charitable Funds: 06.12.22*
5. *Mental Health Legislation & Mental Capacity Act: 31.01.23*
6. *Quality, Safety & Experience: 07.03.23 & 11.04.23*
7. *Health & Safety: 17.01.23*
8. *Stakeholder Reference Group: 24.01.23*
9. *EASC: 14.03.23*

7.11.1a Audit Minutes 07.02.23.pdf (14 pages)
7.11.1b Audit Minutes 04.04.23.pdf (15 pages)
7.11.2a SD Minutes 24.01.23.pdf (10 pages)
7.11.2b SD Minutes 14.03.23.pdf (13 pages)
7.11.3 Finance Minutes 15.02.23.pdf (7 pages)
7.11.4 CFC Minutes 06.12.22.pdf (13 pages)
7.11.5 MHLMCA Minutes 31.01.23.pdf (15 pages)
7.11.6a QSE Minutes 07.03.23.pdf (12 pages)
7.11.6b QSE Minutes 11.04.23.pdf (10 pages)
7.11.7 H&S Minutes 17.01.23.pdf (13 pages)
7.11.8 SRG Minutes 24.01.23.pdf (6 pages)
7.11.9 EASC Confirmed minutes 14.03.23.pdf (15 pages)

14:35 - 14:55
20 min

8. Items for Noting & Information

8.1. Draft Annual Report

5 minutes *James Quance*

The Draft Annual Report can be found under the Supporting Documents Folder

8.1 Annual Report covering report.pdf (5 pages)

8.2. Draft Annual Opinion from Head of Internal Audit

5 minutes *James Quance*

8.2 Draft HIA Opinion Annual Report 22-23 - Covering Report.pdf (2 pages)
8.2a C&V UHB Draft HIA Opinion & Annual Report 22-23.pdf (38 pages)

8.3. Corporate Risk Register

5 minutes *James Quance*

8.3 Corporate Risk Register Update - May 2023.pdf (5 pages)
8.3a Corporate Risk Register May 2023 - Board Summary.pdf (2 pages)
8.3b - Appendix B - Assurance Map.pdf (31 pages)

8.4. Chair's Reports from Advisory Groups and Joint Committees

5 minutes *James Quance*

1. NWSSPC Assurance Report March 2023
2. Stakeholders Reference Group Report March 2023
3. WHSSC Briefing March & April 2023 - ***The April briefing can be found in the Supporting Documents Folder due to it's large file size.***

8.4.1 NWSSPC Assurance Report 23 March 2023.pdf (4 pages)
8.4.3 WHSCC Joint Committee Briefing March.pdf (6 pages)

14:55 - 14:55
0 min

9. Agenda for Private Board Meeting:

i) *Approval of Private Board minutes*

ii) *Accelerated Cluster Development (Confidential Discussion)*

iii) *Major Incident Plan Update (Confidential Discussion)*

iv) *Pentyrch Lease Arrangements (Confidential Discussion)*

v) *Radiology Informatics System Procurement (RISP) Full Business Case (Commercially Sensitive Information)*

vii) *Approval of Private Committee minutes*

14:55 - 14:55
0 min

10. Any Other Business

Charles Janczewski

14:55 - 14:55
0 min

11. Review of the meeting

Charles Janczewski

14:55 - 14:55
0 min

12. Date and time of next meeting:

Thursday 27th July 2023 - All Nations Centre
9.30am

Unconfirmed Draft Minutes of the Public Board Meeting
Held On 30 March 2023
Barry Hospital
9.30am

Chair:		
Charles Janczewski	CJ	University Health Board Chair
Present:		
Paul Bostock	PB	Chief Operating Officer
David Edwards	DE	Independent Member – ICT
Susan Elsmore	SE	Independent Member – Council
Akmal Hanuk	AH	Independent Member – Local Community
Keith Harding	KH	Independent Member – University
Abigail Harris	AH	Executive Director of Strategy & Planning
Angela Hughes	AH	Assistant Director of Patient Experience
Michael Imperato	MI	Independent Member – Legal
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Mike Jones	MJ	Independent Member – Trade Union
Fiona Kinghorn	FK	Executive Director of Public Health
Lianne Morse	LM	Assistant Director of People & Culture
Sara Moseley	SM	Independent Member – Third Sector
Catherine Phillips	CP	Executive Director of Finance
Ceri Phillips	CP	University Health Board Vice Chair
James Quance	JQ	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
David Thomas	DT	Director of Digital & Health Information
Rhian Thomas	RT	Independent Member – Capital & Estates
John Union	JU	Independent Member – Finance
In attendance:		
Stephen Allen	SA	Chief Officer – Community Health Council
Malcolm Latham	ML	Chair – Community Health Council
Melanie Wilkey		Deputy Director of Commissioning
Observers:		
Joanne Brandon	JB	Director of Communications
Tim Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Rachel Jenkins	RJ	Member of the Public
Max Scott-Cook	MSC	Member of the Public
Max Wallis	MW	Member of the Public
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People & Culture
Jason Roberts	JR	Executive Nurse Director
Sam Austin	SA	Chair of the Stakeholder Reference Group

Item No	Agenda Item	Action
UHB 23/03/005	**Welcome & Introductions** The University Health Board Chair (UHB Chair) welcomed all to the Board meeting in English and in Welsh.	
UHB 23/03/006	**Apologies for Absence** Apologies for absences were noted.	
UHB 23/03/007	**Declarations of Interest** The Independent Member – Council declared an interest in the Mental Health Legislation and Mental Capacity Act Committee's Chair's report as she was part of the process for the implementation of Independent Mental Capacity Advocates (IMCA).	
UHB 23/03/008	**Minutes of the Meeting Held on:** The minutes from the Board meeting held on 26 January 2023 were received. The Executive Director of Public Health (EDPH) advised the Committee of 2 amendments: • Page 8 of the minutes to change "no testing" to "*periods of low testing*". • Page 8 of the minutes to change "it was noted that the testing ask was that we move towards meeting other health protection requirements" to "*It was noted that the Welsh Government ask was that Health Boards and regional partners should work towards providing a sustainable, all hazards, health protection joint service provision*'. The Chief Executive Officer (CEO) advised the Committee of 1 amendment: • Page 14 of the minutes to change "the backlog maintenance had grown to £15m" to "the backlog maintenance had grown *by* £15m". **The Board resolved that:** a) The minutes from the Board meeting held on 26 January 2023 were approved as a true and accurate record of the meeting, pending the amendments outlined above.	
UHB 23/03/009	**Action Log** The Action Log was received. The Director of Corporate Governance (DCG) advised the Board that the first items were marked as completed and that the remainder of the actions on the log were marked to be received by the Board at the meeting being held or a meeting in the future. **The Board resolved that:** a) The Action Log was reviewed and noted.	
UHB 23/03/010	**Chair's Report and Chair's Action taken since last meeting** The Chair's Report and Chair's Actions taken since last meeting were received. The UHB Chair advised the Board that in addition to the usual ratification and approval of Chairs' Actions, he had highlighted the range of services that the Adult Mental Health teams provided. He added that the services provided were very comprehensive and that his report outlined how those teams dealt with different areas.	

	The Independent Member – Third Sector (IMTS) thanked the UHB Chair for highlighting the Mental Health services and noted that the Mental Health Clinical Board was now in a much better place than previously reported. She added that her Mother had been a patient on the older adult Mental Health unit and that the average length of stay in those units was 92 days and asked if there was anything that could be done to provide assurance that the number of days could be reduced. The Chief Operating Officer (COO) responded that length of stay data was being looked at and work was ongoing to try and reduce the length of stay across the wider organisation, and that he would report back to Board in due course. The UHB Chair added that there were ongoing discussions with the Director of Operations for the Mental Health Clinical Board around the discharge of patients. **The Board resolved that:** a) The Chairs report was noted. b) The Chairs Actions undertaken were approved. c) The application of the Health Board Seal and completion of the Agreements detailed within the report were approved.	PB
UHB 23/03/011	**Chief Executive Report** The Chief Executive Report was received. The CEO advised the Board that the report marked her 12 months since joining the Health Board and noted that whilst the report highlighted her reflection, a lot of the 12-month period had been challenging for the Health Board. She added that it was important to bring balance to the conversation and to shine a spotlight on many of the great initiatives and innovations undertaken by teams within the Health Board and how the Health Board delivered care and services. A number of initiatives were highlighted which included but were not limited to: • Genomics Partnership Wales – It was noted the Health Board's All Wales Medical Genomics Service had been granted Welsh Government approval and funding to develop a centre of excellence at Cardiff Edge Life Sciences Park in Coryton, which was due to open later in the year and would be home to a national genomic health, research and innovation hub. • Robotic Surgery – it was noted that the state-of-the-art surgical robots enabled surgeons to perform complex procedures precisely and accurately and were supporting the treatment of colorectal and gynaecological cancer patients in Wales as part of the National Robotic Assisted Surgery Programme. • Wellbeing Hubs - Improving the provision of care in the Community. It was noted that Whitchurch Road Surgery and Maelfa Wellbeing Hubs officially opened their doors to patients at the new state of the art medical centres in 2022/23 and that the new buildings would give the teams the modern space it needed to expand the range of services available to registered patients. • Decarbonisation – it was noted that a piece of work was underway to look at, with a Clinical lens, opportunities to decarbonise Health Board's Clinical activity. The Independent Member – Finance (IMF) asked if there had been any initial feedback from the opening of the Wellbeing Hubs. The CEO responded that everybody had welcomed the opening of the buildings and that it had shown what was possible.	

	She added that the real feedback would be how the opportunities could be optimised further. The Executive Director of Strategic Planning (EDSP) added that the patients and also the staff were really benefiting from an improved environment. There were some areas to learn from, such as making sure community rooms were available at night time in order to best maximise the Health Board's reach. The Independent Member – Local Community (IMLC) noted that some GP services were still using a triage system post Covid-19 which was causing issues for some people in the community and asked if there were any successful models that could be used to improve other areas. The CEO responded that the variation was very clear within the Health Board and that there were still one or two single handed practices. She added that clustering was key alongside accelerated cluster development and that Primary Care colleagues were seeing increased demand in access and were ultimately seeing more patients. The CEO concluded that it was a Ministerial priority for the Health Board to provide assurance and that work was being taken to address that demand. **The Board resolved that:** a) The overview of first anniversary key achievements headlines were noted.	
UHB 23/03/012	**Board Assurance Framework** The Board Assurance Framework (BAF) was received. The DCG advised the Board that he would take the paper as read and noted that the risks identified within the report had been through the usual process whereby Executives had been updated and the BAF risks had been presented to the relevant Committees of the Board. He added that the overall picture was stable. The Independent Member – Third Sector (IMTS) advised the Board that under the Leading Sustainable Culture Change risk, the number of requests to facilitate cultural programmes/OD work within Directorates and teams had increased and noted that the new People and Culture Committee should pick up on that risk. **The Board resolved that:** a) The 15 risks to the delivery of Strategic Objectives detailed on the attached BAF for March 2023 were reviewed and noted.	
UHB 23/03/013	**Chairs reports from Committees of the Board:** The Chairs Reports from the Committees of the Board detailed on the agenda were received and the following specific comments were highlighted by Chairs: • **Mental Health Legislation & Mental Capacity Act Committee** – The UHB Vice Chair advised the Board that Mental Health services had seen an increase in referrals which had been managed well. He added that the response trajectory was moving in the right direction and advised the Board that credit was due to the Mental Health Clinical Board staff for their ability to cope with the additional pressures and demands seen on the service. • **Quality, Safety & Experience (QSE) Committee –** The UHB Vice Chair advised the Board that he had chaired the meeting in the absence of the IMC.	

	The UHB Chair thanked the IMC for her contribution as Chair of the Committee and noted that from April 2023, the UHB Vice Chair would be the Committee Chair. The CEO noted that the report had included stillbirth rates and that those had increased. She added that whilst recognising there was no benchmark data at present, no action was described within the report to provide the Board with assurance. The UHB Vice Chair responded that the Chair's report provided an overview of the detailed discussion held by the Committee which could be viewed in the Committee's documents. He added that within the detail it was clear that better and earlier diagnosis in stillbirths could be identified. The Executive Medical Director (EMD) advised the Board that the Committee had looked at stillbirth data in detail and noted that the teams involved wanted to ensure that the service being provided was safe. She added that there had been 2 Health Inspectorate Wales (HIW) inspections and that HIW had responded positively and that further detail could be provided to Board during the Maternity Services update on the agenda. The Assistant Director of Patient Experience (ADPE) commented that a deep dive with regards to stillbirths would be considered at the QSE Committee in the next couple of months. • **Digital & Health Intelligence Committee –** The Independent Member – ICT (IMICT) advised the Board that the Committee had noted the sustained progress on the Digital Strategy and transformation. He added that the challenges around finance and resource were recognised and that the Committee had maintained its focus on information and cyber security. • **Strategy & Delivery Committee** – The Independent Member – Legal (IML) advised the Board that he would provide a verbal update as the meeting had only taken place the previous Tuesday. It was noted that the following areas had been discussed by the Committee: - Strategic Quality Plan - Staff Networks - Gender Pay Gap Report. It was noted that the Gender Pay Gap would be considered at the new People and Culture Committee. • **Finance Committee** – The Independent Member – Capital & Estates (IMCE) provided the Board with a verbal update and noted that the Health Board was on track to achieve its revised trajectory. She added that the Committee had also discussed the following business cases: - New Velindre Cancer Centre - UHW Lift Refurbishment - Mortuary Refurbishment - The Health Board's Revenue Business Cases • **Senior Leadership Board** – The CEO advised the Board that this was the first time the Board had received a report from the Senior Leadership Board (SLB) and noted that it outlined the discussions held by the SLB for the period 5th January – 2nd March 2023. She added that there was point of clarification which was that page 3 referred to a letter received by HIW around harassment of HIW staff and that it was important to note that it was not directed to Cardiff and Vale and was a generalisation.	AH RG

	The Board resolved that: a) The Committee Chairs' Reports were noted.	
UHB 23/03/014	**Integrated Performance Report:** The Integrated Performance Report was received. **Population Health:** The EDPH advised the Board that she would highlight a couple of points which included: • Model for Access to Maternal Smoking Cessation Support (MAMSS) It was noted that the most recent data had outlined that 51% of pregnant women were referred to MAMSS for stop smoking advice, which had reflected a slight decrease from 66% reported in Quarter 2 and 65% for Quarter 1. The EDPH advised the Board that a revised pilot pathway was introduced in November 2022 to increase engagement levels to quit smoking beyond initial support and advice and that 75% of all pregnant women who received an initial intervention with MAMSS, had accepted on-going support which reflected a significant increase. • Covid indicators The Board was advised that in the second week of March 2023, most Covid indicators were stable or had fallen, following a small rise during February 2023. It was noted that in regards to the Autumn 2002 booster and flu vaccination programme 83% had been vaccinated which was the link to breaking the impact on severe ill health and had seen a decrease in admissions to ICU as well as mortality. The EDPH thanked the teams for their hard work in achieving that. She added that the Spring Booster vaccination programme had now been confirmed. The UHB Chair advised the Board that a member of the public had asked for a question to be raised at the meeting and invited the EDPH to respond. The question was: *"I am aware that the National Antiviral Service, which CAVUHB have housed and run so efficiently for the people of Wales, is coming to an end shortly. I am interested to know for the population of CAVUHB what new provisions are being planned to ensure that those at high risk of developing severe COVID-19 will still be identified, notified and have access to appropriate treatments in the community".* The EDPH responded: The National Antiviral Service had been an important service for vulnerable people and the Health Board had hosted the National service on behalf of Wales and had triaged and assessed over 22,000 Welsh citizens. She added that 2,000 had received an infusion of treatment in their local Health Board area and that the Health Board had been informed that WG was withdrawing funding. It was noted that a significant amount of work had been undertaken on behalf of the National Service with regards to what the services needed to look like. The EDPH noted that for Cardiff and the Vale, the plan was to continue to operate a similar service in the way that the National Antiviral Service had worked.	

The EMD added that the service would continue and for the user of the service, it would be the same as it had always been and that the only significant change identified was the way in which medication, specifically tablets, were couriered.

Quality and Safety:

The ADPE advised the Board that she would take the report as read and would highlight some areas for noting which included:

- Concerns

The ADPE noted that despite the current demand on the service, the Patient Experience team had achieved a slight improvement in the overall 30 working day response time for all concerns and had closed 77% of concerns in January 2023 within 30 working days and 81 % in February 2023.

She added that a number of initiatives were in place to capture patient experience data such as:

- Bedside feedback posters
- Telephone systems
- CIVICA text system
- QR codes added to patient letters

- Falls

The ADPE advised the Board that a lead on falls had been appointed.

- Nationally Reported Incidents (NRIs).

It was noted that the number of open and overdue NRIs increased in February 2023 with 46% being overdue however the overall trajectory of NRIs had improved.

The ADPE added that the implementation of the new Duty of Candour should help with the grading of incidents.

- Hospital Infections

The Board was advised that in relation to C'diff, the Health Board could not achieve the expected reduction for 2022/23. However, there were 8% fewer cases than the equivalent period 2021/22, which was the lowest in Wales.

The ADPE added that the total infection rates were falling and that MRSA and E coli had slightly reduced.

The EMD advised the Board that the Integrated Performance Report was still maturing in terms of presentation of the Quality item and noted that a dashboard would be the preferred method of reporting. That was being worked upon.

The CEO noted that no reference to the Children's Hospital was noted under the pressure damage data and asked if it was being collected.

The ADPE responded that the Children's Hospital data was collected as part of the Quality Indicators which were presented to the QSE Committee.

The UHB Vice Chair shared a good news story regarding Ward B1 at UHW and noted that it was the first ward in Wales to receive accreditation which outlined how staff were valued and the patient outcomes.

	The IMCE noted that the concerns data listed “communication” as one of the largest areas where concerns were raised and asked if more detail could be given with regards to what areas of communication had raised the highest concerns. The ADPE responded that communication was complex and featured in every concern such as email, telephone calls and letters. She added that the Patient Experience team was trying to break down the data in the new ‘Once for Wales’ system which formed part of the QSE Framework. The IMCE asked if the top 3 categories in communication concerns could be identified. The ADPE responded that the main concern raised by patients was around the amount of explanation they received and the complexity of communication with people had at some of the most vulnerable times in their lives. She added that ensuring that people could maintain the information they received would help with communication concerns because a number of concerns had escalated from a patient stating “that was not said to me” when it probably had been. **Workforce:** The Assistant Director of People & Culture (ADPC) advised the Board that workforce data was still challenging but improvements had been noted during February 2023. She added that sickness/absence had significantly reduced by nearly 2% and noted that it should continue to reduce as the Spring and Summer period started. The Board was advised that the rate of compliance with Values Based Appraisals (VBAs) had risen over the last 6 months and that Clinical Boards had been set an improvement target of 60% by the end of March 2023, then 85% by the end of June 2023. The ADPC thanked the Clinical Boards for putting additional focus on the importance of having a VBA. It was noted that the Statutory and Mandatory training compliance rate had risen, to 76.06% for January 2023 but that it was 8.94% below the overall target. The ADPC concluded that as noted in previous reports, over the Winter months the People and Culture Team had focussed on the ‘Main Effort’ and the team were aligned to the following Health Board priorities and the People and Culture Plan: - Wellbeing (including cost of living support) - Recruitment - Retention - Workforce Planning She added that in addition to those areas, the People Services Team would be supporting managers with operational matters, e.g. Employee Relations, Managing Attendance, Change Management, Terms & Conditions, etc. The IMTS thanked the ADPC for the hard work undertaken by the People Services Team and asked what progress was being made in relation to supporting staff who were on long term sickness leave with long Covid-19. The ADPC responded that the People Services team was continuing to support staff and managers to help find the best solution for that individual as well as closely working with Trade Union colleagues and the Wellbeing teams. The IMCE noted an increase had been seen in the number of appeals received regarding flexible working and asked if there was a clear policy in place around that.	

The ADPC responded that there was a robust policy in place and that there was a link between staff retention and flexible working.

She added that more could be done within the organisation with regards to flexible working and noted that the People Services team was working closely with Clinical Boards so that other options could be identified (such as different shift patterns).

The IMF noted that a communications plan had been implemented to stop the use of HCSW agency workers by 1 April 2023 and asked for an update.

The ADPC responded that all Clinical Boards had signed up to stop the use of HCSW agency workers and noted that agency HCSWs had been encouraged to join the internal Staff Bank so that resource could be supplied to the relevant areas.

She added that the Health Board was ready for the "switch off" of HCSW agency work and that it would be kept under review.

Operational:

The COO advised the Board that when talking about operational aspects, he tended to focus on the quality, safety and experience side of things rather than targets.

He added that good improvements had been observed across the organisation over the past few months and provided the Board with some examples which included:

- 12 hour waits in the Emergency Department had reduced from 1,100 in October 2022 to around 600 in March.

- 4 hours ambulance waits had reduced from 230 in September 2022 to zero in February 2023.

- 3 hours ambulance waits had reduced from 228 reported in December 2022 to 17 in February 2023.

The COO thanked the organisational teams for their continued hard work.

It was noted that performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) had been poor and the Board was advised that there was not data at present to provide further information, but that work was ongoing to collect the relevant data.

The COO added that a summit with key stakeholders had taken place in February 2023 with the ambition to achieve significant increases in performance to make Cardiff and Vale an upper quartile performer when compared to its UK peers.

He added that the Health Board was measured on Stroke performance through the Sentinel Stroke National Audit Programme (SSNAP).

It was noted that the score provided by SSNAP for October to December 2022 was a grade C.

The COO added that the Health Board aspired to achieve a rating of grade 'A' for SSNAP.

It was noted that the Health Board had held two internal Stroke summits and a number of improvements to the Stroke pathway were now being implemented including:

- Increased Clinical Nurse Specialists during out of hours
- Additional middle grade medical cover for the Emergency Unit (EU)
- Ringfencing of additional stroke beds to deploy the pull model from EU effectively

- Cancer

	The COO advised the Board that there had been a number of actions taken to improve the oversight and operational grip of the process for overseeing Cancer patients. He added that 3 Cancer summits had taken place with the Tumour Group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions were required to reduce the delays experienced by patients. It was noted that there was a current focus on minimising the number of patients waiting over 104 days to start their definitive treatment to less than 45 by the end of March 2023. • Planned Care The COO advised the Board that in March 2022, 7,000 patients had been waiting for over 3 years to be seen and that the aim was to reduce that to 0 by March 2023. He added that, unfortunately, the target would not be met and that around 800 patients were still waiting due to staffing capacity but also other factors, such as the industrial action observed during the Winter months. It was noted that more work was required in relation to the patients who had been waiting over 2 years which had started at 9,000 in March 2022 and had reduced to 2,500 by the end of March 2023. • Primary Care The Board was advised that the Health Board was 100% compliant in January 2023 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 7 of 7 patients receiving their visit with one hour. The COO added that pressure had continued within General Medical Services (GMS) and that there were 8 practices reporting either level 3 or 4 escalation. He added that he planned to share the 6 Goals programme at the next Board meeting to be received via the Integrated Performance Report. The UHB Vice Chair thanked the COO for the report and complimented the developments with regards to the Primary Care and the Mental Health services. **Finance:** The Executive Director of Finance (EDF) advised the Board that month 10 had been highlighted in the report and that since then, month 11 could be reported upon and so she would provide the Board with a brief update prior to the Board receiving more detail later on in the agenda. She added that at month 11, the Health Board was reporting an overspend of £24.658m which comprised of £8.983m of operational overspend and the planned deficit of £15.675m. It was noted that the Health Board had forecast a £26.9m deficit for the end of 2022-23. The UHB Chair thanked Executive colleagues for the report and noted his specific thanks to the ADPC and ADPE for seamlessly stepping into the role of Executive for their respective items. **The Board resolved that:** a) The contents of the report were noted.	**PB**
UHB 23/03/015	**Shaping our Future Wellbeing Strategy Refresh Update**	

	The Shaping our Future Wellbeing Strategy Refresh Update was received. The EDSP advised the Board that she would take the report as read. She added that the Health Board had successfully launched and promoted the dedicated website at the beginning of Phase 1 with over 1,000 visitors to the site as of 30/03/2023. It was noted that the feedback survey had also been launched when the website went live and that a number of staff and public engagement sessions had been held. The EDSP advised the Board that those sessions had been publicised widely through a number of different mechanisms and that in addition to those sessions, Clinical Boards and Corporate departments had also run staff engagement events and the feedback was being collated. She added that the Strategic Planning teams had planned the analysis work required to ensure that all of the feedback received was taken into consideration and that Cedar would be supporting that work. The CEO thanked the EDSP and their teams for the hard work and noted her pleasure at being involved in the engagement process. She added that she found it reassuring that consistency of feedback around key elements had been observed. **The Board resolved that:** a) The progress and risks described in the report and the proposed Strategy Launch date of 19th July 2023 subject to formal Board approval was noted.	
UHB 23/03/016	**Strategic Planning Update** The Strategic Planning Update was received. The EDSP advised the Board that it was a regular item on the agenda and that it updated the Board on key activities from a strategic planning lens. She added that the South East Wales Regional Planning Collaborative continued to make progress across all aspects of its work programme, with one of the prioritised areas being Ophthalmology and the use of the Vanguard theatres. It was noted that the Ophthalmology regional service strategy was led by Aneurin Bevan University Health Board (ABUHB) and that the Board were being asked to endorse that strategy. It was noted that the Ophthalmology regional service strategy set out how the Health Board would together with Cwm Taf Morgannwg and ABUHB to develop and deliver a regional Ophthalmology service model which reflected both the more specialist services and low complexity, high volume services The EDSP advised the Board that a business case was being developed separately which set out how the Health Board planned to operate on a regional basis in relation to non-complex cataracts, making use of the temporary theatres commissioned at UHW and other regional capacity available to the Health Board. The IMLC asked if working with the Third Sector on the Ophthalmology regional service strategy had been undertaken as it had not been identified in the report. The EDSP responded that in terms of community provision, working with community providers was important and noted that the omission of Third Sector information was probably an oversight which would be looked at for future reports.	

	The EDPH confirmed that all optometrists were equally part and parcel of the Health Board's community offer and she could therefore give assurance that the Primary Care contractors were involved. The contract reform was enabling those optometrists with additional skills to do much more so that a patient would only have to go to the hospital when the skills of the hospital staff were required. The IMICT asked what the Ophthalmology regional service strategy did to the Health Board's financial position moving forward. The EDSP responded that the strategy provided the overarching direction of travel and that the specifics would drop out in the annual plan. **The Board resolved that:** a) The progress being made across our strategic planning portfolio was noted b) The regional ophthalmology service strategic plan, as detailed in Annex 1 was endorsed.	
UHB 23/03/017	**Maternity Services Update** The Maternity Services Update was received. The ADPE advised the Board that following the writing of the report, a further HIW visit had occurred and so she would update the Board on the high-level verbal feedback received. It was noted that HIW had provided positive feedback that issues raised in the initial visit in November 2022 had been improved upon. It was noted that HIW had also observed improvements across many areas as well as an improvement in the experience received by service users. The ADPE advised the Health Board had been asked to provide assurance and clarification on a few areas which included: • Routine areas – for example record keeping • Infection control • Medicine Management It was noted that improvements included increased mandatory training compliance and oversight of compliance on the Health Board roster platforms to provide assurance of skill mix on each shift. The ADPE added that a Maternity Oversight Group, chaired by the Executive Director of Nursing and attended by the Executive Medical Director as well as Clinical Board representatives, convened every two weeks with the purpose of the Group being to oversee progress with the HIW improvement plan, the Ockenden improvement plan and wider quality and patient safety themes. She added that the decision had been made to appoint a Director of Midwifery and that the post was currently out to advert. It would be an important appointment for the Health Board. The IMCE asked how staff were reacting to and engaging with the HIW inspections. The ADPE responded that one of the areas identified in the verbal feedback from HIW was that more effort needed to be made to engage staff. She added that it would take some time because it required a cultural change and that the Senior Leadership teams needed to be aware of how staff would feel and react to inspections.	

	It was noted that the positive feedback around the patient experience was being fed back to staff. The CEO concluded that expectations needed to be managed because the original inspection took place in November 2022 and many subsequent conversations had been held with HIW and the written HIW report was not yet available. She added that an improvement plan had been submitted and that the final report had still not been received from HIW. It was expected towards the end of April. She added that it was not clear if this week's unannounced HIW visit would be included in the final HIW report or whether HIW intended to issue two separate reports (ie one to cover the November visit and the other to cover the visit in March). **The Board resolved that:** a) The recent HIW inspection and outcomes to date and the assurance provided in relation to the response were noted.	
UHB 23/03/018	**Integrated Medium Term Plan including: -** **Annual Plan & Medium-Term Financial Plan:** The Integrated Medium-Term Plan including Annual Plan & Medium-Term Financial Plan were received. Annual Plan: The EDSP advised the Board that the Health Board had a duty to submit a 3-Year Integrated Medium-Term Plan (IMTP) to Welsh Government (WG) as part of their statutory duties under the NHS Finance (Wales) Act 2014. She added that last year, the Health Board submitted an annual plan in a three-year context, because it had been unable to deliver a financially balanced plan in-year. It was noted that the 12-month summary or priorities played into the themes identified within the Integrated Performance Report which included: • To enable people with urgent or emergency care needs to access safe and high-quality care at the right time, in the right place, delivered by the right team • To recover, reset and transform planned care, Cancer and diagnostic services • To deliver exceptional specialist and Tertiary services for local, regional and national populations • To ensure that every child had the opportunity for the best start in life and to provide high quality, safe and patient centred women's services • To continue Mental Health transformation with a focus on the principles of home first, integration, safe hospital care and improving access to psychological support and specialist teams • To deliver improved services through the South East Wales Regional Priority Programmes; Ophthalmology, Orthopaedics, Diagnostics, Stroke and Cancer. The EDSP advised the Board that the priorities had been developed through all Clinical Boards and would be the mechanism for delivering against the Ministerial priorities. Medium-Term Financial Plan: The EDF advised the Board that in terms of the annual plan, the Health Board had run in excess of its resources by £26.9m which would worsen as it moved into the next year. She added that there was a responsibility to look at how the Health Board could get back into its allocated resources and that the conversation was ongoing.	

It was noted that the Health Board understood it was in a deficit and the continual pressures of increased demand had been compounded by a number of external factors, including the consequences of Brexit, the cost-of-living crisis and the war in Ukraine, all of which were impacting the Health and Social Care system across the UK.

The EDF advised the Board that it meant, as an organisation, it had been unable to deliver the level of recurrent savings that were set out in the 2022/2023 plan or mitigate a number of escalating cost pressures.

A number of financial plan key components were highlighted by the EDF which included:

- 2022/23 forecast outturn - £26.9m (against original planned position of £17.1m)
- Recurrent impact of 22/23 outturn / underlying deficit £40.3m (planned underlying position of £20m)
- 2023/24 1.5% Welsh Government core uplift in funding
- COVID local response costs £34.2m funded in 22/23, no allocation in 23/24
- Exceptional energy inflation £11.5m funded in 22/23, no allocation in 23/24
- Reduced Health Protection allocation impact - £8.4m
- Core recovery allocation reduced by £6.6m to drive regional solutions
- 2023/24 price and demand growth – inflationary impact/assumptions increase based on current economic outlook
- Essential service investments - £5m

The EDF advised the Board that in relation to the last item (essential service investments) it was a challenging financial position with the planned deficit of £88.4m.

She added that the position included the delivery of an ambitious 4% Cost Improvement which was double that which was achieved the year previously.

The EDF informed the Board that it was likely to take 5 years to achieve the level of savings identified.

It was noted that the plan had been robustly developed and shared widely across the organisation with the Senior Leadership team.

The COO noted that the Board needed to be aware that the plan presented did not close the gap on all of the Ministerial priorities and that the Health Board needed to be ambitious with the expectations on delivery and productivity.

The UHB Chair advised the Board that it was the most significant deficit he had encountered.

The IMLC asked if any plans were in place to look at alternative energy sources.

The EDF responded that energy was procured at an NHS Wales level and that the first thing being looked at was security of the supply already obtained by the Health Board and to ensure it was best value.

She added that a lot of work was required around alternative sources of energy, such as solar panelling, LED lights and other initiatives.

It was noted that it formed part of the wider Decarbonisation Strategy.

The COO advised the Board that from an optimistic operational perspective, the operational teams had not needed to worry about funding over the past 3 years and noted that teams needed to get back into the mindset that there was no more money and to drive ambition.

The UHB Chair advised the Board that Executive colleagues would continually try to mitigate as much as they could in relation to the regional picture.

The CEO added that what was known was that if the Health Board kept doing the same thing it had always done, the same results would be achieved and that was not viable.

	She added that there was a great deal of consistency across Wales and noted that further detail would be provided in the Private session of the Board during the discussion on the Accountable Officer letter. The IMC asked if conversations regarding a whole system approach had been held with Local Authority (LA) colleagues. The CEO responded that key discussions would be held with LA partners to ensure a collective discussion and to recognise the wide range of mutual dependencies. The Chair asked Board Members to note that WG were unlikely to accept the Health Board's plan given the level of deficit. It was noted that most of the factors were external (eg inflation, the Ukraine war and whilst Covid funding had gone, the impact of Covid was still being felt). **The Board resolved that:** a) The contents of the annual integrated plan 2023/2024 were noted. b) The plan for onward submission to Welsh Government on 30th March 2023 was approved.	
UHB 23/03/019	**Cardiff PSB Wellbeing Plan and Vale of Glamorgan PSB Wellbeing Plan** The Cardiff PSB Wellbeing and Vale of Glamorgan PSB Wellbeing Plans were received. The EDSP advised the Board that the report introduced the draft Well-being Plans for Cardiff and Vale Public Services Boards (PSBs): • Cardiff - the Council's Cabinet planned to approve Cardiff's Local Well-being Plan on 30 March 2023, subject to Board endorsement. • Vale – A PSB meeting had been arranged to formally sign off the Vale Well-being Plan for publication on the 3rd May 2023, subject to Board endorsement. She added that she would take the reports as read. The UHB Chair advised the Board that a huge amount of work had been undertaken to get the reports developed and thanked the EDSP and her team for all of the hard work. The IML noted that there was a new Future Generations Commissioner and asked if it was known if there was any change of focus that the Board needed to be made aware of. The EDSP responded that there was not and that the new Future Generations Commissioner had outlined in his March newsletter that it was his intention to take stock of everything before setting out his own focus. **The Board resolved that:** a) The draft Wellbeing Plans as the PSBs' statutory partner was endorsed.	
UHB 23/03/020	**Decarbonisation Action Plan 2023/24** The Decarbonisation Action Plan 2023/24 was received. The EDSP advised the Board that the plan had been taken through the Decarbonisation Delivery Group, Senior Leadership Board and Strategy & Delivery Committee and that the feedback had been reflected in the plan provided to Board. It was noted that the report took 2 views:	

	• What does the Health Board do at each level on decarbonisation and how would the culture be set for it? The EDSP advised the Board that a lot more work was required around how to engage staff and people within the organisation and that actions were being undertaken to set decarbonisation plans at a high level. • What people should be doing as individuals. It was noted that areas such as recycling and minimising waste would be key in that component. The EDSP advised the Board that there would be some resource requirement around making different choices and having different priorities. She concluded that the Decarbonisation Action Plan would evolve because it was a 1-year plan which would run alongside the annual plan. **The Board resolved that:** a) The 2023/24 Decarbonisation Action Plan was approved.	
UHB 23/03/021	**Velindre New Cancer Centre – Full Business Case:** **1. Strategic Case** **2. Management Case** The Velindre New Cancer Centre – Full Business Case was received. The EDSP outlined the position of the Full Business Case and noted that Velindre NHS Trust delivered aspects of specialist Cancer care for the Health Board's population. She added that the main facility was very outdated and did not meet today's hospital build standards and that the Velindre Trust had been working on plans to replace their facilities for a number of years. It was noted that the original Outline Business Case (OBC) was approved by Health Boards in 2018 and an update to the OBC was requested by WG in 2020 and agreed by WG in 2021. The EDSP advised the Board that in September 2022, the Health Board gave its support to two capital and revenue investment full business cases related to Oncology services: • Integrated Radiotherapy Solution to replace the existing 8 linear accelerators • Radiotherapy satellite centre at Nevill Hall Hospital in Abergavenny to provide additional capacity to meet future needs. She added that since 2018 a number of changes had occurred in both the financial and economic climate, which was very different now to 2018, and inflationary costs had risen by about £330K. It was noted that a discussion had taken place regarding the Clinical model and concerns had been raised by Clinicians in relation to the same. The EDSP advised the Board that it was unusual for a Cancer centre not to be on a hospital site and so the Nuffield Trust was brought in to give an independent review of the model of care. She added that the OBC was not seeking approval for a capital element because that was within the WG's remit, hence why the financial and economic cases could not be discussed in public.	

It was noted that WG was using the OBC to test a future funding Mutual Investment Model (MIM).

The EDSP advised the Board that the implications for the Health Board were around the financial consequences of the scale of the building because the footprint had increased from 17,0000 sqm to 30,000 sqm.

She added that in terms of scrutiny, the Deputy Director of Commissioning had undertaken a lot of work in terms of due diligence to make sure the Health Board could be satisfied that the costs identified were the real costs.

It was noted that the costs were taken to the Senior Leadership Board for scrutiny where it was agreed that the building in Velindre was very challenging. In particular, that the Health Board should seek assurance with regards to the Clinical model in light of the recommendations from the Nuffield Trust report. It was also noted that the Health Board's own estate required a lot of maintenance.

The EDSP noted that in terms of a financial risk, a £1.6m revenue investment would be required and noted that there were 2 exceptions outside of that funding arrangement:

- The costs associated with making the building Carbon Zero to meet the Welsh Government (WG) sustainability agenda. It was understood that those costs would be funded directly by WG but the Health Board would want assurance on that.
- Digital Costs to maximise digital potential of the nVCC

The EDSP noted that assurance would be required from WG to ensure that those costs did not fall to the Health Board.

The EMD added that attention was required as to how the OBC would lie within the wider clinical concept because Velindre's ambition to have a state-of-the-art cancer service would require access to emergency services. The Health Board would need to consider investing in services that supported the needs of Cancer patients who received treatment at the Velindre Cancer Centre. It was also highlighted that some of the Health Board's other patients (eg from the Haematology department) might also benefit from the new Velindre Cancer Centre.

The EDF highlighted that this would be a 25-year investment and that inflation was likely to run at the RPI index.

The Board resolved that:

a) The Board supported the case made for the patient and staff benefits of a new Cancer Centre contained within the nVCC business case.

b) The Board considered the revenue implications contained within the FBC, in the context of the Health Board's current and forecast financial position over a five-year time frame, to be unaffordable.

c) The Board required confirmation that the additional revenue costs could be funded through alternative means or mitigated entirely through a further specification review.

d) The Board confirmed its full commitment to working with Velindre NHST and all partners to resolve a number of matters which would facilitate the case proceeding:

(i) Confidence that Welsh Government's appraisal of the capital case fully tests value for money in the context of the current financial situation, recognising that the Commercial Case was for consideration and approval of WG.

(ii) Agreement that all partners were committed to fully implementing all of the recommendations in the Nuffield Trust Report, and the recently published National Cancer Plan, to ensure that the improvements in cancer care along the patient pathway and, in particular, the high-level acute needs of South East Wales population, were realised.

	(iii) Progression of agreement for shared use of the facilities and delivery of CAVUHB services at nVCC for further research and innovation and improvement of patient pathways, including ways of working, outcome monitoring and shared space. (iv) Confirmation of the alternative funding sources for the cost of carbon net zero and the digital transformation (v) Clarification on the rationale for the inclusion of the contract management costs in the revenue case, rather than as an offset for the Annual Service Payment as part of the capital case. (vi) Assurance from WG that Health and Social Services capital would be prioritised to cover the equipment costs.	
UHB 23/03/022	**Business Cases:** The Business Cases were received. • Mortuary Refurbishment Business case: The EDSP advised the Board that Executive Summary of the Business Justification Case (BJC) set out the rationale for the redesign/refurbishment of the Mortuary at the UHW and made the case for a capital investment of £3.385m to be funded from the All Wales Capital Programme. The IMCE advised the Board that the BJC had been received by the Finance Committee and had been scrutinised in detail where it was agreed that the Mortuary was a long standing risk which required the identified refurbishment and so had recommended the same to Board for approval. • Lift Refurbishment Scheme: The EDSP advised the Board that approval of the Lift Refurbishment Scheme would enable the refurbishment of 19 Lifts within Tower Block 1, Tower Block 2 and Ward areas of UHW to ensure the continued provision of safe services for patients and staff. • Revenue cases: The EDSP advised the Board that the following cases were endorsed at Senior Leadership Board (SLB) on the 16th March 2023. The values exceeded SLB's financial limits and therefore required Board level approval: (vii) Ockenden Business Case – The EDSP advised the Board that (viii) Critical Care Expansion and Part Team 24/7 Business Case (ix) Regional Health Protection Service Business Case The UHB Chair invited Board Members to ask questions in order of the Revenue Business Cases. The EMD noted that the Ockenden Business Case triangulated with the conversations held earlier in the meeting around Maternity services and endorsed the business case. The UHB Chair advised the Board that agreement of the Business Cases was part of the financial deficit already noted. **The Board resolved that:** a) The Business Cases were considered and approved.	
UHB 23/03/023	**Scheme of Delegation and Earned Autonomy** The Scheme of Delegation and Earned Autonomy were received.	

	The DCG advised the Board that he would take the paper as read and would provide a very brief update. He added that since the review of governance in Capital and Estates it had come to light that the Director of Capital, Estates and Facilities could only sign off an allocation of capital contract contingency of <£25k which meant anything above the amount was signed off by the Executive Director of Strategic Planning. It was noted that to support the Executive Director in Strategic Planning it was proposed that the Director of Capital, Estates and Facilities capital contract contingency value of sign off would be increased to <75k. The DCG added that the same principle applied to the Executive Director of Finance who could sign off allocation of capital contract contingency of <£125k with the Chief Executive signing all off allocation of capital contract contingency over that value and up to <£500k. He added that it was therefore proposed that the Executive Director of Finance's value to sign off allocation of capital contract contingency of be increased to <£250k to reduce the number of contract contingency increases been signed by the Chief Executive. It was noted that the changes had been discussed and agreed by the Executive Director of Finance and the Chief Executive but required the approval of the Board. **The Board resolved that:** a) The Director of Capital, Estates and Facilities could approve allocation of capital contract contingency of <£75k, was approved. b) Executive Director of Finance could sign off allocation of capital contract contingency of <£250k, was approved.	
UHB 23/03/024	**Armed Forces Covenant Duty Policy** The Armed Forces Covenant Duty Policy was received. The DCG advised the Board that the Armed Forces Covenant was established in 2011 and was seen as a promise by the nation that the Armed Forces Community should be treated fairly and face no disadvantage when accessing public and commercial services. He added that the Health Board had chosen to sign a pledge to honour the Covenant and support their Armed Forces Community. **The Board resolved that:** a) The Armed Forces Covenant Duty Policy (UHB 501) and the associated EHIA was approved.	
UHB 23/03/025	**Assurance Strategy 2021-4 and Risk Management Strategy** The Assurance Strategy 2021-4 and Risk Management Strategy was received. The DCG advised the Board that the documents received were important in setting out the Health Board's strategy with regards to assurance and risk management. He added that the implementation of the Strategy hoped to improve the overall governance of the organisation and the assurance provided to the Board by identifying gaps or limited assurance. It was noted that both documents were approved at the February 2023 Audit and Assurance Committee and referred to Board for ratification.	

	The DCG advised the Board that a fuller picture on audit work would be received at a future meeting. **The Board resolved that:** a) The progress made against the Advisory Recommendations made by Internal Audit were noted. b) The updated Assurance Strategy 21-24 and Risk Management and Board Assurance Framework Strategy were approved.	
UHB 23/03/026	**Board Committee arrangements for 2023/24** The Board Committee arrangements for 2023/24 were received. The UHB Chair advised the Board that he had spoken to each Independent Member regarding the proposed membership. He added that it was important to keep the effectiveness of the Board's Committees under constant review to ensure that they were fit for purpose and supported the Board in discharging its functions. **The Board resolved that:** a) The establishment of the following Committees of the Board were approved for 2023/24: (x) Audit Committee* (xi) Remuneration and Terms of Service Committee* (xii) Charitable Funds Committee* (xiii) Mental Health Legislation and Mental Capacity Act Committee (Mental Health Act requirements) * (xiv) Digital and Health Intelligence Committee (Information Governance) * (xv) Quality, Safety and Experience Committee* (xvi) Finance and Performance Committee (xvii) People and Culture Committee (xviii) Shaping Our Future Hospitals Committee – noting that this Committee was currently paused. b) The membership of Committees of the Board for 2023/24 was approved. *denoted a statutory Committee	
UHB 23/03/027	**Committee Terms of Reference & Work Plans 2023/24** The Committee Terms of Reference & Work Plans 2023/24 were received. The DCG advised the Board that the information linked to the previous item and the continuity of Committees. He added that the Terms of Reference and Work Plans were all reviewed by the relevant Committees. It was noted that it was good practice to have Work Plans in place whilst noting that they needed to be agile and respondent to risks identified across the organisation. **The Board resolved that:** a) The Terms of Reference and Work Plans were approved for the following Committees of the Board for 2023-24: **(xix)** Audit Committee* **(xx)** Remuneration and Terms of Service Committee* **(xxi)** Charitable Funds Committee*	

	(xxii) Mental Health Legislation and Mental Capacity Act Committee (Mental Health Act requirements) * **(xxiii)** Digital and Health Intelligence Committee (Information Governance) * **(xxiv)** Quality, Safety and Experience Committee* **(xxv)** Shaping Our Future Hospitals Committee – noting that this Committee was currently paused. b) The Terms of Reference and Work Plans for the Finance & Performance and People & Culture Committees would be reported to the May meeting of the Board following ratification by those Committees was noted. *denoted a statutory Committee.	
UHB 23/03/028	**Board Annual Plan** The Board Annual Plan was received. The IDCT advised the Board that the Board Annual Plan was subject to the same caveat as the Committee Work Plans around flexibility in response to Health Board risks. **The Board resolved that:** **a)** The Board Annual Plan 2023/24 was approved noting that changes could result from the embedding of proposed revised Committee arrangements and additional items would be added throughout the year to accommodate the delivery of Strategic Objectives which were undergoing a review and refresh.	
UHB 23/03/029	**Committee & Advisory Groups Annual Reports** The Committee & Advisory Groups Annual Reports were received. **The Board resolved that:** a) The Annual Reports from the Committees and Advisory Groups of the Board were approved. b) The proposed submission date for the Health Board's Annual Report and Accounts was noted and might be subject to change as referred to in the body of the report.	
UHB 23/03/030	**Hosting Agreement Extension with National Imaging Academy Wales** The Hosting Agreement Extension with National Imaging Academy Wales was received. The CEO advised the Board that Cwm Taf Morgannwg University Health Board currently hosted the National Imaging Academy Wales (NIAW) on behalf of Health Bodies in Wales. She added that the current hosting agreement expired on 31 March 2023 and therefore the CTM Board, and other Health Bodies in NHS Wales, were being asked to extend the Hosting Agreement for a further 3 years to 31 March 2026 **The Board resolved that:** a) The extension to the hosting agreement for the National Imaging Academy for Wales until 31 March 2026 was approved.	
UHB 23/03/031	**Procurement Contract Award - Vagal Nerve Stimulator** The Procurement Contract Award - Vagal Nerve Stimulator was received. The EDF advised the Board that as part of the Health Board's Standing Orders the contract award needed to be received by the Board due to is value. The EDF added that Livanova UK Limited was the only company that manufactured and supplied the devices.	

	The IMC asked if the Health Board could say that clinically, it was value for money. The EDF responded that it was based on the individual patient and that Livanova UK Limited was currently the provider of those devices. **The Board resolved that:** a) The award of a two-year contract to Livanova UK Ltd for the supply of Vagal Nerve Stimulators at a value of £720,000.00 including VAT was approved.	
UHB 23/03/032	**Committee / Governance Group Minutes:** The Committee / Governance Group Minutes were received. **The Board resolved that:** a) The Committee / Governance Group Minutes were noted	
UHB 23/03/033	**Audit Wales Annual Audit Report** The Audit Wales Annual Audit Report was received. The DCG advised the Board that Audit Wales pulled together all of the work they had undertaken for the Health Board over the year which was then received by the Board. He added that it was a useful document to have all of the work outlined in one place and that within the report were some areas required for improvement. **The Board resolved that:** a) The Audit Wales Annual Audit Report was noted.	
UHB 23/03/034	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Board that he would take the paper as read and that it was for noting. He added that the register was updated in the usual way with the cycle of challenge and report and that the Risk and Regulation team updated it. **The Board resolved that:** a) The Corporate Risk Register and the work in the area which was now progressing was noted.	
UHB 23/03/035	**Chair's Reports from Advisory Groups and Joint Committees:** The Chair's Reports from Advisory Groups and Joint Committees were received. **The Board resolved that:** a) The Chair's Reports from Advisory Groups and Joint Committees were noted.	

	Agenda for Private Board Meeting: ***i.*** *Approval of Private Board minutes* ***ii.*** *Private Chairs Report (confidential - ongoing legal proceedings)* ***iii.*** *Approval of Private Committee minutes:* - *Audit Committee – 8 November 2022* - *Digital and Health Intelligence Committee – 4 October 2022* - *Finance Committee – 14 December 2022 and 18 January 2023* - *Strategy and Delivery – 15 November 2022* ***iv.*** *Cardiff Edge – Lessons Learned (Confidential Discussion)* ***v.*** *Whitchurch Hospital Disposal Options (Confidential Discussion)* ***vi.*** *Rookwood Hospital Disposal Strategy (Confidential Discussion)* ***vii.*** *Mental Health Inquests (Confidential Discussion)*	
UHB 23/03/036	**Any Other Business** The UHB Chair thanked the Chief Officer – Community Health Council and the Chair of the Community Health Council (CHC) for the attendance at the Board meeting. He noted that it was the last Board meeting that they would be attending as representatives of the CHC and thanked them for their constructive and reliable relationship over the years.	
	Date & time of next Meeting: 25 May 2023 – All Nations Centre at 9.30am	

ACTION LOG

Following Public Board Meeting

30 March 2023

(Updated for the meeting 25 May 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
UHB 23/01/010	**S&D Committee – Chair's Report - Decarbonisation**	To consider having a Board Champion role for Decarbonisation. To carry out further work to ensure the impact assessment for Decarbonisation in the covering report template was properly considered/addressed by report authors.	**30.03.2023**	James Quance	**COMPLETED** Discussed on 30.03.23 Agenda item 7.4 Board champion role considered and discussed with UHB Chair – likely to continue to be included within the remit of the existing role of Wellbeing of Future Generations champion. Work is in progress to improve the completion of cover papers in general. Decarbonisation impact identified as an area that requires further guidance which is being developed.
UHB 23/01/005	**Action Log re Integrated Performance Report – Operational Performance**	Update on patient waiting lists should form part of the future integrated performance reports	**30.03.2023**	Paul Bostock	**COMPLETED** Discussed on 30.03.23 Agenda item 6.6
Actions in Progress					

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
UHB 23/01/011	**Integrated Performance Report: Quality and Safety**	Civica 'Once for Wales' – A report on Civica Patient feedback would be provided to the Board later in the year.	**27.07.2023**	Jason Roberts	**Update on 27 July 2023**
UHB 23/03/014	**Integrated Performance Report**	6 Goals programme to be received via the Integrated Performance Report.	**25.05.2023**	Paul Bostock	**Update in May 2023** Agenda item 6.7
UHB 23/01/011	**Integrated Performance Report**	To undertake a review of the Retire and Return Policy	**25.05.2023**	Rachel Gidman/Paul Bostock	**Update in May 2023**
UHB 23/01/018	**Board Champions**	Report to be provided at the end of each year to detail the work undertaken by Board Champions.	**28.09.2023**	Rachel Gidman/James Quance	**Update in September 2023.**
UHB 23/03/010	**Chair's Report re length of stay**	The Chief Operating Officer to report back to Board with regards to the length of stay data.	**28.09.2023**	Paul Bostock	**Update in September 2023**
Actions referred <u>TO</u> Committees of the Board/Board Development					
UHB 22/09/011	**Integrated Performance Report**	Pressure damage – the management approach to mitigating pressure damage issues to be explored further at the Quality, Safety and Experience Committee	**09.05.2023**	Jason Roberts	**Update in May 2023** Due to be considered at the QSE Committee meeting on 9 May 2023.
UHB 23/03/013	**QSE Chair's Report**	A deep dive with regards to stillbirths to be considered at the QSE Committee in the next couple of months.	**July 2023**	Jason Roberts/Angela Hughes	**Update in July 2023**

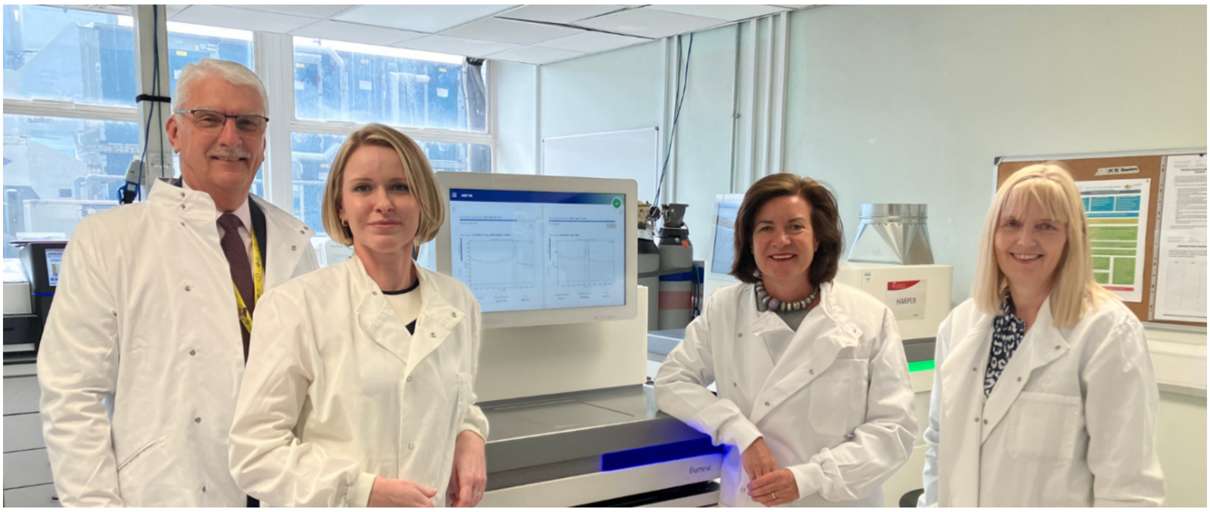
MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
UHB 23/03/013	**S&D Chair's Report**	The Gender Pay Gap is to be considered at the new People and Culture Committee	**July 2023**	Rachel Gidman	**Update in July 2023**
Actions referred <u>FROM</u> Committees of the Board/Board Development					
DHICH 14/02/007	Digital Transformation Progress Report	The Board should be advised on digital transformation matters at least twice a year at the request of the UHB Chair	**27.07.2023**	David Thomas / James Webb	**Update on 27 July 2023**

Report Title:	**Chair's Report to Board**			Agenda Item no.	6.2
Meeting:	**Board**	Public	x	Meeting Date:	25th May 2023
		Private			
Status *(please tick one only)*:	Assurance		Approval	x	Information x
Lead Executive:	**Chair of the Board**				
Report Author (Title):	**Head of Risk and Regulation**				

Main Report
Background and current situation:

The All Wales Medical Genomics Service.

On the 25th April 2023 the Minister for Health and Social Services Eluned Morgan MS ("the Minister") visited the Institute of Medical Genetics at University Hospital of Wales to learn more about the launch of the 'QuicDNA' clinical trial.



Welcomed by myself and project leads Sian Morgan and Dr Magda Meissner of the All Wales Medical Genomics Service (AWMGS), the Minister was invited to learn more about the clinical trial which will evaluate the benefits of an innovative liquid biopsy test in people with suspected lung cancer.

The clinical trial has been made possible through the All-Wales Medical Genomics Service (AWMGS), Illumina Technology, and multiple partner organisations (Welsh Government, Aneurin Bevan UHB, Cardiff and Vale UHB, industry and third sector), with the study attracting investment of over £2 million to assess how the use of the liquid biopsy tests earlier in the diagnostic process can improve and speed up diagnosis, reduce the time between diagnosis and treatment, and eventually inform how this technology can be used for other types of cancer.

Liquid biopsy, as a tool in genomic medicine, is expected to become a pivotal part of healthcare which will provide a better understanding of illnesses and improve patient cancer outcomes. In the future it has the potential to provide a simple, accessible and reliable means of investigating suspected cancer, screen asymptomatic cancer patients and will provide less invasive monitoring for cancer recurrence.

The Genomics Delivery Plan for Wales 2022-25 details how Genomics Partnership Wales will continue to work in partnership with Welsh Government and other stakeholders, to harness advances in the understanding and application of genomics to transform public health strategy and delivery of care. The QuicDNA clinical trial

directly links to the ambition of the strategy to implement liquid biopsy within the NHS Wales national cancer optimal pathways to identify patients with clinically actionable gene targets (personalised treatment).

Following her visit to the Institute of Medical Genetics, the Minister commented:

"Wales has been leading the way in how we integrate genomic testing into health services to revolutionise how we deliver healthcare. Liquid biopsies could deliver real benefits for patients in Wales and save lives by helping us detect and treat cancers earlier.

This is a key example of how working in partnership across a variety of sectors can contribute to improved health outcomes. This is part of our wider work to recover and transform services through the Diagnostic Strategy for Wales."

Alongside the ground-breaking work that our colleagues are undertaking in this field, our patients are also supporting the QuicDNA clinical trial through their own charitable endeavours. Craig Maxwell, patient representative of the QuicDNA steering group has a very ambitious programme of events to raise money for the QuicDNA programme during 2023 having already run the London marathon on 23rd April 2023 raising £160,000 in 5 days.

In support of the QuicDNA clinical trial Craig has commented: 'Being diagnosed at 40 with incurable and inoperable EGFR lung cancer I have first-hand experience with the cancer diagnostic pathway in Wales. Wales is so lucky to have amazing nurses and doctors who support us through this pathway, we all have a responsibility to make sure they have the best and most up-to-date technology available to them to support the diagnostic pathway. This clinical study is a major step forward in helping cancer patients, like myself. From the point of discovering my tumour, it took a stressful and hard 72 days to identify my cancer but this new technology will help support and deliver results quicker, allowing cancer patients to get treatment sooner and help them plan, with their families for the new life that exists in front of them. Let's make sure all of Wales has access to these new innovative tests, and our amazing nurses and doctors have access to this technology to help them help us'.

Those interested in supporting Craig in his fundraising endeavours can do so via the following link: https://craigmaxwell-quicdna.justgiving-sites.com/

We are living through the greatest financial challenge to deliver our health and care system and it is hoped that the QuicDNA clinical trial will critically demonstrate how collaboration across health and industry must be adopted and accelerated, showing what we can do when we work together, flexibly, adopting new technology focused on the needs of the patient.

On behalf of the Health Board, I would like to commend the work of our colleagues within the AWMGS, our partner organisations and stakeholders for their efforts in this clinical trial. I would also like to express my gratitude to Craig Maxwell for his charitable support of the QuicDNA clinical trial, during what are difficult times for Craig and his family. I am sure that the support Craig has provided to the clinical trial will leave a lasting legacy for Cancer patients in Wales and beyond. I wish Craig and his family the very best.

Board Development Session

On the 27th April 2023 the Board undertook a Board Development Session to devote time to the development and discussion of the following topics:

- **Annual Plan Submission 2023-24**

  The Health Board submitted its Annual Plan 2023-24 to Welsh Government by the required deadline of 31st March 2023.

  Following submission of the Annual Plan further discussions have been had with Welsh Government and a supplementary paper to accompany our Annual Plan will be submitted to Welsh Government by the 31st May 2023 which will outline the Health Board's position on delivery of all Ministerial Priorities

and the Health Board's financial assessment. A more detailed update, in this regard will be shared at a future Board meeting.

- **Strategy Refresh:**

  Shaping Our Future Wellbeing II

  This strategy sets out the Health Board's vision for improving the health of the populations it serves, and improving the services we provide for people over the next decade. It builds on our first strategy, Shaping Our Future Wellbeing, developed in 2013 and reflects its underlying principles - 'home first, empowering people, outcomes that matter to people and reducing harm, waste and variation – which have served us well over the last decade.

  The Covid-19 pandemic presented us with the most significant challenges we have ever faced and changed the way we deliver services. It is against this backdrop that the Shaping our Future Wellbeing II Strategy has been drafted and will be implemented. The overarching aim of the strategy is, **'Helping People keep well, Caring for people to get well'** and will refresh and realign our programmes of work and delivery plans over the next decade.

  Our Executive and Operational Leads will continue to refine the strategy over the coming months which will be consulted upon and scrutinised by our stakeholder forums, Committees and the Board prior to approval. Regular updates on the development of the strategy will be shared with the Board and public at regular intervals.

- **Anti-Racist Action Plan**

  Board members received a development session from Race Equality Wales on 'The Health and Wellbeing of Tomorrow's Workforce, through an Anti-Racist Lens. Race Equality Wales has over 40 years' experience as the recognised lead body in South Wales for tackling discrimination and hate crime and promoting the message that Race Equality is a human right.

  They are experts in the field of race equality and are the only Race Equality Council in Wales with the specific remit to address racial equality.

  The work undertaken with Race Equality Wales will continue to inform the Health Board's Anti-Racist Action plan.

- **Further Faster**

  Welsh Government issued a draft Statement of Intent on the 21st March 2022, 'Building Capacity through Community Care, which has a vision for, 'Outstanding whole system-based care that enables older people and people living with frailty to live their best life in their community'.

  Colleagues from Welsh Government and the Health Board's own Director of Health and Social Care Integration and Clinical Lead – Six Goals for Urgent and Emergency Care led a discussion on what the draft Statement of Intent would mean for the Health Board and its population.

- **Board Effectiveness**

  The Board undertook a facilitated discussion to review the Audit Wales report, 'Betsi Cadwaladr University Health Board – Review of Board Effectiveness'. This report was reviewed to inform discussions regarding the steps that the Health Board could take to strengthen its own effectiveness.

  The Board will review its own Board Effectiveness over the coming months and will share the results when finalised.

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

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

The common seal of the Health Board has been applied to 2 documents since the last meeting of the Board.

Seal No.	Description of documents sealed	Background Information
1033	Three-year lease of commercial premises.	Lease of Unit 1 Ty Glas Industrial Estate between (1) Sunflower UK Industrial Property IV LP and (2) Cardiff and Vale University Health Board to support the work of the Wales External Quality Assessment Scheme (WEQAS)
1034	Three-year lease of commercial premises.	Lease of Unit 6 Ty Glas Industrial Estate between (1) Sunflower UK Industrial Property IV LP and (2) Cardiff and Vale University Health Board to support the work of the Wales External Quality Assessment Scheme (WEQAS)

Following the update shared at the March 2023 Board meeting, the following legal documents are reported as having been signed on behalf of the Health Board:

Date Signed	Description of Document	Background Information
23.03.2023	NEC 3 Short Form Construction Contract	A contract between (1) Cardiff and Vale University Health Board and (2) Lorne Stewart PLC for a Gas Main Replacement at the University Hospital of Wales
20.03.2023	NEC 3 Short Form Construction Contract	A contract between (1) Cardiff and Vale University Health Board and (2) 2D Building Contractors Ltd for the refurbishment of the University Hospital of Wales Emergency Unit Specialist Hub
24.03.2023	NEC 3 Short Form Construction Contract	A contract between (1) Cardiff and Vale University Health Board and (2) 2D Building Contractors Ltd for the alteration and refurbishment works to the ALAC toilet building at Rookwood Hospital.
23.03.2023	Settlement Letter	A settlement letter signed agreed between (1) Phillips Electronics UK Limited and (2) Cardiff and Vale University Health Board.
21.03.2023	Investigator-Initiated Research Agreement	A research agreement between (1) Illumina Cambridge Limited and (2) Cardiff and Vale University Health Board for the provision of study materials.
27.03.2023	NEC 3 Short Form Construction Contract	A contract between (1) Cardiff and Vale University Health Board and (2) E T & S Contractors Ltd for Phase 4 of the University Hospital of Wales Emergency Unit refurbishment.
04.04.2023	Call off Contract for External Assessment Centre Work	A contract between (1) National Institute of Clinical Excellence and (2) Cardiff and Vale University Health Board for the provision of

		clinical assessment centre works by CEDAR.
11.04.2023	Service Level Agreement	A Service Level agreement for Extracorporeal Photopheresis Services (ECP) between (1) NHS Blood and Transplant Services and (2) Cardiff and Vale University Health Board.
24.04.2023	Service Level Agreement	A Service Level Agreement to provide Laboratory Medicine Services between (1) Cardiff and Vale University Health Board and (2) Aneurin Bevan UHB.

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	
06.03.2023	Provision of Managed Service for Celluar Pathology UHC Staining	Approval of Contract Award a value of £2,755,816.00 excluding VAT	Approved 15.03.2023	David Edwards 15.03.2023	John Union 09.03.2023	N/A
03.03.2023	Maintenance of AGFA Radiography Equipment	Approval of Contract Award at a value of £1,199,951.41 inc VAT	Approved 15.03.2023	David Edwards 13.03.2023	Michael Imperato 13.03.2023	N/A
13.03.2023	Lease of Units 1 and 6 Ty Glas Industrial Estate between (1) Sunflower UK Industrial Property IV LP and (2) Cardiff and Vale UHB	Approval to enter into both leases and make use of the UHB Seal.	Approved 18.04.2023	Mike Jones 14.03.2023	Rhian Thomas 13.03.2023	N/A
28.03.2023	Contract for garden and grounds maintenance	Approval of contract award at a value of £1,044,768.00 (inc VAT) for a potential 5 year term	Approved 20.04.2023	Akmal Hanuk 19.04.2023	Ceri Phillips 19.04.2023	N/A
03.04.2023	Provision of Two Mobile Theatres and Recovery Area	Approval of contract award at a potential cost of £1,325,727.00 plus VAT	Approved 05.04.2023	Ceri Phillips 05.04.2023	Mike Jones 05.04.2023	N/A
06.04.2023	Mental Health Sanctuary Service	Approval of Contract for Mental Health Sanctuary	Approved 24.04.2023	John Union 19.04.2023	Rhian Thomas 20.04.2023	N/A

		Services at a potential Cost of £800,000.00				
21.04.2023	Approval to enter into a Service Level Agreement to provide Laboratory Medicine Services to Aneurin Bevan UHB.	Approval of income generation to a potential value of £730,302.00.	Approved 26.04.2023	Mike Jones 21.04.2023	Ceri Phillips 21.04.2023	N/A

The Board are requested to:

- **NOTE** the report.
- **APPROVE** the Chair's Actions undertaken.
- **APPROVE** the application of the Health Board Seal and completion of the Agreements detailed within this report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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	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		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

Prevention		Long term		Integration		Collaboration	x	Involvement	x

Report Title:	**Chief Executive's Report to Board**				Agenda Item no.	6.3
Meeting:	Public Board Meeting		Public	x	Meeting Date:	25th May 2023
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	Chief Executive					
Report Author (Title):	Head of Risk and Regulation					

Main Report
Background and current situation:

At the time of drafting this report, the Health Board (the 'HB') is heading into the first quarter of a new financial year and delivery of the Integrated Annual Plan (IAP).

The many challenges we face continue as we; recover from the COVID-19 pandemic, seek and deliver new ways to meet the increasing level and complexity of health care need of the population we serve, support colleagues in building resilience and creating opportunity and evolving our collaborative approach to partnership working with others.

In addition, we must meet statutory duties and build financial sustainability. The back drop to the delivery of the IAP is amongst the most challenging I have experienced, a feeling reflected by many NHS and health care leaders across Wales, the UK and indeed globally. In particular; the financial challenge, the health impacts of the cost of living crisis, the ageing population, prevailing inequalities, associated workforce challenges and continuing industrial action provide for an environment of deep complexity and uncertainty with many emergent and potentially conflicting priorities.

At this time more than ever, a shared vision, clarity of purpose and a systematic and dynamic approach to delivery will be essential if the IAP and the HB's organisational strategy are to be achieved successfully. This brief paper seeks to provide assurance on two key supporting and enabling approaches, the Operating Model (OM) and the Sustainability Programme Board.

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

It is timely that the Shaping our Future Wellbeing Strategy refresh process has progressed well and with the on-going engagement, support and approval of the Board, we are on track to deliver a refreshed iteration of the Strategy in the summer. The Strategy will clarify our shared vision and purpose, reaffirm our organisational values and create the strategic framework for delivery set over short, medium and long term time horizons.

Alongside the Strategy, however, it will be necessary to establish the operational approaches, systems, processes and governance required to convert the vision, purpose, objectives and values into the coordinated actions needed to deliver in an aligned and efficient manner, especially across such a large and complex organisation as Cardiff and Vale University Health Board (CAVUHB).

In order to provide assurance to the Board that mechanisms are being established to achieve the ends described above and to deliver the IAP, I wish to draw attention to two key approaches currently being established and embedded.

The first is a more conceptual piece, the Operating Model (OM) and the other is more structural, the Sustainability Programme Board (SPB), which will provide oversight and governance to the delivery of the Financial Plan and recovery to a financially sustainable position.

To convert ‘strategy’ into ‘action’ an operating model is required. The current economic and regulatory environment has intensified the need for health care systems to reduce costs, efficiently align programmes and improve outcomes. Increasing the quality and consistency of organisational behaviours is one of the best ways to drive down costs and improve patient experience and outcomes. Creating a clear, compelling operating model and supporting structure for both internal and external stakeholders is a crucial factor in coalescing health care transformation. Managed well, health care organisations can use an operating model to streamline relationships, increase collaboration, heighten talent development and invigorate leadership.

An operating model is a conceptual structure or a visualisation that explains how an organisation operates and delivers value to those it serves. It is guided by a strategy to support the viability of the organisation; illustrating how the organisation will orchestrate its capabilities, processes, functions, and resources, including information and technology, physical infrastructure and equipment, and people. As such, an operating model can be described as a framework which sets out “how we do things around here” i.e. the ways of working that will enable us to deliver both strategy and annual and longer-term plans.

Another way in which an operating model can be designed is through the translation of a strategy into a set of design principles – simple yet specific statements that define what the organisation must do to enable execution of the strategy and which help align the leadership team around objective criteria to measure progress towards the identified end state.

In our IAP for 2023-2024 we have committed to “ensuring that the six domains of quality, and their supporting principles, will shape an operating model that drives decision making, planning, delivery and evaluation around the 6 domains of quality and our organisational values”. Thus, the IAP has, through this commitment, set out the articulation of priorities, key areas for focus and progress measurements and commenced the design principles for the HB OM. Alongside the approach described within the IAP I am also keen to consider with others the utility of a concept known as 4PMedicine. 4PMedicine is one articulation of a vision for health and care practice that seeks to deliver care that is; predictive, preventative, personalised and participatory. Bringing together our organisational values and the quality domains with a concept of organising our approach to deliver the benefits of value based healthcare, addressing the wider determinants of health and wellbeing as well as enabling the delivery of genetic medicine, advanced therapies and empowering patients could lead to a powerful and future focused operating model. The work to co-design an effective operating model for the organisation will now be progressed. I would very much welcome Board support and engagement in that developmental work and will ensure the Board and relevant committees are kept appraised of progress.

The second approach that we will utilise to provide assurance to the Board that we are working towards meeting our statutory duties and building financial stability has, at its heart, the establishment of a Sustainability Programme Board.

The Sustainability Programme Board (‘the Programme Board’) will ensure the organisational delivery of the programme of work streams that the Senior Leadership Board has approved in order to lead the organisation on the path to financial sustainability.

To deliver this goal, the Programme Board will oversee the development and delivery of the overall Sustainability Programme (‘the Programme’) and constituent projects within the programme by:

- providing assurance to the Senior Leadership Board that leadership, management and governance arrangements are robust and appropriately discharged to deliver the outcomes and benefits of the Programme;

- providing oversight of the workstreams involved in development of the Programme and the subsequent development of project business cases, including oversight of any external advisors engaged to support the HB;
- reviewing and approving reports, papers and business cases put forward by the workstreams showing progress made in the achievement of cost reduction and value improvement aims; and
- scrutinising the progress of the Programme and providing the Senior Leadership Board, and the HB Board with confidence that any deliverables and outputs are produced on time, to budget and in accordance with all professional standards.

The Programme Board is comprised of the full Executive Board and will also be attended by appropriate and relevant senior leaders within the organisation to discuss and report upon Programme projects within their own areas of expertise and operational delivery.

Meetings of the Programme Board will take place on a monthly basis and, where appropriate, recommendations will be made to the Senior Leadership Board and HB Board in any area concerning the Programme where action or improvement is required. Achievements against the Programme will be shared at Programme Board and Senior Leadership Board meetings and at HB Board meetings via the pre-established work plan of financial and strategy updates that it receives and relevant sub-committees.

As the work of the Programme Board develops I will keep the HB Board and it's Committees suitably appraised of the progress being made.

The developing Operating Model and the Sustainability Programme Board are not the only approaches or activities that will be deployed in the delivery of the IAP and ultimately the Shaping our Future Wellbeing Strategy but will build on pre-existing and established approaches to governance and delivery but should be seen to add value as they seek to strength organisational alignment, clarity of purpose and therefore assurance.

Recommendation:

The Board are requested to:

NOTE the Strategic Overview and Key Executive Activity to provide assurance described in this report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
24/05/2023 15:05:05

Report Title:	Board Assurance Framework 23-24 – May 2023				Agenda Item no.	6.4	
Meeting:	Board		Public	x	Meeting Date:	25th May 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Director of Corporate Governance						

Main Report
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 9th May 2022 in addition to this a further six risks were added to the BAF and agreed at the November 2022 Board meeting for the financial year 2022/23:

1. Workforce
2. Patient Safety
3. Sustainable Culture Change
4. Capital Assets
5. Delivery of 22/23 commitments within the IMTP
6. Staff Wellbeing
7. Exacerbation of Health Inequalities
8. Financial sustainability
9. Urgent and Emergency Care
10. Maternity
11. Critical Care
12. Cancer
13. Stroke
14. Planned Care
15. Digital Strategy and Road Map

These risks are all detailed within the attached BAF.

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

It should be noted that the BAF details the risks in relation to Strategic Objectives. As these are undergoing a process of review the BAF may change to reflect any change made to Strategic Objectives as a result of that review. However, these risks are reflective of the current situation within the Health Board.

There are three broad groups in which the risks have been ordered within the BAF these groups are:

- Patient Safety & Operations Risks (e.g. Patient Safety, Maternity, Critical Care etc.)
- Workforce Risk (e.g. Culture, Wellbeing)
- Corporate (e.g. Finance, Estates, IMTP)

The key changes to the risks on the BAF from the Board Meeting in January 2023 are highlighted in red.

The BAF has undergone a more extensive review as the Health Board enters a new financial year, updating many actions which were scheduled for completion by 31 March 2023 and setting in the context of the new Annual Plan and financial outlook. The score for risk 14. financial sustainability has been increased from 20 to 25, recognising that the Health Board continues to breach its statutory financial duties by being unable to produce a balanced three-year plan.

The following risks have reduced following clarification of Welsh Government expectations and approval of allocation of resources:

2. Maternity
3. Critical Care
7. Planned Care

However, they remain at extreme or high levels.

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.
- Discussion at the various Committees of the Board on the risks allocated to them for review.

Recommendation:

The Board are requested to:

- **Review and note** the 15 risks to the delivery of Strategic Objectives detailed on the attached BAF for March 2023.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Prevention	✓	Long term		Integration		Collaboration		Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/~~No~~

The BAF as a document details the risks in relation to the delivery of Strategic Objectives.

Safety: Yes/~~No~~
There is a risk within the BAF on Patient Safety which also details the impact.
Financial: Yes/~~No~~
There is a risk within the BAF on Financial Sustainability which also details the impact.
Workforce: Yes/~~No~~
There is a risk within the BAF on Workforce which also details the impact.
Legal: ~~Yes~~/No
Reputational: Yes/~~No~~
Having a non-approvable IMTP will impact upon the reputation of the Health Board
Socio Economic: Yes/~~No~~
There is a risk on the BAF on Health Inequalities these inequities have significant social and economic costs both to individuals and societies.
Equality and Health: Yes/~~No~~
As above
Decarbonisation: ~~Yes~~/No

Approval/Scrutiny Route:	
Executive Directors	Individual review undertaken prior to Board with each Executive Lead.

BOARD ASSURANCE FRAMEWORK 2023/24 – MAY 2023

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 2023/24 set in a three-year context.

Strategic Objectives	Key Risks Mapped to Delivery of Strategic Objective
1. Reduce health inequalities	• Sustainable Cultural Change • Exacerbation of Health Inequalities • Patient Safety • Delivery of IMTP 23-26 • Planned Care • Cancer • Stroke • Critical Care • Maternity
2. Deliver outcomes that matter	• Patient Safety • Sustainable Cultural Change • Exacerbation of Health Inequalities • Delivery of IMTP 23-26 • Capital Assets • Financial Sustainability • Urgent and Emergency Care • Planned Care • Cancer • Stroke • Maternity
3. Ensure that all take responsibility for improving our health and wellbeing	• Sustainable Cultural Change • Wellbeing of staff • Workforce
4. Offer services that deliver the population health our citizens are entitled to expect	• Workforce • Exacerbation of Health Inequalities • Patient Safety • Delivery of IMTP 23-26 • Urgent and Emergency Care • Planned Care • Cancer • Stroke • Critical Care • Maternity
5. Have an unplanned care system that provides the right care, in the right place, first time.	• Financial Sustainability • Patient Safety • Exacerbation of Health Inequalities • Workforce • Urgent and Emergency Care • Stroke • Critical Care
6. Have a planned care system where demand and capacity are in balance	• Workforce • Exacerbation of Health Inequalities • Patient Safety • Financial Sustainability • Planned Care • Cancer • Critical Care

7. Reduce harm, waste and variation sustainably so that we live within the resource available	• Patient Safety • Exacerbation of Health Inequalities • Capital Assets
8. Be a great place to work and learn	• Workforce • 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 • Delivery of IMTP 23-26 • Sustainable Cultural Change • Exacerbation of Health Inequalities • Urgent and Emergency Care • Digital Road Map
10. Excel at teaching, research, innovation and improvement.	• Workforce • Sustainable Cultural Change • Wellbeing of staff • Digital Road Map • Delivery of IMTP 23-26

Key Risks

Board approved Overall Risk Appetite: 'Cautious' moving towards 'Seek'

Risk	Risk Appetite	Corp Risk Register Ref.	Gross Risk *(no controls)*	Net Risk *(after controls)*	Change from Mar 23	Target Risk *(after actions are complete)*	Context	Executive Lead	Committee
1. Patient Safety	Open	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21	**25**	**20**		**10**	Patient safety should be the first priority 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 incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring. The Duty of Candour was formally launched in April 2023 and will further improve communication with patients and opportunities for learning across the Health Board.	Executive Nurse Director/ Executive Medical Director /Executive Director for Therapies and Health Science/ Chief Operating Officer **Last Reviewed:** 12.05.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23
2. Maternity Saunders,Nathan 24/05/2023 15:05:05	Cautious	14, 15, 16	**25**	**15**		**15**	The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The Ockenden review and its recommendations is very much in the public domain and attracted significant coverage from the media. Becoming compliant with the Ockenden requirements also brings opportunity benefits such as full compliance with the Cwm Taf and other formal reviews recommendations and achieving BAPM compliance in the Neo-Natal Unit.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 09.05.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23

3. Critical Care	Cautious	18, 19, 20	**25**	**15**	↓	**10**	For a sustained period prior to the COVID19 pandemic there were recognised critical care capacity challenges in CAV. The sustainability of Critical Care Services in Cardiff is reported in the 2014 unmet needs study WG, and the 2019 FICM external review. Following the COVID19 pandemic these challenges remain and still needs to be addressed. Critical care department capacity is not in a position to deliver a sustainable service to the population it serves. To address this the UHB has approved additional investment for 23/24 to open 3 additional level 3 beds and to establish the Patient at Risk Team (PART) from 7/7 to 24/7 by the end of Q3.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 09.05.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23
4. Cancer Saunders.Nathan 24/05/2023 15:05:05	Cautious	7, 9	**20**	**15**	→	**10**	One of the Health Board's Strategic Objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days. To achieve this, the system needs to ensure sufficient capacity is prioritised to meet the predicted weekly demand for cancer patients at the outpatient, diagnostic and treatment stages of the pathway whilst also being sufficiently flexible to respond to peaks and troughs in demand. The recently published Welsh Government Planned Care Plan, the Wales Cancer Network's Quality Statement and the emerging Wales Cancer Network's Improving Cancer Services and Outcomes Action Plan reflect the high priority of cancer services. The UHB is on track to deliver against the trajectories agreed with WG to ensure that 75% of patients on the single cancer pathway commence treatment with 62 days of referral by 30/6/23.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 09.05.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23

5. Stroke	Cautious		**20**	**15**		**10**	Stroke services within C&V UHB have declined since the COVID pandemic, caused by a reduction in clinical services, but an increase in demand, most noticeably in patients self-presenting to the Emergency Department. There has been a real drive to improve this service for the patients and improvement has been seen in thrombolysis rates, achieving >10% since June 22 and now at 10.9%. Challenges include patients self-presenting to ED, dilution of stroke cases within the very busy ED leading to delay in recognition of stroke, scanning and treatment. Despite increased thrombolysis rates, door to needle times are not improving to pre-pandemic performance. There is often no dedicated Stroke medic at the front door meaning Medics are faced with competing given the capacity constraints within the footprint. There has been considerable organisational focus on the stroke pathway and 3 internal stroke summits have been held. There is a clear improvement plan in place and we are already seeing some improvements to the time for patients to be admitted to the specialist stroke ward.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 09.05.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23
6. Urgent and Emergency Care Saunders,Nathan 24/05/2023 15:05:05	Cautious	6, 8, 10	**20**	**15**		**10**	One of the Health Board's Strategic Objectives is to have a sustainable unplanned (emergency) care system that provides the right care, in the right place, first time. To achieve this, a whole system approach is required with health and social care working in partnership – both together and also with independent and third sector partners. The recently published Welsh Government Six goals for Urgent and Emergency Care span the whole pathway and reflect priorities to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The impact of the covid pandemic	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 09.05.23	~~Strategy and Delivery Committee~~ Quality, Safety and Experience Committee **Last reviewed:** 14.03.23

							has had many consequences. This includes sustained pressure across the urgent and emergency care system and, whilst underlying actions to progress the plans to achieve the strategy have progressed, covid-19 has impacted on the speed of ongoing action and implementation of plans. The Sustainable Primary and Community Care risk reported in 2021/22 has been incorporated into this newly reported risk for 2022/23. During Q4 the UHB has been able to make considerable improvements in ambulance handover times and are now better than the October 2021 baseline. We have also seen reductions in the numbers of patients spending more than 24 and 12 hours. We have set ambitious trajectories as part of the 23/24 IMTP to further improve on ambulance hand over times and waiting times in the EU dept.		
7. Planned Care Saunders.Nathan 24/05/2023 15:05:05	Cautious		**16**	**9**		**8**	One of the Health Board's Strategic Objectives is to have sustainable planned care services that deliver the ministerial measures of no-one waiting >52 weeks for a new outpatient appointment by December 2022 and no-one waiting >104 weeks for treatment (all stages) by March 2023. To achieve this, the system needs to ensure sufficient capacity to meet recurrent demand and to increase capacity and activity sufficiently above pre-Covid levels to make inroads into the backlog. The recently published Welsh Government Planned Care Plan reflects the high priority of planned care services.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** 09.05.23	Quality, Safety and Experience **Last Reviewed:** 07.03.23

							The waiting time standards have since been revised by WG and the ask is now for no patients to wait longer than 52 weeks for their first appointment by 30/6/23, no patients to wait longer than 156 weeks for treatment by 30/9/23 and no patients to wait longer than 104 weeks by 31/12/23. Whilst the UHB is not currently predicting to deliver these standards for 8 specialities, we are expecting to be deliver for 22 others so the vast majority of UHB patients will be treated within these timescales. Therefore, the risk has been reduced.		
8. Exacerbation of Health Inequalities	Open		**16**	**12**	⇨	**12**	COVID-19 has compounded existing health inequalities in Wales, which have shown little improvement in the last ten years, based on the gap in life expectancy between the most and least deprived fifth of the population. Although the main disparities have been age, sex, deprivation and ethnicity, there is clear evidence of intersectionality, risk factors compounding each other to further disadvantage individuals with protected characteristics (based on the Equality Act 2010). As the granular level data emerges, there is no evidence to suggest that this pattern is not replicated fully at a Cardiff and Vale UHB level.	Executive Director of Public Health **Last Reviewed:** 04.05.23	~~Strategy and Delivery Committee~~ People & Culture Committee **Last Reviewed:** 14.03.23
9. Workforce Saunders.Nathan 24/05/2023 15:05:05	Open	4, 6, 11, 16	**25**	**20**	⇨	**10**	Across Wales there have been increasing challenges in recruiting healthcare professionals and this situation has got worse over the last two years due to Covid 19. 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 **Last Reviewed:** 05.05.23	~~Strategy and Delivery Committee~~ People & Culture Committee **Last Reviewed:** 14.01.23

10. Sustainable Culture Change	Open		**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 **Last Reviewed:** 07.05.23	~~Strategy and Delivery Committee~~ People & Culture Committee **Last Reviewed:** 15.11.22
11. Staff Wellbeing	Open	4, 6, 11, 16,	**20**	**15**		**5**	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	Executive Director of People and Culture **Last Reviewed:** 07.05.23	~~Strategy and Delivery Committee~~ People & Culture Committee **Last Reviewed:** 24.01.23
12. Capital Assets Saunders.Nathan 24/05/2023 15:05:05	Open	1, 2, 3, 4, 17, 19, 20, 23	**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 within the resources available, though backlogs for a proactive replacement programme remain.	Executive Director of Strategic Planning, Executive Director of Therapies and Health Science, Executive Director of Finance **Last Reviewed:** 10.05.23	Finance & Performance Committee ~~& Strategy and Delivery Committee~~

									Last Reviewed: 24.01.23
13. Delivery of IMTP 23-26	Open	22	**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 **Last Reviewed:** 10.05.23	Strategy and Delivery Committee ~~Finance & Performance Committee~~ **Last Reviewed:** 24.01.23
14. Financial Sustainability	Cautious	5, 22	**25**	**25**		**15**	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 pressures to now deal with.	Executive Director of Finance **Last Reviewed:** 10.05.23	Finance & Performance Committee **Last Reviewed:** 15.02.23
15. Digital Strategy and Road Map Saunders.Nathan 24/05/2023 15:05:05	Cautious	23	**25**	**20**		**15**	CAV UHB board approved a five-year Digital Strategy in 2020 which set out the vision for supporting the organisation, from a digital and data perspective, for the period 2020-2025. Development of the strategy was clinically led and was designed to support the UHB's Shaping our Futures' strategic programmes. To realise the benefits contained with the accompanying roadmap, which sets out what we will do and when, requires significant additional investment to bring the organisation	Director of Digital Health Intelligence **Last Reviewed:** 11.05.23	Digital Health Intelligence Committee **Last Reviewed:** 14.02.23

							up to a level of digital maturity that can support our agreed strategic objectives.		

Lines of Defence

Assurances are categorised into 'lines of defence' as set out in the Health Boards Risk Management and Board Assurance Framework Strategy.

Key:

(1) First Line of Defence – Management level assurance

(2) Second Line of Defence – Risk and Regulation Team, Patient Experience Team, Patient Safety Team, Workforce Governance, Information Governance assurance.

(3) Third Line of Defence – Independent level Assurance (Internal Audit, Audit Wales, HIW, CHC, Other regulatory or inspection reports) Counter Fraud.

Risk Appetite

Key:

Avoid: Avoidance of risk and uncertainty is a key organisation objective

Minimal: Preference for ultra-safe delivery options which have a low degree of inherent risk and only for limited reward potential

Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential reward

Open: Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (VFM)

Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)

Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

1. Patient Safety – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

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 incidents, concerns, claims and learning from such then implementing solutions to minimise/mitigate the risk of them recurring.

Risk	There is a risk to patient safety: Due to post Covid recovery and this has resulted in a backlog of planned care and an ageing and growing waiting list. Due to increased demand, post Covid 19, of unscheduled care of patients with higher acuity and more complexity which is adding to the pressure within the Emergency Unit (EU). Due to a 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 in a larger clinical footprint in relation to post Covid 19 recovery. Due to the ability to balance within the health community and the challenge in transferring patients to EU. Due to the current pressure in EU and inability to segregate patients due to the volume in the department.		
Date added:	April 2021		
Cause	Patients not able to access the appropriate levels of planned care since the onset of the COVID 19 pandemic creating both longer waiting lists for planned care. Resources re directed to address planned care demand leaving unplanned care/unscheduled care pathways with lower staffing		
Impact	Worsening of patient outcomes and experience, with an impact on patient outcomes Post Covid recovery sickness is having a significant impact on staff availability (see separate risk on workforce).		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
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 Private Partner facilities. • In-house and insourcing activity • Additional recurrent activity taking place • Recruitment of additional staff • Workforce hub in place with daily review of nurse staffing by DoN in Clinical Boards to manage the risk • Hire of additional mobile theatres • Quality and Safety and Experience Framework Implementation underway • health and social care actions to assist the current risk in the system with work continuing to be embedded and implemented		
Current Assurances	• Recovery Plans reported to Management Executive, Strategy and Delivery Committee and the Board (1) (3) • CAHMS position reviewed at Strategy and Delivery Committee (1) • Mental Health Committee aware of more people requiring support (1) • Review of clinical incidents and complaints continues as business as usual and has been aligned with core business and reviewed at Management Executives (1)(2) • Recent Executive review with Clinical Teams for understanding and review of front door pressures. (1) • Monthly Clinical Board reviews to map progress		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Local Authority ability to provide packages of care and challenge around discharge to care homes and domiciliary care settings. Deterioration of quality of care provided to patients due to the availability of staff in some key clinical environments.		

Gap in Assurances	Discharging patients is out of the Health Boards control		
Actions	**Lead**	**By when**	**Update since March 2023**
1. Review of hospital acquired COVID 19 and COVID deaths (wave 1) being undertaken and monitored through Nosocomial C&V Programme Board.	Jason Roberts	30.09.23	Work ongoing. Review has commenced early learning shared with operational colleagues and it is informing the development of the recovery plan Review of deaths continues in line with WG requirements with oversight from Nosocomial National Programme Board
2. Choices framework being utilised due to the quality of care and ability to provide safe care with current demand and pressures	Paul Bostock	31.03.23	Complete
3. Programme of work in place and being led by the Chief Operating Officer, supported by Operational Teams to address the backlog	Paul Bostock	31.03.23 Review October 22	Complete
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 (High)**

2. Maternity Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

The recommendations of the Ockenden Review into maternity services in England were published at the end of March 2022. The Ockenden review and its recommendations is very much in the public domain and attracted significant coverage from the media. Becoming compliant with the Ockendon requirements also brings opportunity benefits such as full compliance with the Cwm Taf and other formal reviews recommendations and achieving BAPM compliance in the Neo-Natal Unit.

The background to, and summary of the Ockenden report, is best understood in the quote from Donna Ockenden below

> **"This final report of the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve, and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives. "**

The report details 89 recommendations that should be enacted to improve maternity services across the UK. An immediate self-assessment of the service was undertaken against the requirements, which noted that 45 of the requirements were already met, 27 partially met, and 17 not met at all. The detail of where we are currently not meeting recommendations and the proposal to close that gap has been completed (appendix 1). The recommendations that we currently fail to meet can largely be grouped into 3 categories, patient safety, quality and experience, training, and workforce.

Whilst underlying actions to progress the plans to achieve the recommendations have developed and presented to Execs, UHB agreement of circa £2M recurrent funding is required to deliver progress.

In addition, the service has sustained pressure across Obstetrics and Maternity care system, mainly due to reduced workforce availability, increased interventional birthing as a result of NICE guidance, backlogs on critical incident investigation etc

Risk **Date added: 3/11/22**	We are currently unable to demonstrate compliance against a number of recommendations against the various external reviews and reports. We have a backlog of investigations, RCA's and concerns and as a result LFE delays Workforce concerns and adverse media
Cause	• In England 180 million pounds of funding was released to support each Trust in complying with all of the Ockenden Recommendations. Welsh Government have invested £1 million in to the Mat Neo Safety Programme across Wales, which is currently in its Discovery phase for circa 12 months, next steps of which are yet to be communicated. The operational view is that it is unlikely any further investment will be made available by Welsh Government to support implementation of the recommendations. • NICE clinical guidance Intrapartum care for healthy women and babies resulting in increased instrumental birthing practices. Patients presenting and subsequently admitted have a higher acuity and complexity, particularly in light of NICE guidance. • We continue to experience challenges in our ability to deploy sufficient workforce to cover community, Midwifery-Led and Obstetric-Led care setting services. We struggle with sustained workforce challenges from sickness, maternity leave, resignations, retirement and challenges of retention and recruitment. • One out-take of newly Qualified Midwives and Paediatric Nurses each year from Welsh Universities causing a limited flow of Midwives/Paediatric Nursing staff • Restricted Neonatal capacity continues to add an increased layer of complexity in managing patient flow.

	• T2 new area opened during Pandemic, but with no increase in staffing (loss of 6 beds on Delivery Suite, 14 opened on T2). • Community based care is expanding with the emphasis being placed on 'normal/low risk/need care being provided in community by midwives and MSWs. Reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives are undertaking the New-born and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home. • With the publication of the latest NICE guideline on Antenatal Care that recommends that all women be 'booked' by 12 weeks' gestation, more women are meeting their midwife earlier than previously happened before 10 weeks. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal. In most maternity services approximately 10% of women are 'booked' and then have no further contact with the midwife. • Constraints accommodating the increased number of Inductions of Labour (IOL) and instrumental deliveries within current footprint. • Good level of incident reporting but insufficient resources to complete investigations, action plans and learning from events actions. • Independent external Birth-rate+ re-assessment has been undertaken and verbal findings are circa 16 Midwives short.
Impact	• Closure of Community Home Birth Services and Maternity Led Unit due to lack of staff. • Delays in allocating IO's to investigations, subsequent delays in completing investigations, action plans and LFE • Rise in instrumental deliveries • Delays in IOL and constraints in accommodating elective caesarean sections due to lack of NICU capacity • Congested department and long waits for IOL & ECS • Insufficient consultant cover for labour ward, NCEPOD readmission reviews • Lack of specialist roles; labour ward leads, Foetal surveillance, bereavement, transitional care nursing. • Lack of training in Human factors, CTG, labour ward coordinator leadership. • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) and run of adverse incidents.
Impact Score: 5	Likelihood Score:5 | Gross Risk Score: **25 (Extreme)**
Current Controls	• Induction of 27 Newly qualified Midwives (NQM) and 43 Newly Qualified Paediatrics nurses from Student Streamlining • Introduction of daily clinical huddles between each days Lead Midwife, Lead obstetrician, lead neonatologist and lead neonatal nurse each day • Rollout of 3 extra consultant sessions for obstetric governance and 1 extra consultant session Neonatology governance to enable allocation of IO's to investigations • RAG rating of position against national report recommendations, presentation of gap analysis to executives and to senior Leadership Board for support of required resources • Continued recruitment actions • Board agreement to fund resource necessary to fully meet Ockenden recommendations • Escalation of concerns to HEIW re single out-turn of midwives and paediatric nurses • Establishment of monthly Ockenden Oversight group led by clinical board • Establishment of MatNeo oversight group led by Executive triumvirate • Team continue to support recruitment and retention, submission of request for oversea recruitment. • Daily SiteRep reporting introduced into maternity and Neonates and DoNM/HoM daily catch up

Current Assurances	• Operational position reported into Management Executive (Daily) (1) • Mechanisms in place to monitor key measures being strengthened into visible dashboard.(1) • Key operational performance indicators and progress against plans reported into the Maternity/Neonatal oversight Group being led by Executive Nurse Director. (1) • Midwifery on call manager linked into Executive evening huddle to clarify daily risks.		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	• Confirmation of additional funding resource to fill gaps in assurance mapping • Recruitment strategies to sustain and increase multidisciplinary teams (appendix 1). • Developing an effective, high quality and sustainable model of managing intrapartum care and current constraints • Several incidents out of time • Ability to successfully recruit to additional posts agreed as part of Ockenden.		
Gap in Assurances	• Data and benchmarking information • Resources to meet the national recommendations		

Actions	Lead	By when	Update since March 2023
1. Ongoing recruitment above establishment, increasing training places	AJ	30.11.23	This action continues to take place.
2. Reviewing current obstetric practice in line with NICE guidance	CR/SZ	30.09.23	This action continues to take place.
3. Senior daily oversight of obstetric /Neonatal capacity and escalation to Executives	AJ	30.11.23	This action continues to take place.
4. Continued maternity / Neonatology oversight meetings with Executive lead	JR/AJ	30.11.23	This action continues to take place.
5. Ongoing review of job planning and consultant establishment	CR/AT	30.09.23	Job planning undertaken further resource required to meet Ockenden recommendations. Supporting revenue case approved by Board 30.3.23
Impact Score: 5 / Likelihood Score: 3	Target Risk Score:		**15 (high)**

3. Critical Care Capacity – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

For a sustained period prior to the COVID19 pandemic there were recognised critical care capacity challenges in CAV. The sustainability of Critical Care Services in Cardiff is reported in the 2014 unmet needs study WG, and the 2019 FICM external review. Following the COVID19 pandemic these challenges remain and still needs to be addressed. Critical care department capacity is not in a position to deliver a sustainable service to the population it serves.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable critical care capacity.		
Cause	• There is a progressively deteriorating problem with access for critically ill patients to ICU in Cardiff as a direct result of capacity. This now means patients who would benefit from ICU admission and care are not able to have this. • Gap of 15 ICU beds in CAV (2014 unmet needs study WG) • Funded increase in tertiary workload has increased the overall demands on critical care services in CAV • Poor infrastructure within the critical care unit – limited access to cubicles • Patient at Risk Team (PART) only operate during daytime hours (7am-7pm)		
Impact	• Adverse impact upon the Emergency Department and theatre flow • Untimely patient access • Inequity of patient access • 15% of referrals not admitted to critical care • Impact other operationally e.g. anaesthesia and theatres • Impact tertiary development e.g. ECMO • Patient outcomes worse • Reputation, Professional & Legal risk • Workforce - Reduced Recruitment & Retention • Poor staff morale and retention due to the sustained pressures in the system • Delayed admission and discharge from critical care leading to poor patient experience and outcomes		
Impact Score: 5	Likelihood Score:5	Gross Risk Score:	**25 (Extreme)**
Current Controls	• Strengthened site-based leadership and management • Strengthened OPAT oversight and support for DTOCs • Workforce plans in place to support recruitment and retention • Registered nursing recruited to establishment • Local escalation plan in place and utilised when appropriate to support operational pressures • PART team provide daytime support patients not admitted to critical care • Ringfenced PACU to protect elective urgent and cancer surgery • Winter escalation plan in place to support delivery of critical care to the sickest patients during the winter months		

Current Assurances	• Operational position reported into OPAT [1] • Key operational performance indicators and progress against plans reported into the clinical board 6 weekly [1] • ICNARC audit to provide assurance on outcomes [2] • Plans in development to increase level 3 bed capacity by three beds during 2023/24.[1] • Project team established to address medium term infrastructure constraints.[1]		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Development and implementation of a capacity plan to address the 15-bed gap Achievement of standard to step down patients from ICU within 4 hours to improve efficiency and patient flow 24/7 PART team Development of a fit for purpose critical care unit (UHW2)		
Gap in Assurances	Able to meet the needs of the sickest or highest priority cases. Un-met not fully understood across the organisation.		

Actions	Lead	By when	Update since March 2023
1. Secure funding and develop implementation plan for further three ICU beds	PB	30/04/23	Complete Board approved in April 2023
2. Implementation of 24/7 PART team	PB	31/10/23	Plan developed. Board approved in April 23 Recruitment commenced
3. Implementation of the UHW site masterplan and critical care infrastructure programme a. Medium term development of additional cubicles and support facilities b. Development of a new unit as part of UHW2 development. c. Transfer of LTiV services to a bespoke facility in UHL	AH / PB	31.03.23	Implementation of de-escalation plan commenced – but behind timescale due to ongoing operational pressures and recent increase in covid admissions. Awaiting decision from WG on funding of stage 1 of the infrastructure programme
4. Ongoing development of recruitment and retention strategies	JR / RG	31.03.23	This piece of work continues
Impact Score: 5 Likelihood Score: 2	Target Risk Score:		**10 (high)**

4. Cancer Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

One of the Health Board's Strategic Objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days. To achieve this, the system needs to ensure sufficient capacity is prioritised to meet the predicted weekly demand for cancer patients at the outpatient, diagnostic and treatment stages of the pathway whilst also being sufficiently flexible to respond to peaks and troughs in demand. The recently published Welsh Government Planned Care Plan, the Wales Cancer Network's Quality Statement and the emerging Wales Cancer Network's Improving Cancer Services and Outcomes Action Plan reflect the high priority of cancer services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments to see elective patients in a timely manner has also impacted on those waiting on a cancer pathway. • Referral demand for cancer is now greater than pre-Covid levels and our planned care system has struggled to respond to this increase in demand and carve out sufficient capacity for cancer at outpatients, diagnostics, and treatments stages • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff • Weaknesses in the central cancer team in terms of changes of leadership, structure, vacancies and temporary staffing leading to lack of clarity and consistency		
Impact	• Long waiting times for first contact and diagnostics contributing to lengthening of the overall pathway for cancer patients • Overall PTL has grown 3-fold since pre-Covid • Significant volumes of patients now waiting >62 days and >104 days • Potential for harm e.g. missing the window of opportunity for surgical intervention, delays to starting chemotherapy/radiotherapy • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**
Current Controls	• Strengthened governance and oversight • COO is now Executive Lead for Cancer • Cancer is one of the delivery programmes in the 2022/23 Operational Plan • SOP in place to support tracking process • Roles and responsibilities redefined • Training being rolled out to refresh understanding of SCP guidance • Workforce team continue to support recruitment and retention • Ambition clearly stated – first contact by day 10, diagnosis by day 28, treatment by day 62 • Two cancer summits held with senior leadership teams, directorate management teams and tumour site clinical leads • Demand/capacity work commenced		

Current Assurances	• Operational position reported into Cancer Oversight Meeting weekly tracking improvements[1] • Weekly PTL tracking meeting with General Managers/Directorate Managers now in place • Executive Cancer Board meets quarterly[1] • Mechanisms in place to monitor key schemes in Cancer as part of the Operational Delivery Plan [1] • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee [1] • Breach reports produced for every patient treated >62 days [1] • Harm reviews conducted for every patient treated >146 days [1] • Cancer reported as part of the Board Integrated Performance report [1] • The UHB is on track to deliver against the trajectories agreed with WG to ensure that 75% of patients on the single cancer pathway commence treatment with 62 days of referral by 30/6/23.

Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**

Gap in Controls	• Continuation of demand/capacity work to inform how much capacity needs to be carved out for cancer • Undertake pathway work to streamline the journey for cancer patients and reduce the downtime between steps on the pathway • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)
Gap in Assurances	• Whilst a Cancer Oversight Meeting is in place, there is a need to establish a weekly PTL tracking meeting with General Managers/Directorate Managers • Breach reports need to be shared with the Directorates for validation and themes (e.g. risks/issues/constraints) need to be fed through a continuous improvement loop to ensure mitigation/solutions are put in place • The Cancer Strategy needs to be finalised and a workplan developed

Actions	Lead	By when	Update since March 2023
1. Continue to develop and iterate the demand/capacity work	MT	30.6.23	D&HI team are engaged in the work Work is progressing and more robust plans are being created for sign off at end of Q1
2. Undertake a review of the key tumour site pathways with a view to removing constraints and delays in the patients' journey	MT	30.6.23	Support from the WCN to undertake a number of deep dives: – urology, breast, lower GI and gynaecology 4 areas of focus
3. Establish a weekly PTL meeting with General Managers/Directorate Managers	JC	30.01.23	Complete
4. Finalise the Cancer Strategy and develop a workplan	RL/BW	30.06.23	Draft strategy is out for consultation with stakeholders. Current plan to sign off at exec cancer board in June and to SLB at end of June
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce

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

5. Stroke Services – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

Stroke services within C&V UHB have declined since the COVID pandemic, caused by a reduction in clinical services, but an increase in demand, most noticeably in patients self-presenting to the Emergency Department. There has been a real drive to improve this service for the patients and improvement has been seen in thrombolysis rates, achieving >10% since June 22 and now at 10.9%. Challenges include patients self-presenting to ED, dilution of stroke cases within the very busy ED leading to delay in recognition of stroke, scanning and treatment. Despite increased thrombolysis rates, door to needle times are not improving to pre-pandemic performance. There is often no dedicated Stroke medic at the front door meaning Medics are faced with competing given the capacity constraints within the footprint.

In addition to thrombolysis treatment rates, there has been improvement in thrombectomy assessment, referral and procedures delivered both internally and referred to Bristol. There has also been focused training for acute medics on stroke assessment, thrombolysis and thrombectomy. The Stroke CNS role is being protected where possible; recognised that this team are the drivers and facilitators of the thrombolysis pathway.

Investment is needed for increased Stroke resource at the front door – allowing patients to be seen, diagnosed and treated in a timely manner, ultimately reducing mortality and improving outcomes for patients. The aims are to improve Tier 1 performance and most importantly, safer care for our Stroke patients

Risk **Date added: 01/11/2022**	Poor compliance with SSNAP – currently a C score.
Cause	• An increasingly busy ED (double the number of patients) has seen a high demand upon the Stroke Service. Patients are often self-presenting which may result in an initial delay to be triaged resulting in (i) delays to Stroke calls being put out (ii) delays to patients receiving CT scans within 1-hour (iii) delays in the recognition and subsequent delivery of thrombolysis to patients. • The Stroke Unit at UHW regularly runs at 100% occupancy. Every effort is made to ensure there is a bed available for new stroke admissions. The large volumes of patients in the ED mean there is often a delay in patients being triaged and assessed within 4 hours, making it difficult to get the patients to the acute ward within a timely manner. Patients awaiting admission to the stroke unit in September between them spent almost 70 days in the ED. • Pressures across the system mean that Stroke beds are often used for non-Stroke patients. These short-term gains have long term impact on Stroke affecting the ability to admit new stroke patients within 4 hours, which has knock-on impact on specialist MDT assessments, commencement of rehabilitation and supportive discharge planning. • Since additional capacity beds which were collocated with stroke closed in August 22, performance against the 4 hours admit target improved to 20% in September. Support is needed to protect stroke beds for patients on the stroke pathway • Stroke CNS being pulled into ward numbers due to poor staffing levels

Impact	• Delays in patients receiving their CT scans within 1 hour • Delays in patients being recognised as potential Stroke patients • Delays in patients receiving timely treatment such as thrombolysis • Delays in patients being recognised as potential thrombectomy patients • Patients not receiving swallow screening in a timely manner (<4 hours) • Delays in patients being admitted to the acute Stroke ward in a timely manner (<4 hours) • Delays in patients leaving the acute Stroke ward (long lengths of stay, non-stroke patients being admitted due to ambulance waits) • Poor patient outcomes • Lack of available CRT slots or inappropriate CRT slots meaning patients in SRC are unable to be discharged in a timely manner		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**
Current Controls	• Awareness raising on the importance of early swallow screen assessment – investment in training over the summer needs reinforcement with the timing of swallow screen and its urgency. • Taking any golden opportunities, we can – whenever there is capacity on the stroke unit, the stroke team are driving and pushing the ED stroke pathway to achieve the 4 hours admit wherever we can. The stroke team are real champions of the principles of 'Think Thrombolysis, Think Thrombectomy' and are pushing the imaging pathway to reach diagnosis as early as possible and ensure all patients are considered and assessed for urgent treatments which could reduce the disabling impact of the stroke. • Stroke Service Manager in post since July; Clinical Director for stroke in post from October. Dedicated resource for focused work with ED, radiology and medicine to ensure the optimal stroke pathway is in place and applied for all patients. • Seeking investment for uplift of CNS resource and dedicated stroke medical resource to support the front door for stroke. • Wider programme of works is needed to continue momentum of a stroke service improvement programme, particularly given future requirements for regional network service delivery and for UHW to become the regional thrombectomy centre		
Current Assurances	• Operational position reported into MCB (Monthly) (1) • Mechanisms in place to monitor key schemes in Stroke Operational Group and MCB SMT/IM DPR (1) • Monthly touch point meeting with the Delivery Unit (1)		
Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**
Gap in Controls	Lack of consistent cover to the ground floor by a dedicated Stroke Medic CNS cover not 7/7 Stroke beds not ringfenced SRC capacity		
Gap in Assurances	Competing demand on regional, thrombectomy and clinical board priorities		

Actions	Lead	By when	Update since March 2023
1. Nursing Uplift Stroke CNS cover to 12 hour shifts 7 days per week. **Benefits** Increased out of hours CNS support to Code Stroke, facilitation of thrombolysis and thrombectomy treatment pathways, 4 hours admit target and nurse assessments. **Interdependencies / Risks** Capacity and flow, medical support	NT/JM/LP	31/05/2023	Pilot in place and clinical workforce model to be presented at 3rd stroke summit on the 23/5/23

2. Medical Extend locum SHO for SRC in backfill of specialist middle grade moving to UHW front door (Mon-Fri 9-5) Collaboration with other specialities (e.g. neurology) to improve stroke junior doctor out of hours cover. May incur cost to medicine. Contribute 4 locum consultant sessions to a new post with ITU for a neuro critical care specialist with 4 stroke sessions **Benefits** Cross speciality working - more sustainable OOH model and offers training opportunities. Reviewing the structure of the out of hours rota will offer further support to the medical on call team. Specialist middle grade and uplift of consultant sessions would support TIA clinic reconfiguration and front door senior decision making. Improved selection of patients for C4 beds, improved management of mimics in ED, acceleration of stroke assessment and diagnostics, improvement in 4 hours admit. This model offers the service an interim solution for winter demands, reducing the urgency of consultant uplift, allowing for planned succession and recruitment. **Interdependencies / Risks** Uplift is needed both in and out of hours. Locum posts are expensive but it is unknown if the workforce is there for external middle grade or consultant recruitment.	TH/NT/SB	31/01/2023	Locum SHO secured which will allow 6 sessions of front door Stroke cover – achieved November 2022, sessions in place to support front door stroke and TIA assessments. Funding for 3 sessions reinvested from stroke service; funding for 4th session agreed by MCB Jan 23. Clinical model for delivery 24/7 consistent stroke care to be presented at 3rd stroke summit on the 23/5/23
3. Capacity C4 beds only to admit those patients on the stroke pathway with a protected minimum of 4 beds. Until additional capacity Winter beds open the ask is to cap medical outliers to 4 on the ward at any one time. **Benefits –** median number of admissions per day = 3 in September. 4 beds protected should offer admission capacity for most new stroke patients and we would hope to see the 4 hours admit performance >50%. When necessary to relieve pressure across the system medical outliers would be admitted; the cap would attempt to minimise the impact of these admissions on stroke performance. **Interactions/Risks** – Ability to create 4 beds each day once used is uncertain. Exit strategy needed for any medical outliers and stroke mimics. Flow needed across whole stroke pathway; community services to be approached re options to prioritise stroke beds in CRT slot allocation if possible.	NT/DP/NW/SB	31/03/2023	SOP being produced for the ringfencing of beds Agreement being sought at Clinical Board and Health Board level for ringfencing of beds Ringfenced of C4 stroke beds now in place and SOP agreed
4. Diagnostics Daily imaging 'hot slots' for carotid dopplers/ MRIs/ CTA for stroke patients.	NT/TH	31/05/2023	Ongoing discussions with radiology to create slots Use of the CD&T escalation email to prioritise Stroke

Benefits – Timely diagnoses and treatment for both stroke patients and stroke mimics. Improved discharge profile to support protection of beds. **Interactions and Risks –** hot slots may not be needed every day (would be booked by 10am and released back to radiology if not needed). Ideally would operate over 7 days.				patients for discharge dependent MRIs, etc. Clinical model for delivery 24/7 consistent stroke care to be presented at 3rd stroke summit on the 23/5/23
Impact Score: 5	Likelihood Score: 2	Target Risk Score:		**10 (high)**

6. Urgent & Emergency Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

One of the Health Board's Strategic Objectives is to have a sustainable unplanned (emergency) care system that provides the right care, in the right place, first time. To achieve this, a whole system approach is required with health and social care working in partnership – both together and also with independent and third sector partners. The recently published Welsh Government Six goals for Urgent and Emergency Care span the whole pathway and reflect priorities to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration. The impact of the covid pandemic has had many consequences. This includes sustained pressure across the urgent and emergency care system and, whilst underlying actions to progress the plans to achieve the strategy have progressed, covid-19 has impacted on the speed of ongoing action and implementation of plans. The Sustainable Primary and Community Care risk reported in 2021/22 has been incorporated into this newly reported risk for 2022/23.

Risk **Date added: 09/05/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable urgent and emergency care as close to home as possible.		
Cause	20 The impact of the covid pandemic has resulted in sustained pressure across the urgent and emergency care system. Five factors have combined to cause current operational challenges: (i) Non-covid occupancy remains at a high level and we continue to experience challenges in our ability to achieve timely discharge of patients (ii) Covid continues to add an increased layer of complexity in managing patient flow (iii) Patients presenting and subsequently admitted have a higher acuity and complexity (iv) We have sustained workforce challenges (v) Social Care are experiencing similar workforce and demand challenges • Sustained pressure in Primary and Community Care, including an increased number of GP practices operating at a higher level of escalation, temporary list closures and practice closures • Poor consistency in referral pathways, and in care in the community leading to significant variation in practice • Rollout of multi-disciplinary team cluster models only in limited number of clusters • Lack of co-ordination and / or streamlined services across Health and Social care to ensure a joined-up response is provided and the patient gets the right care, in the right place, first time • Poor response times in the community from WAST due to significant delays in ambulance handovers • Longer length of stay for both medically fit patients and clinically unfit patients, significantly above pre-covid levels		
Impact	• Long waiting times for patients to access a GP • Patients attend the Emergency Department because they cannot get the care or timely care they need in Primary and Community Care • Referrals and admissions into hospital because there are no alternative options or staff are unaware of alternative options • Congested ED department and long waits for patients to be seen • Increase in ambulance handover delays and challenges in timeliness of ambulance response to community demand • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety)		
Impact Score: 5	Likelihood Score:4	Gross Risk Score:	**20 (Extreme)**

Current Controls	• Development of Primary Care Support Team to provide proactive support to fragile practices • Plans agreed and implemented for contract resignations and list closures • Rollout of MDT cluster model to further 2 clusters (1 already implemented) • Urgent Primary Care hubs in the Vale – c.2500 appointments per month • Cardiff CRT and Vale CRT support people to remain at home, avoid hospital admission and be discharged from hospital – but challenges do remain on capacity and timeliness • Implementation of CAV24/7 and transition to NHS Wales 111 • Strengthened site-based leadership and management • Urgent & Emergency Care is one of the five delivery programmes in the 2022/23 Operational Plan. Delivery Group in place. Urgent and Emergency Care System Plan developed, aligned to the National six goals – see actions. • Ambulance handover improvement plan developed and being implemented • Workforce team continue to support recruitment and retention • Local Choices Framework governance in place and utilised when appropriate to support operational pressures
Current Assurances	• Operational position reported into Management Executive (weekly) (1) • Mechanisms in place to monitor key schemes in Urgent & Emergency Care Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee. Specific focus on Six Goals for Urgent & Emergency Care on 12th July 2022. (1) • Urgent and Emergency Care reported as part of the Board Integrated Performance report (1)

Impact Score: 5	Likelihood Score: 3	Net Risk Score:	**15 (Extreme)**

Gap in Controls	Actively scale up multidisciplinary cluster models Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce) Developing an effective, high quality and sustainable Acute Medicine model Reconfiguring our in-hospital footprint to improve efficiency and patient flow
Gap in Assurances	Whilst an Urgent & Emergency Care Delivery Group is in place, the Six Goals Integrated Urgent & Emergency Care Transformation Board is yet to be established

Actions	Lead	By when	Update since March 2023
1. Secure funding and develop implementation plan for further MDT cluster rollout and Urgent Primary care Centre in Cardiff	LD	31/7/23	UPPC in Cardiff CRI went live in December. Further roll out in Cardiff North planned for Feb. 72% of CAV patch now has UPCC provision – 1,200 appointments a week. Plans for remaining areas to be in place by end of July 23 MDT Cluster work is separate and ongoing.
2. Development and implementation of one Urgent and Emergency Care Plan, aligned to the National six goals	PB	31/10/22	Complete - Delivery Board relaunched in January, approach agreed at SLB in December.
3. Introduce Medical Same Day Emergency Care Unit moving to new area whilst introducing senior clinical triaging and hot clinics	PB	30/11/22	Complete -MSDEC moved to interim location.
4. Introducing frail assessment service in emergency and assessment area UHW	PB	30/11/22	Complete - Frail service went live.

5. Develop SOP for A1 (medical short stay ward) and SOP for Zero four-hour ambulance handovers	PB	30/11/22	Complete - Both actions implemented. A1 has led to improved turnaround, reduced length of stay and more patients admitted and discharge. Ambulance handover performance improved.
6. Develop cohesive Winter Plan that introduces 150 beds or bed equivalents	PB	30/11/22	Complete - Circa 150 beds / bed equivalents are being delivered through winter plan
7. Develop acute admission protocols	MJ	05/06/23	Acute referral policy will be formally launched on 5/6/23
8. Continued development of joint Health and Social Care strategies to allow seamless solutions and services for patients with health or social needs	AH / PB	31/03/23	Partnership working continues. Joint action plans in place. Work progressing through RPB, SLG and JME with new IMT introduced bi-weekly chaired by SR to increase focus on actions
9. Introduce integrated care assessment unit as part of the Winter Plan to discharge patients into UHW Lakeside for focused social care intervention whilst maintaining care.	PB	31/10/22 -31/01/23	Complete - IACU opened in LSW. Reduced length of stay for MFFD patients – increasing from 27 to 41 patients in next two weeks.
10. Implementation of the UHW site masterplan, including de-escalation of additional capacity and reconfiguration of the EU	PB	31/07/23	Plan to reconfigure UHW site commences 18/5/23 and will complete by 31/7/23
11. Development of recruitment and retention strategies	RG	31/03/23	See separate BAF risk on workforce
Impact Score: 5 Likelihood Score: 2	Target Risk Score:		**10 (high)**

7. Planned Care – Medical Director /Executive Nurse Director/Chief Operating Officer- (Meriel Jenney/ Jason Roberts/Paul Bostock)

One of the Health Board's Strategic Objectives is to have sustainable planned care services that deliver the ministerial measures of no-one waiting >52 weeks for a new outpatient appointment by December 2022 and no-one waiting >104 weeks for treatment (all stages) by March 2023. To achieve this, the system needs to ensure sufficient capacity to meet recurrent demand and to increase capacity and activity sufficiently above pre-Covid levels to make inroads into the backlog. The recently published Welsh Government Planned Care Plan reflects the high priority of planned care services.

Risk **Date added: 01/11/22**	There is a risk that the organisation will not be able to provide effective, high quality and sustainable planned care services.		
Cause	• The impact of the covid pandemic has resulted in sustained pressure across the planned care system due to the growth in backlog of patients waiting to access treatment. The pressure on capacity in outpatients, diagnostics and treatments for urgent/emergency care has impacted on those waiting to access the system for planned care. • Referrals for planned care are at pre-Covid levels overall, however there is significant variation between specialities. Whilst our planned care system (outpatients, diagnostics, treatments) is almost back to full capacity, it has been challenging to achieve activity levels significantly above pre-Covid activity. • There are sustained workforce pressures at a clinical level with challenges around recruitment and retention of staff		
Impact	• Significant volumes of patients waiting for new outpatient appointments, diagnostics and treatment • Some patients are tipping over into waits of more than 3 years, some of these are still at the outpatient stage • Potential for harm in terms of clinical deterioration whilst patients are waiting, particularly at the outpatient stage where patients have yet to be seen by a secondary care clinician and priority determined • Poor staff morale and retention due to the sustained pressures in the system • Worsening patient experience and outcomes (see separate risk on patient safety) • Organisational/reputational harm due to political and media interest and scrutiny		
Impact Score: 4	Likelihood Score:4	Gross Risk Score:	**16 (Extreme)**
Current Controls	• Planned Care is one of the delivery programmes in the 2022/23 Operational Plan • Demand/capacity work undertaken to model expected delivery against the ministerial measures • Additional capacity schemes funded through WG planned care monies are in place and delivering e.g. independent sector, mobile ophthalmology theatres, 2nd gynae treatment room commissioned, spinal unit commissioned, mobile endoscopy unit in place • Workforce team continue to support recruitment and retention • Suite of reports and dashboard created by the Digital and Healthcare Intelligence team to support Directorate teams and Clinical Board in terms of managing the planned care position		

Current Assurances	• Current position against 52/104weeks monitored via weekly Planned Care Performance meeting (1) • Operational position reported into daily/weekly 'hot' reports(1) • Elective Care Delivery Group in place monthly; suite of metrics reviewed at every meeting (1) • Monthly meeting with the Delivery Unit on Planned Care(1) • Mechanisms in place to monitor key Planned Care schemes as part of the Operational Delivery Plan (1) • Key operational performance indicators and progress against plans reported into the Strategy and Delivery Committee (1) • Planned Care reported as part of the Board Integrated Performance report (1)		
Impact Score: 3	Likelihood Score: 3	Net Risk Score:	**9 (High)**
Gap in Controls	• Further demand/capacity work required together with an indication of the ministerial targets to inform the plan for 23/24 and assess deliverability • Availability of planned care funding may mean that choices need to be made in terms of delivery • Further work required to maximise treat in turn • Solutions required to ensure all specialities can access sufficient capacity to enable a return to pre-Covid levels of activity • Recruitment strategies to sustain and increase multidisciplinary teams (see separate risk on workforce)		
Gap in Assurances	• Since the Operational Plan Delivery Group meeting has been stepped down, there is a need to consider the governance mechanisms by which key risks and messages from the Elective Care Delivery Group are escalated • Whilst a sub-group on supporting patients whilst they are waiting has been established, the group is in its infancy and needs to progress at pace		

Actions	Lead	By when	Update since March 2023
1. Continue to develop and iterate the demand/capacity work for 23/24 to inform the IMTP	AW/JC	31.1.23	Included in development of IMTP
2. Establish key priorities and a work plan for the supporting patients sub-group	EC	31.12.22	Complete. Group is in place and meeting monthly. Two sub-groups have been established with work due to commence in January.
3. Continue to progress plans to maximise activity and monitor via the Planned Care Performance group	JC	Weekly	Complete - Meetings in place
4. Agree formal reporting mechanisms from the Elective Care Delivery group through to SLB	PB	30.04.23	Complete Planned Care Improvement Board now relaunched and has quarterly reporting slot to SLB
5. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
Impact Score: 4 / Likelihood Score: 2	Target Risk Score:		**8 (High)**

8. Exacerbation of Health Inequalities in C&V – Executive Director of Public Health (Fiona Kinghorn)

The COVID-19 pandemic has compounded existing health inequalities in Wales, which have shown little improvement in the last ten years, based on the gap in life expectancy between the most and least deprived fifth of the population. Although the main disparities have been age, sex, deprivation and ethnicity, there is clear evidence of intersectionality, risk factors compounding each other to further disadvantage individuals with protected characteristics (based on the Equality Act 2010). As the granular level data emerges, there is no evidence to suggest that this pattern is not replicated fully at a Cardiff and Vale UHB level.

The vision of our Shaping Our Future Wellbeing strategy is that *"a person's chance of leading a healthy life is the same wherever they live and whoever they are"*. Our goal is to reduce health inequalities – reduce the 12-year life expectancy gap, and improve the healthy years lived gap of 22 years. Addressing inequality linked to deprivation is also a clear commitment of both Cardiff and Vale of Glamorgan PSB Well-being Plans 2018-23.

Our focus on reducing inequalities locally in health and wellbeing are underpinned by both 'Prosperity for All' and 'A Healthier Wales'. The Wellbeing of Future Generations Act also sets out Health and Equality as two main goals and the Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage.

Risk	There is a risk that the exacerbation of inequalities due to the harms caused by the COVID-19 pandemic and cost of living crisis will reverse progress in our goal to reduce the 12-year life expectancy gap, and improvements to the healthy years lived gap of 22 years.
Date added:	29.07.21
Cause	• Deaths from COVID-19 have been almost double in the most deprived quintile when compared with the least deprived quintile of the population in Wales, and there has been a disproportionate rate of hospitalisation and death in ethnic minority communities • In Wales, socio-economic health inequalities in COVID-19 become more pronounced further along the hospital treatment pathway. Based on data from the first few months of the pandemic we can see that inequalities were not particularly pronounced for confirmed cases (unlike England) but the gradient became bigger for admissions, ICU and deaths. This may be related to the idea of staircase effects whereby health inequalities accumulate across the system and the 'inverse care law' whereby people from deprived areas may not seek help until later when their condition has deteriorated, which may be related to accessibility, health literacy and competing demands on their time. The role of the healthcare organisation in flexing to provide effective treatment according to individual need along that pathway is key • It is recognised that the COVID-19 pandemic is responsible for five harms to population health, all of which are experienced inequitably. These are the direct harm caused by infection, indirect harm due to surge pressures on the health and social care system, harms caused by population based health protection measures (e.g. lockdown), economic harm and harms caused by exacerbaing inequalities in our society. The impact of all five harms continues to be experienced by the population of Cardiff and Vale three years after the onset of the pandemic. • Health inequalities arise in three main ways, from ○ structural issues, e.g. income, employment, education and housing ○ unhealthy behaviours ○ inequitable access to, or experience of, services, which can be a result of discrimination due to inaccessible services, public information or healthcare sites that may be relevant/pertinent to their particular needs • It follows, therefore, that services run by organisations which do not address their own structural issues (nor advocate others to do so), do not support staff and their population to take up healthier, or reduce health-harming, behaviours, and which

	are not tailored towards reducing inequalities will fail to address the causes of increasing health inequality • The impact of inflation leading to the 'cost of living crisis' currently being experienced in the UK, with rising prices for energy (gas, electricity) and fuel (petrol, diesel) food and other goods and services has a negative impact on health as real disposable incomes fall with this being more marked in lower income households. High inflation also risks exacerbating mental health challenges with concerns about debt being a leading cause of anxiety
Impact	• The key population groups with multiple vulnerabilities, compounded or exposed by COVID-19, include: ○ Children and young people ○ Minority ethnic groups, especially Black and Asian populations ○ People living in (or at risk of) deprivation and poverty ○ People in insecure/low income/informal/low-qualification employment, especially women ○ People who are marginalised and socially excluded, such as homeless persons • Risk factors interact and multiple aspects of disadvantage come together, increasing the disease burden and widening equity gaps. Underlying chronic conditions, as well as unequal living and working conditions, have been found to increase the transmission, rate and severity of disease including COVID-19 • The longer-term, and potentially largest, consequences for widening health inequalities can arise through political and economic pathways. Areas with higher unemployment have greater increase in suicides; and people living in the most deprived areas experience the largest increase in mental illness and self-harm • This is not simply a social injustice issue, health inequalities are also estimated to cost £3-4 billion annually in Wales through higher welfare payments, productivity losses, lost taxes, and additional illness • This remains an uncertain time with concerns about resurgence of COVID-19 which disproportionately impacts the most vulnerable in society, together with the economic impact of the rapid increase in inflation. This may mean that health inequalities widen if public policy and local interventions do not act to rectify this imbalance swiftly. However, most levers for economic action are at the UK government level. Warmth and food availability will be key issues locally

Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**

Current Controls	**1. Statutory function** The Socio-economic Duty places a legal responsibility on public bodies in Wales when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socio-economic disadvantage. Approaching implementation of the Socio-economic Duty effectively will help us maximise our contribution to addressing such inequalities, and also to meet our obligations under the Human Rights Act 1998 and international human rights law. Of note, but more of a reputational risk, if an individual or group whose interests are adversely affected by our strategic decision, in circumstances where that individual or group feels the Duty has not been properly complied with, they would have the right to instigate a judicial review claim against the UHB **2. Role as an Employer** • In our Equality, Inclusivity and Human Rights Policy, we have an active programme, which sets out the organisational commitment to promoting equality, diversity and human rights in relation to employment, and ensuring staff recruitment is conducted in an equal manner • Our Strategic Equality Plan 'Caring about Inclusion 2020-2024' has a number of key delivery objectives and is premised on the basis of embedding equality, diversity and human rights, and Welsh language, into UHB business processes, for example: Recruitment and Selection Policy, Annual Equality Report, Equality reports to the Strategy and Delivery Committee, Reports/Updates to the Centre for Equality and

	Human Rights, Outcome Report to the Welsh Government Equalities Team regarding sensory loss, provision of evidence to the Health and Care Standards self-assessment, Equality and Health Impact Assessments • All our Executives have taken up a leadership role across the nine protected characteristics specified in the Equality Act 2010 - age, disability, gender identity, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation - our CEO is the lead for race • In August 2022 the Chancellor recognised that support is needed even for staff on wages up to £45,000 and included senior nurses in this description to manage increased energy bills. Staff have been signposted to resources to help them to cope with the cost-of-living crisis this winter **3. Refocused Joint strategic and operational planning and delivery** • The refresh of the UHB Strategy Shaping our Future Well-being continues to shine a light on the issue of equity at the strategic level • Each of our strategic programmes within Shaping our Future Well Being Strategy will consider how our work can further tackle inequalities in health • Our Shaping our Future Public Health strategic programme has a focused arena of work aimed at tackling areas of inequalities. We are working closely with the two local authorities and other partners, through our PSBs and RPB partnerships to accelerate action in our local organisations and communities, particularly in relation to healthy weight, immunisation and screening. This includes building on local engagement with our ethnic minority communities during the Covid-19 pandemic. Such focused work is articulated in 'Cardiff and Vale Local Public Health Plan 2023-26' within our UHB three-year plan, and will be strengthened in 2023/24 by the development of a strategic framework for tacking inequalities • Through our PSB and RPB plans we already prioritise areas of work to tackle inequalities and the refreshed needs assessments for both PSBs and RPB will further identify collective actions • The Youth Justice Board is implementing the recommendations of our Public Injecting & Youth Justice Health Needs Assessments in Cardiff • Cardiff PSB and Cardiff and Vale Substance Misuse Area Planning Board are implementing the recommendations of its Needle Exchange programme review to tackle health inequality as part of COVID-19 substance misuse recovery work • Our Suicide and Self-Harm Prevention Strategy has been published • The multi-agency approach to Seldom Heard Voices, which targeted initiatives towards areas of deprivation during the pandemic e.g. walk in vaccine clinics, will continue as we move through recovery. • The Annual Report of the Director of Public Health (2020), published in September 2021, focusses on reducing inequity and sets out a vision for future partnership working that will enable us to recover strongly and more fairly. • The latest Annual Report of the Director of Public Health report on value, (published January 2023) also contains a chapter which focuses on the relationship between a Value-based approach and reducing inequities.
Current Assurances Saunders,Nathan 24/05/2023 15:05:05	We have identified a bellwether set of indicators to help measure inequalities in health in the Cardiff and Vale population through which we will develop further to measure impact of our actions. This formed part of the Annual Report of the Director of Public Health 2020, published September 2021 (1). Examples include: • The gap in healthy life expectancy at birth between the most and least deprived in Cardiff and Vale UHB reduced from 16.6 years in 2017/19 to 14.4 years in 2018/20 for males. In females however, the gap increased from 14.6 years in 2017/19 to 18.0 years in 2018/20. Neither of these estimates yet takes account of the impact of the pandemic. • As of 10 Dec 2022, the gap in coverage of COVID-19 autumn 2022 booster vaccination between those (all ages) living in the least deprived and most deprived areas of Cardiff and Vale UHB was 29.8%, with fewer people vaccinated from the

	most deprived groups. This compares to a gap of 23% across the whole of Wales between those in the least deprived groups compared to those living in the most deprived groups. • Discussions with Public Health Wales have been held to support the development and regular monitoring on health inequities. • A gap analysis of health inequalities data has been undertaken as part of a national exercise which indicates that data collection on date of birth and postcode are good but that this drops considerably for other important variables.		
Impact Score: 4	**Likelihood Score: 3**	**Net Risk Score:**	**12 (High)**
Gap in Controls	• Unidentified and unmet healthcare needs in seldom heard groups • Capacity of partner organisations to deliver on plans and interdependency of work		
Gap in Assurances	• Monitoring data (often managed via external agencies) and establishing trends difficult to determine over shorter timescales		

Actions	Lead	By when	Update since March 2023
1. Embed a 'Socio-economic Duty' way of thinking into strategic/operational planning, *beyond* complying with our statutory duty	Fiona Kinghorn /Rachel Gidman	2023/24	We plan to strengthen the strategic response to the Socio-economic Duty, ensuring actions are systematically applied. The EHIA process will be reviewed (when capacity allows) with the aim of simplifying it where possible. The new process will consider proportionality, so that the level and depth of the EHIA undertaken is proportionate to the change being introduced. Our UHB will continue to work collaboratively with our stakeholders to shape our services and culture.
2. Within the UHB and through our PSB and RPB partnerships, develop and deliver a suite of focused preventative actions to tackle inequalities in health	Fiona Kinghorn	March 2024	Suite of preventative actions to tackle inequalities developed with PSB and RPB partnerships. Next step is delivery. 'Amplifying Prevention' actions continue to be implemented, for example organisational policies to work collectively to reduce High Fat Sugar Salt advertising are being worked through; targeted offer of Making Every contact Count (MECC) training to front line staff; and support to bowel cancer awareness month (April) coordinated across the partnership, including messages to staff.

		April 2024 June 2023	Following publication of the Population Needs Assessment and the two Wellbeing Needs Assessments, tacking inequalities is recognised as a priority for all local and regional partner organisations. A comprehensive Health Needs Assessment for Inclusion Health has been completed, a Programme Board for Health Inclusion has been established, and a clinical model is being worked through. A strategic framework for tacking inequalities has been drafted and shared with the three Exec Leads by end of March 2023. A meeting was held in April to discuss the process and the Framework with the writing group and lead Execs, and a further iteration will be produced by end of April 2023 based on the feedback. To go to SLB for consideration in June 2023, and Board Development session in June 2023.
3. Improve the routine data collection in relation to equality and inequity, both across the UHB and with partner organisations, and develop a broader suite of indicators to monitor progress	Fiona Kinghorn	March 2023 June 2023 January 2024	Amplifying prevention indicators ~~being~~ developed. The national Gap analysis of health equity data collection was well responded to by C&VUHB teams, and the local survey results are to be discussed at the next C&VUHB Value Based Healthcare and Data Improvement Group. Develop a suite of indicators that can help us to monitor health inequity over time at the population level, and support services to

				consider indicators that relate to specific services.
Impact Score: 4	**Likelihood Score: 3**	**Target Risk Score:**	**12 (High)**	

9. Workforce – Executive Director of People and Culture (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 impact of the pandemic, immunisation programme, Winter, Social Care workforce challenges and urgent service recovery plans has led for an increasing need in clinical staff. 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 attract, recruit and retain people to work in our clinical teams to deliver high quality care for the population of Cardiff and the Vale.
Cause	• The pandemic, Winter and the Recovery Plan has placed significant pressure on our workforce, due to increased demand on services. Demand for staff has been significantly higher than the supply which has meant that our existing teams have been placed under extreme pressure since March 2020. • The increased demand across the NHS and Social Care has left a shortage of people with the right skills, abilities and experience in many professions/roles which has created a more competitive market. • National shortages in some professions has made it difficult to attract people with the right skills/experience and in the numbers required, for example: - Registered Nurses. - Medical staff in certain specialties (e.g., Adult Psychiatry, General & Acute Medicine, Histopathology, Radiology, GP). • Turnover remains higher than pre-pandemic levels but since November 22 it has reduced slightly month on month, from 13.66% to 12.87%. • Sickness Absence rates remain high; although the rates appear to be falling to more 'normal' levels. The monthly sickness rate for March 2023 was 5.40% and February 2023 was 6.13%, after an all-time high of 8.56% for December 2023. The cumulative rate has fallen over the past 3 months to 6.90% (marginally lower than for March 2022, which was 6.92%). This figure is derived from the total absence since April. • Significant operational pressures across the whole system since March 2020 has impacted negatively on the health and wellbeing of our staff. • The development of our existing workforce has reduced as a direct result of the pandemic and the significant operational pressures, which is impacting negatively on retention. • Attraction, recruitment and retention is also being affected by the negative image that is portrayed that NHS staff do not receive the right remuneration for the work that they do. Some Trade Unions have been campaigning and taking industrial actions over the last few months. • The pause in recruiting International educated registered nurses could potentially exacerbate the high number of vacancies within the UHB.
Impact 	• Negative impact on our people and our teams, as a result we are experiencing: - High levels of sickness absence and lack of management capacity to support staff appropriately; - High levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; ~~- Poor compliance with statutory and mandatory training;~~ - Reduced capacity to undertake appraisals, identify development needs, and focus on talent management and succession planning.

- Lack of capacity to upskill and develop our current workforce.
- Negative impact on quality of care provided to the population.
- Inability to meet on-going demands of post pandemic, Winter and the Recovery plan.
- A number of Trade Unions have rejected the WG pay offer and have a mandate to take industrial action up to May 2023.

Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**

Current Controls

- The first meeting of the People and Culture Committee in May 2023 to provide more scrutiny and assurance to Board.
- People and Culture Plan with robust processes to monitor progress against the key deliverables.
- Heads of People & Culture have been reintroduced into the Clinical Boards to provide additional support with strategic priorities, including delivery of P&C Plan, workforce planning, retention, workforce redesign, sustainability, etc.
- Hotspots are identified using our workforce data, plans are coproduced to support with recruitment, retention, staff wellbeing, etc.
- The People Resourcing team continue to improve the way we attract and recruit, they will ensure that any recruitment needed for the remodelling of clinical areas is achieved in a timely manner.
- The Staff Bank are continuing to focus on increasing the supply of HCSW and RN's on the bank which will support the reduction of agency usage and improve quality. No untoward issues have been escalated since the agency HCSW ban was implemented on 1 April 2023. They are also increasing the variety of roles employed by the bank to avoid Agencies which has included Geneticists, pharmacists, Allied Health professions etc.
- A Retention Toolkit has been developed and a number of bespoke action plans have been initiated in some of the hotspot areas to ensure problems are addressed urgently.
- The People Services Team have embedded its operating model, aligned to Clinical Boards, to provide specialist advice and support aligned to the organisation's priorities, e.g. reducing sickness absence, reducing formal ER cases, effective change management, etc.
- Focussed recruitment campaigns to improve the diversity of our workforce and to positively benefit the local community.
- All Wales International Nurse Recruitment Campaign can still be utilised for very specialised roles that are hard to fill through UK recruitment pipeline.
- Welsh Government Campaign *Train, Work, Live* to attract for Wales – GP, Doctors, Nursing and Therapies.
- Medical International recruitment strategies reinforced with BAPIO OSLER and Gateway Europe.
- Medical Training Initiative (MTI) 2-year placement scheme via Royal Colleges.
- Medical Workforce Advisory Group (MWAG) progress and monitor employment matters that directly affect our Medical & Dental staff.
- Central managed Medical and Dental Staff Bank in place to increase the supply of doctors (using temporary workforce), maintain quality and reduce costs. Fill rate is consistently over 95%.
- E-Job Planning system in place to ensure Consultants and SAS Doctors have their job plans reviewed and approved annually.
- ~~E-Rostering Programme Board meet monthly to ensure the roll out of the new e-rostering system and Safe Care is progressing as outlined in the implementation plan.~~
- Health & Wellbeing strategy monitored through the strategic Health & Wellbeing Group.

	• Monthly Executive Performance Reviews with a focus on improving our workforce position are now well established. • Baseline Workforce Plans have been developed for each Clinical Board initially concentrating on our Nursing workforce, which is the staff group where we have the biggest gap in supply. Workforce Plans are also being developed for our Medical workforce. The aim is to have workforce plans for all our Clinical/Service Boards for all staff groups within the next 12 months. • ~~An Industrial Action Contingency Planning Group was established in September 22 and meet regularly to ensure risks are managed and we have robust contingency plans in place to enable the UHB to deliver emergency and critical services to our patients/citizens/population.~~ • Modernising the ward skill mix with the introduction of Band 4 Assistant Practitioners will partly address the Registered Nurses vacancies that we have within the UHB. It will enable the RNs to do what only RNs can do by providing them with appropriately trained staff that meet the needs of the patients.
Current Assurances	• Robust monitoring of People and Culture Plan KPI's at Strategy and Delivery Committee (going forward People an Culture Committee) and Board. (1) • Regular monitoring of forecasted RN vacancies to identify whether International recruitment would need to be re-considered by the Board. • Qtrly IMTP Updates to WG. • Effective partnership working with Trade Union colleagues (WPG, LNC, LPF). (1) • ~~Updates provided to Strategy and Delivery Committee and Board on Industrial Action~~ (1)

Impact Score: 5	Likelihood Score: 4	**Net Risk Score:**	**20 (Extreme)**
Gap in Controls	Workforce supply affected by National Shortages.		
Gap in Assurances			

Actions	Lead	By when	Update since March 2023
1. ~~Approval to engage in the All Wales International Nurse Recruitment Campaign (cohort 2 – end of 2022/early 2023)~~	~~Jason Roberts~~	~~Nov 22~~	~~Complete~~ ~~A paper was considered by SLB in Nov and will be discussed at Board in Jan 23. A workforce plan specific to OSN is being developed which will support decision making.~~

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

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10. Leading Sustainable Culture Change – Executive Director of People and Culture (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, also staff overwhelmed with change and ongoing demands as a result of the pandemic. • 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. • Additional complexities as colleagues continuously respond to the challenges of the pandemic, making involvement in, and response to change complex and challenging.		
Impact	• Staff morale may decrease • Increase in absenteeism and/or presenteeism • Difficulty in retaining and recruiting staff • Potential decrease in staff engagement • Increase in formal employee relations cases • 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 • Staff experiencing fatigue and burnout making active and positive engagement in change challenging and buy-in difficult to achieve.		
Impact Score: 4	**Likelihood Score: 4**	**Gross Risk Score:**	**16 (Extreme)**
Current Controls	• Values and behaviours Framework in place • Cardiff and Vale Transformation story and narrative • Leadership Development Programmes, e.g. Acceler8 and CLIMB supporting inclusive, compassionate leadership principles • Management Programmes offering a blended approach to learning and including development around change and transformation • Talent management and succession planning cascaded through the UHB • Values based recruitment / appraisal • Staff survey results and actions taken, including NHS Staff Survey and Medical Engagement Scale. • Involvement in All Wales NHS Staff Engagement Working Group • Increasing the diversity of the workforce through the Kickstart programme, Apprenticeship Academy, Project SEARCH; development of UHB action plans, e.g. Anti-Racist Action Plan • Patient experience score cards • CEO and Executive Director of People and Culture sponsors for culture and leadership • Raising concerns procedure/Freedom to Speak Up. UHB part of all Wales Group looking at Freedom to Speak Up across NHS Wales • Interviews conducted with senior leaders regarding learnings and feedback from Covid 19 and lessons learnt document completed in September 2020 looking at the whole system. Discovery learning report completed in the Autumn 2020		

	• Strategic Equality Plan and Welsh Language Standards implementation and monitoring via the Equality, Diversity, Inclusion and Welsh Language Team • Executive Team identified as Inclusion Ambassadors, each leading on a Protected Characteristic, and Welsh Language, being cascaded throughout Clinical Boards		
Current Assurances	Internal Audit on Staff Wellbeing, Culture and Values (Sept 2022) report [3]; Engagement of staff side through the Local partnership Forum (LPF) [1] Matrix of measurement now in place which will be presented in the form of a highlight report to Committee [1]		
Impact Score: 4	**Likelihood Score: 2**	**Net Risk Score:**	**8 (High)**
Gap in Controls	Agreed and consistent organisational approach to cultural change Continued high demands impacting on ability to release staff for development / involvement in transformation / development		
Gap in Assurances	VBA rate continues to be low Capacity to respond to requests for cultural and transformation work Effective measures of culture / engagement		

Actions	Lead	By when	Update since March 2023
1. Learning from Canterbury Model with a Model Experiential Leadership Programme- Leadership Programmes have been developed: (i) Acceler8 (ii) Collabor8 (iii) Climb Compassionate and inclusive leadership principles will be at the core of all the programmes	Rachel Gidman	June 2023 May-Sept 2023 June-Sept 2023 Jan-March 2023 July 2023	Acceler8 Senior Leadership Programme Cohort 2 ended in May 2023. Evaluation to take place June 2023. ~~Upon completion, Cohort 2 will join Cohort 1 and Climb delegates in the CAV Leadership Alumni.~~ The Collabor8 Leadership programme, Cohort 1 is continuing. The review of a CAV Leadership Development Strategy is underway. Leadership development across the UHB is being mapped to identify gaps in provision, areas of duplication, and opportunities for collaboration. Education, Culture and OD Team (previously LED) currently reviewing leadership and management development offer to plan schedule from September 2023. Enhancement of a coaching and mentoring network continues. Coaches currently supporting Senior Nurses in Phase 1 of development. Access to coaches continues to be challenging. Development of push-far coaching platform to aid network development underway. Mentoring training has been acquired and the initial training will support the development of the Anti-Racist Action Plan, in supporting Inclusion Ambassadors to hear from colleagues with lived experience. Identification of mentors to take place May/June

			2023, including discussions on reverse mentoring.
		June 2023	3 Coaching supervisors have been identified, training delayed to June 2023 due to availability.
		June 2023	Simplified VBA process has been communicated and training ongoing to support for both managers and staff. Simplified paperwork agreed and part of communication. All CBs have provided an action plan and trajectory for achieving VBA targets by March 2023 (60%) and June 2023 (85%). VBA training continues to be well attended and compliance is showing an increase.
		March-June 2023	There has been an increase in the number of requests to facilitate cultural programmes/OD work within directorates and teams. ALAS discovery phase has been completed utilising Culture and Leadership Programme and Framework. Analysis and recommendations to be provided to DMT ~~early~~ May 2023.
		May-June 2023	
		June 2023	OD support for UHB strategic programmes also requested, SOFH, SOFCS etc and challenges to capacity being discussed.
		June 2023	HEIW has reserved 8 licenses for CAV on the NHSE/I Culture and Leadership Programme Framework to increase capability and understanding of the tool. CAV will also provide NHSE/I with a case study of the existing programme.
		May-June 2023	6-month programme of work developed to support EU, has completed stage 1. Evaluation in progress, People and Culture Team to work with SMT to identify next steps.
		May 2023	Equity and Inclusion Audit has been completed and reasonable assurance obtained. Management response provided and action plan developed to address areas for improvement.
2. Showcase	Rachel Gidman	~~Oct 2022~~ June 2023	~~Showcase launched via all Staff Comms in October 2022~~. Review of showcase required.

3. Equality, Diversity and Inclusion	Rachel Gidman	~~Dec 2022~~ July 2023	Equality Strategy Welsh Language Group under review. To be discussed at People and Culture Committee July 2023. Review of group TOR taking place to ensure all CBs are represented and appropriate governance is in place.
Welsh Language Standard being implemented.		May 2023	A robust translation process is in place supported by 2 Welsh Language Translators and an SLA with Bi-lingual Cardiff. Cost effectiveness of SLA currently being reviewed based on costs per word and waiting times. Initial analysis demonstrates savings to be made through increasing in-house translation capacity. To be presented May 2023.
Inclusion - Nine protected Characteristics		May-June 2023	The UHB continues to receive and respond to inquiries from the Welsh language Commissioner's Office, particularly around recruitment and data. The Welsh language team are supporting prioritised Clinical Boards to further understand their responsibilities and are taking a stepped approach to this due to capacity. All 9 protected characteristics including Welsh language are sponsored by an Executive and an independent member. This approach has also been rolled-out across CBs. An 'Inclusion Ambassador' pack has been circulated that support in understanding and learning.
		Ongoing	Training has been identified for mentors to support Inclusion Ambassadors at executive level. Step two will be identification / nominations for mentors, followed by training.
		May-Sept 2023	Existing networks are collaborating to develop the scope and outline of an 'Ally Network'. Work is at an early stage, initial proposal to be taken to the ESWLSG meeting in June 2023. Review of networks in light of 'Employee resource groups' discussions at Board Development with Race Equality First.

		~~June~~ May 2023 June 2023	The Anti-Racist Wales Action Plan developed by Welsh Government was published in June 2022. Board development continued in May 2023 facilitated by Race Equality First. Anti-Racist Action Plan to be presented at Board May 2023. The draft proposal for a framework looking at Equality, Health Inequalities and Safety. A collaboration of areas including the E&I Team; ADOD; PH; Patient Experience; Quality and Safety formed a working group to review existing documentation and benchmarking.
4. CAV Convention	Rachel Gidman	TBC	Action under review and date to be confirmed once known.
Impact Score: 4	**Likelihood Score: 1**	**Target Risk Score:**	**4 (Moderate)**

11. Impact of Covid19 Pandemic on Staff Wellbeing – Executive Director of People and Culture (Rachel Gidman)

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.

Risk	There is a risk that staff sickness will increase and staff wellbeing will decrease due to the psychological and physical impact of the ongoing 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 / experience • Being merged with new colleagues from different areas • Increased working to cover shifts for colleagues / react to increased capacity / high levels of sickness or isolation due to positive Covid test results • 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 / impact upon manager wellbeing • Conflict between service delivery and staff wellbeing • Continued exposure to psychological impact of covid both at home and in work • Ongoing demands of the pandemic over an extended period of time, minimising ability to take leave / rest / recuperate • Experience of moral injury • Cost of living 'crisis'		
Impact	• Values and behaviours of the UHB will not be displayed and potential for exacerbation of existing poor behaviours • Operating on minimal staff levels in clinical areas • Mental health and wellbeing of staff will decrease, existing MH conditions exacerbated • 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 • Increased referrals to Occupational Health and Employee Wellbeing Services (EWS) • UHB credibility as an employee of choice may decrease • Potential exacerbation of existing health conditions		
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 • Wellbeing Q&As and drop ins (ad-hoc and upon request) • Wellbeing Support and training for Line managers • Development of range of wellbeing resources for both staff and line managers • GP self-referral • Values Based Appraisals including focus on wellbeing • Chaplaincy ward rounds • Health Intervention Team (HIT) established April 2021-March 2023 • Network of Wellbeing champions (training linked with the 'Time to Change Wales Programme')		

	• Health and Wellbeing Strategic group • Development of rapid access to Dermatology • Post traumatic pathway service • Deployment principles to support staff and line managers • Wellbeing walkabouts to signpost resources • Long Covid Peer Support Group • Development of the Employee Wellbeing Support Pathway (based on the CTM pathway) • Implementation of 'Money and Pensions Service (MaPS) training for the wellbeing champions and line managers • Development of the Financial Wellbeing pathway • Establishment of the Cost of Living and Wellbeing webpages on Sharepoint • Dedicated staff benefits, savings and discount web pages • Provision of MaPS presentations on 'pensions' and 'pensions and menopause'
Current Assurances	• Internal monitoring and KPIs within the OH&EHWS (1) • Wellbeing champions normalising wellbeing discussions (1) • VBA focussing on individual wellbeing and development (1) • Successful retention of the gold (and platinum) Corporate Health Standard awards via the 'Enhanced Status Checks' in March 2023 • HIT Team recommendation plan completed following UHB engagement, priority actions to be focus (1) • Substantive funding identified to maintain on a permanent basis the enhanced EWS service from April 2023 • Development of a new and permanent 'Wellbeing' practitioner role • Taking Care of Carers Audit and Action Plan (3) • Internal audit on Staff Wellbeing, Culture and Values (September 2022) Report (3) • Trade unions insight and feedback from employees (2) • Working with HEIW as part of the Financial Wellbeing (FWB) task and finish group to develop a FWB strategy for NHS staff in Wales (2)

Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 (Extreme)**

Gap in Controls	• Staff shortages leading to movement of staff and high demand for cover • Transparent and timely Communication especially to staff who are not in their substantive role e.g. redeployed, hybrid working • ~~Health Charity funding for EWS agreed in principal, to be confirmed by the charitable fund trustees September 2022~~ • Continued increase in referrals to Occupational Health and increased PEHD work to support mass-recruitment • EWS seeing an increase in staff presenting with more complex issues, including a rise in referrals needing a wellbeing check due to the presentation of high risk in the referral
Gap in Assurances	• Organisational acceptance and approval of wellbeing as an integral part of staff's working life balanced against demand and flow • Awareness and access of employee wellbeing services, particularly for staff without email / internet access • Clarity of signposting and support for managers and workforce

Actions	Lead	By when	Update since March 2023
1. Health Intervention Coordinator (1) providing reactive and immediate support to employees directly affected by the ongoing impact of the COVID pandemic	Nicola Bevan	March 2023	The HI Co-ordinator role continues to support the lead counsellor to deliver bespoke support and development in areas of need. This will end at the end of March 2023 when

			the Health Charity Funding ends. From April onwards, the role will be developed to incorporate OD, Wellbeing and employee experience. As requests are rarely limited to 'wellbeing' only, and often include relationships, behaviours, team working and conflict, moving to a more commissioning and collaborative approach with broader People and Culture Team.
		April – June 2023	
		March-June 2023	EWS have continued to run a series of People and Culture Roadshows, visiting sites across the UHB focusing on signposting information around the Cost of Living and where to access Wellbeing support. These have been delivered with the support of the Working with the Money and Pensions Service (MaPS). In total 12 roadshows have been held to date with an approximate 600 staff engaging with the roadshow reps. including Cardiff Credit Union, Staff representatives, P&C, EWS, Occupational Health, the chaplaincy service. Surveys completed during the roadshows by staff are helping shape future communications, and information being shared on cost of living. Financial Wellbeing packs have been circulated to key leads in primary care

			and community for cascading through the teams. On line MaPS presentations on 'pensions' and 'pensions and menopause' sessions have been delivered. 'Stop Loan Sharks Wales' providing an online presentation for staff in May 2023. A staff Financial Wellbeing pathway has been drafted and will be reviewed by the Strategic Wellbeing Group in April 2023. Dedicated staff financial wellbeing and CoL web pages have been established on sharepoint. Ongoing MaPS workshops rolled out across the various network groups, P&C and line managers. Working with ECOD the first training sessions for line managers are taking place and a workshop for the Wellbeing champions ran in Feb 2023.
2. Health Intervention Coordinators (2) conducting research and exploration for long term sustainable wellbeing for the staff of the UHB	Nicola Bevan	Interventions proposed implementation April 22 – 2023 April 2023 March-May 2023	The Health Intervention team Impact Report has been shared with the Strategic Wellbeing Group. Work has commenced on some of the priorities mentioned, including the development of a Wellbeing Strategy. This was presented to the Strategic Wellbeing Group in February 2023, but is currently out for further comment and will be discussed at Workforce

			Partnership Group in May 2023. ~~Implementation of works around rest space has been completed with the refurbishment of over 30 staff areas.~~ The Health Charity are supporting colleagues at Whitchurch to fund a water station onsite following completion of a SBAR. Peer support developments – MedTRiM training is partially completed. Meeting with provider scheduled for May 2023. Sustaining Resilience at Work Pracitioner Training (StRaW) has been undertaken by Children and Women CB supported by P&C Team. An infrastructure that supports the practitioners has been established and is overseen by four StRaW Managers and a StRaW co-ordinator.
3. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources - Improve website navigation and resources	Nicola Bevan	~~Jan-March~~ June 2023 May 2023 May 2023 May 2023 June 2023	A variety of communication models including Twitter accounts are being utilised to share Wellbeing updates across the UHB. A 12-month communication plan has been developed to ensure that wellbeing topics are covered throughout the year and will be reviewed and agreed by the Strategic Wellbeing Group in June 2023. Financial Wellbeing Working group continues

		March – June 2023	to review and implement action plan, designing and communicating signposting for all staff. Having delivered on the main actions the Financial Wellbeing task and finish group will be stepped down in May 2023, the remaining actions on the 'Action Plan' will be delivered and progress monitored via the Strategic Wellbeing group.
		May-June 2023	Presentations were given to SLB in February and April 2023 highlighting the proposed benefits of using Wagestream, a platform that supports financial wellbeing and education and also the ability to 'stream' wages linked to additional hours worked on health roster. A discussion with Workforce Partnership Group is scheduled for May 2023. Implementation planned for June 2023.
		May-June 2023	Cost of Living action plan has been developed, reviewed weekly to ensure information shared and signposting updated. Internal audit highlighted action for SharePoint pages re: inclusion and signposting to wellbeing resources. Work has now been completed all Sharepoint areas are under monthly review.
		May-July 2023	Communication of engagement and wellbeing surveys continue with P&C team attending CB SMTs. Three attended so far, remaining sessions booked in.

		July 2023	Communications also being developed to thank staff for participation in surveys / platforms; to communicate key themes and to outline actions being taken / planned. This will follow attendance at all meetings.
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	Claire Whiles	March – June 2023 May – December 2023 September 2023 March – June 2023 May 2023	Leadership and Management development offerings to support staff health and wellbeing added to existing offerings. Retention toolkit developed to support teams / CBs / managers. Current work planned with Children and Women CB. Acceler8 Cohort 2 completed. Current review and evaluation of leadership training. Futher cohorts planned for Autumn 2023. EWS working closely with Education, Culture and OD Team (ECOD), and Equity and Inclusion Team to ensure alignment and reduce duplication. OD Commissioning model to be developed to support effective and targeted intervention. Financial Wellbeing (FWB) lead working with P&C leads to look at embedding FWB into moments that matter such as staff induction.
5. Wellbeing interventions and resources funding bid approved November 2021. Implementation to start December 2021 for completion March 2022.	Claire Whiles	March - June 2023	Work on evaluation metrics underway with support from innovation and improvement team

Wellbeing Strategy group to shape with feedback from CI Boards.			and public health. This will ensure effective monitoring, evaluation and planning of all wellbeing services and interventions.
		May-August 2023	Wellbeing Strategy and Framework draft presented to Strategic Wellbeing Group Feb 2023. Further engagement with staff networks, TUs and CBs to follow.
		May-July 2023	Schwartz Round clinical leads identified. Training scheduled for June/July 2023. Steering Group Membership to be presented to SLB. Identification of facilitators to be positioned to ensure representation of workforce population, collaboration with existing networks essential. Change of focus from 'local pilots' to whole UHB – plan being adjusted accordingly, scheduled to be in a position to confidently roll-out from late summer 2023. Risk re Schwartz Round Administrator role – currently not assigned.
		June 2023	Wellbeing Retreat Pilot completed, draft evaluation currently in review.
		~~April-June 2023~~	~~Room Refurbishment complete, including delivery and installation of artwork.~~
			~~Concerns of WSG and lack of ownership / accountability for water stations. Health Charity continues to support~~

			~~areas wishing to implement.~~ Cost of Living working group meeting regularly to review actions. UHB Wellbeing Strategy / Framework in draft discussed at Strategic Wellbeing Group Feb 2023 and further consultation and engagement required. ~~Management Response to Internal Audit agreed and returned and presented at Audit Committee.~~ Focus on staff wellbeing to support retention. Culture Assessment Work completed within one directorate, results being presented May 2023, followed by communication / engagement with staff. Collaborative working across P&C Team and CBs, including TU partners. Range of Financial Wellbeing (FWB) resources available to staff via the dedicated FWB webpages with several links to the other recognised resources such as: Money Helper, Cardiff Credit Union, Stop Loan Sharks Wales and many more.
		May - June 2023	
		May 2023	
Impact Score: 5	**Likelihood Score: 1**	**Target Risk Score:**	**5 (Moderate)**

12. Capital Assets (Estates, IT Infrastructure, Medical Devices) – Executive Director of Strategic Planning (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.

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. The condition of facilities within our main hospitals are impacting on our ability to continue to provide the full range of services, and provide the new treatments WHSSC would like to commission from us. This is as a result of insufficient funding and resource to bring the estate up to the required condition in a timely way.		
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 • Lack of timely decisions regarding the development of strategic business cases required to address the significant estates challenges we face.		
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 • Staff facilities are inadequate in many areas.		
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. Subject to mid-point review as covered in Board Development session in February 2023. • 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. • The annual capital programme is prioritised based on risk and the services requirements set out in the IMTP/annual plan, with regular oversight of the programme of discretionary and major capital programmes. • Medical Equipment prioritisation is managed through the Medical Equipment Group • Business Case performance monitored through Capital Management Group every month and Strategy and Delivery Committee every 2 months.		

	• The Health Board has submitted to Welsh Government a 10-year capital outlook, which has been prioritised to reflect the most pressing infrastructure and service challenges and risks. • Shaping Our Future Hospitals Programme Business Case was submitted to WG in October '21 and scrutinised at WG Infrastructure Investment Board in December '21. The WG Cabinet has considered Our Future Hospitals PBC alongside the priorities across the whole of Wales. There is support 'in principle' for the Health Board to proceed with the development of the next stage of the business case process – the Strategic Outline Case. • Welsh Government has agreed the Strategic Outline Case scope and a resource request has been submitted to Welsh Government. • In accordance with the prioritised plan the Board approved and submitted to Welsh Government the Tertiary Tower Business Case and the Vascular MTC Theatres Business Case. This will improve the overarching theatre provision.
Current Assurances	• The estates and capital team have 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 (Strategic Outline Case) as part of Our Future Hospitals Programme to secure funding to enable a UHW replacement/redevelopment to be built. (1) • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised (1) • 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 (3). • Regular reporting on capital programme and risks to Capital Management, Management Executive and Strategy and Delivery Committee (1) (2) • IT risk register regularly updated and shared with DHCW (2) • Health Care Standard completed annually (3) • Medical equipment risk registers developed and managed by Clinical Boards, reviewed at UHB medical equipment group (1) (2) • Strategy and Delivery Committee continue to oversee the delivery of the Capital Programme (1) • Timely decision making in relation to the Shaping Our Future Hospitals Strategic Outline Case (3)

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 size of budget compared with estimated need which will impact significantly on the Capital Programme of the UHB. Not all business cases in the Welsh Government capital plan will be deliverable and the UHB needs to be mindful of the potential reputational risk of delays between OBC and FBC approvals with supply chain partners.
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.

• Despite the substantial end of year capital, the recurrent position remains unchanged. • Full condition surveys of all buildings have not been carried out so not possible to fully understand the condition of the estate.			
Actions	**Lead**	**By when**	**Update since March 2023**
1. The Estates Strategy requires review and refresh and there is a need to ensure that it is future proof. The scoping of this work to understand what is required will take place before Christmas	Catherine Phillips	31.03.24	Mid-term review undertaken and agreed following Board Development in February 2023 to undertake a number of actions overseen by the Health & Safety Committee by the end of 23/24. Refresh of strategy required following sign off of HB strategy with reference to realistic funding available and clarity of funding for UHW2.
2. The Health Board continues to prioritise the use of the discretionary capital budget to target small priority schemes.	Abigail Harris	31.03.24	This continues with discretionary capital.
~~3. The Health Board continues to progress a number of major capital schemes (including Shaping Our Future Wellbeing in the Community and Shaping Our Future Hospitals Programme) aligned to our prioritised 10-year Capital Programme outlook.~~	~~Abigail Harris~~	~~31.03.23~~	Update included under current controls.
4. An acute infrastructure group is overseeing the short – medium term priorities.	Abigail Harris	31.03.24	The group continues to meet to agree priorities with a number of business cases progressed to address significant infrastructure risks such as Mortuary and BMT.
Impact Score: 5	**Likelihood Score: 2**	**Target Risk Score:**	**10 (high)**

13. Risk of Delivery of IMTP 23-26 – Executive Director of Strategic Planning (Abigail Harris)

In October 2021 the Welsh Government signalled a return to a three-year planning approach post-pandemic. Due to the extremely challenging financial position the Health Board submitted an annual plan in a three-year context for 2023/24. The final plan which was approved by the Board on 30th March 2023 and submitted to WG. The plan sets out service delivery proposals reflecting the ministerial priorities, the next milestones in the delivery of our strategy and the financial recovery that will be delivered over the next three years. The plan has not yet been formally accepted by the Minister.

Risk	There is a risk that the Health Board will fail to deliver the commitments set out in the 23/24 Annual Plan both in terms of service and financial commitments. The plan does not achieve overall financial balance in 2023/2024 and it is unlikely to be accepted by the Minister. There are a number of factors in play including the withdrawal of Covid-19 funding and inflationary pressures, for example on energy costs.		
Date added:	May 22 (updated for 2023/24 in May 23)		
Cause	Challenging targets have been set for the Health Board in respect of planned care recovery. Detailed and stretching plans have been developed which the Health Board is committed to delivering but, at this stage the Health Board is not able to achieve all planned care targets for 2023/24. The financial recovery plan will also be challenging to delivery, with stretching targets for sustainable improving our overarching financial position. Whilst we are committed to deliver the actions set out in the plan, there may be dependencies of external factors which impact on our delivery – including constraints relating to funding – capital and revenue, workforce and speed with which we can implement the necessary gearing up to increase capacity.		
Impact	A plan that does not fully meet the requirements for an IMTP is categorised as an annual plan set within a three-year context. The failure to have in place a fully compliant plan could result in the Health Board being escalated to the next level of the performance and escalation framework, which could bring with its reputational loss and increased scrutiny by WG. If we are not able to deliver all of the actions set out in our plan, our planned care recovery could take longer to deliver for the populations we serve and quality of care and patient experience could be impacted. Inability to achieve the commitments for 22/23 impacts upon the ability of the Health Board to develop a balanced IMTP for 2023-26.		
Impact Score: 5	**Likelihood Score: 4**	**Gross Risk Score:**	**20 (Extreme)**
Current Controls	An Operational Plan Delivery structure has been established to drive the delivery of the Planned Care Plan and the Emergency and Urgent Care Improvement Plan. The Performance and Escalation Framework for Clinical Boards has been re-introduced to hold CBs to account for delivering their respective service and financial plans. A process is being established to ensure a programme approach to delivery of the actions within the financial recovery plan. Senior management and oversight arrangements are being strengthened, with the introduction of Director of Operations roles, meetings with Clinical Boards to hold to account with regular reporting and oversight, increased focus on 'hotspots' and summits to address challenges in achieving the 6 goals.		
Current Assurances	Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1) The financial position is reviewed by the Finance Committee which meets monthly and reports into the Board. (1) The Board receive a financial update report from the Executive Director of Finance at each of its meetings. (1) Welsh Government are fully engaged and have been briefed on the Health Board's position. (3) Service delivery performance is tracked through the structures established to oversee planned care recovery and the improvement in emergency and urgent care, with		

	regular reporting into ME and Board on progress. (1) WG also holds monthly Integrated Planning, Quality and Delivery Review meetings with the health board to track progress. (3) Improvement trajectories are being updated quarterly to ensure they remain on track to deliver the agreed targets. (1)		
Impact Score: 5	**Likelihood Score: 3**	**Net Risk Score:**	**15 (Extreme)**
Gap in Controls	Detailed delivery plans are not in place for all elements of the financial recovery plan. Detailed delivery plans are not in place in all specialties to achieve Welsh Government 52-week NOP ambition The Health Board continues to have a high number of medically fit for discharge patients with limited control over actions of partners to assist		
Gap in Assurances	There is currently no assurance on the plan. Once developed assurance will be provided through reporting to Management Executives, Finance Committee and the Board. The Health Boards position has deteriorated in relation to its financial position.		

Actions	Lead	By when	Update since March 2023
1. Ensure detailed plan with programme to drive delivery of financial recovery plan	Catherine Phillips	30/06/23	Detailed Plan and supporting information discussed extensively in Board and provided to WG. Additional oversight arrangements being established to ensure delivery including Sustainability Programme Board chaired by the Chief Executive.
2. Provide Q1 progress report – including mitigating actions, to the Board for scrutiny.	Abigail Harris	31/07/23	This will be presented to Strategy and Delivery Committee and Board in July 2023

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

14. Financial Sustainability – Executive Director of Finance (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 deficit plan submitted for 2022/23 was not achieved and has contributed to a worsened financial outlook for 2023/24 which has also been exacerbated by the cessation of Welsh Government Covid-19 funding and unprecedented inflationary pressures which are not funded. For 2023/24 the Health Board has submitted an Annual Plan in a three year context with a realistic yet challenging plan for restore financial sustainability over the medium-term.

Risk **Date added:** 01.04.2022 (updated May 2023)	There is a risk that the organisation will continue to breach its statutory financial duties by being unable to produce a balanced three-year plan.		
Cause	Cessation of Covid-19 funding and unprecedented inflationary pressures, for example on energy costs. The UHB also has to manage its operational budget and deliver planned savings on a sustainable recurrent basis.		
Impact	Breach of statutory duties, escalation. Unable to deliver a balanced year-end financial position. Reputational loss.		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	Additional expenditure is being authorised within the governance structure and the UHB Scheme of Delegation. Financial Plan submitted to Welsh Government 30th March 2023 explaining inability to deliver financial balance over the three-year period 2023-2026. An additional Performance Review Meeting is now taking place with CB Teams to focus on Financial Performance.		
Current Assurances	The financial position is reviewed by the Finance & Performance Committee which meets monthly and reports into the Board (1) Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting (1) Financial performance is monitored by the Management Executive (1). Assurance from internal audit annual review of core financial controls including budgeting and planning. Sustainability Programme Board in place, chaired by the Chief Executive		
Impact Score: 5	**Likelihood Score: 5**	**Net Risk Score:**	**25 (Extreme)**
Gap in Controls	No gaps currently identified.		
Gap in Assurances	~~To confirm COVID 19 and exceptional funding assumptions with Welsh Government for response and recovery.~~ ~~Certainty of COVID 19 expenditure and the management of non COVID 19 operational pressures.~~ ~~The financial plan 2023/24 does not achieve overall financial balance during the financial year.~~ ~~Our current forecast outturn does not match our financial plan for 2022/23.~~		

Actions	Lead	By when	Update since March 2023
1. Continue to work with Welsh Government to manage our recovery and COVID 19 response as well as exceptional cost pressures.	Catherine Phillips	31/03/23	Complete for 2022/23 as fully funded for the year. See 2023/24 below.

2.	Allocation letter has been received from Welsh Government and impact upon financial performance is being developed	Catherine Phillips	31/03/23	Complete – superseded by production of Annual Plan
3.	To monitor and control additional expenditure and financial performance to ensure that the year-end forecast is in line with financial plan 2022/23	Catherine Phillips	31/03/23	Complete – draft annual accounts produced reporting deficit consistent with the position reported to the Board and WG.
4.	To understand the impact of responding to the Covid 19 pandemic has had on the organisations underlying position. To deliver on our savings plan recurrently	Paul Bostock	31/03/23	Complete – as part of preparation of the Annual Plan.
5.	The organisation has fully identified its savings plan for 2023/24 and actions are in place by the end of Q1 to ensure its delivery	Catherine Phillips	30/06/23	On track by end of Q1.
Impact Score: 3	Likelihood Score: **5**	**Target Risk Score:**		**15 (Extreme)**

15. Digital Strategy and Roadmap – Director of Digital & Health Intelligence (David Thomas)

CAV UHB board approved a five-year Digital Strategy in 2020 which set out the vision for supporting the organisation, from a digital and data perspective, for the period 2020-2025. Development of the strategy was clinically led and was designed to support the UHB's Shaping our Futures' strategic programmes. To realise the benefits contained with the accompanying roadmap, which sets out what we will do and when, requires significant additional investment to bring the organisation up to a level of digital maturity that can support our agreed strategic objectives.

Risk	There is a risk that the Digital Strategy and Roadmap will not be implemented, due to lack of resources, resulting in a deficit in infrastructure, applications and informatics capability.		
Date added:	04.10.22 (updated 10.05.23)		
Cause	CAVUHB IT and digital services are known to have been historically underfunded resulting in a significant legacy deficit in infrastructure, applications and informatics capability that has built up over at least a decade (our PMS and the core module that sit on top for UEC, inpatients and outpatients were built c20 years ago). Colleagues need mobile, scalable, agile solutions which are unachievable whilst we are locked into legacy. There are some programmes and plans identified to rectify these issues however they are unachievable with the current resource allocation		
Impact	We have capability in human resources but lack capacity for planning, management and execution of the activities needed to deliver the digital strategy and roadmap. Just to produce the case(s) for change requires capacity we do not have in the current circumstance ○ Delivery on digital maturity would give capability to colleagues that will reduce inefficiency, release clinical time to care, improve safe practice, allow near real time data to be available to support clinical decision making at the point of care by moving from paper and analogue means of capturing and recording information to digital means where data flows seamlessly between settings Recruitment remains a challenge requiring the use of interim agency support in key areas. Existing resources are consumed with tactical short-term fixes given the legacy so we are unable to prioritise those activities that take us forward – we don't have enough people and we don't have enough money to make the changes we want and need to see. There is a risk that the financial savings and improved staff and patient experience expected from the Digital Roadmap plans will not be fully realised, due to the lack of resources, resulting in a deficit in IT infrastructure, applications and informatics capability and consequential adverse impacts.		
Impact Score: 5	**Likelihood Score: 5**	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• Digital strategy approved by Board in20/21 with roadmap for 21/22/23 • Digital components described in IMTP • Some additional funding secured via the Business Case Advisory Group • IT infrastructure priorities developed and set out for 2022-2025		
Current Assurances	• D & HI have a number of business cases in development which require revenue investment (1) • Risk register articulates the risks of not being able to deliver digital solutions to support delivery of healthcare (1) • Internal audit report highlights the risk in delivering digital strategy citing the investment challenges that will prevent full implementation.		
Impact Score: 5	**Likelihood Score: 4**	**Net Risk Score:**	**20 (Extreme)**

Gap in Controls	• Current annual discretionary funding is insufficient to cover the maintenance upkeep of the core infrastructure.			
Gap in Assurances	• Unable to currently provide assurance that the finance will be provided			
Actions		**Lead**	**By when**	**Update since March 2023**
1.	Discussions with DoF to feed into Digital Financial Plan	DT	31.03.23	Complete
2.	HIMSS assessment of our Digital maturity to be carried out in Qtr 4	DT	31.03.23	Complete
3.	A ten-year investment request developed and submitted to WG outlining capital and revenue requirements.	DT	31.03.23	Complete
4.	Additional investment request submitted to WG for Digital SOC development resources	DT	31.03.23	Complete
5.	Detailed case for investment to be presented at private meeting of DHIC committee (Feb 22)	DT	14.02.23	Complete
6.	External assessment of digital maturity of the acute service completed via site visit on 13/3	DT	31.03.23	Complete
7.	Formal report on digital maturity to be published by HIMSS	DT	31.03.23	Complete
8.	Cyber Assessment Framework update and response to Internal Audit report sets out mitigations and plans to manage cyber risks	DT	31.03.23	Complete
9.	Further update on the investment case to be considered at DHIC	DT	31.05.23	New action
10.	Final report on the UHB's HIMSS digital maturity to be shared and discussed at DHIC and a summary brought to Board	DT	31.07.23	New action
11.	Cyber plans reviewed and further updated to reflect Audit recommendations and Cyber Assessment Framework requirements from the WG Cyber Resilience Unit for 23/24.	DT	30.08.23	New action
Impact Score: 5	**Likelihood Score: 3**	**Target Risk Score:**		**15 (Extreme)**

Key:

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

Report Title:	Senior Leadership Board - Chair's Report			Agenda Item no.	6.5.1
Meeting:	Board	Public	x	Meeting Date:	25.05.23
		Private			
Status *(please tick one only)*:	Assurance x	Approval		Information	
Lead Executive:	Chief Executive				
Report Author (Title):	Head of Corporate Business				

Main Report

Background and current situation:

This report provides a summary over view of the activity of the Senior Leadership Board (SLB) and is produced to provide assurance of the senior leadership oversight, coordination and activity conducted by SLB.

This report summarises SLB activity and decisions in the period 16.03.23 to 04.05.23.

Board are asked to note that the SLB scheduled for 18.05.23 will be included in the Chair's Report to Board in June 2023.

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

16th March 2023

The following items were approved:

- **Internal Audit Plan.** It was agreed that the Internal Audit Plan for 2023/24 should be passed to the Audit and Assurance Committee with a recommendation for approval.
- **Decarbonisation Action Plan.** It was agreed that the Decarbonisation Action Plan should be passed to Board with a recommendation for approval.
- **Investment Group (IG) Decision Report 01.03.23**. The IG decision report from the 01.03.23 IG meeting, and associated business cases were discussed. Business cases up to a value of £500k were approved in line with the Chief Executive's delegation authority and those of greater value were approved for submission to Finance Committee.
- **The Velindre Full Business Case**. The Executive Director Strategic Planning provided context and detail on the Velindre Full Business Case. SLB members expressed concerns over the revenue implications of any agreement to enter into this agreement, questioned the benefits that could be derived from this investment and sought greater clarity on the impact of 'new' Velindre on cancer models of care. It was ultimately agreed that the Velindre Full Business Case should be submitted to Board for their consideration but, with agreement that the concerns expressed by SLB would be represented to Board by the Executive Director Strategic Planning.

The following items were presented for information:

- A presentation from Stephen Allen on Llais which replaced the Community Health Council as a citizen's voice body on 01 April 2023.
- An update on the progress achieved under the 6 Goals Programme workstreams.

The following items were discussed:

- **Implications for CVUHB of the WHSSC ICP**. It was identified that the current WHSSC ICP creates risks for the health board in the following; major trauma schemes, strategic psychology review, thoracic surgery standards, intestinal failure review and contract, cardiac review and assessment.
- **Draft IMTP**. Some suggestions for improvement of the draft were provided and these were incorporated into the final draft submitted for Board approval.
- **An update on progress made by the Strategy Refresh Steering Group**. This focused on the spread and depth of internal and external engagement on the revised strategy.

6th April 2023

The following items were approved:

- **WAGESTREAM**. WAGESTREAM is a private company that provides an opportunity for staff to pull an element of their additional earnings (i.e. overtime or pay for bank shifts) forward early i.e. ahead of their pay day. The company has worked extensively with English NHS trusts and more recently has started working with CTMUHB and HDUHBs and are seen as a retention positive initiative as well as a useful resource in mitigating the impact of the cost of living crisis on staff. A request for SLB to approve use of WAGESTREAM had been made to SLB on 16 February 2023; there had been agreement in principle but a decision to implement had been delayed pending clarification of questions related to data protection, the arrangements for controlling the percentage of wage able to be drawn down, and the WAGESTREAM financial model. SLB were content with the responses to these questions and it was agreed that WAGESTREAM would be implemented.
- **Shaping Change Team Requests and Prioritisation.** A process for recommending to SLB the activities to be conducted by the Shaping Change Team was approved. A process for prioritising the work of the team was discussed but it was agreed that this element needed further consultation and would be brought back to SLB in May 2023.
- **National Anti-Viral Service to Local Provision**. This item reflected recent direction from Welsh Government advising that the provision of the COVID-19 antiviral treatment service for non-hospitalised patients needed to transfer from a national service to one of local provision – with the national service finishing on 31 May 2023. A proposal for the local replacement service was accepted by SLB, for a six-month period pending review and financed from existing Health Protection budget.
- **Investment Group Submission Procedure.** A procedure was approved to ensure the correct progression of Investment Group decisions and corresponding business cases to SLB, Finance Committee and Board.

The following items were discussed:

- **Pharmacy & Medicines Management Update.** A number of key achievements of the Pharmacy and Medicines management team were described. There was particular focus and discussion around the Electronic Prescribing and Medicines Administration (EPMA) transformational digital programme. A local project board and steering group has been established with the Executive Medical Director as SRO – target date for EPMA 'go live' is Summer 2024.
- **Transforming Access to Medicine (TrAMS).** TrAMs is a national programme to transform pharmacy technical service (aseptic product production) by centralizing production to 3 regional hub facilities across Wales, with SE Wales planned to be the first hub rolled out. TrAMS poses a number of risks/issues for CVUHB, primarily around ongoing ability to provide products (mainly clinical trials and the newer Advanced Medicinal Therapeutic Products (ATMPs)). The work underway to manage and mitigate these issues/risks were discussed.
- **Perioperative Care of the Older Patient (POPS).** POPs is an innovative planned care project supported by the Surgery Clinical Board, HEIW and the Bevan Commission. The project facilitates a revised clinical pathway which sees the frailty scoring of all patients of 65 years or older, as they come through Pre-Operative Assessment Clinic. Those patients with a Clinical Frailty Score of equal or greater than five receive a comprehensive Geriatric Assessment by a Geriatric Medicine SpR. The project has resulted in significantly positive outcomes for patient quality, safety and experience as well as significant savings and opportunity costs in relation to reduced length of stay, reduced and amended prescribing and altered surgical plans. SLB welcomed the update and commented favourably on the dedication and innovation of the POPS team.
- **Digital Update.** An extensive update on the CVUHB Digital Strategy and digital roadmap was provided.

19th April 2023

The following items were approved:

- **Cardiff and Vale University Health Board Anti-Racist Action Plan.** The draft Anti-Racist Action Plan was discussed and it was agreed that the plan should be passed to May Board meeting for approval.
- **Revisions to Major Incident Plan.** A draft revision of the Major Incident Plan was discussed in the context of lessons identified from the first phase of the Manchester Arena Bombing Public Inquiry and a recent national resilience exercise (MIGHTY OAK). It was agreed that the plan should be passed to May Board meeting for approval.

The following items were discussed:

- **South East Wales Regional Portfolio.** The Executive Director of Strategic Planning provided an update on progress with the programmes covered under this portfolio; diagnostics, orthopaedics, ophthalmology and stroke. There was also discussion on the emerging collaboration and opportunities presented by the Llantrisant Health Park.
- **Strategy Refresh Update.** Feedback from phase 1 of the strategy refresh engagement was provided and discussed. Methods for improving the extent of staff engagement and contextual understanding were identified.
- **All Wales Medical Genomics Service (AWMGS) Update.** The update provided a briefing on the availability of new HEIW sponsored education and learning opportunities for staff delivering any aspect of genomics related treatment or therapy. Additionally, the update described the background, benefits and project progress related to the creation of a Genomics Centre at Cardiff Edge.
- **HIW Report in Inspection of Hafan y Coed.** The plans for internal and external communications in response to this HIW report were discussed.

4th May 2023

The following items were approved:

- **Investment Group Cases:**
    - **Regional Cataracts Service Expansion Business Case.** Approved for submission to Finance Committee and Board.
    - **Paediatric Chronic Pain, Respiratory and Infectious Diseases Business Cases.** Approved for WHSSC ICP funding.
    - **Sustainability of the Staff Wellbeing Service.** Approved for funding as part of FY 2023/24 investment programme at a cost of £294K.
    - **Pentyrch Surgery Lease Agreement.** Approved for submission to Private Finance Committee and Private Board (commercially sensitive).
    - **Radiology Informatics System Procurement (RISP) FPC Update.** Approved for submission to Finance Committee and Board.

- **Medical Workforce Sustainability Proposal.** The proposal, produced by the Workforce Sustainability Group, provided a suite of proposals to realise opportunities for improved equity, fairness and consistency of pay across the Medical and Dental workforce.
- **Sustainability Programme Terms of Reference.** The Sustainability Programme Board (SPB) has been established to provide senior leadership oversight and coordination of the programme work streams needed to lead the organisation to financial sustainability. The terms of reference for SPB were approved.

The following items were discussed:

- **An update on Regional and Specialist Services collaboration between SBUHB and CVUHB.**
- **The Plan for Reconfiguration of the Acute Site at UHW.** SLB were briefed in detail on the plans to reconfigure the UHW site over the Summer and Autumn of 2023 to:
    - Reconfigure Medicine and Surgery wards.
    - Implement a revised model for MFFD in the Lakeside Wing.
    - Close winter pressure beds
    - Reorganisation of UHW third floor to set conditions for next phase of the repatriation of cardio-thoracic services to UHW.
- **NHS@75**. The variety of activity planned for celebration of the NHS 75th anniversary was discussed.
- **Legal Advice Service for Major Trauma Patients**. A briefing on the potential benefits to patients and the health board of a legal advice service for Major Trauma Patients was provided.

- **Update on the Savings Plan**. The Savings Plan Month 1 situation was described.

Any Other Business:

- The COO described a particularly challenging week of significant demands on emergency and urgent care; options for mitigation and extra-ordinary support to the situation were discussed and agreed.

Recommendation:

The Board is requested to:

a) **Note** the contents of this Report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: N/A
Safety: N/A
Financial: N/A
Workforce: N/A
Legal: N/A
Reputational: N/A
Socio Economic: N/A
Equality and Health: N/A

Decarbonisation: N/A	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Audit and Assurance Committee – Chair's Report				Agenda Item no.	6.5.2	
Meeting:	Board		Public	x	Meeting Date:	25 May 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide Board Members with a summary of key issues discussed at the Audit and Assurance Committee Meeting held on **4 April 2023.**

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

The standard items of business were discussed at the meeting. These included the following:

Progress and Update reports from Audit Wales and Internal Audit in relation to their respective planned activities and audit reports. The Committee was informed that there had been a delay in delivering four of the planned Audits in time for the meeting and that they would be brought to a future Committee meeting.

The Committee also received an update on the Limited Assurance Internal Audit report relating to the Chemo Care IT System. The Director of Digital & Health Intelligence (DDHI) advised the Committee that all of the 8 recommendations made were either in place or a new system was being awaited. A detailed follow up report would be completed by Internal Audit in 2023-24.

Updates from the Corporate Governance Directorate regarding the current status of the (i) **Declarations of Interest, Gifts and Hospitality Report** (ii) **Internal Audit Tracker** and (iii) **Audit Wales Tracker** were received. With regards to the internal Audit Recommendation Tracker, the Committee was advised that the aged entries would be targeted and closed off by the July meeting.

Review changes to Standing Financial Instructions (SFIs) and Accounting Policies – The Committee was advised that the Welsh Government had issued an addendum (which related to procedures for consent to enter into contracts exceeding £1million) to the SFIs and the Finance team was already working to that. The Finance team was also obliged to report to the Committee any major changes to the Health Board's accounting policies. This year there was the IRFS 16 Leases amendment and the Finance team had implemented that in the 2022/23 accounts.

The **Draft UHB Annual Report** was presented to the Committee. It was noted that the Health Board was on track to deliver the Report in May.

The **Annual Internal Audit Plan 2023/24** was approved by the Committee. The plan covered the whole of the 2023/24 audit year but would be subject to regular on-going review and adjustment as required to ensure that the audits reflected the Health Board's evolving risks and changing priorities and therefore provided effective assurance.

The **Audit Wales Outline 2023 Audit Plan** was received by the Committee.

The **Counter Fraud Annual Plan 2023 – 2024** was reviewed, discussed and approved. The plan outlined the work proposed to be undertaken in order to meet the Counter Fraud requirements for the Health Board for the forthcoming year. The plan aligned with the NHS Counter Fraud Authority Functional Standard requirements.

Other key matters of business to highlight to Board Members include: -

a) **Internal Audit Reports** – four reports had been finalised as follows: -

- Decarbonisation (advisory)
- Financial Reporting & Savings Targets (substantial assurance)
- Nurse Staffing Levels Act (reasonable assurance)
- Cyber security (limited assurance). This Audit was considered in the private session of the Committee.

The minutes of the Audit Committee held on 4 April 2023 contain further details of the above matters highlighted in this report.

Recommendation:

The Board is requested to:

a) **Note** the contents of this Report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No

Financial: No

Workforce: No

Legal: No

Reputational: No

Socio Economic: No

Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	Quality, Safety and Experience Committee – Chair's Report				Agenda Item no.	6.5.3	
Meeting:	Board		Public	x	Meeting Date:	25.05.23	
			Private				
Status *(please tick one only):*	Assurance	x	Approval	x	Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Senior Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to highlight the key issues which were raised and discussed at the Quality, Safety and Experience Committee meeting held on 11th April 2023

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

The Committee considered a number of important items of business at the meetings and a brief synopsis of some of the items discussed are set out in this Report.

Children & Women's Clinical Board – a Patient Story – The Patient Story described a Grandmother's reflections of a Looked After Child (LAC), aged 15 who had been in foster care since the age of 3.

The story highlighted the struggles the child had been through and noted that arrangements were made for an independent review officer, a social worker, and a LAC nurse to intervene and contact the child.

The Committee was advised that due to the input from the LAC Nurse, the struggles the child had experienced had started to ease and that they were now happy, smiling and working towards their GCSEs in 2023.

Children & Women's Clinical Board Assurance Report – the Committee was advised of the arrangements, progress and outcomes within the Children & Women's Clinical Board in relation to the Quality, Safety and Patient Experience agenda over the last 12 months. The report highlighted the achievements, innovation and transformational work undertaken to date, and described key residual risks and their mitigating actions that carried forward into 2023/24, which included:

- Workforce
- Maternity Lifts

The Committee was advised the that report provided assurance of the progress being made within the Specialist Services Clinical Board with regard to:

- The Welsh Government Quality Delivery Plan for the NHS in Wales
- The Clinical Board's Operational Plan and IMTP
- Quality & Safety agenda
- Infection, Prevention and Control Annual work programme
- Health and Care Standards
- Patient Experience
- Financial and Information Governance
- Organisational Development and Workforce Planning
- National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive Procedures (LocSSIPs)

Quality Indicators: Peri-Natal Mortality – The Committee was advised that since 2020, the trajectory of stillbirths had increased from 16 to 30 in 2022. The Health Board had, therefore, established a system for a critical review of still births and that when a stillbirth occurred, a monthly MDT review discussion took place very quickly after the incident. e Committee was assured that all incidents had a MDT rapid review undertaken and all incidents reported had gone on to have a full MDT review.

The Committee was advised that the Clinical Board had introduced electronic growth plotting into the system which reduced any risk of human error and was shown to be much safer.

Pressure Damage Collaborative Work Plan – The Committee were provided with assurance of the plan for reducing heath care acquired pressure damage with the Health Board. That included a

Multidisciplinary approach under the Collaborative which encompassed both Primary and Secondary Care.

The Committee was advised that the most recent data available to the Collaborative showed that the current figure for February 2023 for "Health Acquired Pressure Damage" was 2.55 cases of pressure damage per 1000 bed days which had indicated that the initial goal of a 25% reduction had been exceeded as it was now 27%.

Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine & the Flynn Report – The Committee

The Committee was advised that Operation Jasmine was a major and wide-ranging investigation into the deaths of 63 individuals living in residential and nursing care homes in South East Wales and had been carried out by Gwent Police between 2005 and 2013.

It was noted that that since the recommendations from Operation Jasmine and the Flynn Report, much had changed in how Local Authorities, Health Boards and the regulators operated and dealt with monitoring and identifying care concerns with residential and domiciliary care providers.

The Committee was advised that the partner agencies had undertaken a significant piece of work during 2019/20 to review and update their contractual documentation and that a joint Regional Common Contract for residential care had been agreed and had been implemented across all partner agencies in 2021.

BAF – A number of risks linked to Patient Safety were included on the BAF. The highest scoring net risks (which were after controls were in place) were Patient Safety (20), Maternity (20) and Critical Care (20). Further details including cause, impact, controls and assurances were received by the Committee.

National Collaborative Commissioning Unit Quality Assurance and Improvement Service Annual Position Statement 2021-2022 – The Committee was advised that the report came was received for assurance from the National Collaborative Commissioning Unit.

It was noted that the report provided the Committee with an overview of the three National Collaborative Frameworks which were overseen by the National Collaborative Commissioning Unit and included:

- National Collaborative Framework Adult Mental Health and Adult Learning Disability Hospital Services ('Adult Hospital Framework')
- National Collaborative Framework for Child Adolescent Mental Health Service (CAMHS) Low Secure & Acute Non-NHS Wales Hospital Services ('CAMHS Hospital Framework').
- National Collaborative Framework for Adults (18+ years) in Mental Health and Learning Disabilities care homes & care homes with nursing for NHS and Local Authorities in Wales ('Care Home Framework')

It was agreed that any outcomes would be received when future iterations of the report came to the Committee.

The Board is requested to:

a) Note the contents of the Report.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No

Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
24/05/2023 15:05:05

Report Title:	Finance and Performance Committee Chair's Report				Agenda Item no.	6.5.4	
Meeting:	Board		Public	x	Meeting Date:	25 May 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide the Board with a summary of key issues discussed at the Finance and Performance Committee Meeting held on **19 April 2023.**

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

The Committee noted and discussed the following key points: -

Forecast Deficit –The draft Month 12 position had been submitted to Welsh Government (WG). The reported year end deficit was broadly in line with £26.900m. The numbers were subject to verification and would go through the annual accounts work programme and timeline.

Unforeseen Cost Pressures Lessons Learnt Exercise - The following cost pressures were considered to see whether they could be built into the 2022/23 financial plan:

- Patient Catering
- Security at Rockwood and Whitchurch
- Footfall impact on Aroma sales / Concourse leases
- Prescribing costs
- Medical and staff nursing staff
- WHSCC LTA performance
- Children's CHC Placements

Finance Committee Self Effectiveness Survey – The results were received by the Committee. It was noted that there were lots of positive comments and results.

Key Operational Performance Indicators were presented to the Committee.

The **Finance and Performance Committee Terms of Reference and Work Plan 2023/24** were reviewed by the Committee and recommended to the Board for approval on 25 May 2023.

Further details of matters discussed in the Committee meeting held on 19 April 2023, will be set out in the approved minutes.

Recommendation:

The Board is requested to:

a) **Note** the contents of this Report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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	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*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: N/A
Safety: N/A
Financial: Yes
Yes – as set out in the body of this Report.
Workforce: N/A
Legal: N/A
Reputational: N/A
Socio Economic: N/A
Equality and Health: N/A
Decarbonisation: N/A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
24/05/2023 15:05:05

Report Title:	Mental Health Legislation and Mental Capacity Act Committee – Chair's Report				Agenda Item no.	6.5.5	
Meeting:	Board		Public	x	Meeting Date:	25.05.23	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Interim Director of Corporate Governance						
Report Author (Title):	Senior Corporate Governance Officer						

Main Report
Background and current situation:

The purpose of this report is to provide the Board with a summary of key issues discussed at the Mental Health Legislation and Mental Capacity Act Committee Meeting held on 2 May 2023.

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

The standard items of business were discussed at the meeting. The following items are highlighted for the Board's information: -

1. **Mental Capacity Act**

Mental Capacity Act Monitoring Report – The Committee was advised that referral rates had increased 15% overall from last year's average.
It was noted that in relation to Mental Capacity Act Training, whilst booking rates had increased in recent months, the Clinical Board experienced low attendance rates on the day which was likely due to ongoing clinical pressures and staffing issues.

It was noted that recruitment was under way for two new Mental Capacity Specialist Practitioners with the aim for those post holders to be able to deliver training directly within clinical areas in order to improve accessibility and compliance with mandatory training.

Deprivation of Liberty Safeguards (DoLS) - The Committee observed an increase in DoLS applications and an upward trend had continued. That could be linked to the work carried out within the Medicine Clinical Board, as well as awareness raising initiatives.

The Committee was made aware that 78% of applications were within time and 22% had breached. That was an improvement upon the last report's figures, when 34% of applications had been breached (November 2022).

Liberty Protection Safeguards (LPS) - The Committee was advised that the UK Government had recently announced their decision not to progress the Liberty Protection Safeguards (LPS) or implement the Mental Capacity (Amendment) Act 2019 within the current Parliament.

The Committee was informed that the Welsh Government was disappointed with that decision, but had committed to continue to provide increased funding to protect the rights of those who lacked mental capacity.

As such, the focus for the Health Board would remain upon improving understanding and application of the MCA in clinical practice, strengthening the current Deprivation of Liberty Safeguards arrangements and improving ongoing monitoring and reporting.

Mental Health Act

Mental Health Act Monitoring Exception Report – The Committee was advised that during the quarter there were no fundamentally defective applications.

The Committee was made aware of:

- 1 fundamentally defective report
- 1 invalid use of the Mental Health Act

It was noted that during the period, the use of Section 136 in Adults had decreased and that that 71.1% of individuals assessed were not admitted to hospital, with 50.9% being discharged to community services and 20.2% being discharged with no follow up.

It was noted that during the period, the number of those under 18 assessed under Section 136 had decreased from 8 in the previous quarter to 2 in the current quarter. There were no repeat presentations.

Mental Health Review Tribunal for Wales (MHRT) - It was noted that face to face hearings had commenced successfully from 01/03/2023. The President of the MHRT had confirmed that patients could choose (via the appeal application form) whether they wished to have a face to face, a virtual hearing or indicate that they had no particular preference. However, it was noted that whilst the MHRT would seek to facilitate the patient's choice, it could not always be guaranteed.

Development Sessions - The Committee was advised that the MHA office had continued to run awareness sessions which included a monthly MHA training day (which was available to all staff within the Health Board), a monthly Consent to Treatment workshop, a quarterly Rights workshop and a quarterly Forensic workshop.

HIW MHA Inspection Report – The Committee was advised that since the previous report, a further 2 reports had been received for Ash Ward and Pine Ward and a further 2 inspections had taken place on East12 and East16 Wards.

It was noted that the HIW inspection covered a range of areas, including:

- Quality of patient experience
- Delivery of safe and effective care which included:
- Record keeping Mental Health Act Monitoring
- Monitoring of the Mental Health (Wales) Measure 2010
- Quality of management and leadership

It was noted that the summary reports included Action Plans, and Immediate Action Plans and that there were no Immediate Actions required.

2. Mental Health Measure

Mental Health Measure Monitoring Report, including Care and Treatment Plans Update Report – Members were informed of the current compliance rates with regards to the Welsh Government targets set in respect of Parts 1-4 of the Measure.

It was noted that challenges and areas of concern continued to be seen in the CAMHS service. That said, compliance against the Part1A MHM target had been met since October 2022 as a result of a waiting list initiative supported by agency staff.

It was noted that in March 2023, the service had faced significant demand and had seen a43% increase in referrals in comparison to February 2023. As a result, the service had a significant deficit in capacity to meet demand, but through ongoing monitoring and timely remedial action the service hoped to sustain compliance against the Part 1A target.

Actions to sustain compliance against the Part1A target included:

- Active sickness monitoring and wellbeing support to the team
- Support of professionals with the referral process through consultation with the Single Point of Access
- Ongoing capacity and demand monitoring
- Recruitment to vacant posts

3. **Draft Mental Health bill - Joint Committee Report –** The Committee was advised that in 2017 the UK Government had asked Professor Sir Simon Wessely to lead the Independent Review of the Mental Health Act 1983 (MHA) to propose recommendations for modernisation and reform. The final report was published in December 2018 and made over 150 recommendations.

   It was noted that following the consultation, the UK Government set out its response to bring forward a Mental Health Bill and that a draft Mental Health Bill was published in June 2022.

   It was noted that in July 2022 a Joint Committee was established in order to provide pre-legislative scrutiny, review and call for evidence on the draft Mental Health Bill in which a response was provided to the UK Government in December 2022. This included recommendations on how to strengthen the draft Mental Health Bill.

   The Committee received the key legislative changes proposed by the Joint Committee Report on the draft Mental Health Bill.

Recommendation:

The Committee is requested to:

a) **Note** the contents of this Report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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		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*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	C&V Integrated Performance Report			Agenda Item no.	6.6
Meeting:	C&V UHB Board	Public		Meeting Date:	25/05/2023
		Private	X		
Status *(please tick one only)*:	Assurance		Approval	Information	X
Lead Executive:	Fiona Kinghorn, Jason Roberts, Rachel Gidman, Paul Bostock, Catherine Phillips				
Report Author (Title):	Information Manager				

Main Report
Background and current situation:

This report provides the Board with a summary of performance against a number of key quality and performance indicators. This will include areas where the organisation has made significant improvements or has particular challenges including the impact of COVID-19, together with areas where the Health Board is under formal escalation measures from the Welsh Government and/or where local progress is being monitored.

This Balanced Scorecard comprises indicators that cover Population Health, Quality & Safety, Workforce, Performance and Finance for the Health Board.

Population Health

Immunisation	Standard	Trend	2022 / 23 Qtr 3	
% of children up to date with scheduled vaccines by 4 years of age	95%	na	81.8%	**
	Standard		Mar-23	
% of adults aged 50 years and over who have received a Covid-19 Autumn 2022/23 booster vaccination	na	na	72%	*
% of people aged 5-49 years in a clinical risk group who have received a Covid-19 Autumn 2022/23 booster vaccination	na	na	39%	*

Tobacco	Standard	Trend	2022 / 23 Qtr 3	
% of smokers who become treated smokers	5%	na	0.4%	**
% of treated smokers who quit at 4 weeks	40%	na	64%	**

Quality & Safety

Patient Satisfaction	Standard	Trend	Apr-23
30 day complaints response compliance %	75%		84%
Patient Experience			**Apr-23**
Patient Experience	na		75%
Falls			**Mar-23**
Slips Trips and Falls (30 day moving total)	na		323
Slips Trips and Falls with harm - moderate to severe (30 day moving total)	na		40
Serious Incidents	**Standard**	**Trend**	**Apr-23**
Nationally Reportable Incident (SI)**	na		7
Number of Never Events	0	na	0

Mortality	Standard	Trend	Dec-22
Myocardinal Infraction within 30 days of admission, age 35-74 (Rolling 12 Months)	na		4.0%
Stroke within 30 days of admission (Rolling 12 Months)	na		14.2%
Hip Fracture within 30 days of admission, age 65 and over (Rolling 12 Months)	na		2.9%
Crude Mortality (Last Week of the month)	52.6		54
			Jan-23
Still births (Rolling 12 Months)	na	na	-1
Infection Control			**Mar-23**
All Reported Infections (Rolling 12 Months)	743		702

Workforce

	Standard	Trend	Mar-23
Sickness Absence Rate (in-Month)	6%		5.4%
Sickness Absence Rate (12-Month Cumulative)	6%		6.9%
Values-Based Appraisal Compliance	85%		56.4%
Medical Based Appraisal Compliance	85%		79.9%

	Standard	Trend	Mar-23
Turnover Rate	7% - 9%		12.9%
Mandatory Training Compliance	85%		78.3%
Fire Training Compliance	85%		71.5%

Operational Performance

	Standard	Trend	Apr-23
A&E 12 hour waiting times	0		689
A&E 4 hour waiting %	95%		69.5%
Ambulance Handover Times >1 hour	0		470
Ambulance Handover Times >4 hour	0		0
Number of 12 hour trolley waits	0		63
Number of Patients over 24 hours in EU	0		1102
			Mar-23
RTT Waiting less than 26 weeks %	95%		54.2%
RTT Waiting Over 36 Weeks	0		37897
RTT Waiting Over 52 Weeks	0		22664
RTT Waiting Over 104 Weeks	0		3740
RTT Waiting Over 156 Weeks	0		823
Diagnositcs >8 weeks Wait	0		4565
			Mar-23
GP OOH 'emergency' patients requiring an attendance at a primary care centre within 1 hour	90%		100% #
GP OOH 'emergency' patients requiring a home visit within one hour	90%		50%
			Mar-23
#NOF: Time to ward performance (4 hours)	na		3.5%
#NOF: Time to theatre (36 hours)	na		64.6%

	Standard	Trend	Mar-23
Mental Health Part 1a - Assessments within 28 days	80%		96.7%
Mental Health Part 1b - Therapy Commencing within 28 Days	80%		99.5%
			Mar-23
Total number of medically fit for discharge patients	na	na	303
Total number of bed days lost	na	na	10413
Average number of bed days lost per patient	na	na	34
			Feb-23
Number of Patients Delayed over 100% for follow-up Appt	0		51374
			Feb-23
Single Cancer Pathway	75%		61.5%
Total number of patients on Single Cancer Pathway	na		2052
Total number of patients on Single Cancer Pathway over 62 days	0		160
Total number of patients on Single Cancer Pathway over 104 days	0		89
			Feb-23
Stroke: thrombolysed patients door to needle performance <=45 mins	100%		8%
Stroke: CT scan performance 1 hour	100%		53.3%
Stroke: 4 hours to ward	100%		33.3%

Finance

	Standard	Trend	Mar-23
Deliver 2022/23 Draft Financial Plan	£17.1m planned deficit	na	£26.9m deficit
Remain within capital resource limits.	Within planned expenditure £55.410	na	£55.41m
Reduction in Underlying deficit (Forecast)	Under discussion with WG and private fiance committee	na	-
Delivery of recurrent £15.400m 1.5% devolved target (Forecast)	£15.4m	na	£12.721m

	Standard	Trend	Mar-23
Delivery of £4m non recurrent target	£4m	na	£6.622m
Creditor payments compliance 30 day Non NHS (Cumulative)	95%		95.2%
Remain within Cash Limit (Forecast cash surplus)	Within Cash Limit	na	Forecast deficit
Maintain Positive Cash Balance	Positive Cash Bal.	na	£2.845m

Those who have received two Covid-19 doses, with the exception of those who are severely immunosuppressed and are recommended three primary doses

No new data available

 # No patients recorded within this measure during this time period

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

POPULATION HEALTH

Health protection

- **Immunisations**
  - Delivery has commenced for the Covid-19 Spring Booster, with 18,042 doses given in Cardiff and Vale by 26 April 2023, and 37% uptake to date (cf Wales average 26% uptake). Eligible cohorts are: people aged 75 and over; residents in a care home for older adults; and individuals aged 5 and over who are immunosuppressed.
  - JCVI have announced on 6 April a new Covid-19 infant vaccination programme (infants aged 6m to 4y in a clinical risk group). This is expected to commence in May 2023, running alongside the Spring Booster Programme
  - Planning is also underway for the Winter Respiratory Vaccination Programme which will see the co-administration of Covid-19 and Influenza vaccinations where appropriate. JCVI published its interim recommendations for the Autumn 2023 Booster on 25 January 2023, which indicated that people with a higher risk of severe COVID-19 would be offered a booster.
- **Acute respiratory infections**
  - Covid-19 levels remain broadly stable in Cardiff and Vale based on wastewater monitoring. Omicron XBB.1.5 remains the most common variant.
- **Hep B/Hep C elimination plan**
  - A detailed C&V UHB Joint Recovery Plan for Hep B/Hep C is being co-ordinated to address the 13 Actions as outlined in WHC/2023/001, following submission of a strategic high-level plan at the end of March. On track to submit by revised deadline of mid-July 2023
- **Health protection integrated system**
  - Work continues to take place both regionally and nationally to further strengthen regional health protection arrangements by developing a model for a sustainable and integrated system with an 'all hazards' remit. The Cardiff and Vale of Glamorgan COVID-19 Prevention and Response Plan will be updated in coming months to describe our agreed final partnership model, with the first workshop on 10th May 2023; it is anticipated that this will then become the regional Health Protection Plan.

Health improvement

- **Tobacco**
  - The smoking prevalence rate for Cardiff and Vale of Glamorgan is 12% (NSW, 2021-2022), the same as the previous year and is one of the lowest rates in Wales
  - 2.1% of smokers made a quit attempt 2021-2022, reflecting a static position from last year (2.2%)
  - 64% of 'Treated smokers' quit smoking (self-reported) at 4 weeks, Qtr 3, 2022-2023, a decrease from 80%,Qtr 2, 2022-2023. 74% quit smoking (self-reported) 2021-2022
  - The hospital smoking cessation programme achieved an 85% 4 week quit rate (Quarter 3, 2022-2023) and a PGD has been agreed for provision of Nicotine Replacement Therapy (NRT) for patients on admission
  - 42% of Community Pharmacies offer a Level 3 Enhanced Smoking Cessation Programme, 38% a Level 2. 68% of Level 3 services are located within areas of high deprivation

- A MAMSS Programme was implemented in April 2021. 51% of pregnant smokers were referred to MAMSS, (Qtr 3, 2022-2023) – an increase from 25% pre-MAMSS. NRT provision available on first contact with a Midwife with 60% of MAMSS referrals accepting pharmacological support
- No Smoking Enforcement Officer post implemented March 2022, to reduce incidence of smoking at hospital sites. Launch of 'zero tolerance ' No Smoking Campaign, November 2022.
- Mental Health Smoking Steering Group established to implement Smoke-free Regulations with progress on-going

- *To note the contents of this section will vary in future reports, focusing on different health improvement and healthcare public health topics.*

QUALITY AND SAFETY

Concerns

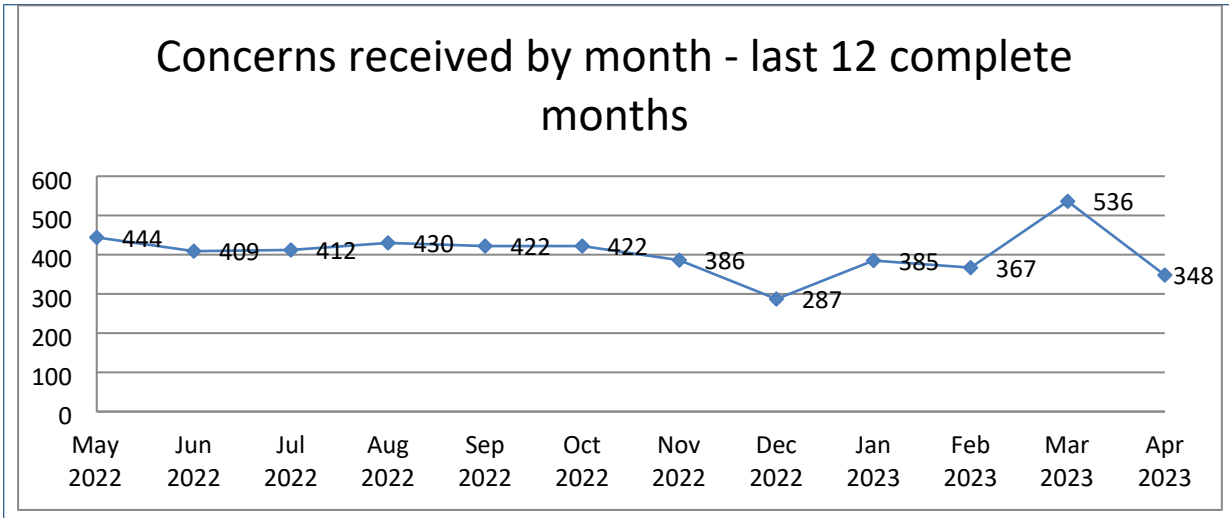
During March and April 2023, it is pleasing to note that, despite the current demand on the service and significant rise in the number of concerns managed, we have achieved an extremely high overall performance of 84% of concerns closed within 30 working days including those managed under Early Resolution.

30-day performance

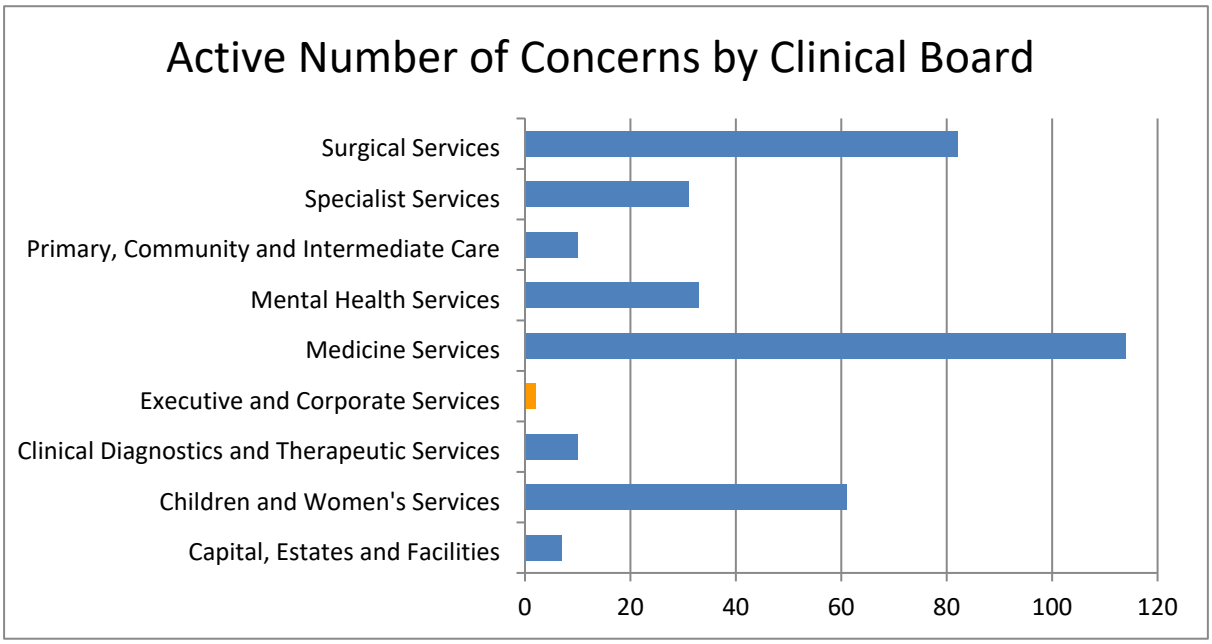
October 85%
November 77%
December 80%
January 77%
February 81%
March 85%
April 84%

In March and April, we continued to focus on timely resolution to concerns in line with Early Resolution (ER) (*this process can be utilised dependent upon the nature of the concern and considering the preferred outcome of the complainant*). We managed 84 % of concerns under ER which is a slight increase of 1% in comparison to February and March.

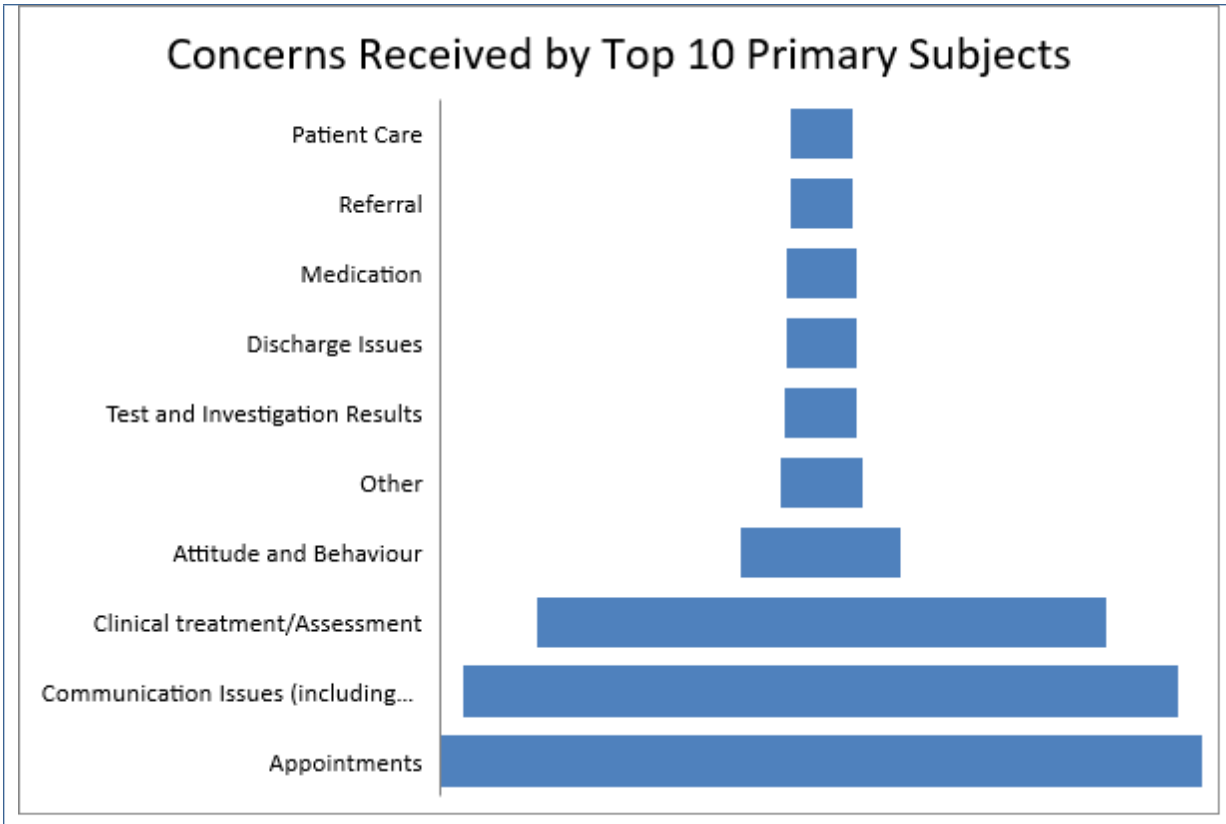
As you will see from the graph below, we have noted a significant increase in concerns during March, however, as anticipated (due to the Easter Holidays) we did note a reduction during April. Whilst the Health Board continues to feel pressures due to the current demands on the service we continue to be focused upon responding to concerns and improving the response times whenever possible. We continue to feedback to Clinical Boards the themes identified in the concerns (complaints, claims and redress process) aligned with the patient feedback and compliments data.



We currently have 341 active concerns which is a slight reduction in comparison to the last report (388). Surgery and Medicine Clinical Boards consistently receive the highest number of concerns, this is in line with the number of patient contacts and complex care both Clinical Board's provide. The number of cancellations and delays due and the significant increase and demand on services like EU are reflected in the numbers and nature of concerns received.



The graph below demonstrates the 10 main themes noted in Concerns.



Communication and Clinical treatment have historically been noted as the primary subject in concerns, however, concerns regarding cancellations of appointments have increased. We continue to see an increase in concerns regarding environment, facilities and attitudes and behaviours.

Duty of Candour

The Duty of Candour is a legal requirement. It requires healthcare organizations and care providers to be open and honest with patients and their families when something goes wrong with their care or treatment.

Specifically, the Duty of Candour requires healthcare providers to:

1. Inform patients and their families as soon as possible when an adverse event has occurred.
2. Offer an apology and provide appropriate support to patients and their families.
3. Conduct a review of the adverse event and share the findings with the patient and their family.
4. Provide information on how the patient can make a complaint or raise concerns.

The Duty of Candour is intended to promote a culture of transparency, openness, and learning within healthcare organizations. By being open and honest about adverse events, healthcare providers can improve patient safety, learn from mistakes, and prevent similar incidents from happening in the future.

In practice this means - the trigger process for Duty of Candour essentially forms another gateway into existing investigation and PTR processes. It does not require additional investigation work.

Organisations will have existing processes in place whereby incidents are reviewed and it is at this point, that a decision is made as to whether the Duty of Candour procedure is triggered.

Once confirmed that duty has been triggered, this will be the Duty of Candour procedure start date, also known as the day the 'NHS body first becomes aware'. The organisation will then have 30 working days to undertake their investigation as per PTR timescales.

There must be a gateway to redress if appropriate.

Initial feedback from cases

On review approximately 37% of Incidents are being regraded from the initial grading and in line with the grading framework. There is discussion with the reporter to agree the rationale.

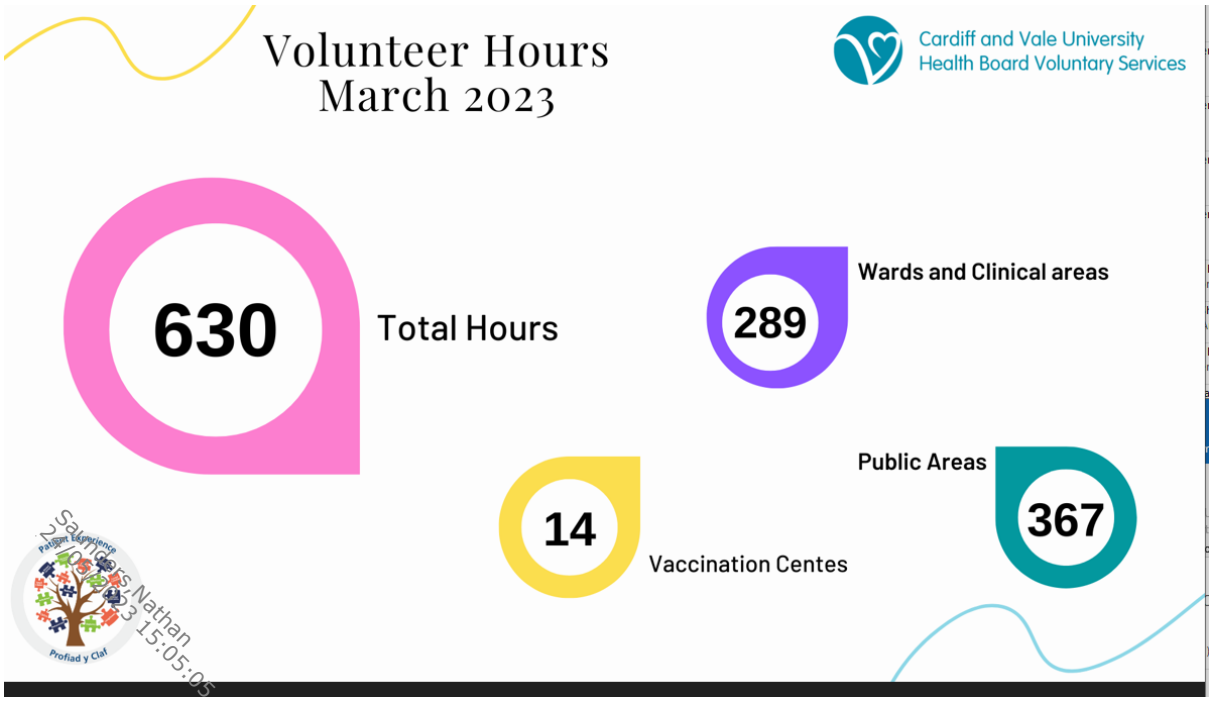
The initial work is focused upon understanding the grading application at the initial recording of the incident and mandatory consideration of the grading on incident closure. Duty of Candour will be managed through the Patient Experience Team, as the process somewhat mirrors the current management of complaints and is part of the Patient Experience Team's function.

The team are reviewing approximately 70 incidents per day and initial feedback has demonstrated some data validation is required with the understanding of the grading of harm and that crucially the person needs to have been in receipt of healthcare and something unexpected and unintended has happened. Often, triggers for review are collated on the system but no adverse incident has been noted, it is an outcome that is outside of the usual expected parameters and needs further review. These are often categorised where someone reports the outcome as a significant harm level when there is no healthcare acquired harm but it is a patients narrative.

We have noted many cases where pressure damage or a fall has been graded as moderate harm but the incidences have occurred pre-admission when healthcare has not been involved in caring for the person. It is evident that the DOC review work will improve data reliability.

Volunteers

We have undertaken a significant recruitment drive for more volunteers and are pleased to be able to share the collation of volunteer hours for March 2023



Compliments

During the last quarter we received 189 compliments. We continue to encourage areas to share compliments they receive directly, in order for them to be recorded and recognised.
Every Friday on Social Media we publish some feedback from our Kiosks on twitter. The feedback from staff and patients to these tweets has been about how they find these tweets very encouraging

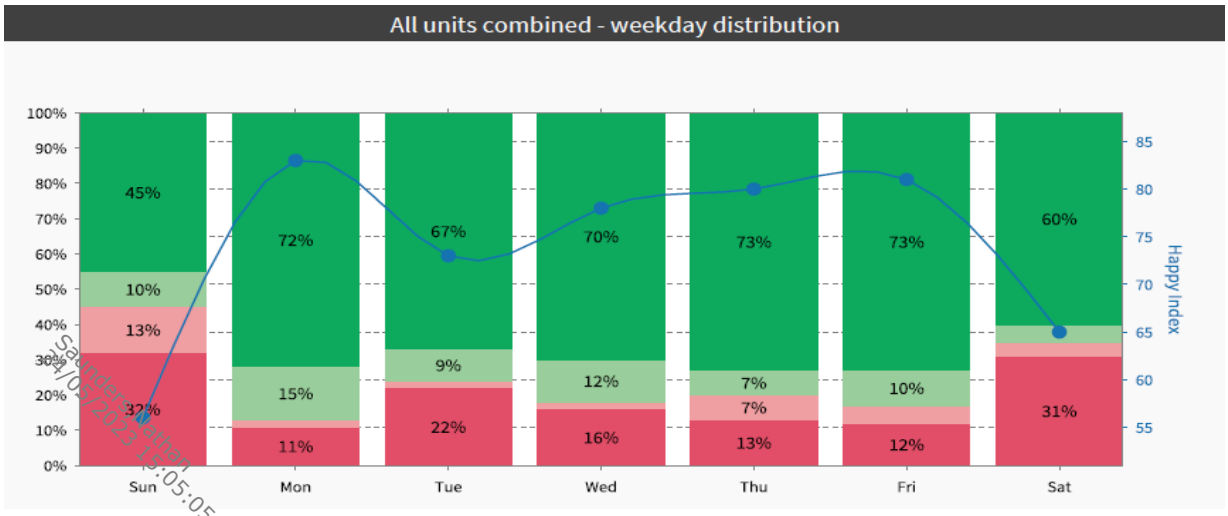
Patient Experience Feedback **HappyOrNot feedback** (All locations)

In relation to the 'HappyOrNot' feedback, those reported as being satisfied are respondents who when asked: ***How would you rate the care you have received?***

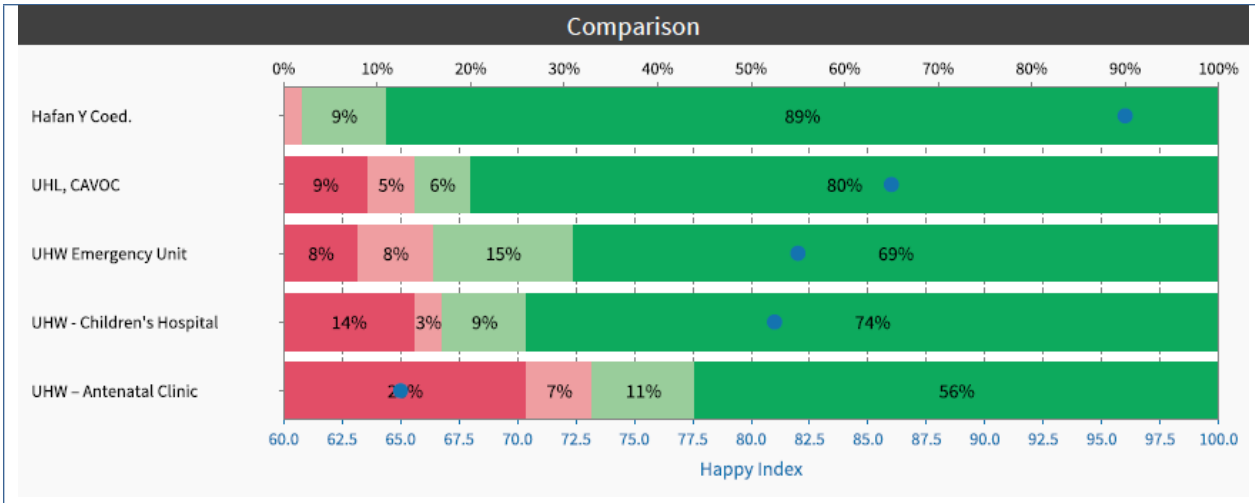
A breakdown of the feedback for March and April is:

Summary values	March	April
Surveys completed	**1338**	**881**
Response: Very happy button (Excellent/Very	62%	66%
Response: Happy button (Good/Positive)	13%	10%
Response: Unhappy button (Fair/Negative)	7%	5%
Response: Very unhappy button (Poor/Very	18%	19%
Respondents satisfied	**74%**	**75%**

Chart below. Gives the April feedback, broken down by which day of the week the feedback was received.



There is a theme of satisfaction being lowest on a weekend across the UHB
Chart below. Gives the April feedback, broken down by kiosk location.



HappyOrNot feedback (EU areas only)

The table below is a basic summary of the information received from the HappyOrNot EU feedback:

Summary values	March	April
Surveys completed	154	-
Respondents satisfied	**58%**	**-**

** March data is based on feedback from the 01/03/2023 – 17/03/2023.*

During April, the 13 kiosk survey completions received need to be disregarded, as the current location of the kiosk is unknown.

Civica 'Once for Wales' platform

Our system went live on Friday 28th October and we are currently surveying up to 600 patients daily via SMS. At the time of reporting we have contacted some 55.622 people for feedback via text messaging and are seeing a return rate of 19%. It is our understanding this is higher than many organisations but will be a focus for improvement with more targeted experience data collection over the next year, with an aim for a minimum return of 25%.

The table and figures below give some of the summary information received during February and March.

Summary values	March	April
Surveys completed	1915	1543
Respondents satisfied	**89%**	**89%**

For March, the 'Respondents satisfied' figure is based on those who answered the rating scale question: *Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?* and gave a score of 7 or more.

As a pilot, for April, May and June, we have changed our routine survey to the Friends & Family Test. Consequently, the 'Respondents satisfied' figure for April is based on those who answered the rating question: *Overall, how was your experience of our service?* and is calculated in line with the weighting used nationally.

Table below. Gives a detailed breakdown of April's rating question feedback.

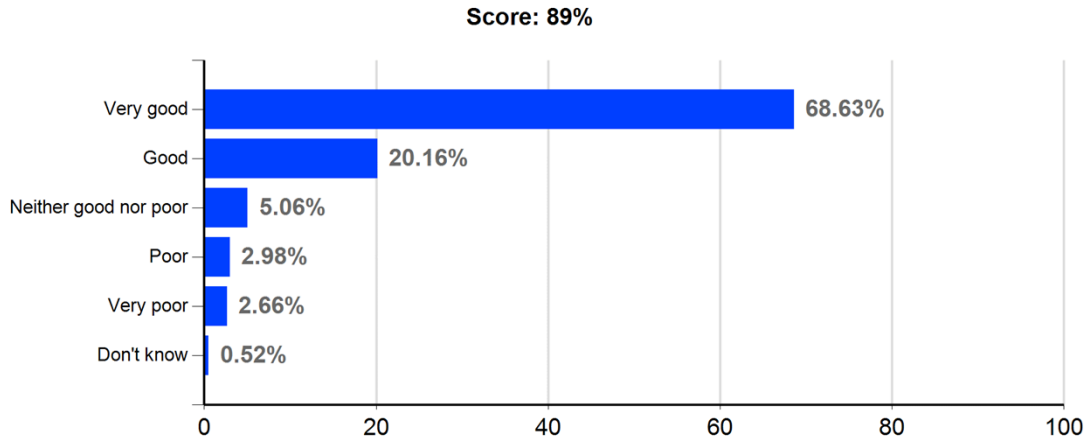
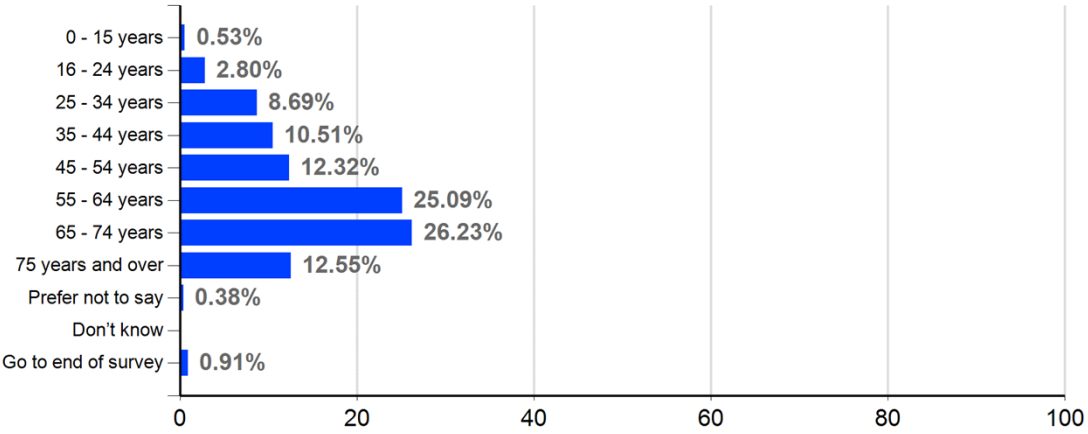
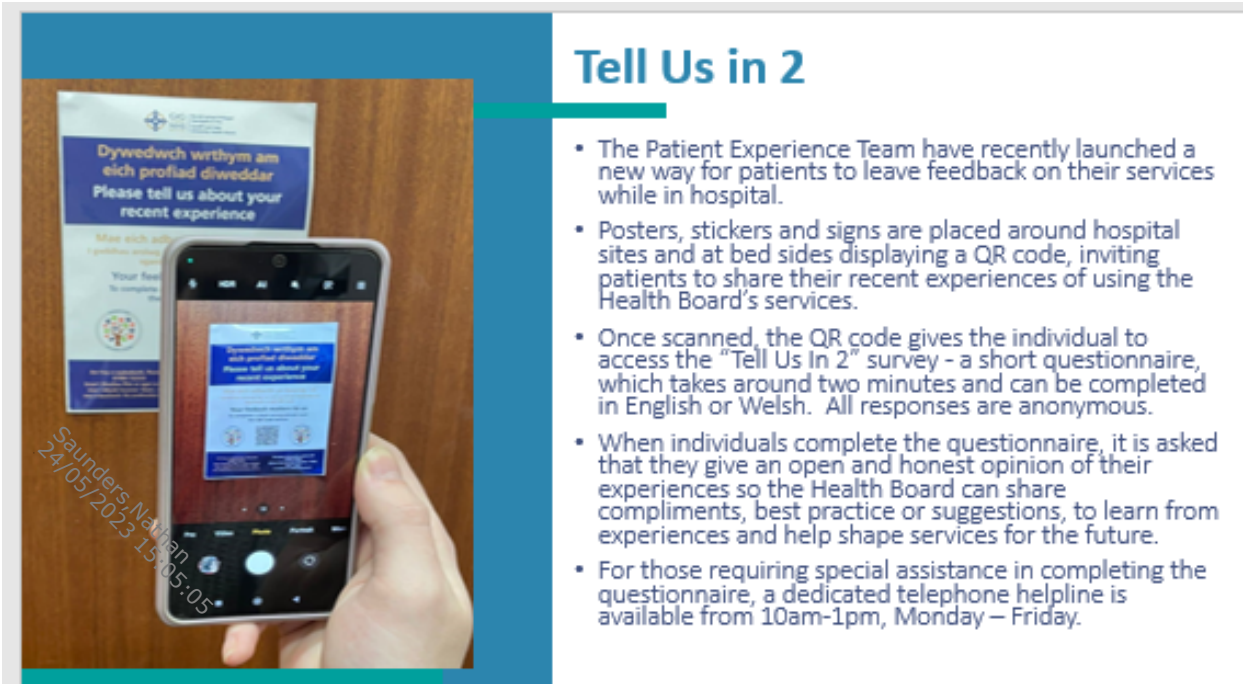


Table below. Gives April's feedback, broken down by age group of respondents.



'Tell Us in 2' bedside survey

In addition to our SMS service, we have recently launched a service whereby patients can leave their feedback whilst admitted/attending one of our main hospital sites. An outline of the process is given below.



The table and figures below give some of the summary information received during April.

Summary values	April
Surveys completed	60
Respondents satisfied	**50%**

The 'Respondents satisfied' figure is based on those who answered the rating scale question: *Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?* and gave a score of 7 or more.

Table below. Gives a detailed breakdown of April's rating question feedback.

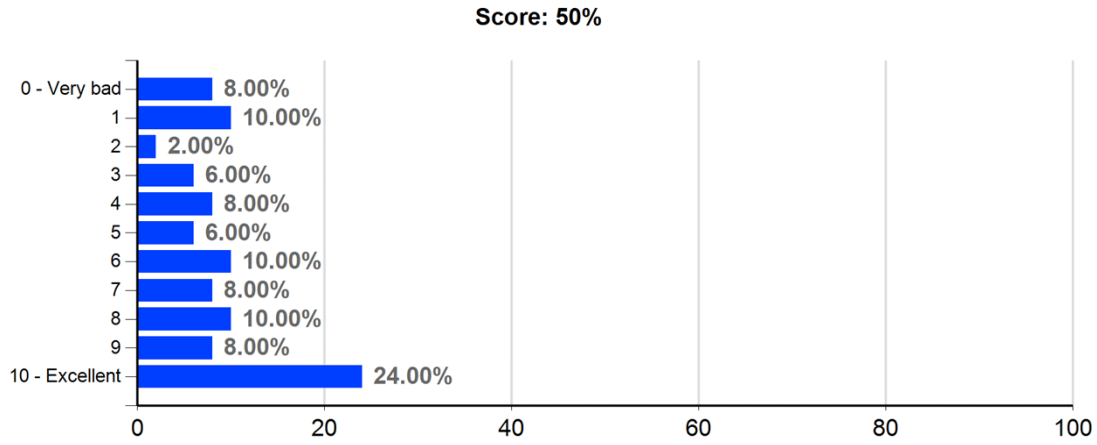
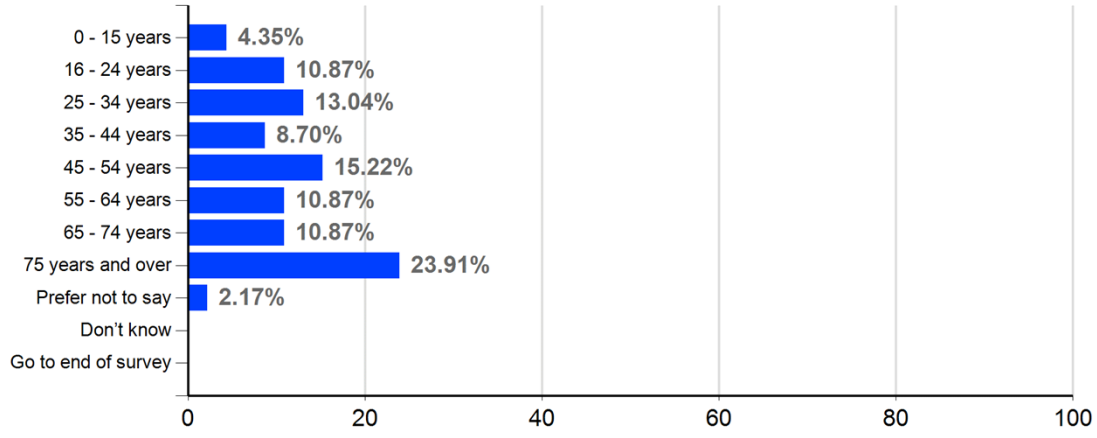
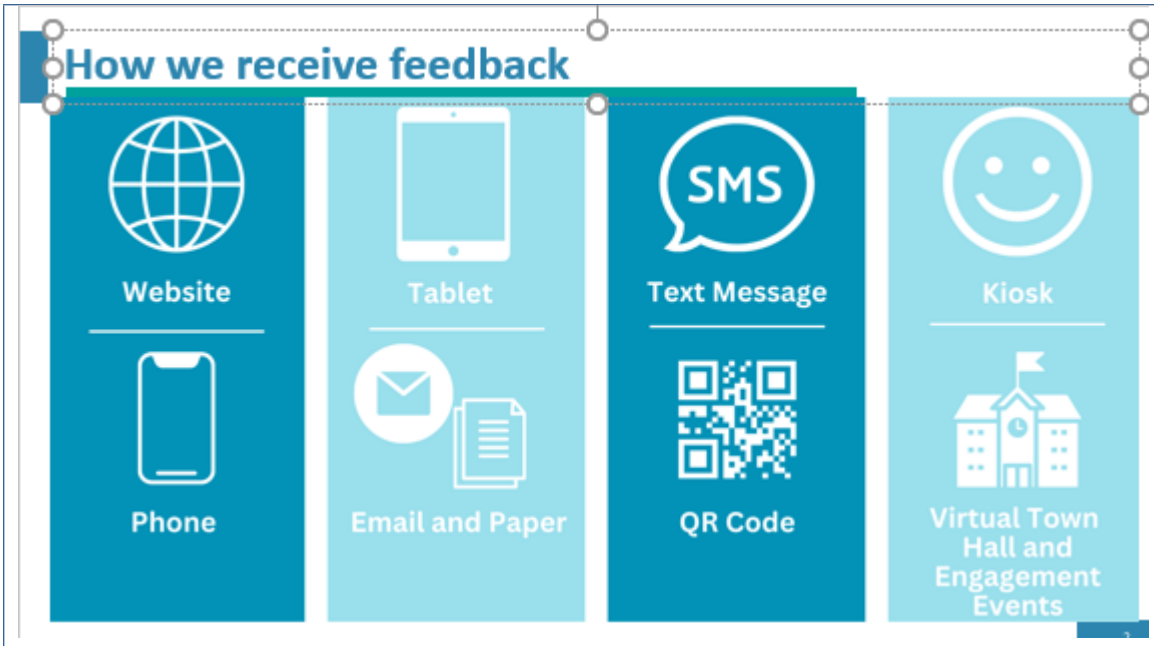
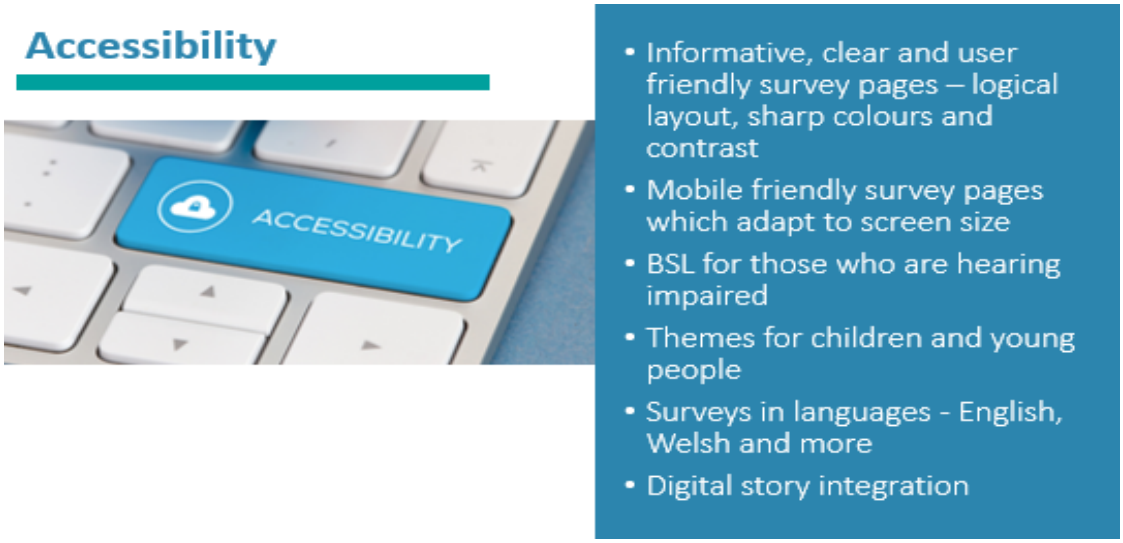


Table below. Gives April's feedback, broken down by age group of respondents.





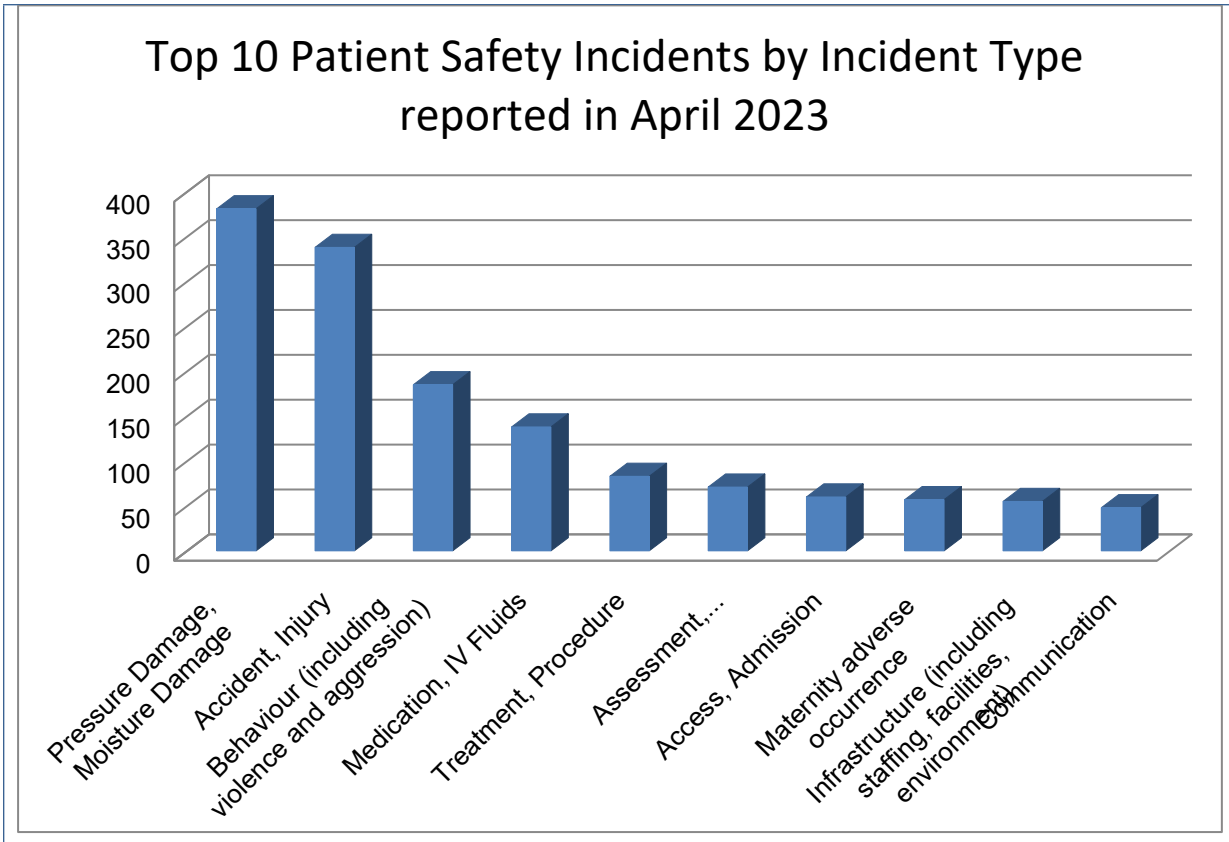
The reports available via the Civica platform are quite detailed and include:

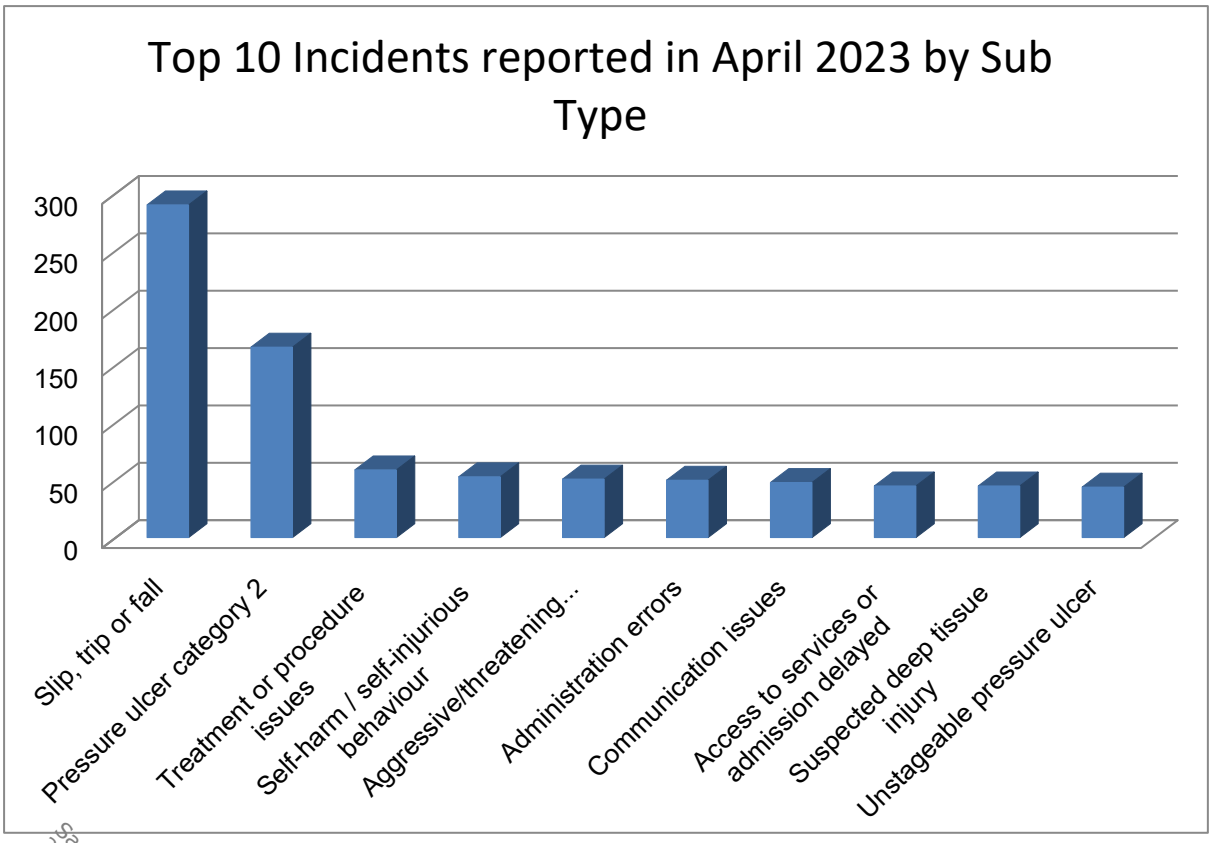


PATIENT SAFETY – Incident reporting

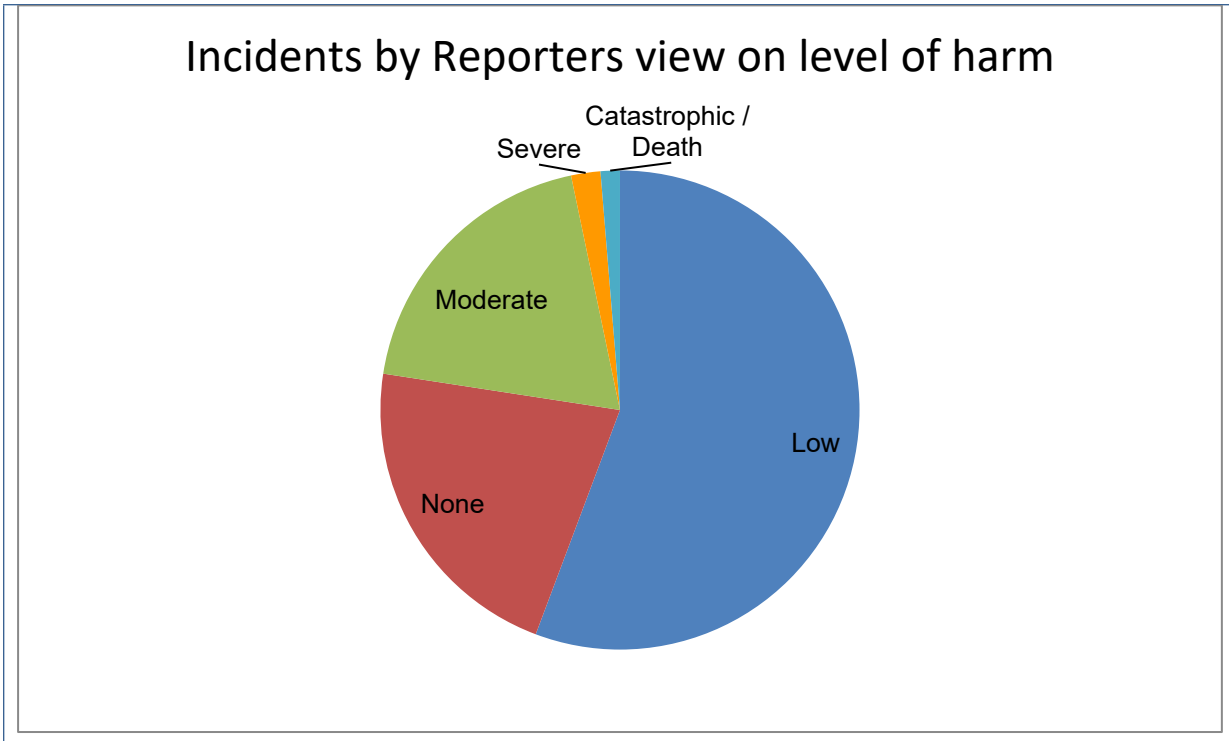
The chart below illustrates patient safety incidents reported during March 2023 by incident type. A total of 1626 patient safety incidents were reported during this period, a reduction from the previous month (March) of 227. The main change is the increase in medication incidents prevalence within the top 10 from the sixth most common to the fourth.

As is usual, pressure damage and accident/injury (falls), are the most commonly reported incidents. The second chart goes further into the detail of the nature of the incident (Incident by subtype).

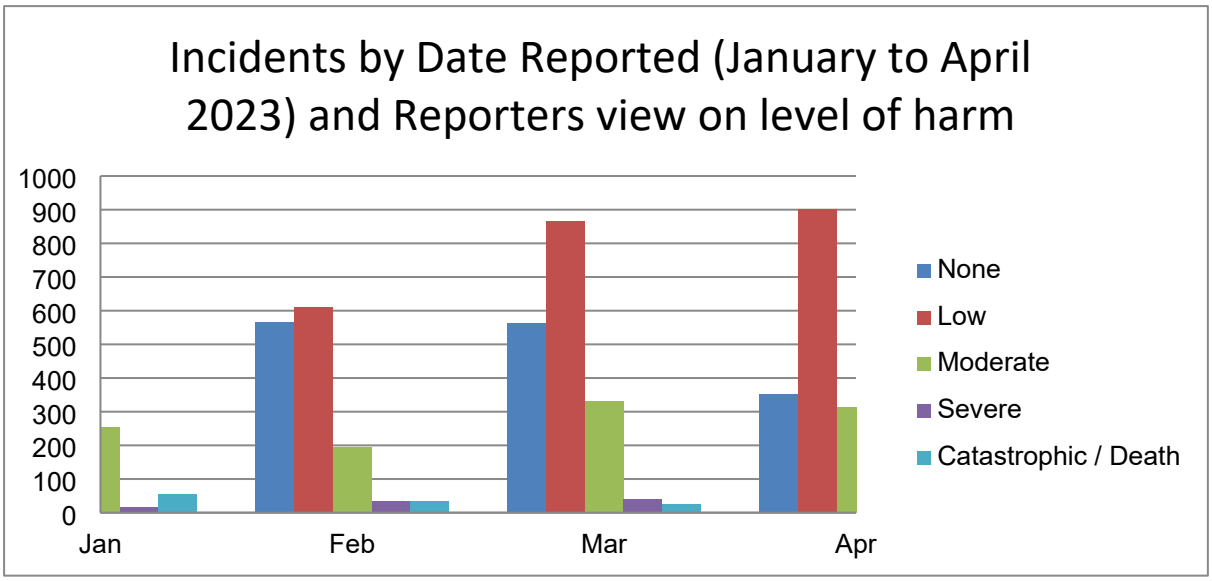




Saunders,Nathan
24/05/2023 15:05:05



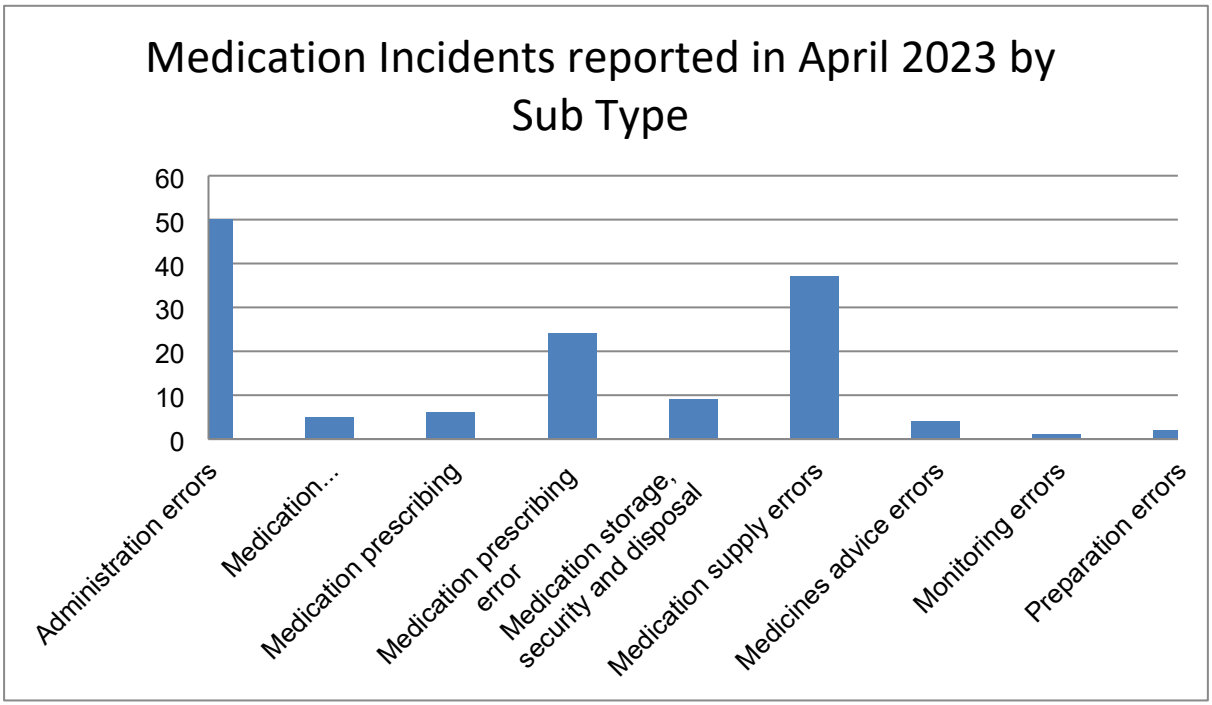
As can be seen in the chart above most of the incidents reported are assessed as being of 'Low' harm. This assessment is being monitored now that the Duty of Candour has gone live, to ensure that incidents are not under or over graded. This is being carried out by the Corporate Team. After the initial management review process, if there is deemed to be an incorrect recording of harm, an email is sent to the incident reporter with the aim of improving learning and accuracy of future harm assessments.



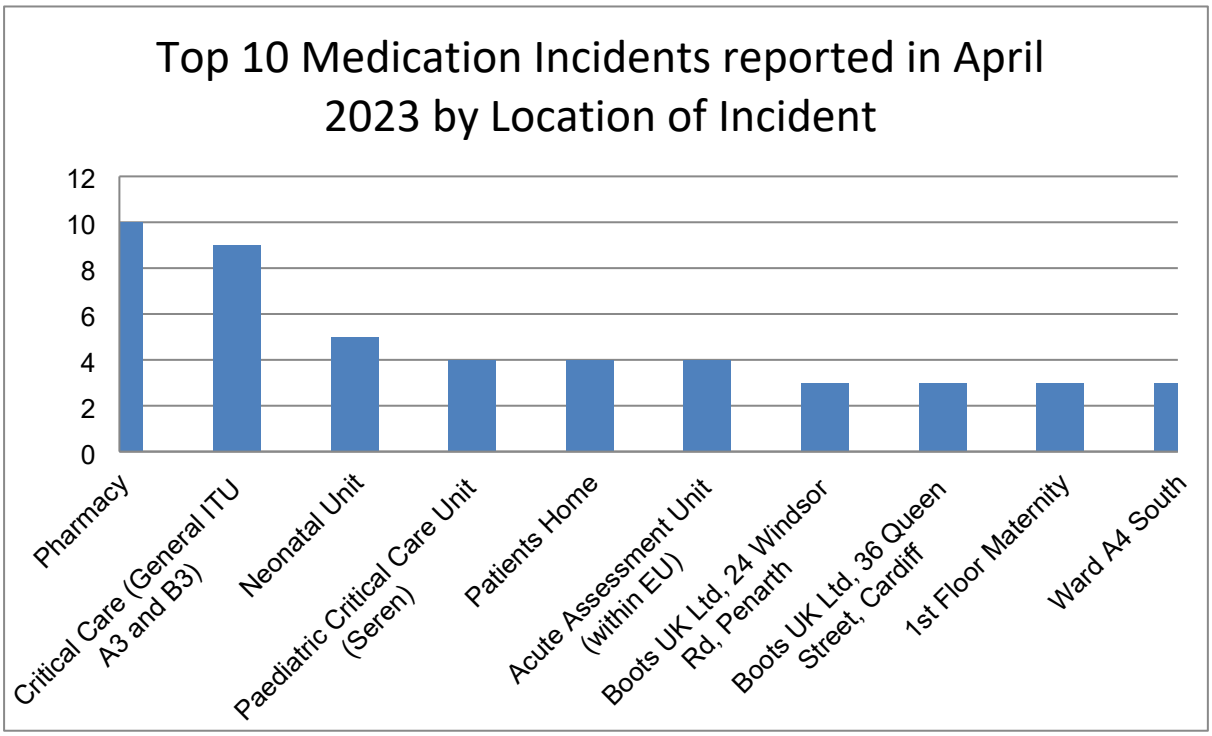
The chart above shows the breakdown of reporter's assessment on level of harm by month. This will be interesting to continue to monitor how harm assessments change with the education/feedback being provided by the Corporate Team. A very early review shows that incidents with 'no harm' assigned has reduced however, it is too early to draw comparisons yet.

Falls and pressure damage were reviewed in detail last month, this will be picked up again in May's report. For April, there is a focus on medication incidents, a category which has increased in prevalence since the March paper.

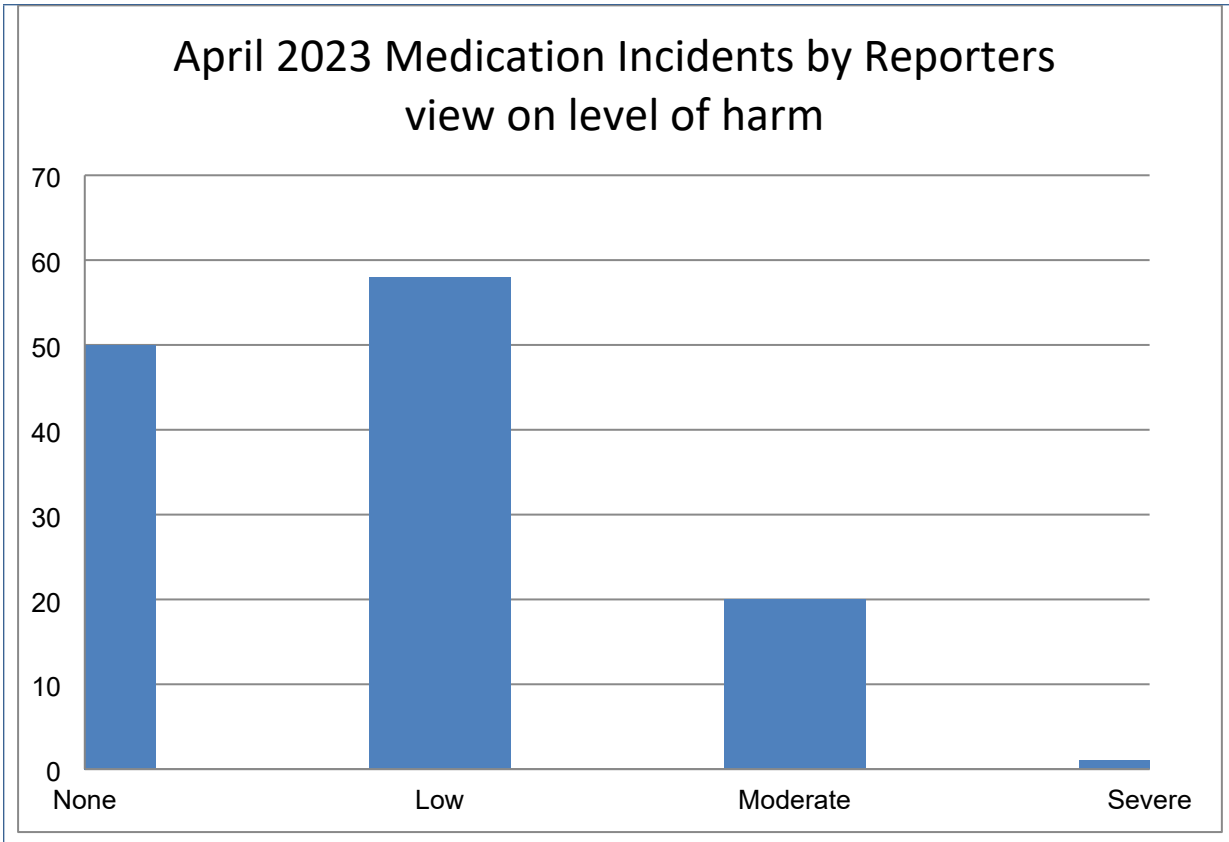
Medication errors



The above chart shows that administration, prescribing and supply errors are the most commonly reported medication incidents.



The above shows the top 10 locations for medication incident reporting and the majority are reported as 'no' or 'low' harm (see below).



Nationally Reportable Incidents (NRIs)

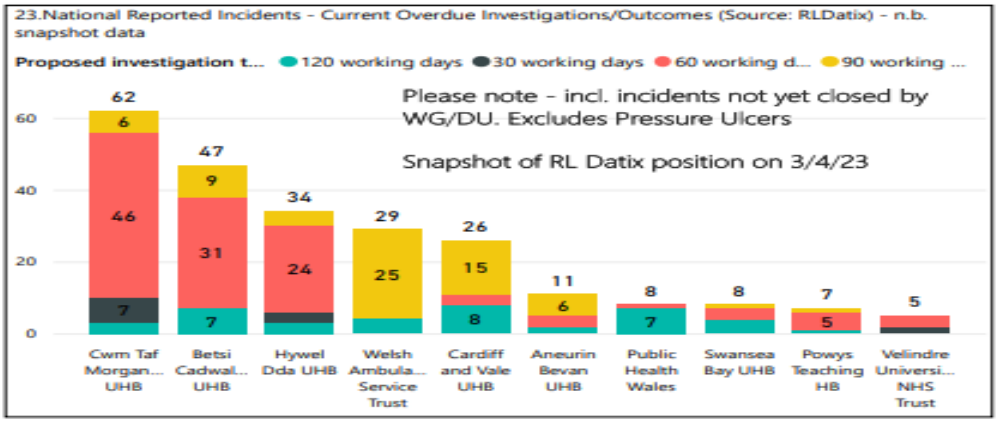
The table illustrates performance of Nationally Reportable Incidents until 30th April 2023. It is an improving position and reflects the focus and hard work of the Clinical Boards and Patient Safety Team, however, the increase in new NRIs is challenging the closure targets, as focus goes on ensuring a robust review of the new incidents.

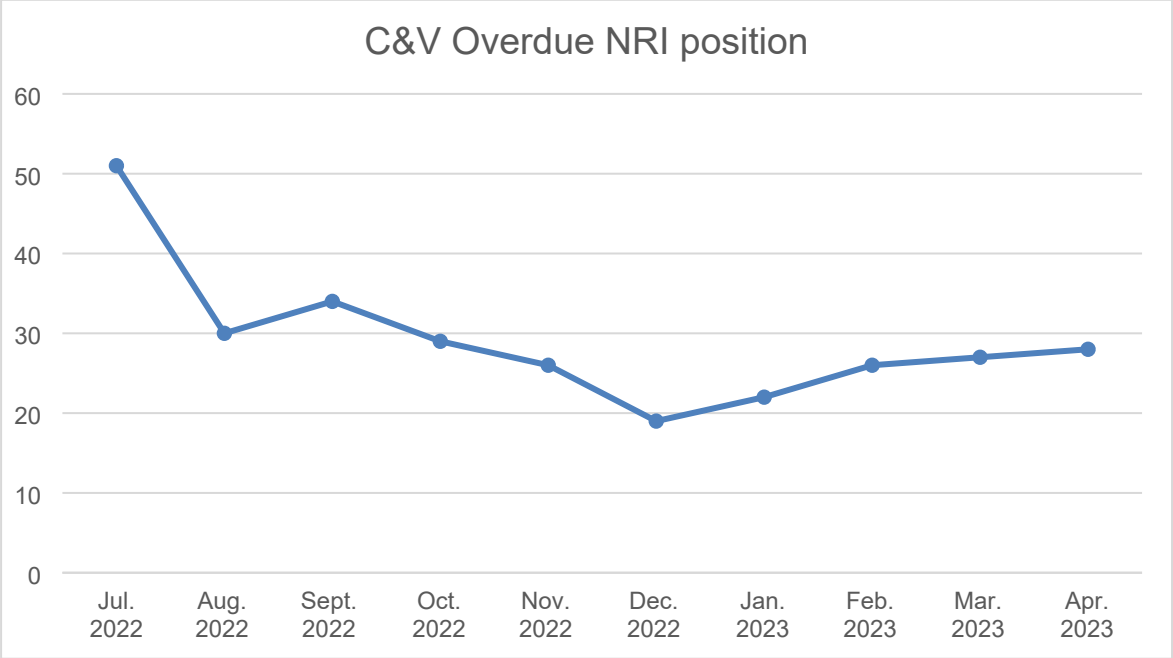
	Open	Overdue
September 2022	53	34
October 2022	48	29
November 2022	51	26
December 2022	43	19
January 2023	46	20
February 2023	57	26
March 2023	65	27
April 2023	62	28

Clinical Board	**Open NRIs as of 02.05.23**	**Overdue NRIs as of 02.05.23**
Children and Women	13 ⟷	5 ⟷
CD&T	3 ↓	0 ⟷
Executive	3 ⟷	2 ↓
Medicine	7 ↓	2 ↓
Mental Health	11 ⟷	6 ⟷
Surgery	8 ↑	4 ↑
PCIC	4 ↑	2 ↑
Specialist	11 ↓	6 ⟷
Total	**62** ↓	**28** ↑

The main factors to note from the figures is that Surgery and Primary Care Clinical Boards have both seen a small increase in their open NRIs with a corresponding increase in the number of overdues for closure. Medicine Clinical Board have reduced their open NRIs from 10 to 7 and their overdues from 4 to 2 since last month.

The report below shows how our overdue NRI position compares with other HBs across Wales. This has been a significantly improving position, over the last year.





The above chart shows how the overdue position is starting to deteriorate which is reflective of the increasing open NRIs. Despite this however, our position is improving nationally in comparison with other Health Boards.

Mortality

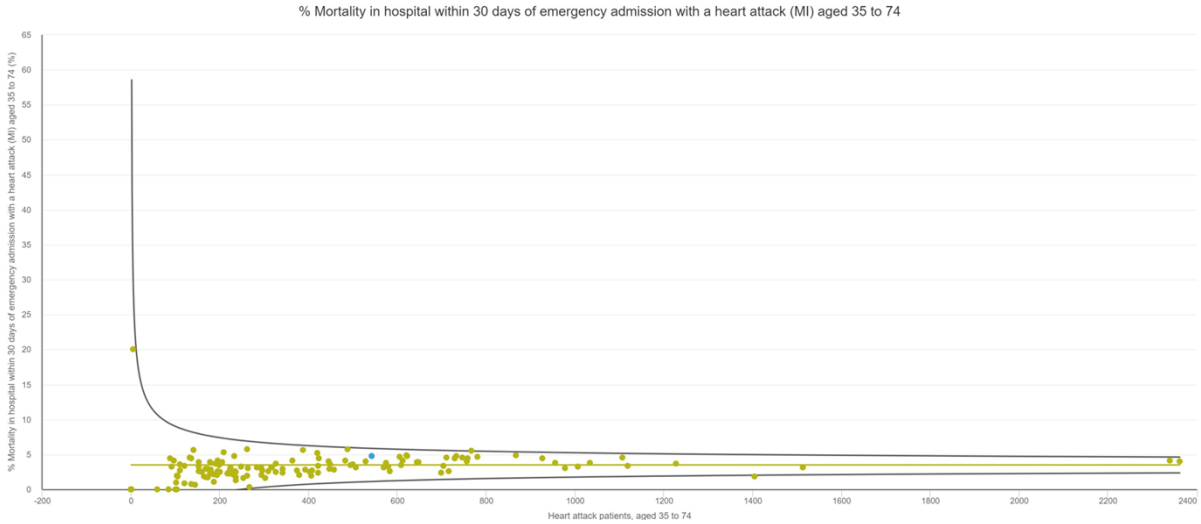
The November 2022 Quality Safety and experience committee agreed a three-tier model for reporting and monitoring mortality data across the Health Board.
Tier 1 - Health Board wide mortality measures which will be reported including All-Cause Mortality and Crude inpatient mortality.
Tier 2 - Clinical Board level mortality indicators which includes some condition specific mortality indicators.
Tier 3 – Speciality level mortality indicators to include condition and intervention specific mortality data.

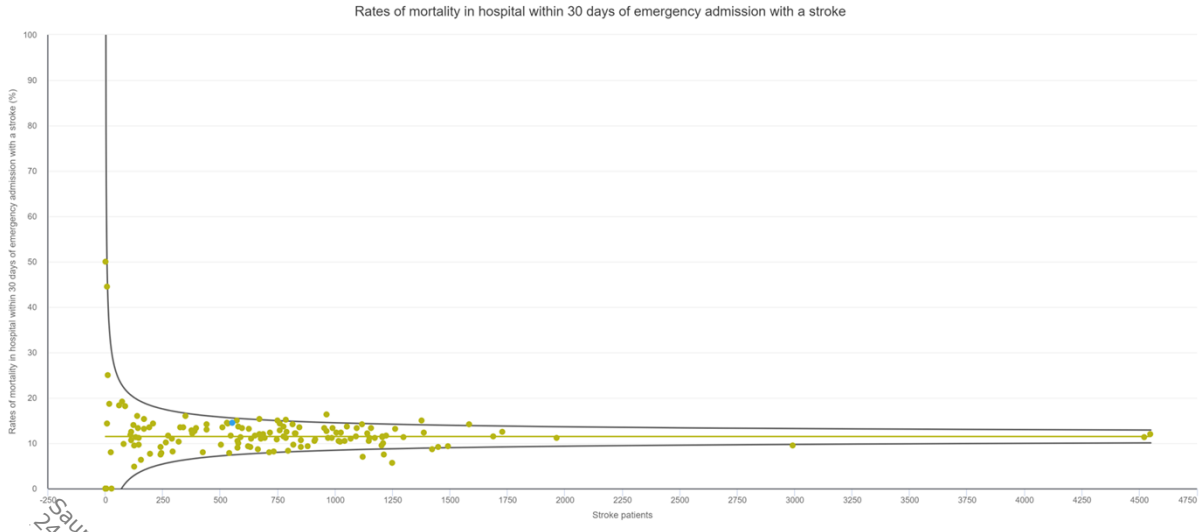
Tier 1 mortality data will be included as part of the quality indicators report on a regular basis and Tier 2 indicators will be reported to board on a six-monthly basis.

Tier 1 Mortality

Measuring the actual number of deaths over time (crude mortality) supports the monitoring of trends in mortality rates. The Crude inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates a mortality rate that is comparable to the 5-year average for the same reporting week, with the exception of March 2020 and December 2020 to February 2021, the first and second waves of Covid-19 where inpatient deaths rose above the 5-year average.

Crude all-cause mortality, demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan, regardless of where they occurred. COVID – 19 deaths the pink line, illustrates the number of deaths where COVID-19 features anywhere on the death certificate. There is a correlation between increases above the five-year average and deaths where the patient had Covid on their death certificate during the first two waves of the pandemic (Spring 2020 and Winter 2020/21).





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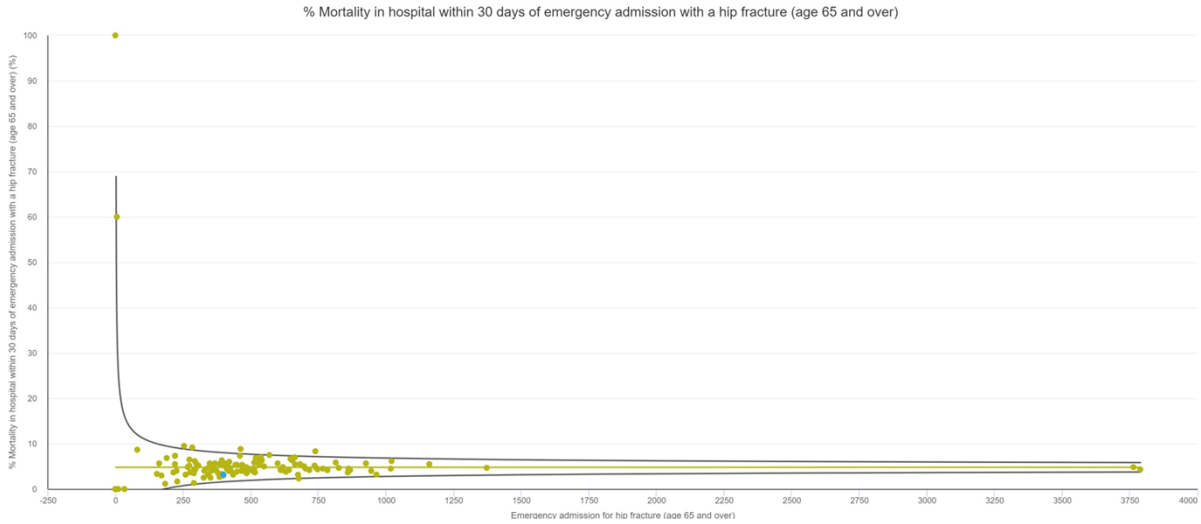
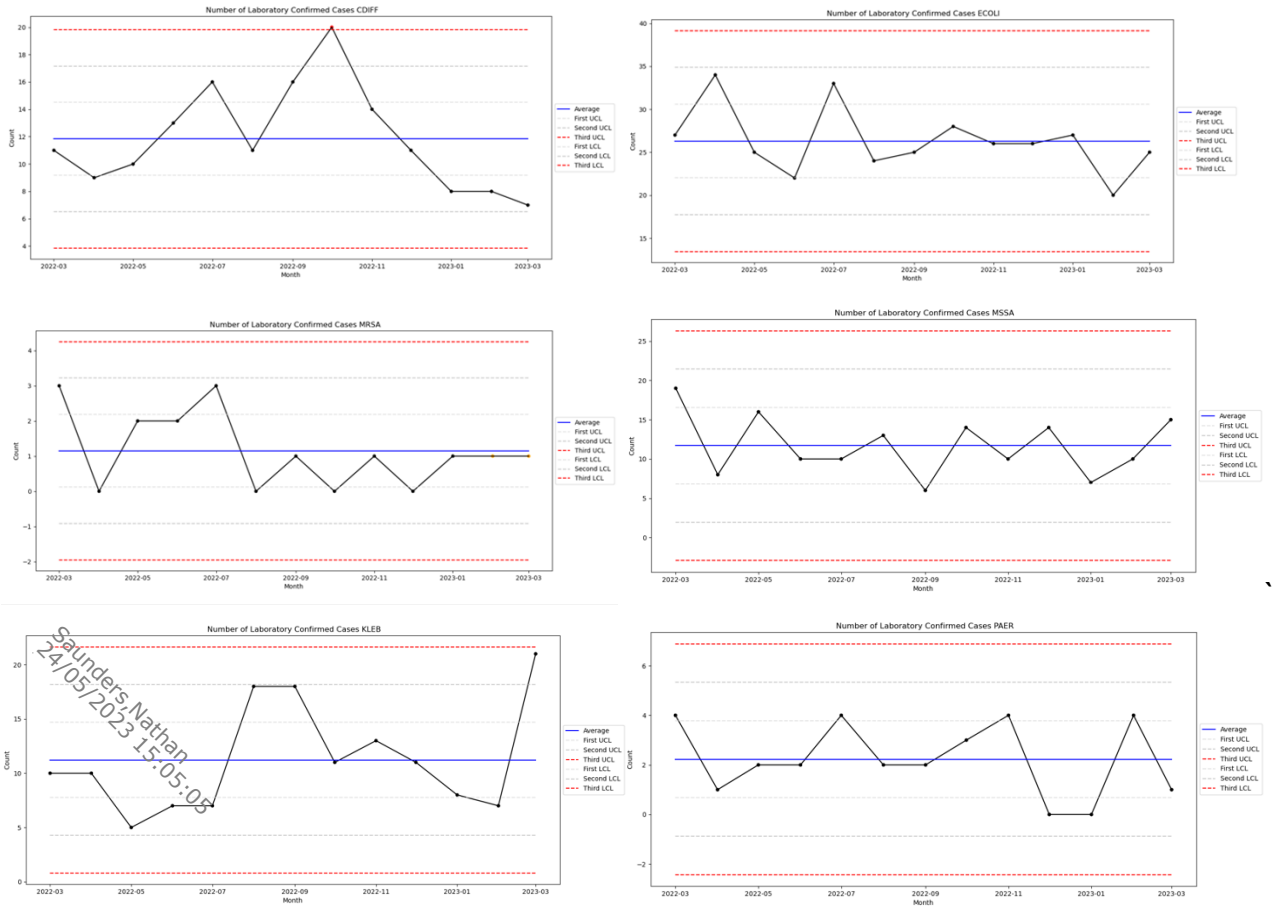


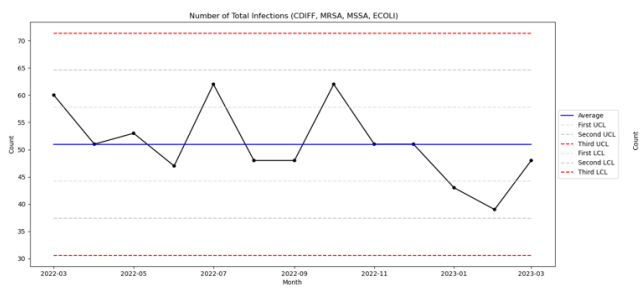
The age standardised cancer mortality, reported as mortality per 100,000 population, demonstrates significant variation in relation to deprivation. Mortality rates in those living in the most deprived fifths in Wales are around 50% higher than those living in the least deprived areas. The pandemic has impacted on this for some diagnoses, particularly marked in colorectal cancer mortality, where inequalities in cancer mortality increased rapidly from a 30% relative difference between the most and least deprived areas of Wales in 2019 to 80% by 2021.

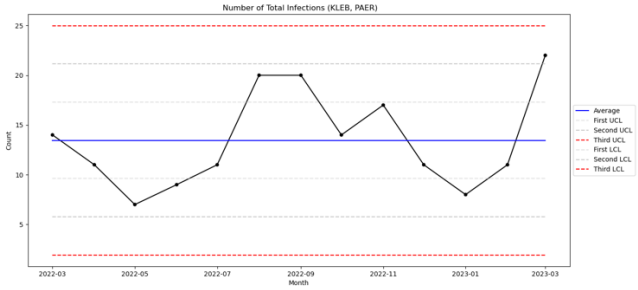
Infection control

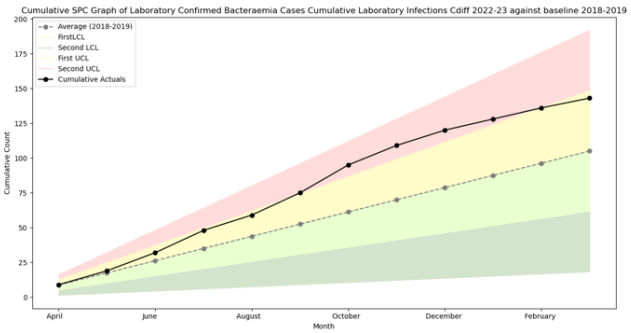
Hospital Infections – the total infection rates are falling. MRSA and E coli have slightly reduced.

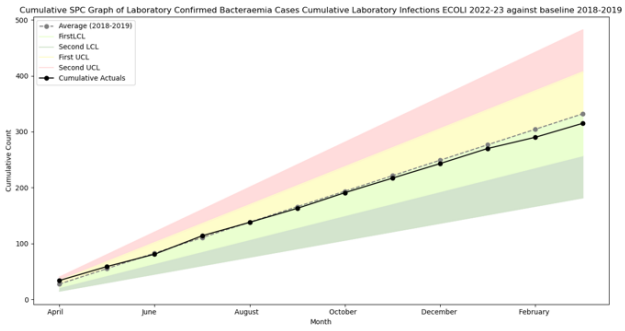
There has been significant investment in the IP&C team in the past 2 years, which has enabled increased audit and review of infections and supports a bespoke approach to supporting wards and primary care reviews.

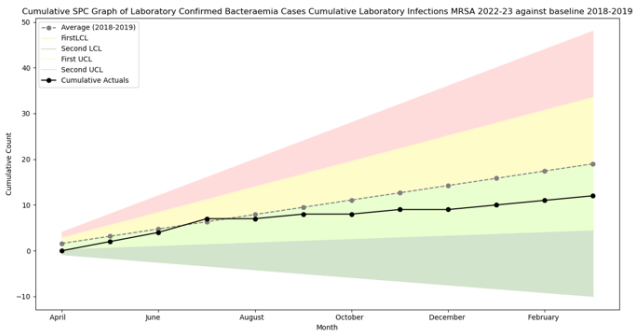


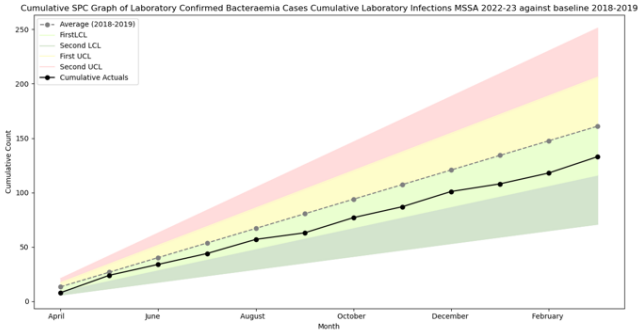


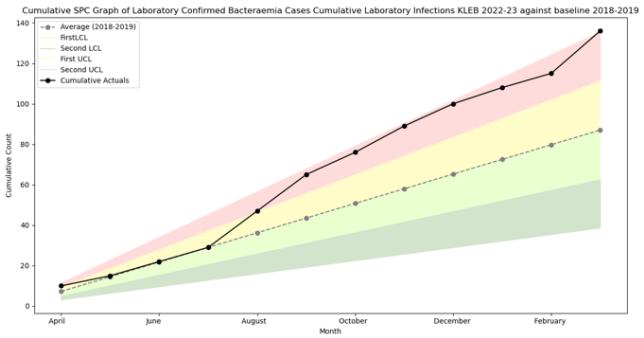


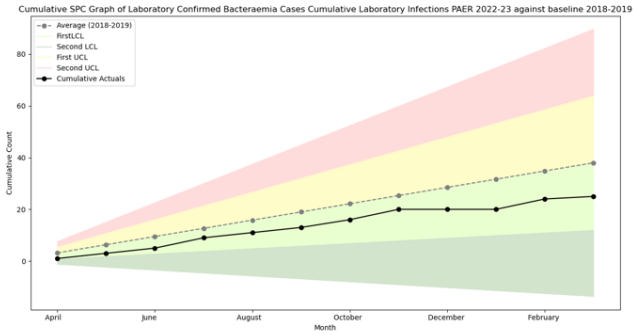


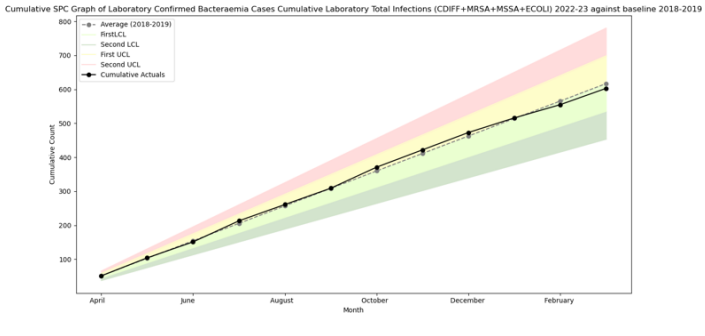


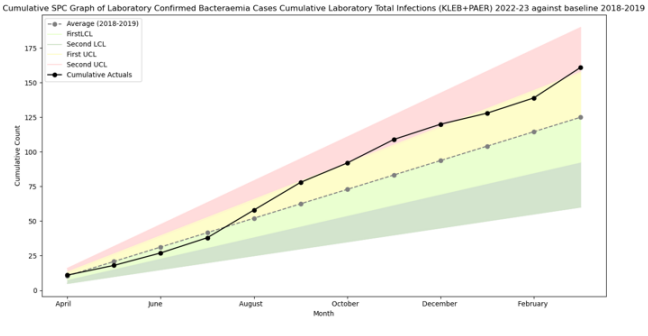








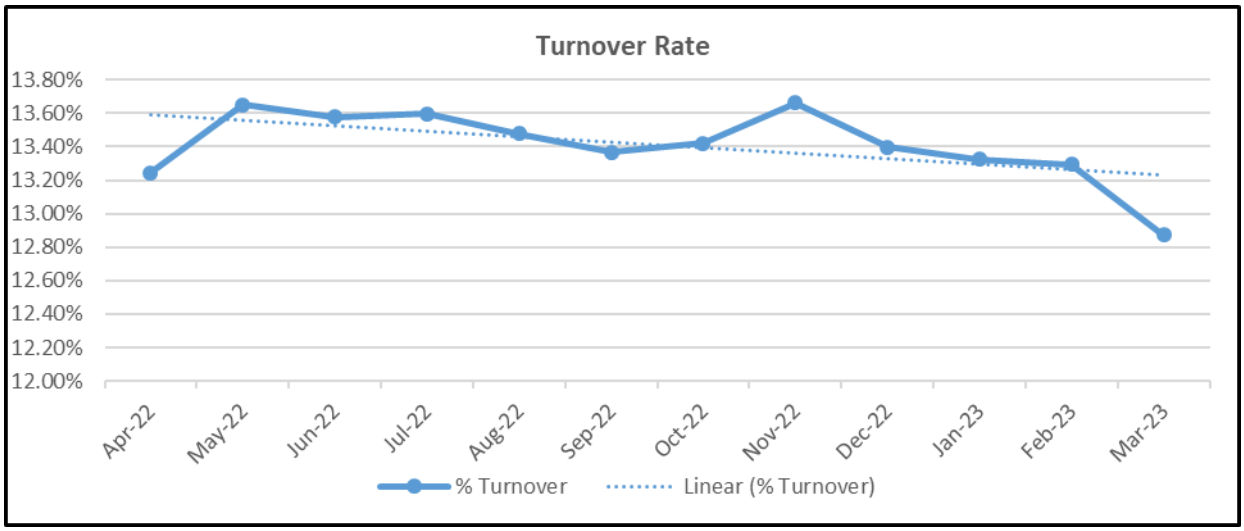




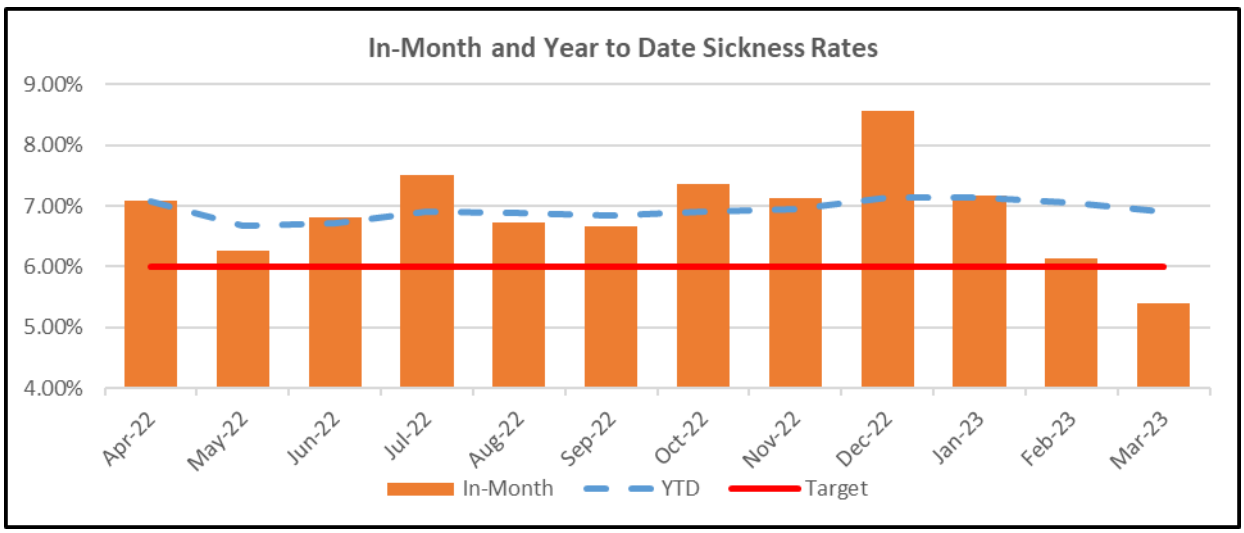
PEOPLE/WORKFORCE

The Executive Director of People and Culture provides regular workforce metrics updates to the Board and an overview report demonstrating progress with the People & Culture Plan.

- **Turnover** rate trend is downwards since Apr-22; the rates have fallen from 13.66% in Nov-22 (the highest rate of turnover in the past 12 months) to 12.87% in Mar-23 UHB wide. This is a net 0.79% decrease, which equates roughly to 109 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Retirement Age', 'Voluntary Resignation – Relocation', 'Voluntary Resignation - Promotion' and 'Voluntary Resignation – Work Life Balance'



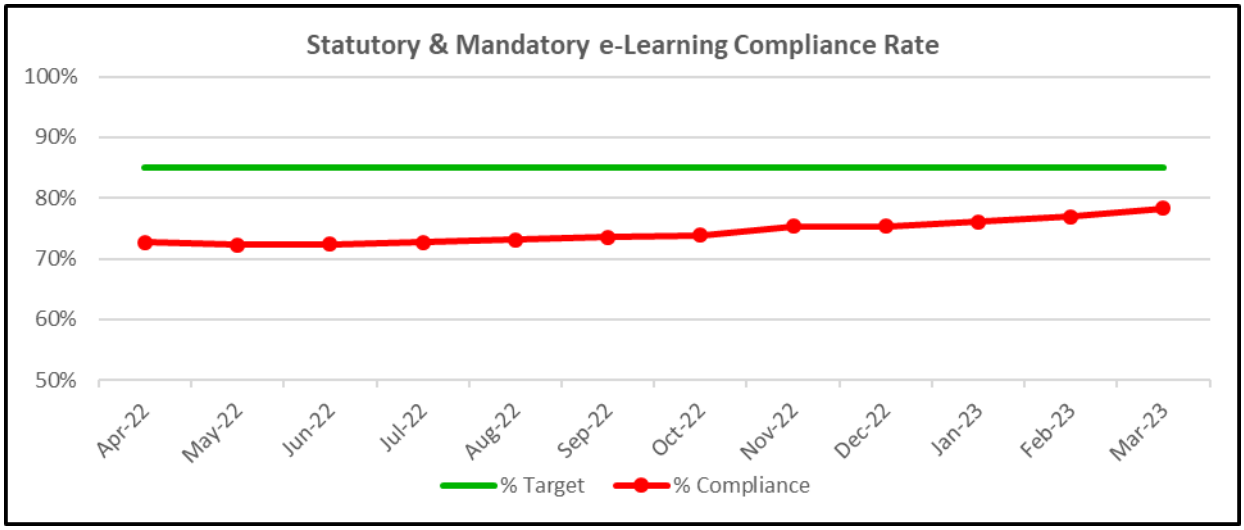
- **Sickness Absence** rates remain high; although the rates appear to be the falling to more 'normal' levels. The monthly sickness rate for March 2023 was 5.40% and February 2023 was 6.13%, after an all-time high of 8.56% for December 2023. The cumulative rate has fallen over the past 3 months to 6.90% (marginally lower than for March 2022, which was 6.92%. This figure is derived from absence since April.



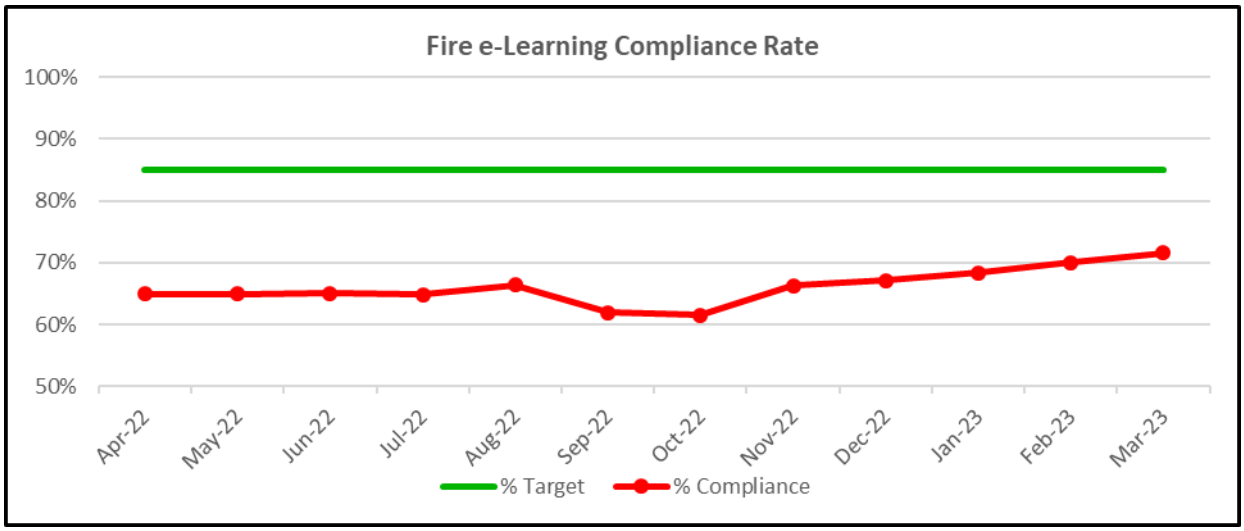
The top 5 reasons for absence for the past 12 months are; 'Anxiety/stress/depression/other psychiatric illnesses', 'Cold, Cough, Flu – Influenza', 'Chest & respiratory problems', 'Other musculoskeletal problems' and 'Gastrointestinal Problems'

The number of staff on long term sick leave suffering where the absence reason has been identified as 'Anxiety/stress/depression/other psychiatric illnesses' has risen slightly. On 31/03/22 there was 284 and as at 31/03/23 there were 295 (an increase of 11 – 3.87%). There are 89 staff on long term absence where Covid-19 has been identified as a Related Reason.

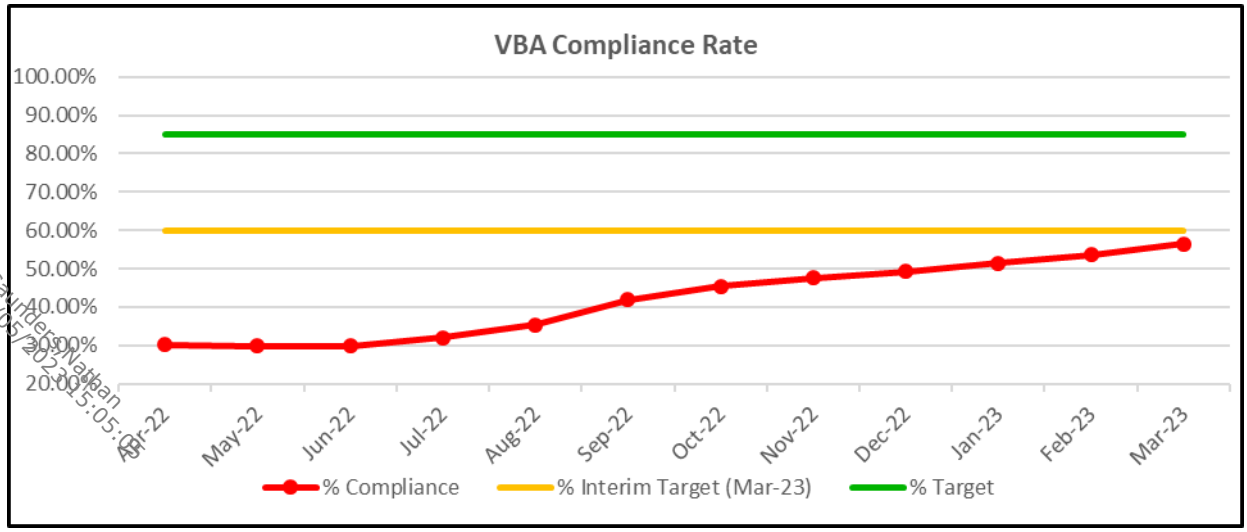
- The **Statutory and Mandatory** training compliance rate has risen, to 78.26% for March, 6.72% below the overall target.



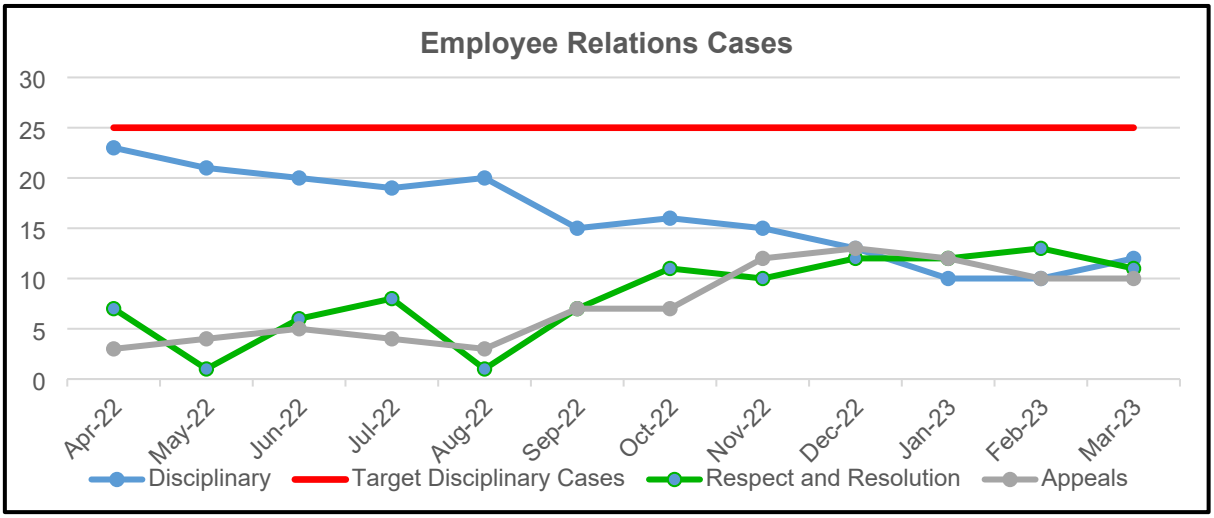
- Compliance with **Fire** training has also risen during March, to 71.53%.



- The trend of the rate of compliance with **Values Based Appraisal** has risen over the last 9 months; the compliance at March 2023 was 56.40%. Clinical Boards had been set an improvement target of 60% by the end of March 23, then 85% by the end of June 2023. Capital, Estates & Facilities (79.88%) Clinical Diagnostics & Therapeutics (67.76%) and PCIC (63.31%) exceeded the 60% transitory target, and Children & Women's reached 59.81%.



- **Employee Relations -** Disciplinary Cases have decreased from 23 in April 2022 to 11 in March 2023. There are currently 12 requests for Formal Resolution under the Respect and Resolution Policy. There are an additional 9 cases being resolved informally with support from the People Services Team.



- **Future Workforce** – a new unregistered Assistant Practitioner role has been developed which provides us with an opportunity to modernise the skill mix, fully implement care around the patient, aligns with prudent health care and ensure the Registered Nurses do what only they can do. The first cohort of 14 Assistant Practitioners commenced their training on 24 April and the next cohort commencing in July are I the process of being recruited to.

- **Workforce Sustainability** – the use of Agency Health Care Support Workers (HCSWs) was introduced during the Covid pandemic. This ceased on 1 April 2023 as part of the Workforce Sustainability Plan and substantive and Bank HCSWs rates have been increased.

Corporate Health Standards - the UHB was successfully re-assessed for the Gold and Platinum Corporate Health Standards in March 2023 and maintained the standards to be recognised as an exemplar organisation. The Wellbeing Strategy Group continues to oversee the delivery of the priorities and actions resulting from the Corporate Health Standard, and much progress has been made over the past year, including staff room and nursery facility refurbishments, provision of financial wellbeing education, signposting and roadshows, and the continued development of peer support. Work has also commenced on developing managers and leaders to effectively support the wellbeing of their teams through effective conversations and a compassionate leadership approach.

OPERATIONAL PERFORMANCE

Emergency & Urgent Care

Performance against the 4-hour standard, 24-hour EU waits, 12-hour trolley waits and ambulance handover times are shown in the balanced scorecard.

There continues to be a challenging position across the urgent & emergency care system, largely driven by high levels of adult bed occupancy, as a result of the high number of patients who are

delayed transfers of care (DTOC) and the continued challenge in our ability to achieve timely discharge and create flow for the Emergency Unit.

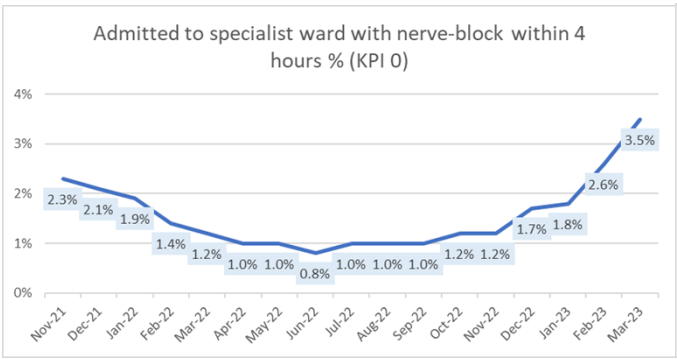
There has been significant improvement in ambulance handover times which has led to an improvement in total number of lost hours and the volume of crews waiting greater than 4 hours to handover.

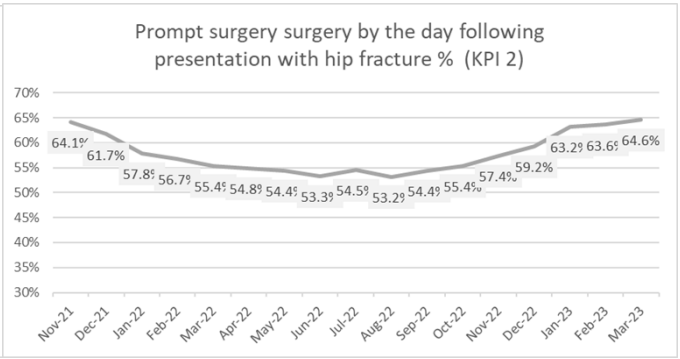
The number of ambulance handovers >4 hours has reduced from 230 in September 2022 to 0 in February, 2 in March and 0 in April 2023. We are now giving the same focus to patients waiting 2-hours for an ambulance handover.

Fractured Neck of Femur

Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. In March 2023, 3.5% of patients were admitted to a specialist ward with a nerve block within 4 hours, with a significant reduction in the median time patients are waiting to move to the ward.

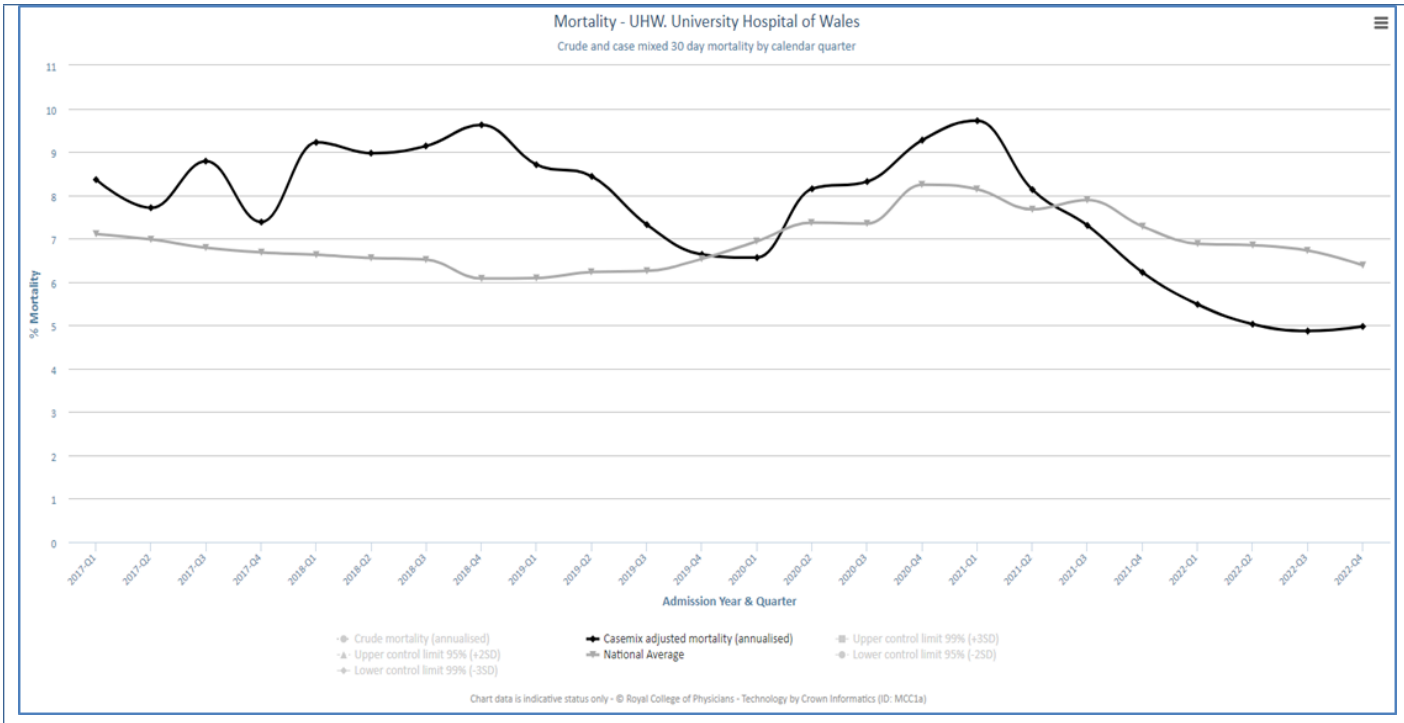
In March, 64.6% of patients received surgery within 36 hours, this is reflective of the general trend during 2022 but a small reduction when compared to October 2021 performance (64.6%). Our performance is above the national average of 56% over the last 12 months.





Summits with key stakeholders were held in March and April with the ambition for significant increases in our performance moving forwards to make Cardiff and Vale an upper quartile performer when compared to UK peers.

In addition to pathway improvements, we are committed to improving outcomes for patients. Data below from the National Hip Fracture Database shows that annualised Casemix Adjusted Mortality rates have falls from early 2021 and is now below the national average.

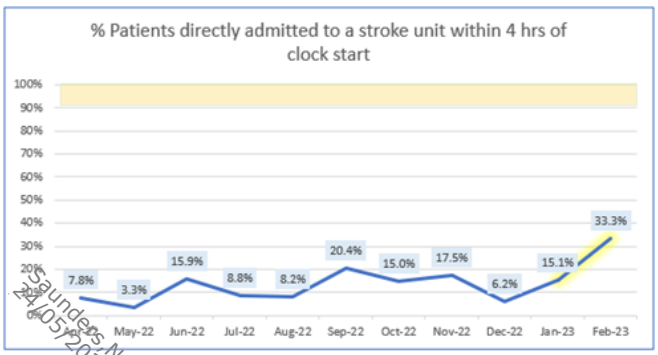


Stroke

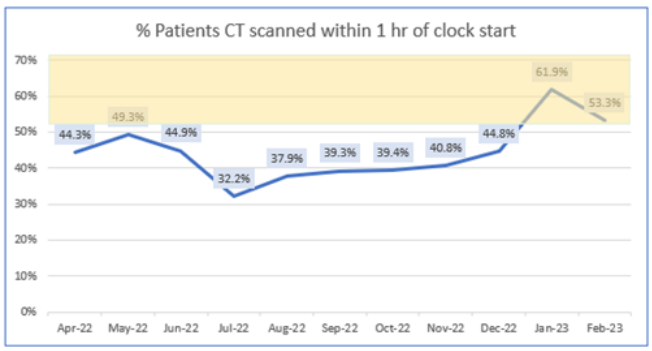
Stroke performance remains below the standards set out in the Acute Stroke Quality Improvement Measures and The Sentinel Stroke National Audit Programme (SSNAP), but February saw an improvement in the thrombolysis rate and door to ward performance. In February:

- 8.3% of patients were thrombolysed within 45 minutes of arrival, the All-Wales average was 14.3%. The percentage of patients given thrombolysis improved to 20%, above the All-Wales Average of 15.9%
- The percentage of CT scans that were started within 1 hour in February was 53.3%, the All-Wales average was 59.7%
- The percentage of patients who were admitted directly to a stroke unit within 4 hours saw improvement to 33.3% in February, the All-Wales average was 22.8%

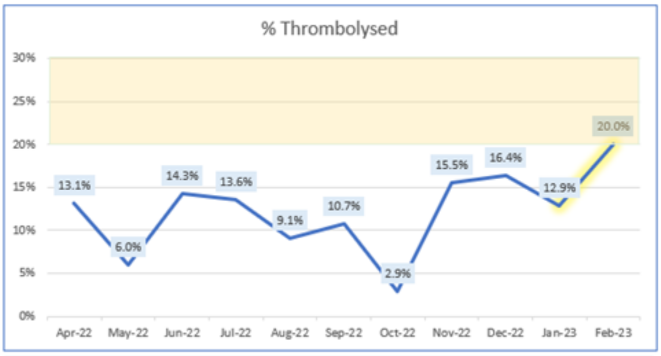
The UHB has held three internal Stroke summits and a number of improvements to the stroke pathway are now being implemented including increased Clinical Nurse Specialists during out of hours, additional middle grade medical cover for the Emergency Unit and ringfencing of additional stroke beds to deploy the pull model from EU effectively. The UHB aspires to achieve a rating of grade 'A' for SSNAP and the gaps for some of the indicators are shown below:



SSNAP A grade: consistent 90% admitted within 4 hours with a median time of <2hr. 90% of patients to spend 90% of their UHW stay on the stroke unit



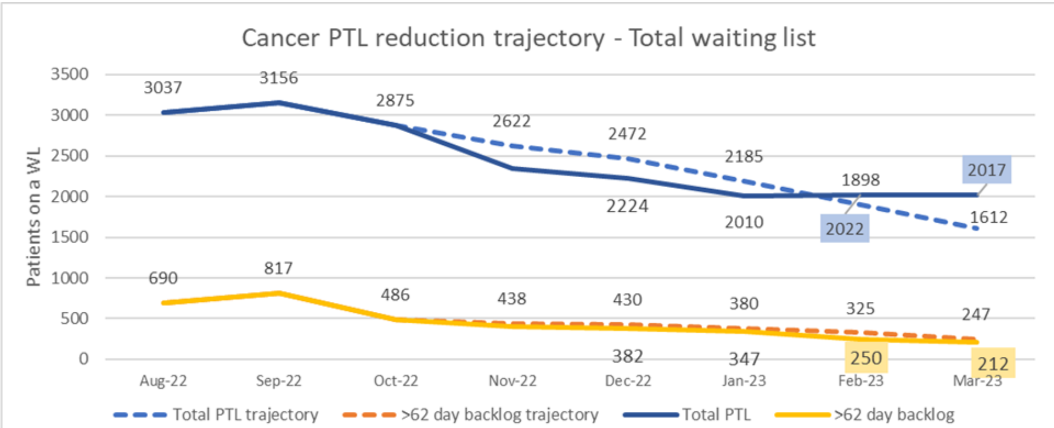
SSNAP A grade: consistent 50% scanned within 1 hour, 95% within 12 hours with a median time of <1hr



SSNAP A grade: consistent 20% thrombolysis rate, 90% of eligible patients thrombolysed. 45 minute QIM (DU) 1 hour standard (SSNAP)

Cancer

There continues to be an improvement against the Single Cancer Pathway and the backlog trajectories agreed with the Delivery Unit. February saw another improvement of 6% compared with January with 61.5% of patients receiving treatments within 62 days.



At the time of writing there are a total of 1914 suspected cancer patients on a single cancer pathway. 258 have waited over 62 days, of which 65 have waited over 104 days.

Of these, there are 1848 Cardiff and Vale patients (excluding tertiary patients) of which 201 have waited over 62 days.

There have been a number of actions taken to improve the oversight and operational grip of the process for overseeing patients. Three cancer summits have taken place with the tumour group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions are required to reduce the delays experienced by our patients.

In addition to internal Cancer summits and the ongoing demand and capacity exercise, there is senior weekly oversite and a current focus on eliminating the number of patients waiting over 62 and 104 days to start their definitive treatment.

Planned Care

The total number of patients waiting for planned care and treatment, the Referral to Treatment (RTT) waiting list was 122,708 as at March 2023. The tail of this waiting list breaks down as follows:

- Patients over 156 weeks – March – 823
- Patients over 104 weeks – March – 3,740

- Patients over 52 weeks – March – 22,644

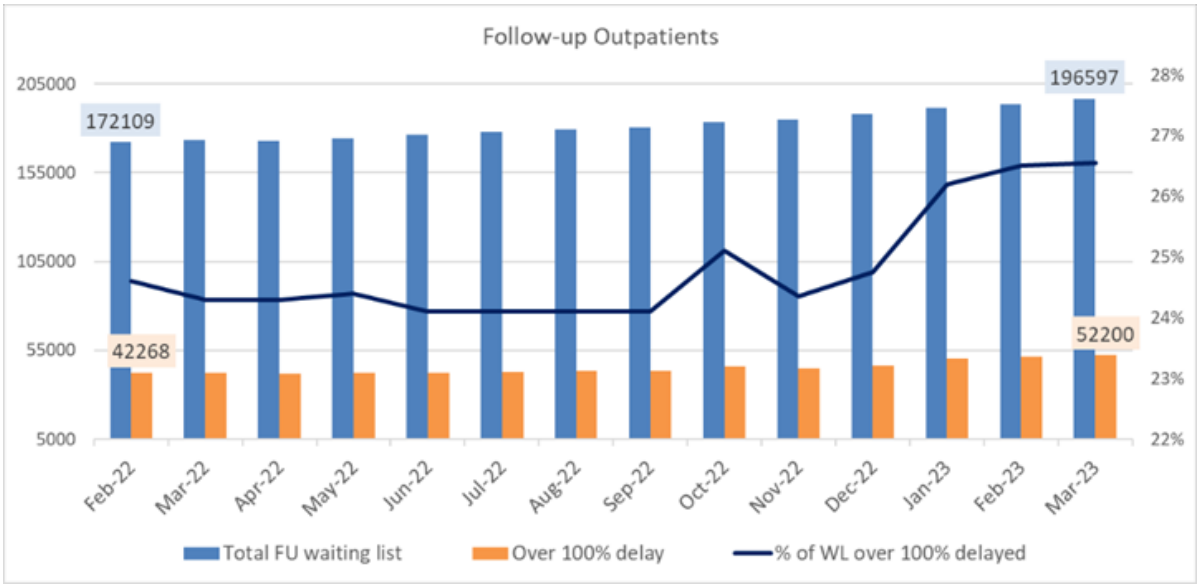
Work continues to reduce the number of these long waiting patients.

The number of patients waiting for planned care and treatment over 36 weeks has decreased to 37,897 at the end of March 2023. 50% of these are at New Outpatient stage.

The overall volume of patients waiting for a follow-up outpatient appointment at the end of March 2023 increased to 196,597. 98.3% of patients on a follow up waiting list have a target date, above the national target of 95%. The number of follow-up patients waiting 100% over their target date has increased to 52,200. This is of concern and will be an area of additional focus and support to improve the position over the next few months. This work will be driven through the Outpatients Delivery Group with action plans being developed by Clinical Boards focusing on:

- Use of COMII system to record and book follow-ups
- Review of automated processes used to maintain waiting lists
- Administrative and clinical validation
- Risk stratification of waiting lists

This is in addition to ongoing pathway work looking at alternatives to traditional follow-up appointments such as the use of see-on-symptoms pathways.



Ministerial Measures

Weekly tracking of delivery against the following ministerial priorities is established. The health board remains on track to deliver against trajectories shared with the NHS Wales Delivery Unit.

Measure	WG Ambition	IMTP commitment	Trajectory shared with DU	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of patients waiting over 52 weeks for a **new outpatient** appointment	0 (end of December 2022)	20,235 (end of December 2022)	15,723 (end of December 2022)	15,588	15,810	16,272	16,584	16,179	15,291	14,697	13,311	11,775	10,951	10,707	10,102
Number of patients waiting over 104 weeks for **treatment** (all stages)	0 (end of March 2023)	750 (end of March 2023)	6415 (end of March 2023)	9,066	8,820	8,300	8,308	7,687	7,038	6,309	5,553	5,099	4,587	4,333	3,740

Where we are not able to deliver against the 104-week ambition, we are working to eliminating 3 year waits in these specialties. We have some further work to do to give full assurance on this for all specialties, there are patients in this cohort requiring a plan across ENT, Ophthalmology, Spines, General Surgery and Urology. The reduction in this 3 year wait cohort is tracked on a weekly basis and reported monthly:

Cohort	Oct	Nov	Dec	Jan	Feb	March
Number of patients who will have waited more than 156 weeks for ***treatment*** (all stages) by end of March 2023	3,491	2,704	2,152	1,611	1,216	823

Diagnostics and Therapies

The volume of greater than eight-week Diagnostic waits has increased to 4,782 at the end of March 2023 from 4,421 in February, largely driven by increased waits in Radiology. Greater than eight-week waits for a diagnostic endoscopy increased and remain high as detailed below:

Radiology modiality	Jan-23	Feb-23	Mar-23	Trend
MRI	1084	915	874	
Non-Obstetric Ultrasound	1311	946	1279	
CT	8	18	15	

Diagnostic endoscopy	Jan-23	Feb-23	Mar-23	Trend
Cystoscopy	241	228	224	
Colonoscopy	239	240	272	
Flexible Sigmoidoscopy	348	337	311	
Gastroscopy	767	679	741	
Bronchoscopy	11	13	15	

The number patients waiting over 14 weeks for Therapy has reduced to 952 in March from 1,113 in February, driven largely by a reduction in waits for Dietetics.

Mental Health

Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, with referrals for the Local Primary Mental Health Support Service (LPMHSS) at 1523 referrals in March 2023. As highlighted at the previous Board meetings, this demand increase includes an increased presentation of patients with complex mental health and behavioural needs.

Significant work has been undertaken to improve access times to adult primary mental health and CAMHS services:

- Part 1a: The percentage of Mental Health assessments undertaken within 28 days was 96.8%, decreased from 99.6% in February 2023. For CAMHS services, compliance decreased from 97.9% in February to 92.7% in March 2023.
- Part 1b: 99.5% of therapeutic treatments started within 28 days following assessment at the end of March 2023, an increase from the reported compliance in February 2023 (91.1%)
- Part 2: 80% of Health Board residents in receipt of secondary mental health services have a valid care and treatment plan (CTP) at the end of February 2023
- Part 3: 69% of Health Board residents were sent their outcome assessment report within 10 days of their assessment in February 2023

Primary Care

The Health Board was 50% compliant in March 2023 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 1 of 2 patients receiving their visit with one hour. For patients that required an 'Emergency' appointment at a primary care centre in March the Health Board was 100% compliant, with 7 of 7 patients receiving an appointment within 1 hour.

Pressure has continued within GMS. There were 9 practices reporting either level 3 or 4 escalation at the time of writing the report. The 2 GMS contract resignations have been effectively managed by the primary care team. General Dental services were operating at around 68% of pre-Covid activity in December, with the uptake of the new Dental Contract this measure has

been discontinued and will be replaced for 23/24 reporting. Optometry is operating at pre-Covid levels. Community pharmacy has remained open with no issues reported.

Integrated and System Working

The number of medically fit for discharge patients remains high and continues to present significant operational and financial pressures. For the four years prior to the pandemic the numbers of MFFD patients were between 120 – 150 patients.

Since January of 2023 the number has remained at c330 – 350, The latest position and reasons for delay are shown below:

January 2023

Constraint	Cardiff	Vale	Other
Social Worker Assessment	74	33	0
Social Worker Allocation	41	8	0
Package of Care	40	23	0
Residential home	21	4	0
Rehabilitation	11	5	3
Get me Home +	11	0	0
Nursing Home	8	7	1
CRT/VCRS	6	2	0
Housing	6	0	0
Legal	6	0	0
Therapy Support	4	2	1
Repatriation	1	1	6
Total by Local Authority	**229**	**85**	**11**
Grand Total		**325**	

Bed days Lost	**8110**	**2625**	**572**

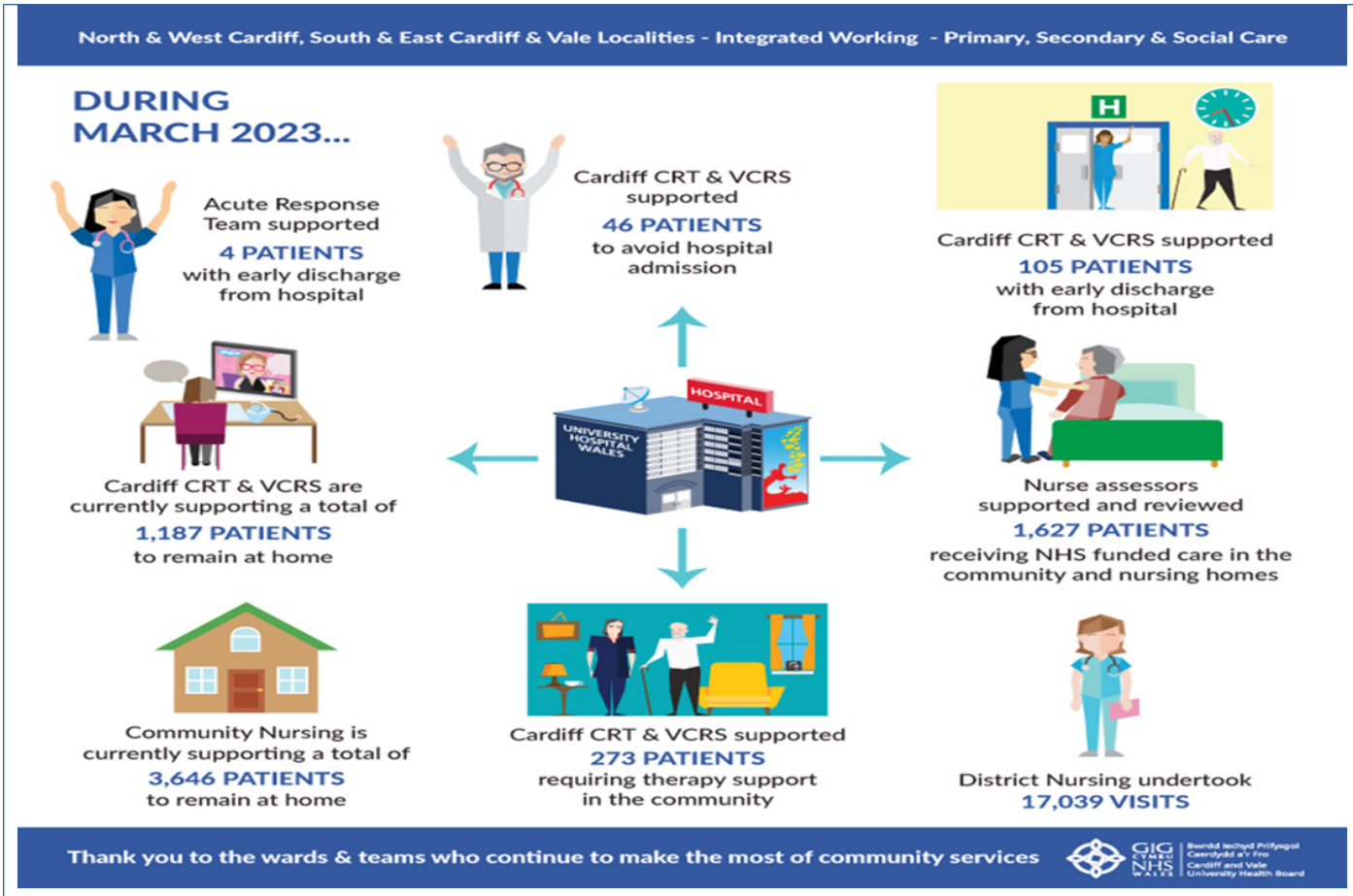
In order to mitigate this increase and to be able continue with planned care and reduce the pressure in EU, the UHB has opened an additional c150 beds since the pandemic.

Although working relationships with local authority partners is good, at the current time there are no obvious solutions to significantly reduce these numbers of delays.

'Further Faster' and the *@home programme* will certainly help in the medium to long term but the UHB will need to continue to manage this significant safety, quality, operational and financial risk for the foreseeable future.

Community Care

Our community teams continue to provide valuable services to the residents of Cardiff and the Vale. Our teams work to care for patients in the community and also provide timely and supportive discharges from secondary care. In March 2023 the community nursing team supported over 3,600 patients to remain at home and the District Nursing team undertook 17,039 visits – seeing 25% more patients than attend the EU each month. A breakdown of our teams' activity across primary, secondary and social care can been seen below:



FINANCE

How are we doing?

The Health Board agreed and submitted a final financial plan to Welsh Government at the end of June 2022. The final plan is structured in three parts in line with Welsh Government guidance as follows:

- Core Financial Plan including recovery
- National inflationary pressures which are out of the direct control of individual Health Boards.
- Ongoing COVID response costs.

The UHB's core plan incorporated: -

- Brought forward underlying deficit of £29.7m
- Allocations and inflationary uplifts of £29.8m
- Capped cost pressures and investments of £36.9
- A £16.0m (2%) Initial Savings programme
- £3.7m Further Financial Recovery Actions (£3.4m Savings & £0.3m reduction in Investments)

This resulted in a 2022-23 planning deficit of £17.1m.

Following discussions with Welsh Government, the Finance Committee and Board, the forecast deficit increased to £26.900m at month 8 in recognition of the cumulative year to date position and additional unforeseen cost pressures that had emerged in 2022-23.

Reported month 12 position

The Welsh Government monthly financial monitoring returns capture and monitor costs due to COVID 19 and exceptional cost pressures that are over and above LHB core plans. At month 12 the UHB reported to Welsh Government that it will meet its control target of a £26.9m deficit for the end of 2022-23 and this is summarised in Table 1.

Table 1 : Month 12 Financial Position

	Forecast Year-End Position £m
Planned deficit	17.100
Operational position (Surplus) / Deficit	9.800
Financial Position £m (Surplus) / Deficit £m	**26.900**

The UHB expects to deliver a £26.9m deficit in its draft accounts. The UHB is reporting that it stayed within its Capital Resource Limit. Creditor payment compliance met the 95% target.

The Board is asked to note that the reported performance is provisional at this stage as the draft accounts have not yet been finalised and will be subject to Audit Wales scrutiny. The year-end reported position is, however, not expected to materially change.

The actual and provisional performance against the 3 year break even duty on revenue is shown in Table 2 below.

Table 2: Performance against the 3 year financial break even duty

	Actual / Forecast year end position surplus/(deficit) £m	Rolling 3 year break even duty surplus/(deficit) £m	Pass or fail financial duty
2014/15	(21.364)	n/a	n/a
2015/16	0.068	n/a	n/a
2016/17	(29.243)	(50.539)	Fail
2017/18	(26.853)	(56.028)	Fail
2018/19	(9.872)	(65.968)	Fail
2019/20	0.058	(36.667)	Fail
2020/21	0.090	(9.724)	Fail
2021/22	0.232	0.380	Pass
2022/23	(26.900)	(26.578)	Fail

The three year break even duty came into effect in 2014/15 and the first measurement of it was in 2016/17. The table above shows the UHB did not meet its financial duty in 2022/23. The tables also outline that the UHB breached its statutory financial duty from 2016/17 to 2020/21 and met the duty in 2021/22.

Savings Programme

The UHB savings delivery was broadly in line with the revised £19.400m savings target

Creditor payment compliance

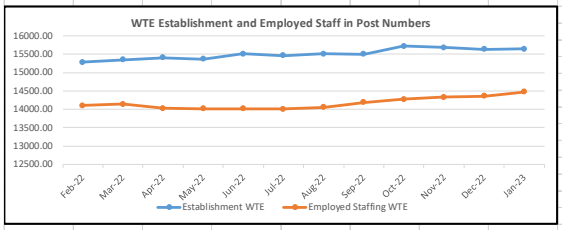
The UHB achieved the public sector payment compliance with performance for the year of 95.2% at the end of March.

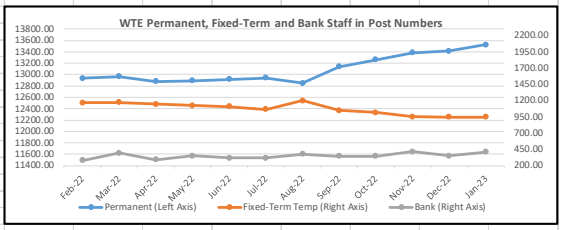
Remain within capital resource limit

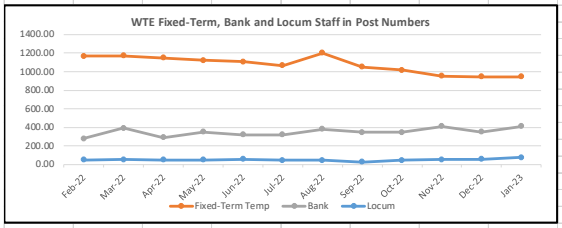
The UHB's remained within its approved annual Capital Resource Limit (CRL) which was £55.410m at the 31st March 2023. Expenditure was broadly in line with the CRL.

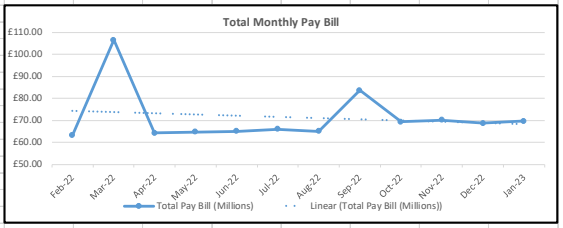
Appendix 1

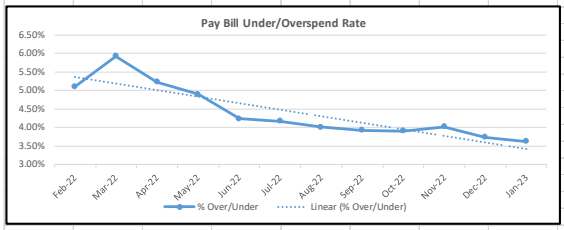
Workforce Key Performance Indicators Trends January 2023

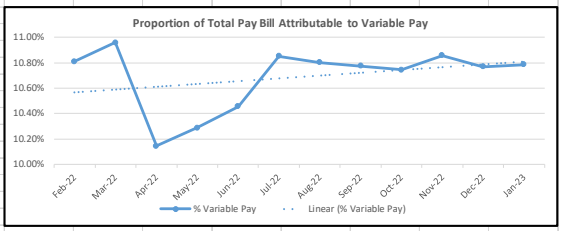


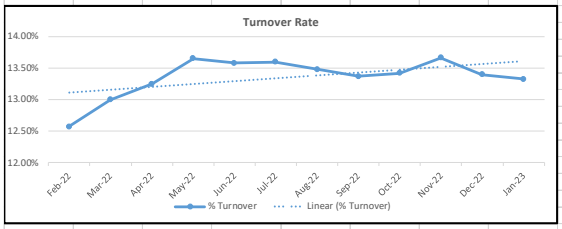


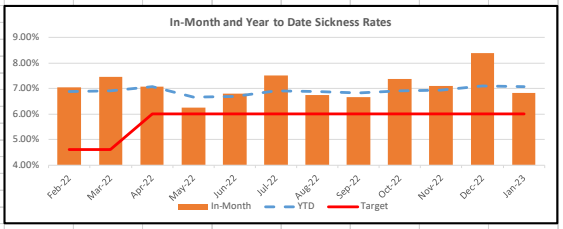


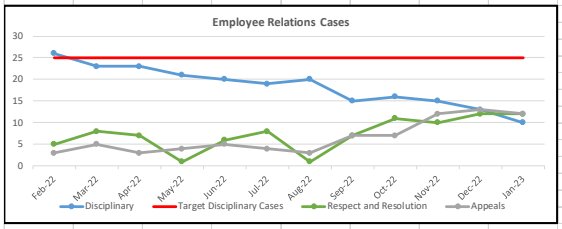


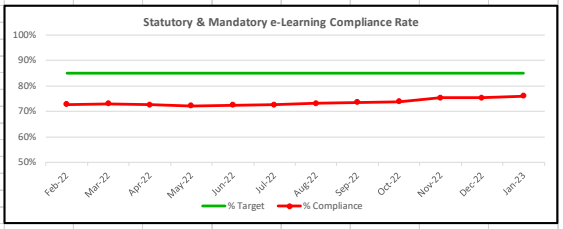


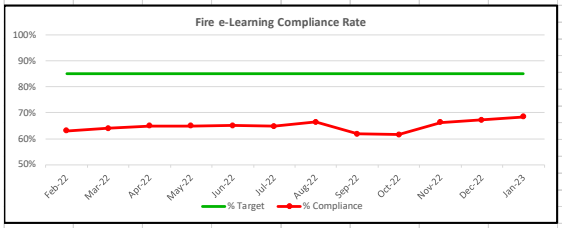


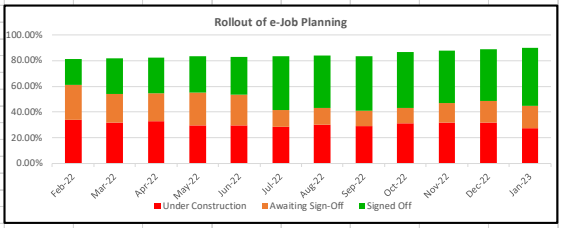


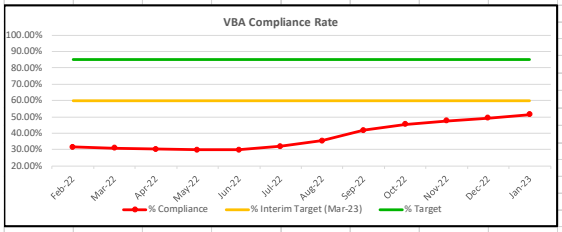


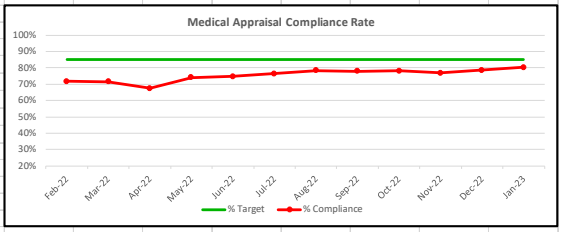


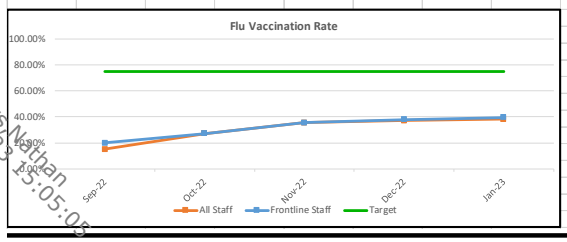












Recommendation:			
The Board is requested to: **NOTE the contents of this report**			
Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
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	x

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	x	Long term		Integration	x	Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
N.A
Safety: Yes/No
N.A
Financial: Yes/No
N.A
Workforce: Yes/No
N.A
Legal: Yes/No
N.A
Reputational: Yes/No
N.A
Socio Economic: Yes/No
N.A
Equality and Health: Yes/No
N.A
Decarbonisation: Yes/No
N.A

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Six Goals – Emergency & Urgent Care
Cardiff & Vale University Health Board

Chief Operating Officer – Paul Bostock
Clinical Director for Six Goals – Katja Empson
Managing Director for Unscheduled Care – Mike Bond
Programme Lead for Six Goals – Alex Bridgman

Six Goals for Urgent and Emergency Care

Goal 1
Population Planning and Support

What: Co-ordination planning and support for populations at greater risk of needing urgent or emergency care

Aim: Health and social care organisations should work in collaboration with public service and third sector partners to deliver a coordinated, integrated, responsive health and care service, helping people to stay well longer and receive proactive support, preventative interventions or primary treatment before it becomes urgent or an emergency

Goal 2
Signposting – Right Place, Right Time

What: Signposting people with urgent care needs to the right place, first time

Aim: When people need or want urgent care they can access a 24/7 urgent care service via the NHS 111 Wales online or telephone service where they will be given advice and, where necessary, signposted or referred to the right community or hospital-based service, first time. This will be achieved through the development of an integrated 24/7 urgent care service.

Goal 3
Alternatives to Admission

What: Clinically safe alternatives to admission to hospital

Aim: People access appropriate and safe care close to home, and with as much continuity of care, as possible. Admission for ongoing care to an acute hospital bed should only occur if clinically necessary.

Goal 4
Rapid Response

What: Rapid response in physical or mental health crisis

Aim: Individuals who are seriously ill or injured or in a mental health crisis should receive the quickest and best response commensurate with their clinical need – and, if necessary, be transported to the right place for definitive care to optimise their experience and outcome

Goal 5
Optimal Hospital Care and Discharge

What: Optimal hospital care and discharge practice from the point of admission

Aim: Optimal hospital-based care provided for people who need short term, or ongoing, assessment or treatment for as long as it adds benefit to outcome, with a relentless focus on good discharge practice

Goal 6
Home First

What: Home first approach and reduce the risk of readmission

Aim: People will return home following a hospital stay – or to their local community with additional support if required – at the earliest and safest opportunity to improve their outcomes and experience, and to avoid deconditioning

How do we keep people safe at home in the community?

People need safe and effective alternatives to admission, what are they and how do we provide them?

How do we provide the best care within hospitals and get people home ASAP?

The Full Picture

The Vision

1

How do we keep people safe at home in the community?

2

People need safe and effective alternatives to admission, what are they and how do we provide them?

3

How do we provide the best care within hospitals and get people home ASAP?

The Priorities

Community	Urgent Primary Care	Alternatives to admission	Inpatient Flow, Discharge and Front Door
• High Risk Cohort • Hospital @ Home • Single Point of Access – Community step up Cluster MDT roll out • Step up delivery – Admission Avoidance • Health Inclusion Team	• Vale to Barry UPCC • Redirects (111, EU, CAV24/7) • High Risk Cohort Pathways • Consultant Connect	• SDECs – Medical, Surgical and others • Direct Referrals from WAST • High Risk Cohort pathways • Virtual Wards	• Lakeside House • Acute Medicine Model • Medicine / Frailty Bed Base • High Risk Cohort pathways • Implementation of SAFER and Red to Green • Roll out of Releasing Time to Care • Ambulance Handover • Step Down – D2RA • E-Triage

HIGH RISK COHORT + 20% MFFD SOCIAL ADMISSION DRIVE ACTION WITHIN THE BIG 4

INTERMEDIATE CARE

Crisis Response Model

Single point of access
(based on existing e.g.CAV24/7, Wellbeing Matters)

NOW (1 hour)

New: Crisis Response Clinical Decision-making Hub:

immediate triage, assessment and treatment to stabilize crisis situation and prevent avoidable admissions

- **Crisis Response GP**
- **Community Emergency Medicine** — Doctors and/or Physician Associate
- **Advanced Paramedic Practitioner**
- **Advanced Practitioners (nurses and Allied Health Professionals (AHPs))**
- **Nurses, Allied Health Professional and Social Worker**
- **Integrated Care Support Workers** — Potential new role to be developed in follow-up workshop

Deploys and coordinates support from 'menu' as required, either immediately as part of NOW response, or a follow-up once the situation is stabilized

SOON (72 hr)

- **Cardiff Community Resource Team / Vale Community Resource Service** including AHPs, Therapy Techs, Pharmacy Techs
- **Integrated Care Support Worker** (care, reablement, practical support)
- **Independent living resources:** Tech-enabled care, equipment, adaptations, housing support
- **Third sector support**
- **Hospital at Home** home-based secondary care medical management: diagnosis and treatment alternative to a hospital attendance or admission.
- **Step-up therapy-led reablement beds**
- **EU / MEAU Attendance / Admission**

Discharge to mainstream community services as appropriate, following resolution of crisis

Notes:

1. Professional skill mix to be determined
2. Team provides immediate phone assessment and triage
3. Team able to deploy appropriate member/s to patient to undertaken medical assessment and POC testing
4. Intercept on-site ambulance crews to provide clinical advice to avoid conveyance and/or on-site assessment and intervention
5. Ability to admit to step-up reablement bed or hospital admission
6. Need to determine how we can support care homes better e.g. the ability to put in temp support into the care home until the situation is stabilised? Better access to information and advice?

Flow

Alternatives

Integrated community care system

Acute in-patient medicine
3 – How do we provide the best care within hospitals and get people home ASAP?

Alternatives to admission
2 -People need safe and effective alternatives to admission, what are they and how do we provide them?

NHS, social care, third sector
1 – How do we keep people safe at home in the community?

Urgent primary care

Information, advice and assistance

Saunders,Nathan
24/05/2023 15:05:05

Non-elective admission

SDEC
Front door/EU turnaround services
Virtual wards

Intermediate care step up/step down

Cluster MDT

111 and CAV24/7
UPCC

Vale Wellbeing Matters
Cardiff Council

Social Services

Primary Care

Mortality and Morbidity

EU performance and Length of Stay

SDEC performance and direct referrals

Urgent Primary Care Utilisation + Redirects

MDT admission avoidance

Healthy Days at Home

Person centred value based Health care

How will we judge ourselves?

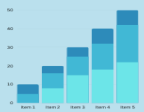
6 GOALS

MARCH HIGHLIGHTS

URGENT PRIMARY CARE

90%

Utilisation



Increased capacity
4751 appointments offered

INTEGRATED WORKING CRT, VCRS & DN

- 1187 people supported @ home
- 46 admissions avoided
- 17039 patients supported by DN
- 109 early discharges

VIRTUAL WARD

- 304 medical bed days avoided
- 7 admissions per day

SAME DAY EMERGENCY CARE

- 1121 patients seen in Surgical SDEC
- 576 patients seen in Medical SDEC

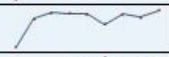
PATHWAY OF CARE DELAY

- 247 patients delayed pathway of care
- Cardiff = 166
- Vale 70
- Out of Area = 11

Metrics In Development

1. Healthy Days @ Home
2. Mortality and Morbidity
3. MDT admission avoidance across all MDTs
4. UPCC Redirects from EU

KPI and Outcome Measures

	Workstream	Metric	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend	Ambition	Current Position
3	Surgical SDEC	Total patients seen								347	899	1000	1062	1060	907	1035	988	1121			80% of Surgical pt in EU	70%
3		Total discharged								282	727	833	819	813	647	809	762	877			85% Discharge Rate	75% Discharge rate
3		Total admitted								65	172	167	243	247	260	226	226	224			15% admitted	25% admitted
3		Unplanned re-presentations within 7 days								1	9	4	4	6	5	20	15				<5%	1.50%
3	Medical SDEC	Total patients seen							259	259	286	272	297	351	473	477	488	576			30% of EU take	To Be Developed
3		Total discharged							240	248	274	241	272	316	442	450	463	543			85% Discharge Rate	94% Discharge rate
3		Total admitted							19	11	12	31	25	36	31	27	25	33			15% admitted	6% admitted
3		Unplanned re-presentations within 7 days																			<5%	To Be Developed
4	MFFD	Total														357	340	330			To Be Developed	To Be Developed
4	Delayed Pathways of Care	Total																247*				
4		Cardiff																				
4		Vale																				
4		Out of Area/No Fixed Abode																				

***Shadow running since October 2022, national go live from April replaces old DTOC measure and we will continue to report the MFFD and DPOC for the time being.**

KPI and Outcome Measures

	Workstream	Metric	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend	Ambition	Current Position
2	UPCC	Capacity									2663	2530	2818	2680	2825	3516	4111	4751			To Be Developed	1072 UPCC appointment per week
2	UPCC	Capacity used									2287	2207	2552	2462	2584	3020	3748	4266			>90%	>89%
2	UPCC	% of capacity utilised									86%	87%	91%	92%	91%	86%	91%	90%				
2	OOH	Calls to OOH											10143	9216	10763	10176	10753	13278	14773		To Be Developed	Avg.11300 per month
2	111 p2	Calls to '111 press 2'															263	412	409		To Be Developed	Avg.361 per month
2	Integrated working	CRT/VCRS patients supported at home									1173	1194	1105	1146	1120	1214	1226	1187			To Be Developed	Avg.1171 per month
2		CRT/VCRS admissions avoided									27	28	23	22	33	22	27	46				Avg.29 per month
2		CRT/VCRS supported early discharge									79	79	103	101	98	77	92	105				Avg.92 per month
2		ART supported early discharge									11	6	12	12	8	2	1	4				Avg.7 per month
2		District Nurse visits									17687	16253	16172	16524	15845	17100	15527	17039				Avg.16518 per month
3	Virtual Ward	Total referrals	78	88	132	132	157	165	138	160	191	189	193	142	158	152	143	207			To Be Developed	Avg.152 per month
3		Estimated medical bed days avoided	161	273	211	245	214	232	264	200	238	225	255	215	243	203	217	304				Avg.231 per month
3		Estimated MSDEC visits avoided	36	13	45	40	11	62	56	51	59	56	46	45	43	38	49	63				Avg.46 per month
3		Average admissions per day	3	4	5	4	5	5	5	5	6	6	6	5	5	5	5	7				Avg.5 per month
3		Longest virtual ward admission (days)	14	27	21	24	28	31	22	29	26	20	33	28	49	30	28	31				Avg.28 per month
3		Average virtual ward admission (days)	5	5	6	7	8	8	7	6	6	6	8	7	8	7	7	8				Avg.7 per month

Next Steps

- Develop Healthy Days @ Home metric
- Further understand our ambitions for each workstream
- Formal counting of Delayed Pathways of Care

Good News Stories

<u>Medical SDEC</u>

Has seen a dramatic increase in volume of patients being seen which has had a positive impact on flow through EU

- 22/23 Q3 = Avg 11 patients per day
- 22/23 Q4 = Avg 17 patients per day
- 23/34 Q1 = Avg 31 patients per day so far

Good News Stories

Frailty

- 36% increase in the number of patients aged 75+ who have been discharged directly from AU since implementation of the enhanced frailty pathway (equivalent **to 21 additional discharges/week**) between Dec-March 2023. This is despite a 23% increase over 75s being referred in to the medical take over the same period
- LOS for over 75s was steadily increasing on AUN prior to the frailty zone. Since its implementation older patients have stayed an average of **5.3 fewer hours** on AUN
- The mean LOS for over 75s in MCB at UHW (including EU/AU stay) has reduced by 2.4 days (Jan-April '22 vs '23) This equates to **3113 bed days saved**
- The LOS reduction is maintained when looking at the post-AU stay only. This demonstrates that the reduction in LOS is not only due to increased discharges from the LGF but due to **improvements in the onward frailty pathway that has been initiated in AU/EU.**

Key Achievements & Wider Plan

Cluster MDT

- South West MDT, Discharge Hub and Social Prescribing model continues to successful
- MDTs fully operational in two additional clusters (North and East)
- North Discharge Hub and social prescribing model ready for launch in March 23
- High Risk Cohort data ready for MDT use in May

Urgent Primary Care Centres

- CAV now has capacity for 1092 appointments per week
- UPCCs now operating in 6 locations
- Dedicated Paediatric stream added in response to Strep A.
- Robust plan to relocate central Vale UPCC to Barry Hospital

SDEC

- Surgical SDEC continues to succeed seeing 3144 patients in Q4 with 78% discharge rate
- Medical SDEC continues to grow seeing 1541 patients in Q4 with an 93% discharge rate
- Virtual wards running
- Direct access for paramedics in place for Surgical SDEC and in development for Medical SDEC

Emergency Unit

- Significant and sustained improvement in ambulance handover times – achieving under 2 hours consistently
- A1 short stay treatment ward delivering real improvement to flow.
- Reduction in Long waits in EU.
- Redesign of Acute Medical model.
- Frailty Zone

Acute Wards

- Releasing Time to Care pilot ward has seen a 20% increase in discharge rates
- Rollout following successful pilot is now under way
- Rolling programme of focused reset weeks after completion of pre and post Christmas resets – SAFER, Red to Green and High level Constraints are key drivers.
- Redesign of Medicine Inpatient footprint
- STAMP system

Discharge

- Introduction of Lakeside House to support integrated discharge
- Additional capacity as part of "1000 beds"
- Step down to recover
- New D2RA pathways agreed with rollout anticipated in June

JOURNEY THROUGH OUR HEALTH SYSTEM

What does this mean?

We need you to come with us on this journey

Tell us how we can improve the system

We need to use our funding differently

Our focus must be on prevention

There will be significant system wide changes

Everyone needs to play their part

Report Title:	Transforming Access to Medicines (TrAMS)				Agenda Item no.	6.9	
Meeting:	Public Board Meeting		Public	X	Meeting Date:	25th May 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		X
Lead Executive:	Executive Medical Director (Meriel Jenney)						
Report Author (Title):	Clinical Director Pharmacy & Medicines Management						

Main Report
Background and current situation:

Transforming Access to Medicines (TrAMs) is a national programme to transform pharmacy technical service (aseptic product production) by centralising production to 3 regional hub facilities, operated and managed by NHS Wales Shared Services Partnership, with SE Wales planned to be first.

Whilst this centralisation is welcomed the detailed service standards are not yet developed. For Cardiff & Vale this has resulted in identification of a number of risks, primarily around ongoing ability to provide products (mainly clinical trials and the newer Advanced Medicinal Therapeutic Products (ATMPs)). Work is underway to mitigate these risks and ensure ongoing supply of medicines to our citizens.

This briefing provides a background to the programme and an update of current local and national positions.

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

An understanding of the TrAMs programme and identification/mitigation of the key programme risks for C&V.

Recommendation:

The Board is requested to:

a) Note the attached report.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect		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*									
Prevention		Long term		Integration	X	Collaboration	X	Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Senior Leadership Board	06.04.23

Saunders,Nathan
24/05/2023 15:05:05

Transforming Access to Medicines (TrAMs) Briefing Paper – Cardiff & Vale Impact

Background

TrAMs is an all Wales programme to transform Pharmacy Technical Services within NHS Wales led by NHS Wales Shared Services Partnership (NWSSP).

Pharmacy Technical Services involves the sterile preparation of medicines (also known as aseptic services) and is predominately a specialty area within hospital pharmacy services. Aseptic Services are responsible for the development, preparation and supply of unique patient-centered medicines, including the preparation of injectable systemic anti-cancer therapy (SACT), preparation of parenteral (intravenous) nutrition for people whose medical condition mean they are unable to absorb nutrients from the food they eat, and radio-pharmaceuticals used in diagnosis and treatment of cancers.

With the advances in medicines that deliver improved outcomes for patients, demand for these critical services have been growing. Currently, much of this work is undertaken in hospitals throughout Wales.

Traditionally the service has involved Pharmacists and Technicians working in small clean room suites within acute hospitals.

Cardiff & Vale currently has St Marys' Pharmaceutical Unit (SMPU), a standalone commercial production facility located behind Woodland's House, a radiopharmacy unit in UHW and a smaller aseptic unit in UHL pharmacy department.

Within Cardiff & Vale main role of these services is the preparation of injectable medicine in ready to use formats including:

- Systemic Anti-Cancer Therapies (SACT)
- Parenteral Nutrition products (PN)
- Radioactive injectables
- Central Intravenous Additive injectables including for critical care (CIVA)

and

- Classical Manufacture of Sterile and Non-Sterilised medicines
- Pre-packing and over labelling of tablets and capsules.
- Quality Assurance function which also supports Medical Gas testing and other activities.

Assessment

Across Wales these facilities are in a deteriorating condition, are subject to increasing regulatory pressure and unable to meet the current and future demands of the service without significant local investments. Within Cardiff & Vale radiopharmacy and UHL are at a higher risk of failure.

Due to this deterioration of smaller aseptic units across Wales an initial business case was prepared and overseen by NWSSP. A Programme Business Case (PBC) was prepared between 2018 and 2021 by a team of seconded pharmacists and others from Health Boards across Wales, with support from NWSSP Project Management Office. The PBC examined a number of options to transform and recapitalise the service, including not only the physical assets but also the organisation, education, and training challenges which the service currently has. The additional benefits to this approach are a reduction in the outsourcing of medicines supply to private companies, release of space on acute hospital sites, a reduction in the need for nursing time, increased contingency and improved environmental performance.

In summary the TrAMs PBC recommended reconfiguring the service as:

- A national service, delivered through 3 regional medicines hubs (SE Wales, SW Wales and North Wales) operated and manged by NWSSP.
- Supporting product standardisation and reduction of variation between hospital sites
- Increase in the use of standard batched products where appropriate, to secure the ability to continue supply of bespoke products where these are essential
- Staffing transformation based on more use of Science graduates alongside Pharmacists and Technicians
- Revised suite of educational qualifications and training courses to support this transition
- Leveraging the high-quality product distribution provided by NHS Wales Health Courier Service
- Service delivered in collaboration through a new All Wales Pharmacy Technical Service under the Shared Services Partnership Committee arrangements.

The Programme Business Case (PBC) was fully endorsed by Shared Services Partnership Committee and the Minister for Health and Social Care in March 2021.

Current Position

South East Wales will be the first hub to be developed with TrAMs and Welsh Government currently in negotiation to secure a suitable site for this facility (a site short-listing exercise was held with key stakeholders) – once this is agreed then timeframes for the delivery of the programme will become clear and the service model will be developed further. The full details of these negotiations are currently subject to commercial in confidence negotiations.

The overall aim and purpose of TrAMs is supported and welcomed by CVUHB. We are working closely with the TrAMs team to ensure safe delivery and governance of future routine product supply alongside more complex programmes such as clinical trials and research and development aseptic production that the Health Board currently provide.

South East Wales regional Chief Pharmacists regularly meet with the TrAMs clinical director to discuss current progress and review regional aseptic capacity to maximize local resilience in service provision until TrAMs is fully operational.

What this means for C&V

TrAMs will be starting with SE Wales (Cardiff & Vale, Cwm Taf Morgannwg, Aneurin Bevan and Velindre Cancer Center), which should result in respective local aseptic units being replaced by the regional hub. TrAMs is estimated to be operational for SE Wales in 2024-2026 depending on site selection and required works. The programme has already undertaken the first phase of recruitment to appoint the senior National and South East hub leadership team, further recruitment for the remaining staff is planned for later this year. Due to the size of the affected units in CVUHB this will affect around 80 wte staff locally – though not all will be moving to TrAMs.

The full details of the scope and operational service model have not been fully developed yet so we are working with the TrAMs teams to gain assurance that the full aseptic requirements of the Health Board can be delivered by TrAMs. There are two main areas of focus in these discussions - clinical trials aseptic production and Advanced Therapeutic Medicinal Product (ATMP) manufacture (both routine and trial based).

Clinical trial products are becoming increasingly complex to produce with shorter time available between production and expiry (current local standard from SMPU is 4 hours but recent trials have initially required less expiry time making production logistically challenging). ATMPs are currently not within scope for TrAMs (though a case for inclusion is being prepared by Advanced Therapies Wales in partnership with TrAMs and Welsh Government). CVUHB are a leading site within the UK

for ATMPs, both routine and trials, so alternative options for production will need to be considered if not included within TrAMs.

The current Health Board pharmacy estate will be retained, with elements of current activity, such as pharmacy wholesaler licensed activity still required to operate from SMPU, requiring significant floorspace.

A local aseptic and radiopharmacy transition group has been formed to work through a transitional plan, with local stakeholders represented, and identify/propose mitigation to the local risks – working towards successful implementation of the regional TrAMs unit. This group is working mapping out current local services, including the staffing and financial resource associated with each activity in preparation for negotiation with TrAMs around service and resource transfer. This local work is due to be completed by end of May 2023.

Timothy Banner

Clinical Director Pharmacy & Medicines Management, Cardiff & Vale University Health Board.

May 2023

Report Title:	Strategic Planning Update	Agenda Item no.		6.10	
Meeting:	Board	Public	X	Meeting Date:	25 May 2023
		Private			
Status *(please tick one only):*	Assurance	x	Approval	Information	
Lead Executive:	Executive Director of Strategic Planning				
Report Author (Title):	Executive Director of Strategic Planning				

Main Report

Background and current situation:

This report provides the Board with an update on key areas of strategic planning work programme progressed. Its purpose is to give the Board assurance that actions agreed in our annual work programme or Annual Plan are being progressed and risks around delivery are being managed. The five items are as follows:

- Progress with the strategy.
- Progress with our strategic programmes.
- The development of the 2023 – 2026 Integrated Medium-Term Plan (IMTP).
- Progress with the regional planning work programme.
- Progress with our partnership planning and commissioning.

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

The strategic planning team holds the ring on a number of key planning arenas including the updating of the Health Board's overarching strategy and strategic plans the annual planning process leading to the production of our IMTP, regional planning and partnership planning – including both the RPB Area Plan and the two PSB Wellbeing Plans. It is key that there is alignment between the emerging refreshed strategy, our IMTP/annual plan and our regional and partnership plans.

1. **Strategy Refresh:** at its development meeting in April, the Board agreed the draft text for the refreshed strategy and supported the recommendation of the Steering Group to progress to the next phase of engagement. The launch of this second phase commenced on 9th May and will run until the end of June. It is recognised that the final version of the strategy will need explicit measurable objectives for each of the strategy themes, as well as confirmed priority actions. The aim remains to bring a final strategy to the Board for approval in July.

2. **Strategic Programmes**
   - Management Executive continues to meet monthly to provide oversight of these programmes. They will need to be reviewed in the Autumn when the refreshed strategy is approved. The Strategy and Delivery Committee receives an assurance report at every meeting via a series of flash reports on these programmes plus the enable programmes (digital enables services, workforce modernisation and infrastructure via the capital report).
   - Shaping Our Future Clinical Services: work is progressing with the development of the health board's 10-year clinical services strategic plan (CSP). The programme board meets monthly and is chaired by the SRO. Prof Meriel Jenney. The CSP outline chapters have been agreed and project board set up to oversee delivery of the plan within the next 12 months on behalf of the programme board. The programme team are currently in the process of ensuring that all relevant plans, projections and assumptions are gathered in key areas (i.e. digital, workforce etc) to inform subsequent CSP chapters. Two supporting workstreams have also commenced and include: Involvement, Communication and

Engagement and Business Intelligence and Modelling. The programme will be tailored to reflect the current operational pressures and the limited ability to commit the necessary resources. The delay to WG funding for SOFH impacts on the SOFCS programme, this risk is being monitored via the Programme Board.

- Shaping Our Future Hospitals: Welsh Government has agreed the scope of the Strategic Outline Case, confirming that it needs to be a high level SOC that builds on the PBC which was very detailed. The Programme Board now includes the Vice Chancellor of Cardiff University to reflect the independencies between this programme, and the University's strategic infrastructure programme and longer-term strategy. The independent review of the clinical model set out in the PBC being commissioned by WG has been delayed and this could impact on the timetable for developing the clinical services plan and the SOC. Further clarification is being sought on when a decision will be made about resourcing for the SOC. In the meantime, the preparatory work is underway for both the internal team we will need to build up and the sourcing of external specialist advisors.
- Shaping Our Future in the Community/the RPB @home programme: this programme continues to drive the development of our locality placed-based model of community and intermediate care services. Work is ongoing to ensure this work aligns with the 6 goals emergency and unscheduled care programme, and the development of plan cluster planning groups (on the LA footprints) which are still very much in their infancy. The Area Plan refresh will enable clear milestones and outcomes to be further developed in the RPB annual plan which will be finalised in April.
- Shaping Our Future Population Health: this programme continues to provide a key focus to the work we are doing with a wide range of partners on improving population health, tackling explicitly the health inequities that exit between our communities and to ensure we provide a greater focus on prevention (primary, secondary and tertiary). Whilst not explicitly described in the Ministerial Priorities for 2023/2024, it is critical that the Health Board continues to provide an increased emphasis on health improvement and disease prevention articulated clearly in the commissioning and deliver services, as this is a fundament aspect of our longer-term strategy.

3. **2023 – 2026 IMTP/Annual Plan:**
The Welsh Government has provided feedback on the plan and a review meeting has taken place. Further work on our annual plan in two key areas has been requested: achievement of Ministerial Targets and improving the financial plan. A further submission to WG with updates on the Ministerial Targets templates and the financial plan are due to be submitted on 31st May. The further submission is subject to a separate Board agenda item.

4. **Regional Planning**:

The South East Wales Regional Planning Collaborative continues to make progress across all aspects of its work programme, with the prioritised areas being ophthalmology, orthopaedics, diagnostic and stroke services. The governance arrangements for our regional cancer planning work are currently being aligned with the new Collaborative arrangements. Each programme has a dedicated programme manager and a clinical lead. Learning from the recently implemented regional vascular service model is being taken into consideration as we develop this work. Headlines to note:

2.1 Ophthalmology (led by AB): a regional service strategy has been developed and is attached. A business case has been finalised, which sets out how we plan to operate on a regional basis next year in relation to non-complex cataracts, making use of the temporary threatres we have commissioned at UHW as the South Hub for the region and theatres in Nevil Hall as the North Hub. This is based upon a mixed model of NHS workforce undertaking sessions during the week, and insourcing on the weekends. The business case has been supported by the Regional Oversight Board and is on the agenda for consideration under separate cover. Implementation will be dependent upon securing monies through the Planned Care Recovery Fund.

Orthopaedics (led by C&V): a similar approach is being taken to the ophthalmology programme – a short term plan is being developed to look at how we optimise use of existing capacity across region, particularly in relation to low complexity, high volume procedures. A medium-term strategy is being developed which will look at how services should be organised to address the current service sustainability challenges to ensure we can meet demand as it continues to grow. This will include the role that the Llantrisant Health Park facility could play in supporting services across the three health boards. Clinical teams have visited two places in England that have developed regional centres for providing arthroplasty procedures for low risk patients to bring the learning back to our planning.

Diagnostics (led by CTM): work is progressing at pace to finalise a business case for the commissioning of community diagnostic facilities that would bring additional capacity on board during the first half of 23/24 to support delivery of our planned care and cancer delivery plans. We are developing plans for a Community Diagnostic Hub to be located in Cardiff, aligned to the regional vision and model, funded through Planned Care Recovery Fund.

Options to deliver a single site model for cellular pathology across South East Wales are being worked up and evaluated through the Regional Pathology steering group.

Stroke services (led by C&V): The National Programme has commissioned a new public awareness campaign which has been launched based on the FAST (face, arm, speech, time) and supported by the Regional Stroke Programme Board.

CTM received funding from Welsh Government in early 2023 to support the purchase of a non-healthcare facility adjacent to the Royal Glamorgan Hospital for conversation into a regional diagnostic and treatment facility known to be known as the Llantristant Health Park (LHP). Programme governance arrangements continue to be stood up in regard to the LHP and these arrangements will require close working arrangements with the Ophthalmology, Orthopedic and Diagnostic programmes referenced above.

5. Tertiary and Specialist Services:

The next joint workshop with Swansea Bay UHB clinical leadership team is due to take place at the end of the month. This will explore the shared delivery model options we might want to consider as part of a strengthened provider partnership. Work continues of determining the most appropriate regional service delivery model for hepatobiliary services.

6. Commissioning

The ***Individual Patient Funding Request*** (IPFR) process was subject to an internal audit and received substantial assurance. The audit report and action plan has been considered by the Audit Committee.

The ***Commissioning Intentions*** for 2024-2025 are in development and will be presented to the July Board for noting after going through internal review and governance processes.

Recommendation:

The Board is requested to:

a) Note the progress being made across our strategic planning portfolio.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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		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*									
Prevention	X	Long Term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
No risk assessments relevant to the content of this report.
Safety: Yes/No
No specific safety issues highlighted by this report. There is a general safety issue if we are not able to deliver sustainable services for our population.
Financial: Yes/~~No~~
There will be financial implications in relation so some of the work highlighted in this report, but the details will be developed as part of the ongoing work. Plans for services should look to reflect the Health Board's overarching financial plan that is looking to reduce the cost of delivering services. Where a specific need for investment is determined, a business case will be developed and follow our governance processes. The plans described in the paper are reflected in our Annual Plan.
Workforce: Yes/~~No~~
There will be workforce implications relating to the introduction of regional service models.
Legal: Yes/~~No~~
There is a requirement to ensure we have engaged appropriately on any significant changes to the way we have delivered services. Plans for engagement are being developed.
Reputational: Yes/No
No specific risks to highlight.
Socio Economic: Yes/~~No~~
All of our plans need to be assessed for socio-economic duty. There is an overlay with the EHIA work which identifies any equality impacts we need to take into consideration. Reducing long waits for treatment has a positive socio-economic impact.
Equality and Health: Yes/No
EHIAs will be undertaken for the key plans described in this report.
Decarbonisation: Yes/No
Decarbonisation impact will need to be considered as each plan is developed.

Approval/Scrutiny Route:	
Committee/Group/Exec	N/A

Report Title:	2022-25 Integrated Medium Term Plan: Quarter 4 Delivery Assurance				Agenda Item no.	6.11	
Meeting:	Board		Public	X	Meeting Date:	25.05.23	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Abigail Harris- Executive Director of Strategic Planning						
Report Author (Title):	Ashleigh O'Callaghan- Head of Strategic Planning						

Main Report
Background and current situation:

Background

The Health Board (UHB) has a Board approved 22-23 annual plan which is set in a three-year context. This follows a decision by the organisation that it would not be able to develop a balanced full three-year Integrated Medium-Term Plan (IMTP).

This report and associated annex present the UHBs quarter 4, and therefore year-end, position regarding delivery of the commitments within the plan.

Summary of Position

Many critical milestones were achieved as per the plan during 2022/2023 against the backdrop of significant and sustained system wide pressures, compounded by a particularly challenging winter period which included responding to industrial action and the impacts of a growing cost of living crisis whilst managing high demand for urgent care services.

The achievement of these milestones despite the factors outlined above is testament to the hard work and dedication of our staff.

Some of these achievements are outlined below:

Delivery of operational priorities

- Urgent Primary Care Centre went live in Cardiff North- over 75% of Cardiff and Vale now have direct access to an UPCC with the remaining practices able to request access as needed
- Improved diabetes performance – increase % patients received all 8 NICE recommended care processes
- Increase in primary and community care activity – dental and eye care
- NHS 111 press 2 launched
- Achieved over 90% part 1a and 1b (mental health measure) in adults and over 90% part 1a in CAMHS
- Improved eating disorder access times – reduction of longest wait
- Met ambulance handover commitment in minimising delays
- Delivered additional winter capacity in conjunction with partners
- Continued to deliver covid vaccination programmes and developed regional model for health protection services
- Activity levels increased across planned care but challenges persist with long waiting times
- Alignment of the @home and 6 Goals for emergency care programme around shared vision, principles and programme structure

Regional and Tertiary Services

- Business case for 14th month interim regional cataract solution finalised and currently seeking local HB approval via respective governance routes

- South Wales Spinal Network team established

Estates

- Construction has commenced for genomics, UHL engineering, UHL expansions and adult fracture clinic as part of the acute infrastructure programme
- Launch of the Maelfa Wellbeing Hub
- Business cases developed for the UHW lift refurbishment, mortuary refurbishment, tertiary tower, CAVOC theatres and Hybrid/vascular
- Business cases submitted for Wellbeing Hub Ely, Sexual Assault Referral Centre and CRI health and well-being hub
- Scope of Strategic Outline Case for UHW2 has been agreed with Welsh Government and delivery plan has been created

Quality and Workforce

- Clinical Safety Group established
- Agreed use of mortality indicators for all specialties
- Employee Wellbeing services have been maintained
- Gold and Platinum Corporate Health Standards have been maintained
- Sickness absence rates for March 2023 have returned to pre-covid 19 levels and turnover rates has been on a downward trend since April 2022

There were some milestones/performance ambitions that were not fully realised this year, and these are summarised below:

- Did not achieve part 1b performance ambitions for CAMHS (mental health measure)
- There continues to be long waiting times for access to neurodevelopmental services
- Over 104-day cancer standards waiting times position improved from >200 to 57 patients waiting at the end of March but did not meet the 0 patients waiting ambition set
- 52-week new outpatient and 104-week treatment waits are in excess of ministerial priorities.
- Progress against original digital plan limited by resource and funding availability- resource diverted to meet organisational priorities and operational needs (6 Goals)

Plans to improve these areas are built into the Annual Plan 2023/2024.

There are some milestones that were planned to be achieved by the end of the year but have rolled over to Q1 in the 2023/2024 plan.

These include:

- Launching Sanctuary service- crisis care in adults
- Fit for purpose ED, assessment and SDEC areas (part of acute site changes)
- Adult Fracture Clinic handover
- High risk adult cohort approach to be rolled out to clusters
- Development of vaccine equity strategy
- Agreement of regional oesophageal cancer service model (tertiary services)
- Implementation of Scan4Safety, PROMs, ePMA

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

Annex 1 provides the UHB's position regarding 22-23 plan delivery as at quarter four.

Annex 2 provides a summary of the UHB's baseline position i.e. what the original plan stated would be achieved.

In considering **annex 1**, the Board are asked to note the following:

I. **Triangulation with wider organisational intelligence**: Given that our plan is an integrated finance, workforce, operational and quality plan, this assurance report should not be considered in isolation of wider finance and operational performance reports which will give important context and the wider holistic picture of the issues which the organisation is facing.

It should therefore be recognised that this report represents a *'moment in time'* snapshot of plan delivery.

Refreshing the quarterly report for the 2023/2024 annual plan

The Strategy Development and Delivery Group (SDDG) plan to review the quarterly reporting format at their June meeting with the view to strengthening the process, particularly around ensuring the report clearly assesses delivery against the original plan for the quarter and highlighting variation to the original plan, challenges to achieving plan milestones and actions to recover and mitigate.

There will be a strong focus on progress against achieving the milestones as set out within the Ministerial Priorities 2023/2024.

Recommendation:

The Board is requested to:

a) NOTE the progress achieved in delivery of the 22-23 plan

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No

Financial: No

Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Report Title:	CAVUHB Anti-racist Action Plan			Agenda Item no.	7.1
Meeting:	Public Board Meeting	Public	X	Meeting Date:	25 May 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Equity & Inclusion Senior Manager				

Main Report
Background and current situation:

The Anti-racist Wales Action Plan was published in June 2022 outlining the vision to create and Anti-racist Wales by 2030. Included in the plan are specific actions for 'Health' which are set out under five headings:

- Goal 1: Leadership & Accountability
- Goal 2: Workforce
- Goal 3: Data
- Goal 4: Access to Services
- Goal 5: Tackling Health Inequalities

As an action, the UHB is required to develop an organisational anti-racist action plan. The CAVUHB Action Plan will align closely with the all Wales version and will set out how the UHB will go about building an anti-racist organisation.

In line with advice from experts in race equality, including Prof. Uzo Iwobi and Race Equality First, the UHB has co-designed a draft version of its action plan (Appendix 1) alongside colleagues from the One Voice Staff Network and trade union partners.

The draft CAVUHB Anti-racist Action Plan has been pulled together taking account of the actions set under the Anti-Racist Wales Action Plan, recommendations from reports including the Race Equality Taskforce led by Cardiff Council, and feedback from One Voice Staff Network members.

Discussions have been undertaken regarding feasibility and delivery of the plan with the identified action leads, who have all agreed and approved the content.

The Equity & Inclusion Senior Manager and Assistant Director of OD, Wellbeing and Culture presented CAVUHB's approach to the Welsh Government's steering group responsible for the delivery of health actions under the Anti-racist Wales Action Plan. The group were pleased with CAVUHB's proactive approach.

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

The plan has been presented to Local Partnership Forum and Senior Leadership Board and the People & Culture Committee will consider the recommendation for Board approval on 16th May 2023.

In the meantime, work has already begun to take forward some of the key actions with plans in place to progress others. Some of the key areas of focus over the coming months will be:

- Improving data collection
- Continuing to develop the Inclusion Ambassador programme
- Continuing to deliver anti-racist sessions for Board through Race Equality First
- Supporting the One Voice Staff Network
- Undertaking an organisational listening exercise to better understand the experiences of our colleagues from ethnic minority communities
- Developing a Health Equality, Equity, Safety and Experience Framework

The success of the action plan will be measured using the Workforce Race Equality Standards, currently being scoped by Welsh Government.

The progress of the plan will be monitored through the Equality Strategy and Welsh Language Standards Group (ESWLSG) where key stakeholders, including Clinical and Service Boards will report progress. The ESWLSG will then update the People & Culture Committee who will provide assurance to Board. Each Clinical and Service Board will be encouraged to develop their own local action plan to take forward the actions outlined in the CAVUHB Anti-racist Action Plan, as well as any priorities identified in their areas.

Recommendation:

The Board is requested to:

- **Approve** the contents of the report and the Cardiff and Vale UHB Anti-racist Action Plan.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	x	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	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	
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

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes

Safety: Yes
Risk to the safety of patients and staff who do not trust the organisation will treat them fairly.
Financial: Yes
Potentially through claims for discrimination.
Workforce: Yes
Attracting and retaining a diverse workforce
Legal: Yes
There is a legal requirement as part of the Public Sector Equality Duty under the Equality Act 2010, with race being a protected characteristic.
Reputational: Yes
CAVUHB viewed as an organisation that is not inclusive of our communities.
Socio Economic: Yes
Linked to demographics served / represented.
Equality and Health: Yes
Health inequalities and inequities within our communities are exacerbated.
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
People and Culture Committee	16 May 2023

Cardiff & Vale UHB Anti-racist Action Plan

Leadership & Accountability				
Action	Outputs	Impact	By when	Lead and partners
Establish a dedicated Race Equality Steering Group to have oversight over the Anti-racist Action Plan, creating accountability for implementation and delivery.	Steering group established with clear governance frameworks agreed; Monitor progress of action plan.	The Anti-racist Action Plan will maintain momentum and deliver on the actions set out in the plan. Clear governance structures in place to create organisational accounability for the plan.	0 - 6 months	**LEAD: CAV Anti-racist Action Plan Steering Group** People Assurance and Experience One Voice Staff Network Trade Union Partners ESWLSG
Design and implement anti-racist education programmes for Board members and senior leaders to improve understanding of anti-racism, including session delivery and pilot mentoring scheme. Board members to report progress against personal objectives (for all Board members), in line with requirements of ArWAP.	Anti-racist education programmes to be co-designed and co-delivered to Board members and senior leaders, including sessions as part of Board development; Pilot mentoring scheme to take place with nominations from Board members and the One Voice Staff Network, following the delivery of mentoring training; Feedback from the pilot to be used in shaping any future cohorts.	Senior leaders will be aware of what anti-racist behaviours look like within the leadership framework for Cardiff and Vale UHB. Visible change, where required, in decision-making, evidencing that anti-racism, equality, diversity, and inclusion have been considered and acted upon. Visible and transparent allyship and leadership provide confidence to the workforce and service users that racism is being proactively addressed.	6 - 12 months	**LEAD: Education, Culture and OD** Equity and Inclusion Team One Voice Staff Network Board Members Communication and Engagement
Inclusion Ambassadors for the protected characteristic of race to be recruited at Board level and in each of the Clinical and Service Boards.	Nominations from each of the Clinical and Service Boards and Board to be put forward; Development of a network for Inclusion Ambassadors for race; Platform created for shared learning to take place.	Increased awareness of the lived experience of colleagues from ethnic minority communities. Visible change, where required, in decision-making, evidencing that anti-racism, equality, diversity, and inclusion have been considered and acted upon. Visible and transparent allyship and leadership provide confidence to the workforce and service users that racism is being proactively addressed.	0 - 6 months	**LEAD: Equity and Inclusion Team** ESWLSG Board Members Clinical and Service Board
People & Culture (Workforce)				
Action	Outputs		By when	Lead and partners
Win hearts and minds throughout CAVUHB through raising awareness, capturing and sharing stories, and focussing on the 'why' we need to become an anti-racist UHB.	Organisation-wide listening exercise to take place to capture the lived experience of our workforce and share stories to highlight the 'why' and necessity of an anti-racist approach; Creation of a resource to support the work and capture the stories; Organisational Ted Talks and sharing personal stories events; Awareness dates throughout the year to be commemorated or celebrated, as appropraite.	Increased awareness of the lived experience of colleagues from ethnic minority communities. Greater understanding of what an anti-racist approach entails and the impact of racism. Organisational buy-in for taking forward the anti-racist approach.	0- 24 months	**LEAD: Equity and Inclusion Team** One Voice Staff Network Trade Union Partners Communication and Engagement Education, Culture and OD Patient Experience Inclusion Ambassadors Clinical and Service Boards
One Voice staff network to be appropriately developed and resourced in order to support the organisation in becoming anti-racist.	Scoping exercise to understand how One Voice can be resourced, which could include financial support and/or allocated time.	Effective and sustainable One Voice Staff Network. Support the organisaton through co-design and co-delivery of the the anti-racist approach.	6 - 12 months	**LEAD: Assisstant Director of Organisational Development**
Implement the recommended changes of the all Wales audit of policies, procedures and processes through an anti-racist lens.	Following the all Wales audit CAVUHB to commit to and implement the recommendations put forward by the all Wales group.	Independent assurance, workforce policies address systemic and instructional racism. Confidence in the workforce that anti-racist principles are threaded through policies and scrutinised. Colleagues from ethnic minority communities have increased confidence that they will work in a safe and inclusive workplace that recognises and promotes their performance and progression. This will also address ethnic diversity at all levels of the CAVUHB workforce.	12 - 24 months	**LEAD: People Assurance and Experience** People Services Trade Union Partners Clinical and Service Boards

CAVUHB anti-racism training sessions to be scoped, designed and implemented throughout organisation.	Scoping exercise as to how the organisation can deliver in person/virtual training on anti-racism with view to co-delivery with members of the One Voice staff network and/or external providers; Once suitable option agreed, training to be implemented throughout organisation; Training to include what is meant by a 'Zero tolerance' approach to racism.	Organisational awareness of anti-racism and what part colleagues can play in eliminating racism. Greater understanding of what an anti-racist approach entails and the impact of racism.	12 - 24 months	**LEADS: Education, Culture and OD** **Equity and Inclusion Team** One Voice Staff Network Clinical and Service Boards
Implement the NHS Wales anti-racist mandatory elearning module once designed and launched by HEIW.	Following the launch of the anti-racist mandatory learning module, CAVUHB to commit to promote and measure compliance alongside other statutory and mandatory training.	Organisational awareness of anti-racism and what part colleagues can play in eliminating racism. Greater understanding of what an anti-racist approach entails and the impact of racism.	12 - 24 months	**LEAD: Education, Culture and OD** Equity and Inclusion Team Clinical and Service Boards
Review recruitment and retention practices and processes ensuring they are as inclusive as possible and support staff from ethnic minority communities to stay, grow and develop with CAVUHB.	Analyse current recruitment and retention practices to ensure they are as inclusive as possible; Recruitment training to be implented to support recruiting managers.	Improved and robust HR policies, procedures and practices which are anti-racist and ethnic minority staff experience better outcomes in recruitment, progression and exit practises measured through the Workforce Race Equality Standards (WRES) and NHS Wales Staff Survey.	12 - 24 months	**LEADS: People Services** **People Assurance and Experience** People Resourcing NWSSP Education, Culture and OD Clinical and Service Boards
Representation at all levels and professions throughout the organisation to reflect the communities that we serve, including greater representation of ethnic minority staff in senior leadership roles.	Engage with our ethnic minority communities within Cardiff and the Vale to promote career opportunities with the organisation; Implementing a leadership and progression pipeline for ethnic minority staff, as per ArWAP.	A workforce that is more representative of the communities we serve at all levels of the organisation. Measured through the WRES.	12 - 24 months	**People Resourcing** One Voice Staff Network Clinical and Service Boards Chaplaincy People & Culture Communication and Engagement Equity and Inclusion Team Trade Union Partners Nursing Education Team Corporate Nursing Medical Resourcing and Systems
Clear communication plans to create transparency around the journey to an anti-racist CAVUHB to engage with and gain the confidence of our workforce in the steps we are taking.	Draft a communication and engagement plan for the action plan with regular organisational updates.	Confidence in the workforce that anti-racist principles are being taken forward by the organisation.	0 - 6 months	**LEAD: Communication and Engagement** Equity and Inclusion Team CAVUHB Anti-racist Steering Group
Third party organisations, including Race Equality First and Diverse Cymru, have been instrumental in improving organisational understanding of anti-racism. CAVUHB should continue to work with these organisations, using their expertise, to build an anti-racist CAVUHB for all its people.	Scope and agree future relationships with third party organisations who can support CAVUHB in becoming anti-racist; Establish a working relationship and/or contract, so Clinical and Service Boards throughout the organisation are able to have direct access to support.	Organisational awareness of anti-racism and what part colleagues can play in eliminating racism. Greater understanding of what an anti-racist approach entails and the impact of racism.	6 - 12 months	**LEAD: Equity and Inclusion Team** Race Equality First Diverse Cymru Clinical and Service Boards
Data				
Action			By when	Lead and partners
Raising awareness of the importance of capturing data whilst aiming to improve the data held in ESR in relation to ethnicity of staff, so we can better understand the composition of and representation within our workforce.	Promote and implement the Equality Data Campaign. Remove any barriers that may exist to the capture of data. Provide assurance for how the data is going to be used.	High quality workforce data, underpinned by a culture where staff can be safe, and confident to provide ethnicity data and speak up against racist discrimination and practice.	0 - 24 months	**LEAD: People Analytics** Equity and Inclusion Team Trade Union Partners Clinical & Service Boards
Capture and monitor equality data in relation to HR processess, such as grievances, disciplinaries and Freedom to Speak Up, eDatix Reports, so any themes and disproportionate impact on those from ethnic minority communities can be identied and addressed.	Development of appropriate processess or for capturing, reporting and monitoring of equality information.	High quality workforce data, underpinned by a culture where staff can be safe, and confident to provide ethnicity data and speak up against racist discrimination and practice.	6 - 12 months	**LEAD: People Services** Information Governance Corporate Governance Health & Safety Equity and Inclusion Team Trade Union Partners
Implement and report on the Workforce Race Equality Standards, once scoped and agreed by Welsh Government.	Once agreed, CAVUHB to commit and implement the Welsh WRES in line with Welsh government requirements; Scope any additional data not captured currently that will be required under the WRES; Raise organisational awareness of WRES.	High quality workforce data, underpinned by a culture where staff can be safe, and confident to provide ethnicity data and speak up against racist discrimination and practice.	12 - 24 months	**LEAD: Equity and Inclusion Team** People Services People Analytics Clinical and Service Boards

Improve the capture of data in relation to the ethnicity of our patients and service users held in our patient administration systems so we can better undertand any issues with access to our services and patient outcomes.	Scope how the organisation can capture the ethnicity data of our patients and service users; Support the implementation of a new patient administration system, if and when appropriate; Training for staff in relation to capturing the data and inputting into system.	Transparency and accountability levels raised increasing confidence by population, and providing the organisation with data they can be confident to act against.	12 - 24 months	**LEAD: Health Records** Patient Experience Clinical and Service Boards Digital and Health Intelligence Local Authorities
Tackling Health Inequalities				
Action			By when	Lead and partners
Establish a framework for Equality, Health Inequity, and Patient Experience in Cardiff and the Vale alligned to our *Shaping our Future Wellbeing* strategy and IMTP with the aim of tackling health inequalities within our communities, ensuring that *'a person's chance of leading a healthy life is the same wherever they live and whoever they are'.*	Establish a working group to scope a framework; Draft framework and gain approval; Implement framework.	The voices and lived experience of people and communities are effectively heard and their concerns acted upon, with improvements made to service delivery for those communities.	6 - 12 months	**LEAD: Public Health** Equity and Inclusion Team Corporate Nursing Strategy & Planning Clinical and Service Boards Patient Experience

Report Title:	**Regional Cataracts Expansion Business Case – Cardiff Implications**			Agenda Item no.	7.2.1
Meeting:	Board	Public	X	Meeting Date:	25.05.23
		Private			
Status *(please tick one only):*	Assurance		Approval x	Information	
Lead Executive:	Paul Bostock- Chief Operating Officer				
Report Author (Title):	Matt Temby- Interim Managing Director for Planned Care				

Main Report
Background and current situation:

Purpose

This report provides an assessment of the Cardiff specific implications of the Regional Cataracts Expansion Case.

This report is not intended as a summary of the case (there is a concise executive summary within the Business Case itself) or as a substitute to reading the case in full but rather compliments the case with additional information specific to Cardiff and Vale Health Board and the impact on our local population, to support decision making.

Development of the Case and Endorsement

The case has been developed through the Regional Ophthalmology Programme Board.

A working group with representation of Assistant Directors of Finance from each Health Board developed and signed off the financial case.

The case was endorsed by the Regional Delivery Board (Directors of Planning) on the 6th April and by the Regional Oversight Board (Chief Executives) on the 13th of April.

Regional cases require approval through each of the sovereign bodies, and as such, the case was scrutinised and supported by Cardiff and Vale Investment Group on the 18th April on the proviso that:

1. *There is confirmation from Cwm Taf Morgannwg (CTM) and Aneurin Bevan (AB) that they will cover the cost of their share of the capacity that has been allocated in the business case so that CAV isn't holding the financial risk*

Conclusion: A Memorandum of Understanding will be developed, which will outline provider/commissioner agreements and will provide confirmation from CTM and AB that they will cover the cost of their share of the capacity that has been allocated in the business case so that CAV isn't holding the financial. This will likely mean financial coverage of the infrastructure costs as opposed to payment on a case by case basis. This will be signed off by the Regional Oversight Board (CEOs) in May.

2. *Assurance is provided by the Clinical Board on confidence in delivering the productivity levels within the case*

Conclusion: The Clinical Board have provided supporting evidence and assurance that productivity levels are achievable.

Senior Leadership Board (SLB) supported Investment Groups recommendations and conditions of approval as above at their meeting on the 4th May.

Key principles

When reading the Regional Cataracts Expansion Case, it is critical to understand that:

- The case is stage 1 of a 2-stage process; it is an **interim case** for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 14 months whilst a more sustainable staffing and clinical model is developed alongside
- As such, CEOs have agreed that the preferred option for the interim case is one that is deliverable and quick to implement to achieve an impact on waiting lists and will not necessarily represent a value for money solution when benchmarked
- CEOs have agreed the principle that the capacity will be focussed on **treating the longest waiters first, regardless of their home health board**, and so a shared waiting list will be adopted for the region
- There is agreement across the region that the case and therefore activity delivered is dependent upon accessing the retained planned care recovery monies
- The total timeframe for the implementation for the activity planned in the business case is 14 months and this is largely due to the longer lead in times for other sites across the region. In Cardiff the activity will run for **12 months** from 1st July 2023 to 30th June 2024 as the Vanguard unit is already operational.

Regional Demand and Capacity

The region is presented with a sizable challenge for backlog, demand and capacity. Demand continues to outstrip capacity and is forecast to grow year on year.

Eliminating the waiting list backlog in 23/24 would require a capacity of 28,960 in one year, almost five times the projected combined core capacity. With no further intervention the projected waiting list of 19,000 in March 2023 would therefore be over 23,000 by March 2024.

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

Preferred Option

The preferred option in this business case is option 3b.

This is an insourcing and outsourcing option involving a two-hub model utilising Nevil Hall hospital in the North and the Vanguard Unit (UHW) in the South.

After 14 months the regional waiting list is reduced from 19,000 across the region to 14,168.

Commissioning Proposal

The costs of this proposal will be apportioned in line with actual activity undertaken within these schemes.

All three Health Boards provide a service that is predominantly for local residents and as such consideration of LTA baselines are not considered an issue in this instance.

The costs for planning purposes are estimated based on waiting list size, as follows

Health Board	**Wait %**	**2023/24 £'m**	**2024/25 £'m**	**Total £'m**
Aneurin Bevan	36	3.765	1.731	**5.496**
Cardiff and Vale	15	1.569	0.721	**2.290**
Cwm Taf Morgannwg	49	5.125	2.356	**7.481**
Total	**100**	**10.459**	**4.808**	**15.267**

Implementation

Detailed implementation planning is underway through the Regional Programme Board, with a number of workstreams established to ensure that plans are progressed at pace and operating models are finalised.

One of these groups will be a contracting group led by the Director of Finance in ABUHB; it is likely that NWSPP will develop a National Contract.

Regional Cataracts- Performance Management

There are several areas of the implementation of the Regional Cataracts Expansion that will require careful monitoring and management as the project progresses. They will be monitored weekly by sites and teams and reviewed monthly by the Programme Board. In the case of performance below expected levels, corrective action will be taken by sites and teams and escalated to Programme Board. The measures will be based on the following domains:

- Vanguard Site Efficiency and Effectiveness
- Nevil Hall Site Efficiency and Effectiveness
- Allocations
- Core activity
- Financial and Contract management

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

The implications for Cardiff and Vale UHB are summarised below:

Clinical and Service Model

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is was originally contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit has been extended until 30th June 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service.

The Vanguard Unit requires capital funding. 100% of the Vanguard capital will be funded through the regional business case but 62.5% of the capacity of for regional patients (12.5 sessions out of a possible 20 per week)

This split is based on the pre-covid sessions for cataracts for Cardiff and Value which are 7.5 sessions per week.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

Through this option The South Hub (Vanguard) would provide outpatient and inpatient provision for patients in the south of the region 7 days per week.

On weekdays the twin theatre unit will be staffed by Cardiff staff. These 20 sessions will be split, 7.5 for CAV and 12.5 for regional patients. On the weekends the provision in the vanguard unit will be staffed via an insourcing company.

Impact on Cardiff Waiting List position

The predicted planned waiting list position at the end of June 2024 will be 0 outpatients waiting over 78 weeks and 0 treatments waiting over 78 weeks. This is based on core capacity of 7.5 outpatients' sessions per week, 7.5 treatment sessions per week along with 15% of regional capacity, insourcing and outsourcing contracts being in place as per implementation plan.

Cardiff is predicted to achieve 78 weeks earlier than June. To maintain the 78 week position Cardiff would require capacity for 182 outpatients per month and 199 treatment per month (this includes 2nd eyes), maintaining this activity through Cardiff core capacity.

There is high confidence of delivering the core capacity within Cardiff, however at the time of writing this report no contracts have been awarded for insourcing and outsourcing and it is highly likely that the implementation dates for this additional capacity, outside of the weekday vanguard sessions, will be delayed.

The regional plan is based on stabilising waiting lists across the region working to one combined waiting list. It is therefore important to note that as the waiting list progresses, the percentages are likely to change over time, reflecting demand.

Financial

This proposal has a total revenue cost of £12.867m, split over two financial years. In addition, the costs of hiring the two mobile theatres will need to be capitalised in accordance with IFRS16. The capital cost is £2.4m.

The estimated financial commitment to Cardiff and Vale UHB is £2.290m, to include capital.

The revenue assessment includes an uplift of 5% in line with agreed pay award for 2023/24. There is no RPI commitment within the current mobile theatre contract.

The costs are summarised in the table below:-

	2023/24 £'m	**2024/25 £'m**	**Total £'m**
Revenue	8.859	4.008	12.867
Capital	1.600	0.800	2.400
Total	**10.249**	**4.808**	**15.267**

Cardiff and Vale will have lead responsibility for the mobile theatre lease and capital planning and financial arrangements on behalf of the South-East region.

Key Benefits for CAV

- 100% of the Vanguard capital will be funded through the regional business case but 62.5% for the capacity of for regional patients (12.5 sessions out of a possible 20 per week)

- It is likely that the outpatient waiting times will be lower than the predicted 78 weeks and whilst not achieving 52 weeks the volumes will be significantly lower

Key Risks for CAV

- Implementation of insourcing and outsourcing timescales are tight within the implementation plan
- Clarity required over roles and responsibilities of host organisation are required
- Single waiting list may impact on CAV patients waiting longer for treatment
- Sustainable solution for the region must be defined at pace in order to ensure implementation at the end of the 12 months (when Vanguard contract comes to an end)

Recommendation:

The Board is requested to:

a) **NOTE** the benefits and risks associated with the Regional Cataracts Expansion Business Case;
b) **NOTE** the implications specific to Cardiff and Vale University Health Board ; and
c) **APPROVE** the Regional Cataracts Expansion Case subject to sign off of formal Memorandum of Understanding between the 3 Health Boards which mitigates Cardiff and Vale financial risk (to be agreed through the Regional Oversight Board)

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Prevention		Long term		Integration	x	Collaboration	x	Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: **Yes**/No
Outlined in the body of the report

Safety: Yes/**No**

Financial: **Yes**/No
Risk and mitigation outlined in the body of the report

Workforce: **Yes**/No
There are additional workforce requirements as outlined within the case

Legal: Yes/**No**	
Reputational: Yes/**No**	
Socio Economic: **Yes**/No	
Case is predicated on treating the longest waiting first regardless of home health board.	
Equality and Health: **Ye**s/No	
Case is predicated on treating the longest waiting first regardless of home health board.	
Decarbonisation: Yes/**No**	
Approval/Scrutiny Route:	
Regional Delivery Board	6th April
Regional Oversight Board	13th April
CAV Investment Group	18th April
CAV Senior Leadership Board	4th May
Finance and Performance Committee	17 May 2023

Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg

University Health Boards

Business Case

Title	Regional Cataracts Expansion Business Case		
		Date Last Updated	05/04/2023
Accountable Executive	Chris Dawson Morris, Director of Planning (AB)	**Lead /Project Manager** **Clinical Lead**	Hannah Brayford, Programme Manager Dr Rhianon Reynolds, Dr Siene Ng, Dr Anjana Haridas
Clinical Service		Planned Care, Ophthalmology	

1. Executive Summary

This Business Case seeks to provide a 14 month solution for additional regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.

This additional capacity will provide a service for health board patients from Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards.

Aims

The aims of the regional solution outlined in this business case are

- to enact a collaborative regional approach to recovery
- to provide additional regional capacity for cataract outpatient and inpatient stages
- to demonstrate optimal utilisation of our assets and resources across the region
- to address current waiting list backlogs
- to reduce clinical risk on an equitable basis across the region

The Regional Ophthalmology Programme Board have also agreed a set of regional working principles on which the approach to expanding cataract capacity will be based.

- Treating the longest waiters first, regardless of their 'home' health board
- Using the outsourcing, insourcing, evenings and weekends capacity for less complex patients
- Adopting best practice guidance in all sites
- Adopting shared waiting list (PTL) management arrangements

Each health board is at a different starting point for their waiting list and this is reflected in the trajectories and projections. It is anticipated that as a result of this business case the following trajectories will be met:

- Aneurin Bevan: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cwm Taf Morgannwg: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cardiff and Vale: no patients waiting over 78 weeks for an outpatient appointment by the end of the funding period

Staged Delivery

The Regional Ophthalmology Programme Board have agreed the following staged approach to delivering sustainable cataracts solutions in the region, whilst balancing the need to activate capacity quickly and reduce the rate that the backlog is growing. This business case represents the first stage.

- Stage 1 – A Business Case for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 14 months.
- Stage 2 – Developing sustainable staffing and clinical models for the region. For cataracts and VR in University Hospital Wales (UHW), Cardiff, and cataracts and VR referral pathways across the region. To include new staffing models, new clinical models and costings, this model will be operational on the conclusion of stage 1.

Demand and Capacity

The region is presented with a sizable challenge for backlog, demand and capacity. Demand continues to outstrip capacity and is forecast to grow year on year.

- The total number of patients waiting for assessment and treatment for cataracts is forecast to reach over 19,000 by the end of March 2023.
- Demand across the region has returned to pre-pandemic levels and is forecast to be 9,960 per year for 23/24

- The projected combined core capacity across the region for 23/24 with no further intervention is 5,940 treatments and assessments per year, broken down as follows
    - Aneurin Bevan UHB – 2,400
    - Cardiff and Vale UHB – 1,440
    - Cwm Taf Morgannwg UHB – 2,100

Eliminating the waiting list backlog in 23/24 would require a capacity of 28,960 in one year, almost five times the projected combined core capacity. With no further intervention the projected waiting list of 19,000 in March 2023 would therefore be over 23,000 by March 2024.

Delivery Assumptions

Shared PTL

To support a regional approach, the three health boards have agreed to pool their patient treatment lists (PTL) and adopt shared waiting list management arrangements for the allocation of the additional regional capacity. This will be supported by a regional booking team who will also manage the shared patient waiting list ensuring that the patients who have been waiting the longest are treated first, regardless of their 'home' health board.

North and South Hubs

The geography of the region lends itself to distributing the capacity is across a North and South Hub model. This model that will keep service delivery closer to home and reduce patient travel as far as possible.

Insourcing and Outsourcing

The capacity across the region can be rapidly increased by utilising the local opportunities for insourcing and outsourcing. These arrangements make the best use of our assets across the region for short-term flexible arrangements that protect our core capacity.

Patient Second Offer and Travel

Patients will be offered the opportunity to travel to receive their assessment and treatment as part of the additional capacity arrangements where thy may be able to be treated sooner. At a maximum travel would be 40 miles and 55 minutes by private car under normal traffic conditions and most of the patient travel will be shorter. Patients unable or unwilling to travel will keep their place on the waiting list and receive treatment from their home health board. A recent survey of 140 patients across the region shows that 71% of patients would be willing to travel.

Allocation by Health Board

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

Options

To achieve the stated aims of the business case, the options need to:

- Be mobilised quickly
- Be deliverable with the resources available
- Protect the viability of the core capacity
- Keep patient travel to a minimum

The options are:

- **Option 1: Do nothing**
  - Core capacity 5,940 only

- **Option 2: Maximising the use of NHH and POWH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (3,558, for 1 NHS session and Evenings and Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 8,668 (plus 5,940 core is 14,608 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 3a: Vanguard and NHH**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 7700 (plus 6,120 core is 13,820 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 3b: Vanguard and Maximising NHH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)

  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 9,310 (plus 7,140 core is 16,450 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 4: Weekend Insourcing and Outsourcing only**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 5: Outsourcing activity to external provider (s)**
  - Outsourcing (5,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)

Options Summary

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH **	Option 4 Weekends	Option 5 Outsourcing
North Hub: NHH Weekdays NHS Staff		1610		1610		
North Hub: NHH Weekends Insourcing		1500	1500	1500	1500	
South Hub: Vanguard Weekdays NHS Staff			2700	2700		
South Hub: Vanguard Weekends Insourcing			1500	1500		
South Hub: POWH Evenings insourcing (+1 NHS session)		2058				
South Hub: POWH Weekends Insourcing		1500			1500	
Outsourcing		2000	2000	2000	2000	5000
Total Additional	0	8668	7700	9310	5000	5000
Plus Core	5940	5940	6120	7140	5940	5940
Total	**5940**	**14608**	**13,820**	**16450**	**10940**	**10940**

*Yellow – Provision on AB site, Blue – provision on CAV site, Green – provision on CTM site

**Option 3b is for 14 months

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m
Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*

***Costing for this option include 5% increase on all pay costs*

Waiting List Changes

The table below shows the impact of each of the options on the total size of the waiting list. The start position for each option is 19,000 patients waiting.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Waiting list project end	23,046	14,352	15,186	14,168	18,483	18,483
Waiting list change from 19,000 baseline	+4,046	-4,648	-3,814	-4,832	-517	-517

Options Appraisal

The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.
Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

Preferred Option
The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures

- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

Preferred Option Financials

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

Host Health Board	Delivery	Pre Go Live costs	2023/24 Patients	2023/24 Patients	2023/24 Total Estimated Costs	Cost per Patient	2024/25 Host Health Board	2024/25 Delivery	2024/25 Patients	2024/25 Patients	TOTAL ACTIVITY Patients	TOTAL COST Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW		**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS		**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

Report Title:	Development of Replacement Orthopaedic Theatres at UHL			Agenda Item no.	7.2.2
Meeting:	Cardiff & Vale University Health Board			Meeting Date:	25 May 2023
Status *(please tick one only):*	Assurance		Approval ✓	Information	
Lead Executive:	Abi Harris, Executive Director of Strategic Planning				
Report Author (Title):	Marie Davies, Deputy Director of Strategic Planning				

Main Report
Background and current situation:

The attached Outline Business Case (OBC) executive summary sets out the rationale for a proposed capital investment of £37.551m to enable the replacement of the existing theatres 5 and 6 within Cardiff and Vale Orthopaedic Centre (CAVOC) at the University Hospital of Llandough (UHL). The existing theatres 5 and 6 are no longer fit for purpose and cannot be utilised to deliver the clinical services required by the Health Board.

The SOC was previously approved by Welsh Government, with funding support to progress the OBC.

The scheme addresses:

- the replacement of 2 theatres (theatres 5 & 6 that were old reconditioned military field theatres) that have been subsequently decommissioned due to their failure to meet critical functional and environmental standards
- the essential improvement to two existing theatres already used by Orthopaedics within the main theatre complex to enable compliant laminar flow infrastructure to be installed in order to comply with the British Orthopaedic Association (BOA) report infection prevention and control improvement requirements.
- the main theatre complex will undergo internal reorganisation allowing for improved patient flow, infection control measures, and theatre efficiency. This addresses those points raised in both the GIRFT and BOA reviews.

This proposed replacement of un-useable theatre infrastructure and the upgrading of existing main theatre and recovery areas fits well with the UHB's long-term strategy for developing Llandough as our routine, low risk, elective facility for planned care and also aligns with and complements the national and regional orthopaedic network plans.

The modest revenue consequences of the scheme are directly associated with the change in the size of the footprint.

Governance
The business case has been approved by the Health Board's Capital Management Group in January and by the Investment Group in Febraury 2023.

The full OBC is available on request.

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

- This scheme represents an excellent opportunity to provide integrated theatre infrastructure which is functionally compliant, fit for purpose to deliver local and - if required - regional orthopaedics surgical services. It will enable the full range of appropriate orthopaedic surgery to be provided on a safe and sustainable basis and will bring the UHB's elective orthopaedics

infrastructure capacity back to previous levels providing the opportunity to restore the balance in local demand and capacity.

Recommendation:

The Board is asked to:-

1. **NOTE** the contents of the attached OBC;
2. **APPROVE** the submission of the OBC to Welsh Government with a recommendation for approval to progress to the next stage - Full Business Case.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/~~No~~

Risk Potential Assessment has been undertaken, which considered the project risk in relation to strategic alignment, finance/funding, stakeholder engagement, governance, project dependencies, and concluded that the overall risk is **medium**

A project risk register has also been completed.

Safety: Yes/~~No~~

The capital design incorporates statutory health and safety requirements

Financial: Yes/~~No~~

Capital funding for this project is anticipated to come from the All Wales Capital Programme. The FBC sets out the rationale and capital costs for the theatres. Cardiff and Vale UHB has a robust project management structure in place to manage the project.

The revenue business case to support the MTC activity has been approved by WHSSC. A revenue business case for vascular activity is in development by the network and has been approved by the appropriate SE Wales health boards.

Workforce: Yes/~~No~~

The revenue business case was included in the vascular network business case and the MTC business case and will be subject to BCAG Approval prior to Board submission

Legal: ~~Yes~~/No
Reputational: ~~Yes~~/No
Socio Economic: Yes/~~No~~
Socio-economic assessment undertaken as part of the EHIA
Equality and Health: Yes/~~No~~
A completed EHIA is appended to the main FBC document.
Decarbonisation: Yes/~~No~~
The capital design incorporates required decarbonisation measures

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Project Team	15th September 2022
Capital Management Group	January 2023
Investment Group	February 2023
Senior Leadership Board	February 2023
Finance and Performance Committee	May 2023
CAV Board	May 2023
Submission to Welsh Government for scrutiny and approval	May 2023

University Hospital Llandough - Theatre Development

Outline Business Case Executive Summary (Document 1)

February 2023 – Final v9

Document Information

Status	Final
Date	8th February 2023
Authors	Adcuris/CVUHB
Circulation	CVUHB Project Team

Version	Date Issued	Summary of Change	Document Owner
Draft v1	10th July 2020	First Draft OBC based upon SOC	Geoff Walsh
Draft v2	19th January 2022	Review of strategic and economic cases	Geoff Walsh
Draft v3	24th January 2022	Strategic case reviewed by clinical team and finance	Geoff Walsh
Draft v4	7th December 2022	Finance section completed for CMG review	Geoff Walsh
Draft v5	16th December 2022	Strategic Case updated and revenue added	Geoff Walsh
Draft v6	19th December 2022	Revenue wording changed	Geoff Walsh
Draft v7	13th January 2023	Updated following CMG comments	Geoff Walsh
Final draft v8	24th January 2023	Capital charges added	Geoff Walsh
Final v9	8th February 2023	Capital charges updated	Geoff Walsh

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1.7 Recommendation 14

Executive Summary

1.0 EXECUTIVE SUMMARY

1.1 Overview and Introduction

This Outline Business Case (OBC) seeks the approval for a capital investment of £37.551m to enable the replacement of the existing theatres 5 and 6 within Cardiff and Vale Orthopaedic Centre (CAVOC) at the University Hospital of Llandough (UHL). The existing theatres 5 and 6 are no longer fit for purpose and cannot be utilised to deliver the clinical services required by the Health Board. It has therefore been deemed that the only solution is a replacement to ensure the continuation of these services by the Health Board.

1.1.1 Progress since the Strategic Outline Case

Since the submission of the SOC the scope of the project has changed and a decant ward is no longer included.

Also since the submission of the SOC the COVID pandemic has taken place. During the development of the preferred solution consideration has been given to the impact of this pandemic on healthcare services and where possible the design has been developed to facilitate the delivery of surgical services at UHL during a future pandemic scenario as well as offer potential capacity aligned with the emerging regional orthopaedic solution.

British Orthopaedic Association (BOA) also carried out an Elective Care Review (May 2021) of the orthopaedic services at UHL and made a range of important recommendations impacting the design solution in this business case.

1.2 Strategic Case

1.2.1 The Strategic Context

The strategic drivers for this investment and plans include:

- National Strategies
  - National Clinical Strategy for Orthopaedic Surgery (NCSOS) (2022)
  - Getting it Right First Time (GIRFT) Orthopaedic Review (2022)
  - British Orthopaedic Association (BOA) Elective Care Review (May 2021)
  - Anaesthesia and Perioperative Medicine - GIRFT Programme National Specialty Report (September 2021)
  - NHS Wales Planning Framework (2022 – 2025)
  - Future Wales – The National Plan (2021)
  - NHS Wales Decarbonisation Strategic Delivery Plan (2021)
  - A More Equal Wales - The Socio-economic Duty (2021)
  - A Healthier Wales: Our Plan for Health and Social Care (2018)
  - Prudent Healthcare (2016)
  - Health and Care Standards (April 2015)
  - Digital First (2015)
  - Well-being of Future Generations (Wales) Act (2015)

- Regional Strategies
  - The South East Regional Orthopaedic Programme
- Local Strategies
  - Shaping Our Future Wellbeing Strategy 2015 - 2025
  - Shaping Our Future Wellbeing - Future Hospitals Programme Business Case (2021)
  - Shaping Our Future Clinical Services Plan 2019 - 2029
  - 2023 – 2026 Integrated Medium Term Plan
  - Cardiff and Vale People and Culture Plan 2023 - 2026
  - Cardiff and Vale UHB Delivering Digital (2020)
  - Cardiff and Vale UHB Estates Strategy

1.2.2 The Case for Change

The Cardiff and Vale Orthopaedic Centre (CAVOC) has 4 laminar flow theatres and additional access to 1 non-laminar and 1 laminar flow theatre of the 4 existing theatres in "main theatres". The CAV Orthopaedics service are therefore currently utilising 6 theatres on the UHL site - of which 5 have laminar flow and 1 does not.

The CAVOC theatre complex has recently been reviewed by the British Orthopaedic Association (BOA) (2021) and the GIRFT Wales wide initiative (2022). Concerns were raised regarding the increased infection risks associated with major joint arthroplasty performed in these theatres. The reports identified significant cross-infection risks with the patient pathways within the CAVOC and UHL main theatres footprint. As such, the number of laminar flow theatres suitable for major joint arthroplasty is further diminished, compounding those problems encountered from the loss of theatres 5 and 6.

The proposed development will replace CAVOC 5 & 6, restoring the UHL overall orthopaedic theatre capacity to that in 2019 when they were decommissioned i.e. 8 theatres. The replacement theatres will be large, laminar flow theatres, capable of accommodating revision arthroplasty surgeries in line with those recommendations made by the BOA (2021).

Furthermore, the two existing theatres already used by Orthopaedics within the main theatre complex will be have compliant laminar flow infrastructure installed to comply with the BOA report infection prevention and control improvement requirements.

Finally, the main theatre complex will undergo internal reorganisation allowing for improved patient flow, infection control measures, and theatre efficiency. This addresses those points raised in both the GIRFT and BOA reviews.

This scheme is essential to address the local and regional backlog of elective orthopaedic cases as described in the NCSOS report (2022). It is essential to note that this development should be viewed as supplementary to the emerging plan for a regional orthopaedic elective centre in line with the regional orthopaedic programme.

Further theatre reorganisation in the current CAVOC and Day Case theatres will permit improved access to day case theatre capacity and flexible theatre solutions for other surgical specialities. This will maximise theatre utility across the elective surgical specialties in UHL.

1.2.2.1 Potential Scope

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

Minimum	Intermediate	Maximum
A theatre unit that meets minimum statutory requirements with regard to environmental standards	A theatre unit that meets statutory requirements with regard to environmental standards	A theatre unit that meets statutory requirements with regard to environmental standards, best practice models and addresses service model, known capacity issues and clinical flows
Sized to meet current demand	Sized to meet current demand and future demand	Sized to meet current, projected future and potential future demand (following outcome of regional reviews)

Executive Summary Table 1: Potential Scope

This project will take forward the intermediate scope which is to provide fit for purpose theatres which will deliver the current and future demand. The maximum scope has been excluded at this stage as the outcomes of the various workstreams will not be delivered within an acceptable timescale as there is some urgency around addressing the issues within the current theatres at UHL.

1.3 Economic Case

1.3.1 The Long List

Within the potential scope, the following options were considered using the options framework:

Option	Finding
1.0 Scope	
1.1 Do Nothing	Discounted (carried forward for comparative purposes)
1.2 Do Minimum	Discounted
1.3 Refurbish	Possible
1.4 Re-provide	Preferred

2.0 Service Solutions	
2.1: New build at front of CAVOC	Possible
2.2: Two new builds either side of CAVOC	Discounted
2.3: New build at rear of CAVOC	Possible
2.4: Provide new build adjacent to the existing main theatres at UHL	Preferred
2.5: Departmental new build	Discounted
3.0 Service Delivery	
3.1 In House	Preferred
3.2 Partial Outsource	Discounted
3.3 Strategic Partnership	Discounted
4.0 Implementation	
4.1 Big Bang	Discounted
4.2 Phased	Preferred
5.0 Funding	
Only public funding has been considered as it has been agreed with Welsh Government that this project will be supported.	

Executive Summary Table 2: Summary of Long Listing

The main benefits are:

- To provide safe and appropriate environments of care for patients and improving the patient experience and for staff to work within
- Compliance with statutory standards and NHS guidance/best practice
- Improved environments to enable productivity gains
- Removal of various short life expectancy and inefficient plant and realised revenue benefits of new efficient M&E plant
- Improved waiting times

1.3.2 The Short List

In summary the short-listed options are:

- Option 0 – do nothing
- Option 1 – do minimum - replace the theatre plant and ducts and refurbish the existing theatres without altering the layout
- Option 2 – supply and install two modular laminar flow theatres adjacent to CAVOC with direct access utilising existing recovery and trolley bay area
- Option 3 – a modular building to provide staff changing facilities and provide two additional theatres within the existing footprint along with a reconfiguration of the department to improve flows and provide the appropriate recovery spaces
- Option 4 – a new build option to provide two laminar flow theatres, recovery and support accommodation adjacent to the existing main theatres

1.3.3 Qualitative Benefits Appraisal Key Findings

A workshop event was held at University Hospital of Wales on the 3rd July 2017 to evaluate the qualitative benefits associated with each of the shortlisted options. The workshop was attended by project team members, service leads and clinical representatives.

Key considerations that influenced the scores achieved by the various options were as follows:

- Option 0 – do nothing, this option ranks 5th (last) of particular concern is the fact that is doesn't provide a safe environment and will continue to limit the available theatre capacity as theatres 5 and 6 are not fit for purpose;
- Option 1 – this option ranks 4th, whilst it resolves the immediate environmental concerns it does not provide a good medium/long term solution. Also, clinical staff have lost confidence in theatres 5 and 6 which were designed to last 7 years and have been in service some 20 years;
- Options 2 ranked 3rd. The main concern being the difficulty of breaking through to the existing department;
- Option 3 – this option ranks 2nd as it provides the appropriate departmental adjacencies and flows, it also provides the opportunity to reconfigure the waiting area and discharge lounge to improve flows and patient privacy;
- Option 4 – this option ranks 1st and is the preferred option as it provides two replacement laminar flow theatres in a location to create a six theatre main theatre suite at UHL to provide maximum flexibility and efficiency of service.

Option 4 is, therefore, the preferred option from a non-financial point of view.

1.3.4 Economic Appraisal Key Findings

The economic costs for the scheme are as follows:

Capital Costs at PUBSEC 250	Option 0 £000	Option 1 £000	Option 2 £000	Option 3 £000	Option 4 £000
Works Costs	1196	2,646	16,713	16,134	20,433
Fees	199	441	2.916	2,814	3,682
Non-Works	215	302	1,315	1,066	2,036
Equipment Costs	698	800	2,200	2,460	2,200
Planning Contingency	231	419	2,314	2,247	3,620
Optimism Bias	0	0	3,847	4,259	6269
Subtotal excluding VAT	**2,539**	**4608**	**29,306**	**33,930**	**38,240**
VAT @ 20% less reclaimable	444	781	5,082	4,949	6,676
OBC Total Capital Cost	**2,983**	**5389**	**34,388**	**33,930**	**44,916**

Executive Summary Table 3: Economic Costs

On the basis of the economic appraisal undertaken:

- Option 0 (business as usual) is included for illustrative purposes only since it is not capable of delivering the required outputs

- Since at this stage the appraisal only incorporates capital and lifecycle costs with little impact on revenue costs, the economic impact is largely a reflection of those cost inputs and Option 1 is the clearly preferred development option
- Options 2, 3 and 4 which reflect the capital investment are ranked in order therefore of capital investment largely based on the initial capital outlay

1.3.5 Preferred option – Conclusion

The preferred way forward is confirmed as Option 4, due to its capability of meeting the spending objectives and critical success factors of the project.

The works included within the preferred option are:

- Demolition of existing medical records & theatres 5 & 6 buildings to make way for a new 3 storey building housing at first floor level; two orthopaedic operating theatres with supporting accommodation, staff support & patient reception
- The building will connect to the existing day & orthopaedic theatres block, with first floor level refurbished as part of Phase 2 works, with two main theatres suites upgraded to provide compliant laminar flow functionality, the existing recovery ward capacity extended along with decant of the staff accommodation to make way for centralised storage space
- Enclosed plant space will be accommodated at second floor level
- The building will be constructed with open space at ground floor level for future fit out

1.4 Commercial Case

1.4.1 Procurement Strategy

The preferred procurement route is to use the NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) established NHS 'Building for Wales' Framework. The Supply Chain Partner (SCP) Wilmott Dixon has been appointed under the framework to develop both the design and construction of the proposed facility.

The procurement strategy is in line with the procedures and practices as laid down in the NHS Building for Wales framework.

1.4.2 Required Services

The required services are for the demolition of the existing German theatres block adjacent to main theatres at UHL, the delivery of two WHBN/WHTM compliant laminar flow theatres within the space along with additional recovery and support spaces.

1.4.3 Potential for Risk Transfer and Potential Payment Mechanisms

The general principle is to ensure that risks should be passed to "the party best able to manage them", subject to value for money (VFM). The ongoing future management of risks during the life of the scheme, will generally follow the process described in the Management Case: Arrangements for Risk Management.

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

- Charging will be completed under the 'Building for Wales' Framework terms and conditions
- The contract will be managed by Cardiff and Vale University Health Board under the NEC3 Option C Target Cost Contract

1.5 Financial Case

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

Capital Costs	£000
Building/Engineering	34,912
Equipment Costs	2,640
OBC Total Capital Cost	**37,552**

Executive Summary Table 4

	£'000
Impairment	24,159
Depreciation - Building/Engineering	225
Depreciation – Equipment	528
Accelerated Depreciation	1,951
Total Capital Charges/Depreciation	**26,863**

Executive Summary Table 5: Summary of Capital Charges and Depreciation

Impairment is calculated based on advice from the District Valuer. The asset value post impairment has been depreciated over the estimated useful economic life provided by the District Valuer.

The following is a summary of the total impact of impairment and depreciation by year until the planned opening of the facilities:

	2028/29 £'000	2029/30 £'000
DEL Impairment	0	0
AME Impairment	24,159	0
Total Impairment	**24,159**	**0**
Depreciation – Build	169	225
Depreciation - Equipment	396	528
Total Depreciation	**565**	**753**

Executive Summary Table 6: Summary of Total Impact of Impairment / Depreciation Year on Year

This OBC assumes all capital charges and depreciation will be funded by Welsh Government in each of the years provided in the table above.

1.5.1 Overall Affordability and Balance Sheet Treatment

It is assumed the impairment and recurrent charges for depreciation will be funded by Welsh Government.

There is no net additional direct service-related revenue costs as the proposals set out in this OBC relate to the re-provision of existing surgical capacity, with no additional service revenue required.

However, there is an additional annual cost of £284,000 for equipment servicing/ maintenance - this is an estimate based upon 10% of the planned new equipment spend, which is typical of such cost.

There is a net additional revenue costs of £108,000 relating to Facilities Management.

Facilities Cost	Additional Annual £000s	Total Annual £000s
Business Rates	6	14
Energy	73	163
Estates Maintenance	8	18
Domestic Services	18	41
Security	1	1
Waste	2	2
Total	**108**	**239**

Executive Summary Table 7: Revenue Costs

The total additional revenue impact of commissioning these theatres will therefore be £392,000.

The cost of meeting the additional direct revenue costs can be met in a number of ways:

- The Health Board can include this cost within its planned care plan for increasing its surgical capacity in line with the ministerial requirement to reduce our local backlog
- The Health Board can include this cost within wider regional plans to increase the planned surgical capacity to meet the regional demand for additional capacity to reduce the regional backlog

Work is continuing to ensure that fully costed and affordable revenue plans will underpin the operationalisation of this capacity.

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

1.6 Management Case

1.6.1 Project 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.

For the Health Board to successfully deliver this project, it is vital that the following overall approach is taken for the organisation and management of the project:

- The Health Board will adopt the general principles of PRINCE 2 methodology in managing the activities and outputs of the project and will meet the requirements of the WHC (2015): 012; Infrastructure Investment Guidance; and subsequent guidance which may be issued during the projects' lifespan
- The project will use NHS Wales standard documentation and products where these are available, and will seek to benefit from experience and best practice from other NHS Wales projects
- Specialist professional and technical advisers will be employed for those activities where the necessary skills and experience are not otherwise available to the project team. The transfer of skills and knowledge from specialist advisers to the project team will be achieved wherever possible and appropriate

The project structure has been well-defined and includes the following identified key roles:

- Investment Decision Maker
- Senior Responsible Owner
- Project Director
- Project Board
- Project Team
- Other Roles:
  - Capital Planning
  - Finance
  - Strategic Clinical Engagement
  - Workforce
  - IM&T

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

Milestone Activity	Date
FBC submission to WG	May 2024
Commence construction	June 2024
Construction completion	April 2028
Facility operational	May 2028

Executive Summary Table 8: Key Project Milestones

1.6.2 Benefits Realisation and Risk Management

A benefits realisation plan has been developed that outlines the key objectives, benefits and measures, which will be used to evaluate the project, it also shows who has the accountability for its realisation. The plan will ensure that the project is designed and managed in the right way to deliver quality and value benefits to patients, staff and the local community. The risk management strategy has been integrated into the project management procedures, with responsibility for implementation of the strategy resting with the Project Director. The key risks of the preferred option have been assessed and strategies for managing them outlined. An initial risk register has been developed for the preferred option which includes all risks identified to date.

1.6.2.1 Gateway Review Arrangements

Gateway Reviews undertaken across the health service have identified a range of common deficiencies within projects. The impact of the project has been scored against the risk potential assessment (RPA) and a RPA stage 1 form has been completed.

1.6.3 Post Project Evaluation Arrangements

The Health Board is committed to ensuring that positive lessons are learned through full and effective evaluation of key stages of the project. This learning will be of benefit to the Health Board in undertaking future projects, and potentially to other stakeholders and the wider NHS. The Health Board has therefore identified a robust plan for undertaking PPE in line with current guidance, which is fully embedded in the project management arrangements of the project.

1.7 Recommendation

This scheme represents an excellent opportunity to provide integrated theatre infrastructure which is functionally compliant, fit for purpose to deliver local and - if required - regional orthopaedics surgical services. It will enable the full range of appropriate orthopaedic surgery to be provided on a safe and sustainable basis and will bring the UHB's elective orthopaedics infrastructure capacity back to previous levels providing the opportunity to restore the balance in local demand and capacity. Without this scheme, the waiting list back log will continue to grow.

It is therefore recommended that subject to Welsh Government approval, the Cardiff and Vale University Health Board approve this Outline Business Case to enable full contracts with the Supply Chain Partner to be entered and further development of this project to progress to Full Business Case stage.

Report Title:	New Velindre Cancer Centre (nVCC) Full Business Case (FBC)			Agenda Item no.	7.3
Meeting:	Board	Public	X	Meeting Date:	25th May 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of Strategic Planning and Commissioning				
Report Author (Title):	Deputy Director of Commissioning				

Main Report
Background and current situation:

Purpose of this report

This paper aims to present the Velindre University NHS Trust's (VUNHST) response to the letter from the Chair of Cardiff and Vale University Health Board (CAVUHB) following the Board's consideration of the Full Business Case (FBC) for the new Velindre Cancer Centre (nVCC). VUNHST have requested that CAVUHB reconsider the FBC and look to a more definitive approval. This paper does not repeat all of the information previously presented to the Board in the Full Business Case considered at the March 2023 Board meeting.

Background

The Welsh Government's health and cancer policy aims to improve the quality of cancer treatment and care to further improve the experience of care and patient outcomes.

To recap, the drivers for the development of a new cancer centre are stated as:

- Continuing growth in the incidence of cancer and the demand for cancer services across Wales; with incidences expected to grow at approximately 2% per annum.
- The role of Velindre Cancer Services and Velindre Cancer Centre in the South-East Wales region as being the sole provider of highly specialist non-surgical tertiary oncology for the resident population. (See comments below regarding the wider Transforming Cancer in SE Wales Programme.)
- The need to keep pace with the advances in treatments and technology which support the provision of cancer care that achieves the required clinical standards.

The limitations of the existing VCC fabric and functionality are stated as:

- The existing Velindre Cancer Centre has insufficient space and if built on a 'like for like' basis, and in line with Health Building Notes (HBN's), it would have a footprint of circa 28,000m2 compared to the existing building footprint of 17,777m2;

ii. The existing Velindre Cancer Centre (VCC) has no expansion space. For example, the Trust could not install any additional linear accelerators, which limits the Trust's ability to expand its radiotherapy capacity in response to increasing demand for its clinical services.

iii. A high proportion of accommodation at the existing VCC is non-compliant with statutory requirements and creates challenges in maintaining high levels of patient safety and confidentiality.

iv. The existing patient environment at the VCC is sub-optimal in promoting patient dignity, experience and well-being.

v. The existing VCC has limitations in its ability to provide the most up to date treatments for patients to support improved outcomes and quality of life.

vi. There is insufficient car parking at the existing VCC

In 2015, VUNHST established the Transforming Cancer Services (TCS) in South East Wales Programme. The programme's objectives are to:

- Provide patients and carers with quality services that deliver optimal outcomes
- Deliver sustainable cancer services to the population in the most effective way
- Be a leader in education, research, development and innovation
- Comply with relevant standards

The TCS programme was intended to be a collaborative between all Health Boards in the SE region to drive forward better outcomes for patients with cancer. The business case to secure the funding to replace the Velindre Cancer Centre has been in development for a number of years, and this forms one part of the developments required to deliver the TSC objectives for cancer services in SE Wales.

In October 2018, the Health Board, along with other health boards in the region, approved the Outline Business Case for the new Velindre Cancer Centre. Discussions that followed as part of the next stage of the work raised issues regarding some aspects of the clinical model proposed and the Nuffield Trust was commissioned by VUNHST on behalf of the region to provide an independent view on the clinical model proposed for the new VCC and the regional configuration of cancer services. All of the recommendations were supported by members of the SE Wales Cancer Collaborative.

CAVUHB is working closely with Velindre and other regional partners to drive the Transforming Cancer Services programme forward and to ensure the Nuffield Trust report recommendations are implemented, through the South East Wales Cancer Collaborative and a formal partnership with Velindre. This includes the safe management of patients at higher clinical risk and who require complex specialist acute cancer care. There is also the requirement for patients with cancer to access

complex, high risk treatment, early phase and advanced therapy research, all of which need to take place on an acute hospital site. Of note, a CAVUHB capital business case is in progress to develop the BMT and Haematology services. This provides an opportunity to develop the infrastructure required to accommodate this.

VUNHST commissioned advice from the Nuffield Trust on the proposed model for non-surgical tertiary oncology services. The Nuffield Report stated that stand alone cancer centres are no longer the preferred model and most new cancer centres are co-located with acute hospitals. However, given the condition of the Velindre estate and the timescales for the new UHW, the nVCC proposal represented the most appropriate solution at the time of the report in December 2020.

In September 2022, the Health Board gave its support to two capital and revenue investment full business cases related to oncology services which formed part of the TCS programme:

- Integrated Radiotherapy Solution to replace the existing 8 linear accelerators
- Radiotherapy satellite centre at Neville Hall Hospital in Abergavenny to provide additional capacity to meet future needs

Both of these cases are with Welsh Government for the Minister to decide on. Additionally, enabling works for the new Velindre Cancer Centre have begun, supported by a £28m investment by Welsh Government.

Current Situation

The Full Business Case was considered by CAVUHB at its public and private Board sessions in March 2023. The cover paper for the public session is included as Appendix A (which can be located in the Supporting Documents Folder). Following challenge and scrutiny of the FBC and supporting information, the Board supported the revenue case, but noted that the additional revenue costs required of CAVUHB are unaffordable in the context of the Health Board's current and forecast financial position over the next five years. There was also concern that the business case did not adequately reflect the wider elements of the TCS programme and Nuffield Report recommendations that must all be delivered in order to achieve improved patient outcomes and experience, and services that are sustainable into the future. The full letter to VUNHST from the Chair of CAVUHB is included as Appendix B (which can be located in the Supporting Documents Folder). CAVUHB committed to work with VUNHST to resolve the following issues:

i. Confidence that Welsh Government's appraisal of the capital case fully tests overall value for money in the context of the current financial situation recognising that the Commercial Case is for consideration and approval of WG.

ii. Agreement that all partners are committed to fully implementing all of the recommendations in the Nuffield Trust Report, and the recently published National Cancer Plan, to ensure that the improvements in cancer care along the patient pathway and in particular, the high-level acute needs of South East Wales population, are realised and recognition that there are financial requirements beyond the nVCC in order to be able to achieve this.

iii. Progression of agreement for shared use of the facilities and delivery of CAVUHB services at nVCC to further research and innovation and improve patient pathways, considering ways of working, outcome monitoring and shared space and including the delivery of services such as outpatient appointments and day cases.

iv. Confirmation of the alternative funding sources for the cost of carbon net zero and the digital transformation.

v. Clarification on the rationale for the inclusion of the contract management costs in the revenue case, rather than as an offset for the Annual Service Payment as part of the capital case.

vi. Assurance from Welsh Government that Health and Social Services capital will be prioritised to cover the equipment costs.

A summary of the responses received from VUNHST to the Health Board addressing the issues above is set out below.

Further details on the case presented at the March Board are included in the appendices to this paper which can all be found in the Supporting Documents Folder; the cover paper for that session (Appendix A), VUNHST's cover paper for the FBC (Appendix D) the nVCC FBC Strategic Case (Appendix E) and the nVCC FBC Management Case (Appendix F).

As a result of the review of costs, and where responsibilities for some of the costs sit, commissioners are now being asked to approve funding at OBC levels plus inflation. The LHB total requirement is £4.08m compared to the FBC additional funding requirement of £5.155m; a reduction of £1.075m. This brings the financial revenue ask of health boards back to the approved OBC level, plus adjustment for inflation.

The recurrent revenue investment sought from CVUHB is **£1.261m** recurrent revenue; a reduction of **£0.332m** from the FBC considered by the CVUHB Board in March 2023.This is set out in table 1 below:

Table 1 - Revised Recurrent Revenue

	October 2018 As Approved by CAVUHB	Inflated to November 2022	Additional Funding	Original FBC Request	Revised Funding Ask post Funding Assumptions change
Recurring Revenue	£0.827m	£1.261m	£0.434m	£1.593m	£1.261m

The non-recurrent revenue investment sought from CVUHB is **£0.745m** has not changed from the originally presented case and is shown in table 2 overleaf:

Table 2 - Non-Recurrent Revenue

	October 2018 As Approved by CAVUHB	Inflated to November 2022	Additional Funding	Original FBC Request	Funding Ask
Non - Recurring Revenue	£0.445m	£0.745m	£0.299m	£0.745m	£0.745m

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

Responses to the issues raised in the letter from the Chair of CAVUHB to VUNHST are shown in table 3 below:

Table 3 – VUNHST Responses to CAVUHB Issues

i	Confidence that Welsh Government's appraisal of the capital case fully tests overall value for money in the context of the current financial situation recognising that the Commercial Case is for consideration and approval of WG. VUNHST can confirm that the nVCC FBC will be subject to scrutiny by Welsh Government utilising the normal business case assurance processes, this includes the involvement of the Infrastructure Investment Board (IIB) and ministerial signoff. Additionally, there will be input / signoff from treasury officers through the Welsh Government Health Strategy Board (HSB); a specific function set up by the Welsh Government to oversee the nVCC project. The FBC has determined the preferred option by using Better Business Case guidance, this includes the development of a Comprehensive Investment Appraisal (CIA), formerly the GEM, and an economic evaluation which takes into account the costs, benefits, and risks associated with all options. Additional assurance will also be provided by the following: • Gateway Review, Gate 3 Investment Decision • Commercial Approval Point (CAP) – MiM Policy • Comparison to the Public Sector Comparator ***CAVUHB Comment:*** *The information provided by VUNHST around the WG scrutiny of the case provides sufficient assurance against this point.*
ii	Agreement that all partners are committed to fully implementing all of the recommendations in the Nuffield Trust Report, and the recently published National Cancer Plan, to ensure that the improvements in cancer care along the patient pathway and in particular, the high-level acute needs of South East Wales population, are realised and recognition that there are financial requirements beyond the nVCC in order to be able to achieve this. There are a number of recommendations specific to CAVUHB and VUNHST which have progressed, these are: ***Recommendation 3/4:*** unwell patient: unscheduled care pathways have been revised and admission criteria reviewed to ensure safe and effective management of patients. This is supported by the provision of an Acute Oncology Services which is currently being

implemented across the region following business case approval (see also complex specialist oncology described below).

Recommendation 8: Cardiff Research Hub: a strategic partnership between CAVUHB, Cardiff University and Velindre University NHS Trust. The development of the Cardiff Cancer Research Hub (CCRH) which brings together research activity across CAVUHB, Cardiff University and VUNHST, already describes an approved Clinical Output Specification for research requirements. Recent productive conversations between CAVUHB and VUNHST have focused on describing the clinical operating model to meet both the CCRH criteria, as well as the emerging wider service requirement for patients requiring Complex Specialist Oncology Care.

The Nuffield Trust advice also makes reference to 'bring the models for haemato-oncology and solid tumour work' together. There is a clear recommendation to develop an oncology footprint at UHW (page 28 of Nuffield advice) to include complex early phase trials, working with the haemato-oncology specialists to deliver advanced therapies including CAR-T, and caring for those with severe treatment related complications e.g. immuno-oncology toxicity. This is a specialist activity, most clearly defined as Complex Specialist Oncology and will support the complex care of patients from across SE Wales. It is an extension of the acute oncology service which is delivered in all health boards.

The CAVUHB Bone Marrow Transplant Business Case is critical in providing the opportunity to deliver the capital development required to implement the recommendations from the Nuffield report and VUNHST is committed to support the work to finalise the clinical model for the BMT specification and support its case. Further work is also required to ensure a sustainable workforce for the effective implementation of these services.

Recent productive conversations between CAVUHB and VUNHST have focused on describing the clinical model to meet both the CCRH criteria, as well as the emerging wider service requirement for this Complex Specialist Oncology need.

Work has commenced between VUNHST and CAVUHB to develop the requirements for the complex specialist oncology function and include these in the Bone Marrow Transplant Business Case submitted to the Welsh Government in July/August 2023.

CAVUHB Comment:

This provides helpful information as the delivery of the Nuffield recommendations can be facilitated within the BMT capital business case. However, this does not cover the revenue case which falls under WHSSC's commissioning remit for the BMT and CAR-T clinical services or the other aspect of this proposal (Complex Specialist Oncology and the Cardiff Cancer Research Facility), These will form part of the Integrated Commissioning Plan process for future years.

The Complex Specialist Oncology Service will support the care of the most unwell patients from across SE Wales who are experiencing severe side effects from the systemic anti-cancer therapy, or who require access to early phase or complex new therapies (e.g. CAR-T). CAVUHB would look to VUNHST to support the Health Board, including the revenue business cases that will be produced by the relevant responsible commissioner, to secure appropriate revenue support from WHSSC and responsible commissioners and will be key to the development of sustainable services for the population of SE Wales

CAVUHB would be unwilling to support the nVCC FBC in isolation from the rest of the Nuffield Trust recommendations as they are inextricably linked to the development of cancer services for the catchment population. It needs to be recognised that the revenue case to support the nVCC is a singular element of that development and that recognition of the required additional revenue business case(s) is noted and supported in principle by VUNHST and Welsh Government.

	Work is progressing at pace to finalise the plans for the replacement of the BMT facilities (which currently do not meet JACIE accreditation standards), provide for the expansion of CAR-T and related AMTP treatments which have NICE approval (and which WHSSC wishes to commission from us), and the development of the Cancer Research Hub, which has been supported by the Board, and which forms a partnership between VUNHST, Cardiff University and ourselves. WHSSC has confirmed that future CAR-T treatments will need to be provided in JACIE accredited facilities so it is essential that we are able to provide the necessary facilities. A business case (Strategic Outline Case (SOC)) will be brought to the Board for approval in July. It will require a fairly substantial capital investment which we are looking to Welsh Government's All-Wales Capital budget to fund, plus a revenue investment, the majority of which will relate to WHSSC commissioned activity. It is critical that in our consideration of the nVCC, it is approved on the basis that nVCC and our other SE Wales health board partners will support the SOC and subsequent business cases for the BMT, research and specialist tertiary oncology cancer services which cannot be provided at the nVCC.
iii	Progression of agreement for shared use of the facilities and delivery of CAVUHB services at nVCC to further research and innovation and improve patient pathways, considering ways of working, outcome monitoring and shared space and including the delivery of services such as outpatient appointments and day cases The work being undertaken will also look at how we best use capacity across the system i.e. the need for patients with cancer from CVUHB with less complex needs (e.g. haematological malignancies) to receive care at nVCC and patients with more complex needs at nVCC being treated at UHW (making best use of overall system capacity and capability). Further work is also required to ensure a sustainable workforce for the effective implementation of these services. ***CAVUHB Comment:*** *CAVUHB commits to working with Velindre on the development of patient pathways, outcome monitoring and sharing the space to ensure that the nVCC is a shared resource for the patients of South East Wales. CAVUHB seeks a more definitive response from VUNHST of their commitment to these developments, particularly with respect to access for patients with haematological malignancies who require low intensity care.*
iv	Confirmation of the alternative funding sources for the cost of carbon net zero and the digital transformation VUNHST have subsequently worked with a range of stakeholders to review the costs and funding requirement with a view to reducing the levels of investment required and the risk sharing of partners. VUNHST have been engaging with WG officers to seek agreement to certain costs being funded by WG and not by the Trust's commissioners. This has led to VUNHST reducing the commissioner funding requirement based on the following positions in respect of the key areas for further work raised by the CVUHB Board following consideration of the FBC in March 2023: ***Position 3:*** VUNHST continue to accept the financial risk on contract management, energy (if there is any future premium) and any digital requirements that are not core to the nVCC project. This was the position in the FBC presented in March 2023 and has been re-affirmed by the VUNHST Board. ***CAVUHB Comment:*** *CAVUHB would seek assurance on this financial risk and request that VUNHST provide written confirmation that they fully accept this financial risk and should they fail to manage this, that they will not seek to recoup any shortfall from commissioners.*
v	Clarification on the rationale for the inclusion of the contract management costs in the revenue case, rather than as an offset for the Annual Service Payment as part of the capital case

	VUNHST have subsequently worked with a range of stakeholders to review the costs and funding requirement with a view to reducing the levels of investment required and the risk sharing of partners. VUNHST have been engaging with WG officers to seek agreement to certain costs being funded by WG and not by the Trusts commissioners. This has led to VUNHST reducing the commissioner funding requirement based on the following positions in respect of the key areas for further work raised by the CVUHB Board following consideration of the FBC in March 2023: ***Position 1:*** Welsh Government agreement to funding insurance as its directly related to the MIM procurement approach ***Position 2:*** Welsh Government agreement to VUNHST retaining underspend of the Annual Service Payment (ASP) in the event there is relief due to non-availability or other performance issues to fund the cost of contract management. VUNHST are finalising arrangements with WG to seek Ministerial approval for positions 1 and 2 and are aware that the Finance Case of the FBC now reflects this position. ***CAVUHB Comment:*** *See previous comment about the ownership of financial risk. CAVUHB would want to receive Ministerial approval of the points above.*
vi	Assurance from Welsh Government that Health and Social Services capital will be prioritised to cover the equipment costs. VUNHST can also confirm that that clinical equipment will be prioritised for WG capital, and the split of funding sources is set out in the Financial Case. Some Group 1 equipment relating to areas such as fitted equipment and hard FM services are the responsibility of the MIM provider (Acorn consortium) to provide and will be contained with the ASP revenue charge that WG will fund. ***CAVUHB Comment:*** *See previous comment about the ownership of financial risk. CAVUHB would want to receive WG assurance of the prioritisation of the capital funding and receive the updated financial case for commissioner scrutiny, noting that this may be received after this paper is scrutinised for approval by Board.*

Recommendation:

The Board is requested to:

- Consider the revised revenue consequences of the nVCC
- Consider the responses to the issues raised
- Consider and approve the nVCC Full Business Case, subject to:
  - Provision of updated detailed financial tables for commissioner scrutiny reflecting the revised assumptions and revenue consequences.
  - Written confirmation from VUNHST that they accept the financial risk on contract management, energy and digital requirements and will not seek to recoup these costs from commissioning health boards if the risk is not sufficiently managed.
  - Written commitment from VUNHST to work in partnership with commissioning health boards on the development of patient pathways, outcome monitoring and sharing the space to ensure that the nVCC is a shared resource for the patients of South East Wales
  - Confirmation of Ministerial approval for positions 1 & 2 in the table above and Welsh Government prioritisation of capital funding for equipment not part of the MIM responsibilities.
  - VUNHST coordination of the delivery of the additional Nuffield Trust recommendations, as part of the programme management of the Transforming Cancer Services programme.

- Agreement of the responsibilities for the development of the required future revenue business cases to support the delivery of the Nuffield Trust report. This includes receiving written commitment from VUNHST and other regional partners to support the BMT + business case which is currently being finalised.
- Recognition that CAVUHB is not in financial balance, so the revenue costs would increase the deficit, unless fully funded by Welsh Government.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	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

Prevention		Long term	X	Integration	X	Collaboration	X	Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No

No new risks as a result of this paper, but it needs to be considered in the light of the revenue cost pressure, the political environment and the reputational risk.

Safety: No

Proposal will improve the environment for patients, delivering a modern cancer facility, albeit that the facility will not be based on an acute hospital site.

Financial: Yes

An outline of the indicated financial impact has been included within this paper.

Workforce: No

Not for CAV UHB, but an independent report suggests that a standalone cancer centre needs additional clinical staff to support acutely unwell patients, which could increase the cost of activity at Velindre in the future.

Legal: No

Not for CAV UHB. Velindre will have considerable legal and governance considerations for the development of the new centre.

Reputational: Yes

The process for the nVCC has been protracted and contentious. It should be noted that Welsh Government has supported the OBC and invested £28m capital in the enabling works for access to the site. It is a flagship programme, and the first in Wales to use the new MIMS funding model. Not supporting the overall case would generate some difficult political discussions and may have reputational impacts. However, there is scope to scrutinise and challenge the costs, to ensure that the nVCC delivers value for money.

Socio Economic: No

No new services will be provided as a result of this development, but the improved patient environment will make the service more effective.

Equality and Health: No

There are no policy changes as a result of this development.

Decarbonisation: Yes	
This is a new build that will have a negative impact on the immediate environment as it is being built on a green field site, but is being proposed to achieve net zero, moving to an electricity only building with gas solely in the laboratories.	
Approval/Scrutiny Route:	
Committee/Group/Exec	**Date:**
Investment Group	1st March 2023
Strategic Leadership Board	16th March 2023
Finance Committee	22nd March 2023
Board	30th March 2023

Report Title:	Clinical Consultation Plan – Welsh Language			Agenda Item no.	7.5
Meeting:	Public Board Meeting	Public	X	Meeting Date:	25th May 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Executive Director of People & Culture				
Report Author (Title):	Head of Equity and Inclusion				

Main Report
Background and current situation:

The Welsh Language Standards were established by the Welsh Language Commissioner in 2019 under the Welsh Language (Wales) Measure 2011. The Standards aim to promote and facilitate the use of the Welsh language, particularly in public services, ensuring that Welsh is treated no less favourably than English.

Standard 110 requires the Health Board to publish a Clinical Consultation Plan, outlining how it will improve the offer of clinical consultations in Welsh to patients and service users. The attached five-year plan (Appendix 1) outlines the actions to be taken to increase organisational ability to deliver on this offer.

The plan has been developed through consideration of existing plans in place in other NHS Wales organisations, balanced with our priorities as a Health Board (e.g. the need to improve the recording of Welsh language skills).

Through the publishing of this plan, the Health Board is also progressing the *Mwy na geiriau / More than just words* national strategy, which requires the Health Board to make an 'active offer' to patients, service users, and visitors to engage with our services through the medium of Welsh.

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

It is a legal requirement for the Health Board to publish a Clinical Consultation Plan, as outlined in Standard 110 of the Welsh Language Standards. Approval of the proposed Clinical Consultation Plan will therefore mean the Health Board is in compliance with its legislative duty, whilst failure to publish the plan will likely lead to an investigation by the Welsh Language Commissioner and potentially further sanctions.

The proposed plan aims to meet the needs of Welsh-speaking patients, including Welsh language sessions for staff, promoting the use of Welsh in clinical settings and the workplace, and ensuring that information and resources are available bilingually. It also intends to improve the recruitment of staff with the necessary level of Welsh language skills to deliver a bilingual service.

To create accountability and ensure the success of the Clinical Consultation Plan, progress will be reported and monitored through the Equality Strategy and Welsh Language Standards Group and ultimately the People & Culture Committee.

The successful delivery of this plan will rely on the active support and collective ownership of the plan by the Clinical and Service Boards.

Recommendation:

The Board is requested to:

a) approve the Clinical Consultation Plan – Welsh Language 2023-2028.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities	X	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	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	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes:

The Clinical Consultation Plan will ensure the organisation's compliance with Standard 110 of the Welsh Language Standards. Failure to develop and action the Welsh Language Consultation Plan will mean that the organisation could face investigations and sanctions by the Welsh Language Commissioner.

Safety: Yes

Patients and Service users will be able to discuss their healthcare and treatment in their preferred language of Welsh. This could lead to improved communication and better patient experience.

Financial: Yes

Not complying with the Welsh Language Standards can ultimately lead to a fine from the Welsh Language Commissioner.

Workforce: Yes

To action this plan, the organisation will need to improve its understanding of the Welsh language skills of the workforce and be able to use that effectively to workforce plan.

Legal: Yes

By approving and actioning this plan, the organisation will comply with Standard 110 of the Welsh Language Standards.

Reputational: Yes

The organisation may suffer reputational harm for not developing a plan and therefore complying with Standard 110 of the Welsh Language Standards.

Socio Economic: No

Equality and Health: Yes	
There is no requirement for it to be assessed under the Equality Impact Health Assessment.	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
People and Culture Committee	16 May 2023

Clinical Consultation Plan – Welsh Language

2023 – 2028

Executive Summary:

In line with Section 44 Welsh Language (Wales) Measure 2011, in particular Standard 110, the Health Board is required to publish a plan for each 5-year period setting out –

(a) The extent to which you are able to offer to carry out a clinical consultation in Welsh;

(b) The actions you intend to take to increase your ability to offer to carry out a clinical consultation in Welsh;

(c) A timetable for the actions that you have detailed in (b).

The organisation recognises that the recording of Welsh Language skills of staff on its Electronic Staff Record (ESR) has been challenging, but is now putting arrangements into place to ensure that staff are recording their Welsh Language skills.

The Equity and Inclusion Team has also continued to support staff in developing an awareness of Welsh language and cultures, as well as of the active offer outlined in 'More than Just Words', which ensures patients are offered a Welsh medium service without having to ask. This has been achieved through the provision of free Welsh lessons for staff, Welsh language awareness sessions during the mandatory training sessions.

The plan will focus on the following:

- Improve the registration of the Welsh Language skills on the ESR system.
- Work with local organisations (e.g. schools and councils) to drive the recruitment of new staff with Welsh language skills.
- Mainstream the Welsh Language into the recruitment process.
- Improve the awareness of staff in the importance of the Welsh Language in healthcare.

- Improve the opportunities for patients and service users to use their preferred language by implementing processes, monitoring, and sharing good practice.

Particular focus will be given to increase the offer of Welsh clinical consultation in services accessed by the 'vulnerable groups' noted in the 'More than Just Words' Strategy.

These groups are:

- Children and young people
- People with learning disabilities
- People with mental health problems
- Older people

The Standard:

Standard 110:

"You must publish a plan for each 5-year period setting out - (a) the extent to which you are able to offer to carry out a clinical consultation in Welsh; (b) the actions you intend to take to increase your ability to offer to carry out a clinical consultation in Welsh; (c) a timetable for the actions that you have detailed in (b)."

Three years after publishing a plan in accordance with standard 110, and at the end of a plan's 5-year period you must - (a) assess the extent to which you have complied with the plan; and (b) publish that assessment within 6 months.

Definition Clinical Consultation

The Welsh Language Standards (No. 7) Regulations 2018 define a clinical consultation as *"a health provision interaction between one or more individuals and a body*". With this definition in mind, multiple clinical consultations take place across Cardiff and Vale UHB every day which are provided by our clinical staff and allied healthcare professionals.

Existing Strategies and Plans:

Welsh language is mainstreamed into all of our long-term plans to ensure that we are able to meet the needs of our service users. These include overarching and specific actions which will help Cardiff and Vale UHB increase our capacity to undertake clinical consultations in Welsh. The UHB has the following plans in place, which focus on patient experience in terms of equality, fairness for all, and driving forward service improvement:

- Equality, Inclusion and Human Rights Policy
- People and Culture Plan
- The organisations' plan for the More Than Just Words Strategic Framework
- Shaping our Future Wellbeing Strategy
- Integrated Medium-Term Plan
- Dementia Strategy
- Children and Young People's Health Charter

Links to legislation

- Welsh Language Standards Measure 2011
- Wellbeing of Future Generations Measure Act 2015

Action Plan

Below are outlined our key objectives as we work towards providing the 'active offer' and being able to deliver clinical consultations in Welsh:

Objective 1: Engaged and Motivated Workforce

- Monitor ESR data to ensure Welsh language skills are recorded and overall figures of completion increase by 10% each year.
- Numbers of staff enrolling and completing Welsh Language Training is monitored and increase by 10% each year.

Objective 2: Recruiting Welsh Language Skills

- Work with local Welsh medium schools in Cardiff and Vale area to promote careers in the NHS.
- Develop online promotional material on careers in the NHS and attend career fairs.
- In conjunction with local organisations (local Welsh Language Enterprises, colleges and councils) attend events to promote potential careers in the NHS.
- To develop guidelines for managers to ensure that Welsh language requirements for vacant posts are assessed appropriately and considered during the recruitment process.
- To monitor the Welsh language requirements when advertising for new and vacant posts.

Objective 3: Raise cultural awareness and educate staff on the importance of the Welsh Language through the organisation's "*Meddwl Cymraeg – Think Welsh*" Campaign.

- To raise awareness of the 'Active Offer' principle so departments are better equipped to deliver clinical consultations in Welsh.
- To promote the use of Welsh in the workplace and to increase cultural awareness of the language amongst staff and service users.

- To encourage participation in Welsh language initiatives to foster inclusive attitude towards providing services bilingually.

Objective 4: Promoting, offering, and recording Welsh Language Choice.

- Welsh Language Service Leads to monitor current procedures for recording patient language choice and to work with key staff within their respective areas to identify any improvements.
- To monitor Patient Management Systems within Clinical Diagnostics and Therapies to ensure that language choice is recorded and flagged to clinical departments when booking patient appointments.
- To work with other Health Boards and Trusts to share examples of best practice in recording language choice and utilise this information to deliver clinical consultations in Welsh.
- To capture and analyse feedback in terms of patient experience for Welsh speaking service users.
- To work with other Health Boards and Trusts to share best practice relating to undertaking clinical consultations in Welsh and to strive for consistency in achieving compliance with Standard 110.

To develop mechanisms for recording the number of clinical consultations undertaken in Welsh (*to include those that are facilitated by Welsh speaking support staff*).

Monitoring the assessment to the action plan

Clinical Boards Action Plan

The Clinical Boards will integrate the Clinical Consultation Plan into their Clinical Boards action plan.

Equality Strategy and Welsh Language Standards Group

The group, which is accountable to the People and Culture Committee, will receive assessment and assurances from all areas in actioning with the Clinical Consultations Plan.

Welsh Language Leads in the Clinical Board

Welsh Language Service Leads to monitor compliance with Standard 110. They will report back on the progress of the plan during the lifetime of the 5-year plan.

Actions: 2023 - 2028

Objective 1 *Assessing Welsh Language Skills*	**Action Points**	**Responsibilities**	**Date**
Monitor ESR data to ensure Welsh language skills are recorded and overall figures of completion increase by 10% each year.	• Continue to promote and encourage staff to update their Welsh language skills on ESR. Carry out a baseline assessment of the Health Board's ability to offer clinical consultations in Welsh. • Success is celebrated and communicated Health Board wide.	• People and Culture • Clinical Boards	March 2026
Number of staff enrolling and completing Welsh Language Training is monitored and increase by 10% each year.	• Assess locality/departmental representation on training. • To identify staff with level 3 and 4 speaking and listening Welsh language skills and to offer opportunities to attend training courses designed to build confidence in using Welsh in the workplace and improving existing skills. • To identify staff with level 1 and 2 speaking and listening skills and offer training opportunities to increase existing skills levels. • To encourage all staff to complete the 10hr online level 1 Welsh language training provided by the National Centre for Learning Welsh.	• Equity and Inclusion Team. • People and Culture Team • Clinical Boards	March 2026

Objective 2 *Recruitment of Welsh Language skills*	**Action Points**		
Work with local Welsh medium schools in Cardiff and Vale area to promote careers in the NHS.	• Identify schools and attend their careers fairs or meetings	• People Resourcing • Equity and Inclusion	March 2026
Develop online promotional material on careers in the NHS and attend career fairs.	• Work with Communications Team, Medical Illustration and Workforce to develop careers information aimed at recruits with Welsh language skills	• Communication and Engagement • People Resourcing • Clinical and Service Boards	March 2024
In conjunction with local organisations (local Welsh Language Enterprises, colleges and councils) attend events to promote potential careers in the NHS.	• Further work and collaboration through the Cardiff and Vale Welsh Language Forum, attend local events (Tafwyl, Eisteddfod etc) to promote recruitment.	• People Resourcing • Equity and Inclusion	March 2024
To develop guidelines for managers to ensure that Welsh language requirements for vacant posts are assessed appropriately and considered during the recruitment process.	• Recruitment policy team and Workforce to develop Welsh language and recruitment guidelines	• Equity and Inclusion • People Services • People Assurance and Experience • Clinical and Service Boards	March 2024
To monitor the Welsh language requirements when advertising for new and vacant posts.	• Work with Shared Services to assess how many new or vacant posts required Welsh as an essential skill.	• Clinical and Service Boards • People Resourcing • People Assurance and Experience	March 2026

Objective 3: Cultural Awareness and importance of the Welsh Language under the "*Meddwl Cymraeg – Think Welsh*" Campaign.	**Action Points**		
To raise awareness of the 'Active Offer' principle to encourage more clinical consultations in the medium of Welsh.	• Raise awareness on promotional days (Welsh Language Rights Day, Diwrnod Shwmae etc.) of the importance of the active offer • Raise awareness during mandatory training days and corporate induction.	• Equity and Inclusion • Communication and Engagement • Clinical and Service Boards	March 2025
To promote the use of Welsh in the workplace and to increase cultural awareness of the language amongst staff and service users To encourage participation in Welsh language initiatives to encourage an inclusive attitude towards providing services bilingually.			
Objective 4 *Monitoring the progress*	**Action Points**		
Welsh Language Service Leads to monitor current procedures for recording patient language choice and to work with key staff within their respective areas to identify any improvements.	Welsh Language Ambassadors to monitor and feedback to the ESWLG how local teams are recording patient language choice, feedback on good practice and effective processes.	• Health Records • Clinical and Service Boards	March 2026
To monitor Patient Management Systems within Clinical Diagnostics and Therapies to ensure that language choice is recorded and flagged to clinical departments when booking patient appointments.	Clinical Diagnostics and Therapies to report back on the ESWLG on how many patients and service users have registered their language preference.	• Health Records • Clinical and Service Boards	March 2026

To work with other Health Boards and Trusts to share examples of best practice in recording language choice and utilise this information to deliver clinical consultations in Welsh.	Co-operate with the South East Wales Health Boards to share practice and information.	• Equity and Inclusion	March 2024
To capture and analyse feedback in terms of patient experience for Welsh speaking service users.	Work with concerns team and patient experience team to pick up any issues with patient experience survey or concerns received.	• Patient Experience • Equity and Inclusion	March 2026

Report Title:	Cardiff and Vale Regional Partnership Board Joint Area Plan 2023-2028					Agenda Item no.	7.6
Meeting:	Public Board Meeting		Public	X		Meeting Date:	25 May 2023
			Private				
Status *(please tick one only):*	Assurance	X	Approval	x		Information	
Lead Executive:	Abigail Harris Executive Director of Planning						
Report Author (Title):	Meredith Gardiner, Head of Partnerships and Assurance						

Main Report
Background and current situation:

The Cardiff and Vale of Glamorgan Regional Partnership Board (RPB) has a statutory obligation via the Social Services and Well-being (Wales) Act 2014 to prepare a Joint Area Plan (JAP) in response to requirements identified within the region's Population Needs Assessment. The JAP must provide a description of the range and level of services proposed to be provided or arranged in response to the care and support needs, including the support needs of carers. As a lead statutory partner, the Health Board is statutorily required to collaborate with local authority partners in the preparation, development and assurance of the JAP before final approval by the RPB.

JAPs must focus on the integrated services planned in response to each core theme identified in the population assessment. As part of this, JAPs must include:

- the actions partners will take in relation to the priority areas of integration for Regional Partnership Boards;
- the instances and details of pooled funds to be established in response to the population assessment;
- how services will be procured or arranged to be delivered, including by alternative delivery models;
- details of the preventative services that will be provided or arranged;
- actions being taken in relation to the provision of information, advice and assistance services; and
- actions required to deliver services through the medium of Welsh.

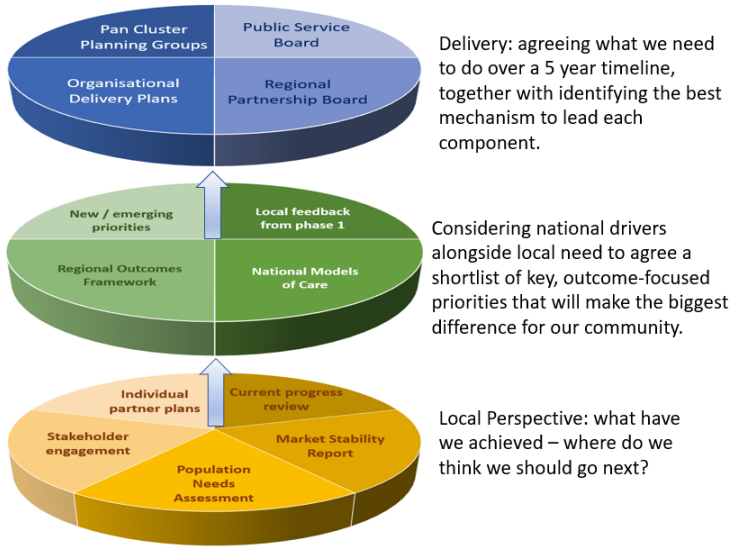
Each population assessment report must include specific core themes dealing with:
- children and young people;
- older people;
- health/physical disabilities;
- learning disability/autism;
- mental health;
- sensory impairment;
- carers who need support
- violence against women, domestic abuse and sexual violence.

The JAP should set out the services planned by local authorities and local health boards in response to the core themes above. Services planned in respect of the violence against women, domestic abuse and sexual violence core theme will be included within joint local strategies required by the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. That strategy can be referenced within the Joint Area Plan.

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

The Joint Area Plan for 2023 to 2028 has been developed through a three phased programme of engagement with a wide range of over 500 stakeholders including c.130 from the Health Board at operational, strategic and board level.

Area Plan 2023 – 2028 Roadmap



Phase 3: Delivery planning
March to May 2023

Delivery: agreeing what we need to do over a 5 year timeline, together with identifying the best mechanism to lead each component.

Phase 2: Strategic Prioritisation
January – March 2023

Considering national drivers alongside local need to agree a shortlist of key, outcome-focused priorities that will make the biggest difference for our community.

Phase 1: Looking Back and casting forward
October – December 2022

Local Perspective: what have we achieved – where do we think we should go next?

This has culminated in the identification of the following key commitments where partners consider that combined, focused effort might make the biggest impact for our priority population groups.

Making a Difference – Our Commitments for 2028

We will:
- Work together to keep our babies, children and young people healthy, well and safe from harm
- Deliver a Nurturing, Empowering, Safe and Trusted approach to emotional wellbeing and mental health
- Improve the support offer for babies, children and young people with complex needs.

Unpaid Carers will be recognised for the vital contribution they make to the community and the people they care for and enabled to do the things they want to alongside caring.

With people with **physical and sensory disabilities** we will find out more about their needs, experiences and priorities, developing and delivering changes that enable people to live as independently as possible.

People will be able to **age well** at home with more opportunities for wellbeing and independence. Services will reflect the diversity of people as they age well.

People with **Learning Disabilities** will have the ability to live as independently as possible in their local community.

We will support all people in our region to have the opportunity to live positive, independent lives without being affected by **violence and abuse.**

We will build a co-produced plan with stakeholders and people with **mental health needs** that enables people to do the things that matter most to them.

Neurodiversity services will have strengthened provision with a focus on providing the right support at the right time.

People with Dementia will be supported to live well and do the things they need to and enjoy in their communities.

Detailed delivery plans are being established to ensure progression towards these commitments, identifying the key enabling support required to achieve stated goals whilst also ensuring that effective links are made with activities already being delivered by the partner organisations.

Outcomes monitoring will be a fundamental part of this work, using the Regional Outcomes Framework to demonstrate progress towards the priorities that the Health Board has agreed previously with partners. Together, these plans will form a fundamental building block within the array of Health Board strategic plans with a focus upon developing home-based, integrated models of care.

The final draft of the Joint Area Plan is being shared with the following groups for consideration and assurance before final approval is sought at the next meeting of the Regional Partnership Board in July 2023:

- Vale of Glamorgan Public Service Board
- Cardiff Public Service Board
- Vale of Glamorgan Local Authority Social Care and Health Scrutiny Committee
- Cardiff Council Scrutiny Committee
- Cardiff Pan Cluster Planning Group
- Vale of Glamorgan Pan Cluster Planning Group
- Cardiff and Vale UHB Board meeting.

Recommendation:

The Board is requested to:

a) Consider the Joint Area Plan commitments;
b) Endorse the Joint Area Plan on behalf of the Cardiff and Vale University Health Board; and
c) Ensure CVUHB plans align to the Joint Area Plan, where relevant.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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

Prevention	✓	Long term	✓	Integration	✓	Collaboration	✓	Involvement	✓

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The three phased approach taken to identify the key commitments for each priority area has been predicated on asking colleagues to identify the shared priorities and concerns where working together might create the biggest impact across our local population. Risk assessments for each priority-focused delivery plan will continue to be reviewed and updated regularly as we progress implementation over the next 5 years.
Safety: No
Financial: Yes
Delivery of these commitments will require use of additional funding and / or re-distribution of existing funding streams across the partner organisations within the region. The Regional Integration Fund is already contributing towards delivery of these commitments with annual review to ensure it focuses on the right things. The Regional Integration Fund reduces over the period of the JAP, and will require an increased contribution from partners to continue funding of projects which are assessed as appropriate to move into business as usual services and associated funding. *Across the next five years, this Plan can be used to test whether existing core funding is being focused in the most helpful way to achieve these shared commitments.*
Workforce: Yes
The development of our workforce will be fundamental to ensuring delivery of these outcomes. Workforce considerations are being collated as part of the delivery planning process to facilitate the creation of a shared workforce development plan.
Legal: Yes
Working to develop the Joint Area Plan with partners is a statutory obligation for the Health Board. Any legal implications from delivery of specific commitments will be addressed within the delivery plans for each priority area.
Reputational: Yes
The Joint Area Plan contains a series of challenging commitments for focused work over the next 5 years. It will be important for the UHB to be seen to demonstrate ongoing commitment and support to enabling delivery.
Socio Economic: Yes
The Joint Area Plan has been developed in direct response to the region's Population Needs Assessment 2022 which outlines the specific needs of key population groups across our region including those with various socio-economic disadvantages e.g. mental health, learning disabilities, VAWDASV. The delivery plans for each priority area will include an overview of engagement intentions and the outcomes to be achieved as a result.
Equality and Health: Yes
Given the broad nature of the JAP, Equality Health Impact Assessments (EHIA) will be undertaken for each priority area as part of the Development Plan process.
Decarbonisation: Yes
Decarbonisation is a shared commitment for all partners within the RPB and delivery plans will be required to take this into account where appropriate.

Approval/Scrutiny Route:	
Committee/Group/Exec	Date: Signed off at Regional Partnership Board 25.04.23

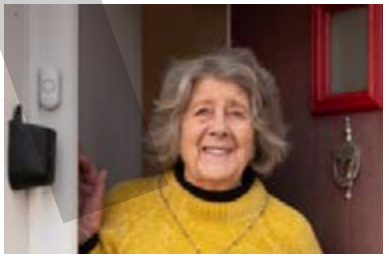
Cardiff and Vale Regional Partnership Board

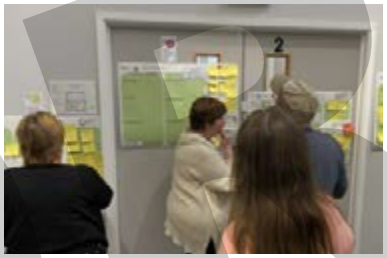
Joint Area Plan

2023-28















CARDIFF CAERDYDD

C3SC Cardiff Third Sector Council Cyngor Trydydd Sector Caerdydd

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

GVS Empowering people. Ensuring excellence. Strengthening communities. Grymuso pobl. Ysbrydoli rhagoriaeth. Cryfhau cymunedau.

VALE of GLAMORGAN BRO MORGANNWG

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru / Welsh Ambulance Services NHS Trust

BWRDD PARTNERIAETH RHANBARTHOL CAERDYDD A'R FRO
CARDIFF & VALE REGIONAL PARTNERSHIP BOARD

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Neurodiversity services will have strengthened provision with a focus on providing the right support at the right time.

People with Dementia will be supported to live well and do the things they need to and enjoy in their communities.

Introduction

The RPB's Joint Area Plan is the place where partners come together to set out their plans to improve the health and wellbeing of the local population. The strategic direction set out in this plan specifically relates to the joint activities we are committing to as a partnership, building on a long history of collaboration.

Our plan sits in the context of a vast array of activities being delivered by the partner organisations, from multi-billion pound capital developments to improve housing and communities being delivered by our local authorities, to world-leading medical interventions by the Health Board, to a vast array of services and activities provided by voluntary groups and organisations that support more people to live well within their community. These provide the building blocks and foundations for the additional work we are doing together to develop integrated models of care.

Our Joint Area Plan draws on those plans and enhances them in areas that can only be addressed by working together.

The RPB will also produce a Strategic Capital Plan later this year, setting out the long-term plans across each of the partners to ensure there are homes and places in communities that enable people to stay well and independent, and when they need it, receive care and support closer to home.

We are working together in very challenging and uncertain times. There are significant workforce challenges and a highly challenging financial position across all partners . We know that having a sufficient resources, including an appropriately trained and qualified workforce is fundamental to the success of this plan. This is why our focus on what matters to people and the outcomes they value is so important.

This plan is ambitious but realistic and recognises the very real challenges being experienced by local people, our staff and services. We are committed to improving and joining up support and services for healthy lives, wellbeing and independence.






Working with the Public Services Boards

The RPB's Joint Area Plan sits alongside the Wellbeing Plans from Cardiff Public Services Board (PSB) and Vale of Glamorgan Public Services Board to provide a whole system approach to improving the health and wellbeing of the population of Cardiff and the Vale of Glamorgan.

The RPB's plan supports the health and wellbeing of the population through improvements to health and care services specifically, PSB plans aim to improve environmental, social, economic and cultural well-being, which have a direct influence on the health and wellbeing of the local population.

This Area Plan and the Wellbeing Plans are dependent on organisations working in partnership towards common ambitions. Joint working on housing solutions, homelessness, substance misuse, immunisations, and addressing violence against women, domestic abuse and sexual violence and safeguarding is led by the PSBs, hence limited reference to these important areas within this plan.

The Vale of Glamorgan PSB's Wellbeing Plan's priorities include:

- Working with the most deprived communities
- Becoming an age-friendly Vale
- A more active and healthier Vale

Cardiff PSB's Wellbeing Plan vision aligns to and supports the RPB's ambitions, including:

- A great place to grow up
- A great place to grow older
- Supporting people out of poverty

In order to achieve this vision, emphasis is placed on:

- Supporting children's health and education, with particular focus on children who live in poverty or are at risk of Adverse Childhood Experiences
- Making provision for new homes, support for people who are homeless, affordable, accessible and suitable housing and jobs, and ensuring people have the skills they need
- Preventing ill health and addressing inequity and inequality and the impact of social factors on health
- Addressing the impact of COVID-19 restrictions, for instance on take up childhood immunisation, screening services as well as physical activity and healthy eating
- Continuing to ensure that services work together and are fully integrated

What is the Regional Partnership Board?

Our Regional Partnership Board (RPB) includes representatives from Cardiff Council, Vale of Glamorgan Council, Cardiff and Vale University Health Board, Welsh Ambulance Service NHS Trust, housing, Third & Independent sectors and carer representatives.

We work with our population, recognising its diversity, and colleagues from across our region to improve the health and wellbeing of everyone living in Cardiff and the Vale of Glamorgan. We share resources, skills and services to ensure people can access the right service, in the right place, at the right time so, you can do the things that matter most to you, at all times of life.

What is a Joint Area Plan?

This is the RPB's plan for the next five years. It builds on what is already happening across the partnership and sets out how together, we will address the gaps. The plan has been jointly prepared by Cardiff Council, Vale of Glamorgan Council and Cardiff and Vale University Health Board under the direction of the Regional Partnership Board.

Every 5 years, we review our plans, partner priorities, emerging innovation and Welsh Government policy. We look in detail at our Population Needs Analysis and Market Stability Report. We share these with as wide a range of people as possible to identify how, by working together, we can make the biggest difference for people in Cardiff and the Vale of Glamorgan.

The RPB is committed to achieving the outcomes for people described within our Regional Outcomes Framework. This plan sets out how we will achieve them.

Our priorities

As a partnership, we work together to support people when they need it at every stage in their lives. Our Area Plan is organised around three life-stage themes:

Starting Well: giving every child the best start in life.

Living Well: supporting people to live well and do the things that matter to them.

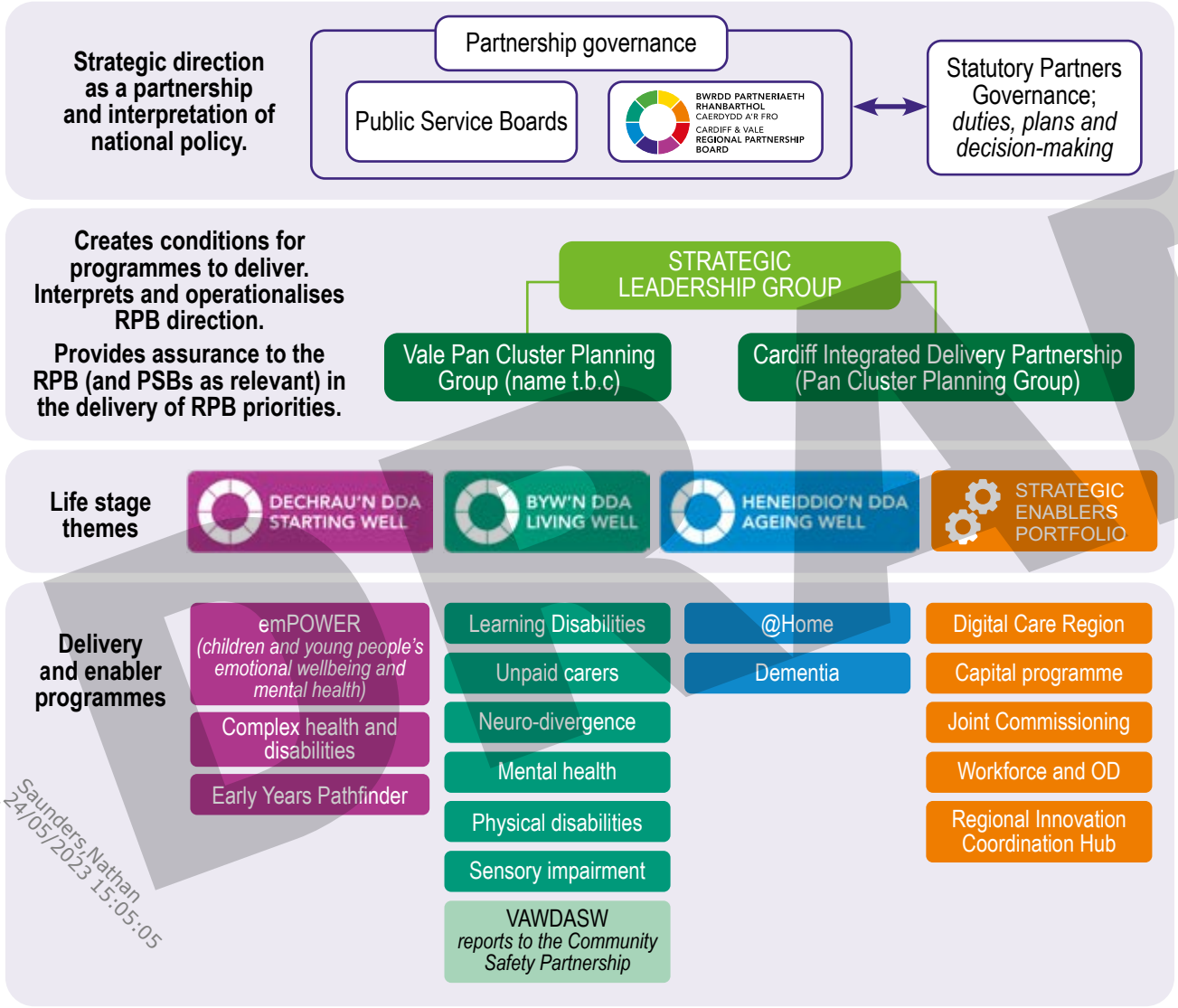
Ageing Well: enabling people to stay independent as they become older.

Our delivery programmes are based on achieving better outcomes for people in each life stage.

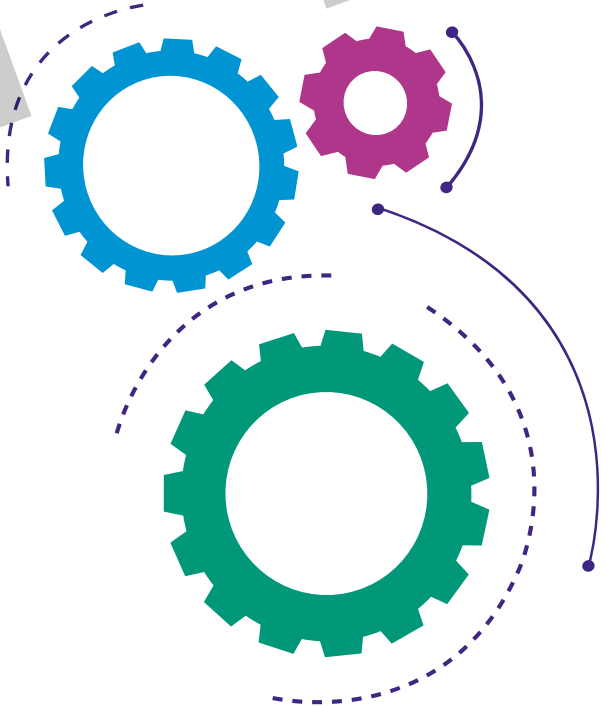
We also work together on the enablers of joint working, such as joined up care records, technology-enabled care, how we use our buildings to enable community-based support.

Across the partnership, we are the largest employer across the Region, and it is our people who make these plans a reality. Our aim is that people don't experience gaps between services or professionals, just the right support from the right person at the right time.

Our structure



Whilst section 169 of the Social Services and Well-being (Wales) Act 2014, places the duty on the 'relevant bodies' (the statutory organisations in the partnership) to produce a Joint Area Plan, the third sector's role is vital and must not be underestimated. Without their reach into our rich and diverse communities, supporting local people and providing person-centred support and advice many of the RPB's ambitions would be unattainable.



Our policy environment

This plan is supported by and set in the context of a wide range of national legislation and policy:

The NEST Framework - NHS Wales Health Collaborative

Equality Act 2010

No Wrong Door: bringing services together to meet children's needs - Children's Commissioner for Wales

Review of Neurodevelopmental Services Programme Board policy statement: Removing profit from the care of looked after children

National Trauma Framework for Wales

Healthy Child Wales programme 2020

Third Sector Scheme

VAWDASV: Strategy 2022-2026 (Wales)

Learning Disability - Improving Lives Programme (2018)

Equality Act 2010

Together for Mental Health

Talk to Me 2

6 Goals for Urgent and Emergency Care

National Strategy for Unpaid Carers: Delivery Plan

Third Sector Scheme

Autism Code of Practice

Age Friendly Wales

Equality Act 2010

6 Goals for Urgent and Emergency Care

Further Faster Integrated Community Care Services for Wales

National Strategy for Unpaid Carers: Delivery Plan

Dementia Pathway of Standards

Third Sector Scheme

Wellbeing of Future Generations (Wales) Act 2015
Social Services and Well-being (Wales) Act 2014
National Strategic Programme for Primary Care and National Models of Care (See Appendix 1)

Our partnership environment

The RPB operates in the context of the strategies, plans and day-to-day work of all our partners. We add value when we bring partners together to address issues or deliver change which no one organisation can address alone.

These are the **principles** that will guide our work together over the next 5 years:

Prevention: promoting early intervention that prolongs good health and well-being for all age groups whilst reducing reliance on long term service provision

Care closer to home: providing care and support as close to people's homes as possible;

Inclusion and diversity: ensure that people are involved in planned their care, and that we work to reach out to all people from across our diverse communities;

Sustainability: ensuring the long-term viability of our environment through carbon reduction is a fundamental necessity and we are committed to ensuring that our plans reflect this need.

Social value: ensuring that the things we do have the best possible impact on our well-being.

Engaging to build the plan

Our plan is the outcome of many conversations which have taken place across the region with a range of staff and people who live and work in our region.

Our Population Needs Assessment included:

661 responses from the general public to our online survey

35 responses from children and young people

96 responses from residents within HMP Cardiff

118 responses from professionals and service providers.

We also held 23 focus groups with a total of 132 people.

Development of our Market Stability Report involved conversations with c.60 colleagues including private providers from across the region.

In developing the Area Plan we have worked with over 500 people (Councillors, staff and members of the public) and held 700 conversations to develop our Area Plan.

We will continue these conversations throughout the lifetime of this Area Plan to refine and review our commitments regularly and ensure we're progressing in the right direction.

You can view examples of our Public Ideas Boards here:

Children and Young People

People with Dementia






Our shared outcomes

The RPB is committed to achieving the outcomes for people described within our Regional Outcomes Framework. This plan sets out how we will achieve them.

In this document, the following symbols indicate where each of our commitments relate to these shared outcomes:

- **Increasing time for people to live their lives**
- **Increased living well in their own home and community**
- **Improved environment that enables people's choices**
- **More empowered workforce**
- **Better start for children and young people**
- **People get a safe response when in urgent need**
- **Decreased avoidable harm or mortality**
- **Reduced wasted system resource**

Click **here** to view a short film about our **Regional Outcomes Framework**.

Section 2: Our Commitments

In this section we set out our commitments to our population linked to our life stage programmes:

DECHRAU'N DDA
STARTING WELL

BYW'N DDA
LIVING WELL

HENEIDDIO'N DDA
AGEING WELL

These commitments are linked to the shared priorities and direction of all our partners and so we have also provided an overview of the existing partnership activity that is already in place across our region and within local cluster areas for further context.

Existing work across the partnership

DECHRAU'N DDA
STARTING WELL

Cardiff Council with Partners

Children's Services Strategy '2023-26:
the right support, from the right person at the right time, in the right place and at the lowest safe level of intervention, enabling them to remain with family where it is safe for them to do so.

Including:
- Becoming a child-friendly city by Summer '23
- Parenting and Family Support Services
- Early Help and Cardiff Family Advice and Support
- Flying Start (Outreach)
- Support for young carers

Place:
- Accommodation Strategy (including the Right Place model)
- Reunification Framework
- In house fostering
- Family Drug and Alcohol Court

People:
- Workforce Action Plan
- New Operating Model
- Locality working

Practice:
- Safeguarding Adolescents From Exploitation (SAFE) model
- Trauma Informed Practice Interventions Hub
- Safe & Together Model

Together, as partners

Increasing joined up provision in the region for children and young people with complex needs:

The EmPower Programme
- Accommodation and psychologically-informed care and support for young people with complex emotional and mental health needs
- Implementing the NEST Framework
- 'No Wrong Door'
- Enfys: therapeutic support for care experienced children

Strategic developments
- Exploring the feasibility of co-location of various Health Board and LA services at Michaelston.

The Early Years Programme
- Pathways to support for Neurodiversity
- Perinatal support for Mental Health

Vale of Glamorgan Council with Partners

Corporate strategy for children who need care and support '19 - '23

'Delivering our ambitions together'
- Supporting families to stay together
- Manage risk confidently and provide support at the 'edge of care'
- Provide and commission a flexible and affordable mix of high-quality placements
- Develop effective plans in partnership with children and their families.

Including:
- Adolescent Resource Centre ARC
- Intake and Family Support Team
- Provider partnerships in accommodation
- Therapeutic support for CLA
- FACT (Team Around Family)
- Vale Parenting Service
- Vale Youth Wellbeing Service
- Vale Family Support Services
- Families First Advice Line
- Flying Start Outreach

Cardiff and Vale University Health Board with Partners

Sustainable, cluster-based community services; Resilient and high performing unscheduled care system; Continued transformation of mental health and learning disability services focusing on a community, home first model; Continued improvements in delivery of emotional well-being services for young people from Single Point of Access to specialist care & treatment.

Our commitment to babies, children and young people

DECHRAU'N DDA
STARTING WELL

Over the next 5 years we will:

- Work together to keep our babies, children and young people safe from harm
- Deliver a Nurturing, Empowering, Safe and Trusted approach to emotional wellbeing and mental health
- Improve the support offer for babies, children and young people with co-occurring complex needs

This is important because:

- The first 1000 days are critical to future life chances
- c. 118,000 of our population are between 0 and 19 years old
- The 2011 Census identified 1,579 young carers in Cardiff and the Vale of Glamorgan, but this is known to be an underestimation
- The pandemic had a significant negative impact on mental health and well-being
- We see increased paediatric emergency attendances for mental health disorders and strain on specialist services such as Child and Adolescent Mental Health Services (CAMHS) crisis teams
- The developmental trauma caused be Adverse Childhood Experiences (ACES) will have an impact on adult mental health. Addressing these issues will reduce likely demand for services in the long term

We will deliver:

- Preventative approaches in education, health and support
- Service delivery improvements aligned to NEST
- Our plans for No Wrong Door
- Accessible information to children and young people
- Enough provision in our region to meet care and support needs
- A Joint Recovery Service for emotional wellbeing and mental health by Summer '23 including increased accommodation in Cardiff
- Better transition between services
- Integrated care model for co-occurring complex needs
- A joint approach to commissioning and funding complex care and support
- Therapeutic support for care experienced children such as Enfys and ARC
- A Trauma Informed Approach where appropriate

With the following results:

Children and young people will:

- Feel involved with service changes
- Receive the support they need at the time they need it
- Have early responses that are needs led and trauma informed, not diagnosis dependent
- Experience a joined-up approach across services
- Early intervention and prevention across a child's journey starting within the first 1000 days and beyond
- Strengthen data and information that supports better partnership planning

This will mean

- Increased involvement of young people in service development
- Reduced waiting times for assessment
- Reduced unscheduled admissions to hospital
- Reduced length of hospital stay
- Increased local placements
- Joint service delivery
- Increased access to community support

Existing work across the partnership

BYW'N DDA LIVING WELL

Cardiff Council with Partners

- Hubs with a focus on well-being
- Joined up working between Day Centres and Hubs
- Community Engagement and Wellbeing Teams
- First Point of Contact and Independent Living Services
- Community Living Schemes
- Equality and Inclusion Strategy
- Liberty Protection Safeguards
- Carer Assessments and support

Together, as partners

- A variety of services to support people with learning disabilities to maintain their independence in their local communities, for instance Supported Living Services, Complex Needs Day Services and use of technology to support independent Living
- Charter for Unpaid Carers
- Providing the Carers Gateway
- Integrated Autism Service
- Local delivery of the new Autism Code
- Ensure our work links to, supports and enhances that of the Public Service Boards and their Wellbeing Plans
- Recognise and support Area Planning Board on substance misuse and the ongoing work that is meeting the health needs of particularly vulnerable homeless citizens

Vale of Glamorgan Council with Partners

- Shared Lives (Adult Placement Service)
- Wellbeing Matters Service
- Day Services and Respite Care
- Community Drug and Alcohol Team
- Adult Advocacy
- Housing solutions and telecare
- Direct payments and 'Your Choice' Scheme
- Carer assessments and support
- 'Smart' Houses for people with learning disabilities

Cardiff and Vale University Health Board with Partners

Sustainable, cluster-based community services; Resilient and high performing unscheduled care system; Continued transformation of mental health and learning disability services focusing on a community, home first model

Our commitment to people with learning disabilities

Over the next 5 years we will:

Develop integrated support services enabling people with learning disabilities to live as independently as possible in their local community

This is important because:

In 2017, an estimated 7,081 adults in Cardiff have a learning disability, of whom 1,175 received support from Learning Disability Services (equal to 78% of people with a moderate or severe learning disability).

For the Vale of Glamorgan and estimated 2,400 adults have a learning disability, of whom 448 received support from Learning Disability Services. This represents 90% of those with a moderate or severe learning disability.

People with learning disability are more likely to have or develop other co-morbidities and experience greater health inequalities.

These people are also more likely to have been dis-advantaged by COVID-19 and the cost-of-living crisis.

We will deliver:

- Improved access to annual health checks and wider primary health choices
- Smooth transitions between services and support
- Improved access to information on local services
- Improved services for people to live closer to home with the right support and maximise their independence
- Access to work, activities and volunteering (employment opportunities)
- Improved information to young people and carers on moving from child to adult services
- Increased the number of Adult Placement Carers
- Increased the availability of technology to support independent living
- Ensured people with learning disabilities and Down Syndrome have equitable access to dementia screening
- Develop outcome-based commissioning for service delivery

With the following results:

People with learning disabilities will:

- Be involved in service developments
- Receive the support they need at the time they need it
- Have equitable access to health care and support
- Be able to live independently and have equal access to their community
- Have access to information and technology to support their independence
- Have increased access to work, volunteering and day opportunities
- Have increased access to GP and other health checks

This will mean:

- Increased number of people accessing health check with GP (collected already)
- Increase in access to local offer (complex needs day service data)

Our commitment to unpaid carers

Over the next 5 years we will:

Identify and recognise unpaid carers for the vital contribution they make to the community and the people they care for, and in doing so enable unpaid carers to have a life alongside caring.

This is important because:

Unpaid carers play a vital role in our communities by providing care and support to people who would otherwise require health or social care intervention.

The economic value of the contribution made by unpaid carers in Wales is estimated at £8.1 billion a year. It is estimated that there are over 50,000 unpaid carers across Cardiff and the Vale of Glamorgan.

Our Unpaid Carers Partnership exists to:

- Increase awareness of the role of unpaid carers
- Increase identification of unpaid carers
- Improve services and access to support for unpaid carers
- Improve the wellbeing of unpaid carers and therefore reduce the need for crisis or long-term intervention

We support the region to deliver against the priorities of the National Strategy for Unpaid Carers in Wales:

- Identifying and valuing unpaid carers
- Providing information, advice and assistance
- Supporting life alongside caring
- Supporting unpaid carers in education and the workplace

We will deliver:

- The Unpaid Carers Charter
- Continued delivery of the Carers Gateway
- Specific support for Young Carers
- Strengthened the role of carers in discharge planning
- Improved carers assessment process
- Inclusion of unpaid carers needs across all our partnership commitments

We will also:

- Build mental health and wellbeing support for unpaid carers
- Improve physical and emotional support for young carers to reduce the risk of adverse childhood experience (ACE)
- Reduce waiting times for specialist services
- Early access to the right advice and support
- Improve flexible planned and emergency respite for unpaid carers including young carers
- Support employment alongside and after caring,
- Support employers to understand the role of unpaid carers and ensure they are supported and maintained in employment
- Update and publicise the carers directory

With the following results:

Carers will:

- Be recognised for the vital role they play in providing care and support
- Understand their rights
- Have access to support that enables them to carry out their role
- Have access to breaks and respite
- Be supported to have fulfilling lives that work alongside their caring role
- Play a fundamental role in planning care and support for the person they look after

This will mean:

- Increased numbers of carers assessments
- Increased number of recognised unpaid carers
- Increased numbers of unpaid carers accessing information and support

Our commitment to reducing Violence Against Women, Domestic Abuse and Sexual Violence

Over the next 5 years we will:

Ensure that people who live, work, study in and visit Cardiff and the Vale of Glamorgan can live positive, independent lives without being affected by violence and abuse.

This is important because:

Violence against women, domestic abuse and sexual violence (VAWDASV) has far-reaching consequences for families, children, communities and society.

Whilst anyone (women, men, children and young people) can experience VAWDASV, it is women and girls who are disproportionately affected by domestic abuse, rape and sexual violence, sexual exploitation, including through the sex industry, modern day slavery, forced marriage, honour-based abuse, female genital mutilation, child sexual exploitation and abuse, stalking and sexual harassment.

This can happen in any relationship regardless of sex, age, ethnicity, gender, sexuality, disability, religion or belief, income, class, geography or lifestyle.

We will deliver:

- Improved awareness amongst survivors, bystanders, and service providers of the recognition and management of VAWDASV
- Deliver the required elements of the National Training Framework to all relevant staff
- Improved multi-agency responses by increasing understanding of risk factors & lived experiences
- Monitoring of evolving trends in all forms of abuse & ensure services anticipate changes in demand
- Continued investment in specialist support services and strengthen availability of provision
- Increased practitioner understanding of perpetrator behaviour

We will build on this by:

- Ensuring the lived experiences of survivors informs ongoing service development and delivery
- Maintaining and extending a range of interventions to target known and potential perpetrators of abuse
- Challenging victim blaming attitudes to restore survivors' confidence & ability to access services
- Prioritising intervention for children & young people to prevent issues from arising or escalating

With the following results:

- Strong partnership working to deliver timely and effective victim-centred service responses
- Accountability for abusive behaviour remains with the perpetrator(s)
- A range of opportunities to break the cycle of all forms of victimisation are available to perpetrators through education, early intervention and behaviour changing programmes
- Children and young people are informed and understand the importance of consent and healthy relationships
- Communities are supported to understand the nature of VAWDASV and the action(s) that they can take to challenge
- Specialist, high quality, needs-led, strength-based, trauma-informed and person-centred services are available to survivors of VAWDASV in the region
- Survivors can access therapeutic support to rebuild their lives free from abuse

Our commitment to people with physical and sensory impairment

Over the next 5 years we will:

Work with people with physical and sensory disabilities to find out more about their needs, experiences and priorities, developing and delivering changes that enable people to do the things that matter most to them.

This is important because:

Around 1 in 5 people in Cardiff and the Vale of Glamorgan have a disability. We recognise the importance of coproducing our regional plans to ensure they reflect the priorities and experiences of disabled people.

The Welsh Government published its 'Action on Disability: The Right to Independent Living Framework and Action Plan' in 2019 stating their commitment to disabled people fulfilling their potential and achieving their ambitions and dreams in line with the 'Social Model of Disability' and recognises the persistence of poverty and exclusion.

Saunders,Nathan 24/05/2023 15:05:05

We will deliver:

- During 23/24 we will co-produce a plan for an integrated delivery model for people with physical and/ or sensory impairment

We are committed to:

- Services that are integrated and easily accessible if support from more than one agency is needed
- Enabling people to work or engage in day opportunities
- Focusing on 'what matters' to people
- The social model of disability
- Developing peer support and advocacy
- Prevention and early intervention and support
- Therapy, accommodation, assistive technology and support that enables independence
- Ensuring communication, support and services are accessible

By April '24 we will update the Joint Area Plan to include the co-produced delivery plan.

With the following results:

- A delivery plan co-produced with people with physical and sensory impairment and stakeholders, setting out the changes we are committing to and measures that will demonstrate impact

Our commitment to people with neurodiversity

Over the next 5 years we will:
Strengthen provision of neuro-diversity services with a focus on providing the right support at the right time.

This is important because:

There are over 6,000 people with a diagnosis of Autism in the region. Not all autistic people will have been diagnosed.

The number of people aged 18-64 with an autism spectrum disorder is expected to increase by about 13% (425 people) between 2017 and 2035, with the largest increases being seen in people aged 35-44 those aged 75+.

Across Wales, negative mental health impacts were particularly significant for autistic people during the pandemic, specifically depression and anxiety.

Welsh Government is expanding the RPB's focus from Autism to include all Neurodiversity issues.

We will deliver:

We will build on our existing service provision by:

- Strengthening support to ensure the right support is available at the right time
- Improving ADHD service provision
- Transitional arrangements which enable a seamless journey for young people into adult hood
- Meeting the new national guidance on neurodiversity requirements
- Improving timeliness and access to assessment and diagnosis
- Implementing the Code of Practice

With the following results:

People with neurodiversity will have:

- Timely access to assessment, diagnosis, care and support
- Access to a skilled, multi-agency service
- Stronger links with Children and Young People's provision to maximise prevention and early intervention opportunities and promote better transitions into adult life

This will mean

- Reduced waiting times for access to assessment
- Increased access to support
- Increased practitioner awareness
- Increased well-being of adults

Our commitment to people with mental health needs

BYW'N DDA LIVING WELL

Over the next 5 years we will:
Work with people with mental health needs and other stakeholders to find out more about their experiences and priorities, then develop and deliver services that support people to have good mental health.

This is important because:

A recent ONS survey recorded that 9% of our regional population had a self-reported mental disorder.

This is likely to have increased in the aftermath of COVID-19.

Welsh Government's cornerstone strategies for mental health – Talk to Me 2 and Together for Mental Health have reached their conclusion and new strategies are under development.

Locally, we recognise specific concerns relating to the impact of increases in the cost of living, homelessness, social isolation along with the needs of a range of people recognised as priority groups within other sections of this Area Plan.

We need to ensure that enabling good mental health is a key priority for all priority groups.

We will deliver:

During 23/24 we will review previous strategies and action plans, working with people to identify and deliver key priorities for development over the next 5 years.

This is likely to include:

- Identifying new ways of building and retaining our workforce
- Delivery of the psychological support wherever it is required
- Delivering trauma informed care in all our mental health provision
- Making best use of technology and social prescribing
- Pathways for people with emotionally unstable personality disorders
- Development in adult fostering as an alternative to hospital and placement
- Developing effective links with groups across our community with a high prevalence of mental health disorders
- Include needs-based mental health support within integrated cluster-based services
- Effective transition arrangements for young people with a mental health need/serious emotional distress when entering adult services (18+)

With the following results:

A delivery plan co-produced with people with mental health needs and other stakeholders setting out setting out the changes we are committing to and measures that will demonstrate impact.

Existing work across the partnership

HENEIDDIO'N DDA
AGEING WELL

Cardiff Council with Partners

Ageing Well Strategy

- Well-being focused Hubs / Day Centres
- Age and Dementia Friendly City
- Community Engagement and Wellbeing Teams
- Community Occupational Therapy
- First Point of Contact and Independent Living Services
- Community Resource Teams,
- The Pink Army
- Technological solutions, aids and adaptations
- Community Living Schemes
- Trusted assessment across services

Together, as partners

@Home Programme

- (supporting delivery of the Six Goals for Urgent and Emergency Care and Strategic Programme for Primary Care and Ageing Well Strategy and national Further Faster mandate)
- Access
- Intermediate Care
- Locality model / cluster-based working
- Health and Well-being Centres

Dementia Programme

- A series of regional approaches to support learning and development of dementia care services

Falls prevention

- Keeping Me Well
- Technology-enabled care and alternative responses to ambulance call outs, that are focused on a proportionate response that keeps people safely at home

Vale of Glamorgan Council with Partners

Vale Alliance

- Shared Lives (Adult Placements)
- Vale Community Resource Service
- Wellbeing Matters Service
- Day Services and Respite Care
- Community Drug and Alcohol Team
- Council-run care homes
- Adult Advocacy
- Housing solutions and telecare
- Direct payments and 'Your Choice' Scheme
- Trusted assessment across services

Cardiff and Vale University Health Board with Partners

Sustainable, cluster-based community services;
Resilient and high performing unscheduled care system;
Continued transformation of mental health services focusing on a home first model

Our commitment to ageing well @Home

HENEIDDIO'N DDA
AGEING WELL

Over the next 5 years we will:
Establish integrated, locality-based, health & care services focused on meeting and improving the health and wellbeing of the local population.

This is important because:

The number of people aged 65 to 84 years is expected to increase from c. 70,000 people to c. 93,000 people between 2019 and 2039 - a rise from 14% to 16.2% of the total population.

Life expectancy is known to be associated with socio-economic status: in 2017, there was a life expectancy gap of 8.6 years for males and 6.6 years for females, between the most and least disadvantaged areas in Cardiff and the Vale of Glamorgan (PNA 2022).

'A Healthier Wales: our Plan for Health and Social Care' sets out a clear vision for a 'whole system approach to health and social care' focusing on supporting health and wellbeing and preventing illness.

The @Home programme will deliver:

- a new model of place-based, joined-up care and support across NHS, councils, third sector services and local community networks
- designed around the person and their family/support network
- independence through care and support delivered at home or closer to home

We will deliver:

An Integrated Community Care Service including key enablers – an integrated workforce, integrated care records (Digital Care Region) and integrated Business Intelligence to support delivery of:

- Coordinated access to community services – improve and streamline community referral routes through a single point of access
- Intermediate care – crisis response and step-down reablement
- MDT clusters – roll-out of the learning and development of the Southwest Cardiff Cluster model together with a co-produced new locality operating model
- Health and Wellbeing Centres – delivery of the capital assets which support joined up community services

We will build on this by supporting:

Mental Health with a focus on increased prevention and support for people who may have delirium, dementia and/or depression

Advance Care and End of life planning - Improving services to support planning that empowers choice and reduces avoidable, multiple hospital admissions

Cost of living - providing effective information and support to help address the impact of rising food, energy and travel costs

Loneliness and isolation - increasing identification of those at risk and improving access to services which can support them

Healthy approach to alcohol consumption - Reducing harm from substance use, focussing on prevention and early identification of harmful alcohol use

Falls prevention: Extending community services to reduce risk of falls

Tech-enabled care: extending access to support independent living

With the following results:

Ageing Well @home will ensure:

- Access to a range of services which help long term wellbeing and prevent reliance upon long term health and social care
- Opportunities for home-based re-ablement instead of a hospital stay
- Those at greatest risk of an emergency hospital attendance will have specific plans in place to reduce that need
- Advance care planning is in place
- Access to the right accommodation, assistive technology and support to enable independence
- Safe alternatives to avoidable admissions

This will mean:

- Reduced unplanned admissions to hospital and long-term care
- Reduced attendances at EU and crisis-led packages of social care
- Reduced hospital length of stay
- More healthy days at home
- Reduced attendances at EU and unplanned admissions because of falls

Our commitment to people with dementia

HENEIDDIO'N DDA
AGEING WELL

Over the next 5 years we will:
Raise awareness of Dementia and its determinants whilst working to develop community-based services that enable equitable and timely access to diagnosis and person-centred care.

This is important because:

There are approximately 7,000 people living with dementia assumed to be living in our region. However, 47% of these people are currently un-diagnosed.

It is anticipated that these numbers will increase by c.25% over the next 5 years.

One third of this population live in care homes whilst the others live within the community.

The condition brings with it co-morbidities and complications including delirium and increased infection risk.

Our local plan is already in place that focuses on bringing dementia management closer to home.

We will deliver:

- Compassionate communities who are aware of their risk factors through a coordinated campaign of raising awareness and an increased number of 'dementia friendly' communities
- Community-based care and support through increasing advocacy in the design of person-centred care plans and service developments
- Clear community-based pathways for timely assessment and diagnosis
- The Dementia Friendly Hospital Charter
- A regional approach to dementia care learning and development

We will build on this by:

- Improving accommodation solutions
- Innovating research including 'technology enabled care' to support strength-based approaches in care for all ages and stages
- Building pathways for people with learning disabilities who are at higher risk of developing dementia
- Improving awareness and access to Advance Care Planning
- Hospital-based Liaison Support to create a dementia friendly journey through hospital
- Innovating flexible support for unpaid carers, including responsive respite options for different needs

With the following results:

People experiencing dementia will:

- Know how to actively reduce their risk factors
- Live in local communities who are empowered to be safer places for people with dementia
- Receive an earlier diagnosis, especially in those population groups where dementia is likely to be most prevalent.
- Have specific plans in place to reduce the need for an emergency hospital attendance / admission
- Have plans in place to support their needs when a hospital visit is necessary
- Receive support to develop advance care plans where appropriate
- Receive optimised access to the right accommodation, assistive technology and support to enable independence
- Unpaid carers will have access to a wide range of help and support

This will mean:

- Reduced waiting times for assessment and diagnosis
- Increased numbers of dementia friendly businesses and communities
- Reduced attendances at ED
- Reduced unplanned admissions due to lack of support for unpaid carers
- Increased numbers of workforce trained through the Good Work Framework for dementia

Section 3: Strategic Enablers

The development of new models of care cannot be achieved in isolation of a number of significant enablers; in particular how we support and co-produce with our staff across the partnership, new care models and ways of working that lead to better health and wellbeing outcomes for the population.

The following set out the main strategic enabler themes which have programmes of work directly connected to the delivery of the commitments set out in the Joint Area Plan and the successful operation of the RPB.

Appendix 1: Models of Care

Strategic Programme	Strategic Project	Models of Care					
		Community Based Care - Prevention & Comm Co-ord	Community Based Care - Complex Care Closer to Home	Emotional Health and Wellbeing	Families Staying Together & Therapeutic Support for CEC	Home from Hospital	Accommodation Based Solutions
At Home	Access - prevention	yes	yes	yes		yes	yes
	Access - Hospital to home (incl. acceleration component)	yes	yes	yes		yes	yes
	Intermediate Care Crisis and home-based response (incl. acceleration component)	yes	yes	yes		yes	yes
	Intermediate Care - Bedded reablement					yes	
	Accelerated Clusters	yes	yes	yes		yes	
Dementia Strategy	Assessment and Diagnosis	yes	yes	yes			
	Community: Prevention and compassionate communities	yes	yes	yes		yes	
	Community: Care and support	yes	yes	yes			
	Hospital Support	yes		yes		yes	
	Dementia training and development	yes	yes	yes		yes	yes
emPower	Early intervention and prevention	yes		yes	yes		
	No wrong door	yes	yes	yes	yes	yes	
	Right Support	yes	yes	yes	yes	yes	yes
	CYP with complexity of needs - Community		yes	yes	yes	yes	yes
	CYP with complexity of need - Hospital		yes	yes	yes	yes	yes
Complex Health and Disabilities	Planning for my future	yes	yes	yes	yes	yes	yes
	Continuing care	yes	yes	yes	yes	yes	yes
	Children's learning disability services	yes	yes	yes	yes	yes	yes
Learning Disabilities	Fit for my future (incl. acceleration)	yes	yes	yes	yes		yes
	Right support, right time (incl. acceleration)	yes	yes	yes	yes		yes
	Having my own home (incl. acceleration)	yes	yes	yes	yes	yes	yes
Carers	Access	yes	yes	yes	yes	yes	
	Young Carers	yes	yes	yes	yes		
	Adult Carers	yes	yes	yes	yes	yes	
Autism	Integrated Autism Service	yes	yes	yes			

This table provides an overview of how our commitments fit with the Models of Care defined by Welsh Government in its Regional Integration Fund Guidance. Red boxes indicate the primary focus of the project whilst amber boxes indicate secondary contributions to other Models of Care. These are underpinned by a focus on prevention and supporting people to stay well in their community and environment.

Report Title:	Integrated Annual Plan 2023/2024- Additional Requirements by 31st May			Agenda Item no.	7.7
Meeting:	Board	Public	X	Meeting Date:	25.05.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	Abigail Harris, Executive Director of Strategic Planning				
Report Author (Title):	Ashleigh O'Callaghan, Head of Strategic Planning				

Main Report
Background and current situation:

Submission of Integrated Annual Plan 2023/2024

Each year, Health Boards in Wales are required to submit a 3-Year Integrated Medium Term Plan (IMTP) to Welsh Government (WG) as part of their statutory duties under the NHS Finance (Wales) Act 2014.

Cardiff and Vale University Health Board (CAVUHB) were unable to achieve a balanced 3-year IMTP and as such, developed an Integrated Annual Plan 2023/2024 which was supported by Board on the 30th March and submitted to Welsh Government on the 31st March.

Given the scale of operational delivery and the financial challenge, the year-end forecast deficit position for 2023/2024 is £88 million inclusive of a 4% recurrent cash-releasing savings target.

Despite the challenging financial and operational context, our plan committed to achieving 14 of the 16 ministerial priorities. Detail is provided below for the two we are unable to commit to:

- The plan demonstrated that we would not be able to achieve the 52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones by 30 June 2023 and maintained throughout 2023/24 moving to "36 weeks RTT standards by March 2024" for a number of specialties even when productivity and efficiency measures are factored in to our planning.

- Due to our waiting list position, the plan was unable to fully comply with the priority to address capacity gaps within specific specialties to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025, however commits to undertaking numerous actions to address the capacity gap, including a reduction of outpatient follow ups.

Through plan development, the Board considered a range of options to achieve balance in year. These included a complete stop of all non-clinical non-pay expenditure, stopping essential investments in service safety, delivery and in commissioned services as well as an immediate exit of our temporary workforce (including bank and overtime payments).

Following an extensive discussion, the Board came to the view that taking this action would lead to negative quality and safety impacts of a level that would seriously threaten the health and well-being of both patients and teams, regulatory and compliance failures and a significant deterioration in the performance of the organisation and achievement of Ministerial Priorities. The Board's view was that action of this nature would not be consistent with our organisational values and would lead to deep detriment of a scale that recovery would both be extended and more expensive.

Post-submission Feedback and Next Steps

CAVUHB received a letter from Judith Padget dated 21st April which indicated that given the scale of risk, urgent work is required on setting out an improvement in the position on delivery of all Ministerial priorities and a de-risking of the financial assessment, by the 31st May.

The letter did not seek resubmission of full plans, rather a supplementary paper by 31st May outlining further work undertaken and the impact this has on plan assumptions.

A WG Annual Plan Scrutiny meeting was held on 4th May, chaired by the Deputy Chief Executive Officer NHS Wales and attended by the Health Board Chief Executive Officer, Chief Operating Officer, Executive Director of Strategy & Planning, Executive Director of People and Culture, Executive Director of Finance and the Welsh Government Director of Planning.

At this meeting, positive feedback was shared; it was recognised that the CAVUHB plan is well presented, understood and credible and that there is confidence in the Health Board's ability to deliver.

It was relayed that there is high confidence in our ability to deliver against the Ministerial Priorities and from a planned care perspective, recognition that out of 30 specialties, we have a credible plan to deliver 52-week target for 22 of those specialties and a plan to deliver 104 week target for 23 specialties.

The drivers of the underlying deficit were accepted and understood and it was agreed that whilst our current Cost Improvement Programme is stretching but credible, improvement in degree of assurance is required.

Additional Requirements

The following requirements were set out for resubmission on 31st May:

1. Updated Planned Care Ministerial Template and Urgent Care Templates based upon specific WG feedback
2. Greater detail on Investment Cases, justification and benefits realisation
3. More assured Cost Improvement Programme aiming for a minimum 75% plans in place.

In a follow up letter from Nick Wood, Deputy Chief Executive NHS Wales, received on the 15th May, it was further emphasised that in addition to the above ask:

- Updated financial returns are required including Month 1 return as usual (15 May) and updated MDS financial sections that reflect the changes identified as part of the overall review of plans (31 May). The Financial Planning & Delivery team of the NHS Executive will also provide specific feedback on the financial plans.

- An updated Minimum Data Set will be required where any material changes have been made to plans.

Further work has been undertaken on the above areas and are presented to Board for approval prior to submission to WG on 31st May.

Our approach to meet these requirements are set out as follows:

- Annex 1 - describes our plans for Planned Care Recovery and updating our Planned Care Ministerial Priority template (Updated template and MDS to follow as **supporting document**)
- Annex 2- describes our plans to update the Urgent Care Ministerial Priority template (Updated template to follow as **supporting document)**
- Annex 3 - provides a summary on rationale for investment cases above the allocation
- Annex 4- provides an update on the Cost Improvement Programme

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

- The context across Wales is extremely challenging and the position described above is not unique to CAVUHB; all Health Boards in Wales were unable to submit an IMTP and the collective deficit position across Wales is estimated to be circa £630 million

- Despite the challenging financial position set out in the CAVUHB plan, there remains high confidence in the organisation to deliver

- The updates required for resubmission on the 31st March are on track for completion

Recommendation:

The Board is requested to:

1. **NOTE** the requirements for resubmission of elements of the Annual Plan as set out above, by 31st May

2. **APPROVE** the approach to addressing these requirements as set out in Annexes 1-4

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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	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

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Annex 1- Plans for Planned Care Recovery

Recovery Fund

A letter was issued on the 21st March from the Deputy CEO NHS Wales outlining a process for Health Boards to access the Retained Planned Care Regional Recovery Fund (£50 million top-sliced across NHS Wales), with bids to be submitted by 12th May.

Since then, the Health Board has worked closely within the NHS Wales Executive Team and partners within the South-East Wales Regional Portfolio to co-produce a robust plan enabled by the retained planned care recovery funds.

The CAVUHB response, submitted to WG on 12th May, seeks funds for three core schemes on a recurrent basis:

- The CAVUHB component of the Regional Cataract Expansion Case
- The CAVUHB component of the implementation of the Regional Diagnostic Programme (specifically implementation of Community Diagnostic Hubs)
- An extension of our protected Green Zone operating at University Hospital Llandough (additional day case capacity)

As the proposed implementation timescales vary across each of these schemes according to lead-in times, there is a part year effect to our delivery and costs for this financial year. As such, to improve our organisational response to the ministerial ambitions for planned care in the immediate term and at pace, we have developed non-recurrent schemes focused on improved delivery in advance of implementation of the three core schemes noted above.

These schemes include delivery of additional outpatient and operating sessions across specialties via a combination of locums and additional hours undertaken by our own staff.

This would improve our position in comparison to our annual plan out-turn described within the original submission of the Planned Care Ministerial Template.

The improved position is as below:

Specialty	104-week position (end of December)	156-week position (end of September)
Orthopaedics (spines)	600	200
Urology	1400	150
Ophthalmology	1000	
Gynaecology	350	
General Surgery	420	
ENT	100	
Total	3870	350

CAVUHB has also undertaken a similar review of the opportunities available to support the single cancer pathway standard and associated diagnostic improvements in advance of Community Diagnostic Hubs going live- non-recurrent funding would support diagnostic capacity in ultrasound (through insourcing) and MRI.

The total request is as per the table below and is supported by a detailed plan including capacity and demand modelling and indication of benefits, which has been submitted to WG alongside the response letter.

Total CAV UHB Request £7,900,000		
CAV UHB 2023/24 request **£7,968,886**	CAVUHB 2024/25 request **£7,173,000**	CAV UHB recurrent request **£6,383,000** (NB: excludes phase 2 Ophthalmology plan)

Specific Feedback on the Planned Care Ministerial Template

WG feedback on the CAVUHB Planned Care Ministerial template submission is as follows:

- Strengthen milestones and actions to deliver improvements
- Provide more detail on how achievement of 8-week target will be delivered through collaboration

The CAVUHB Ministerial Template and the Minimum Data Set will be updated to reflect this position based on the assumption that the planned care funding requested will be received.

Early indication is that there is strong support from WG for our proposition.

We do not know at the time of writing when confirmation of funding will be received.

Annex 2- Re-submission of Urgent and Emergency Care Ministerial Priority Template

WG feedback on the CAVUHB Urgent and Emergency Care Ministerial template submission is as follows:

- Strengthen the ambition of this section. Provide more detail and outline clear measurable milestones/timelines.
- Provide baseline data for OOHs/ 111 and 24/7 urgent care
- Clarify the assumptions made for six goals funding
- Strengthen actions regarding SDEC (Same Day Emergency Care)

It was noted at the feedback meeting that some of these actions are articulated within the plan document itself but were not reflected in the template.

The submission will be strengthened to reflect the points above.

Annex 3- Rationale for Investment Decisions Above Allocation

During 2022/2023, CAVUHB chose to invest in a small number of business cases over and above the Health Board's financial allocation. These investment decisions will have a financial impact for 2023/2024.

All investments were appraised as critical by the organisation when balancing cost, safety and quality.

Cases underwent significant scrutiny and challenge through the governance processes for investment, including:

- Sign off by Clinical Boards,
- Support and challenge through the executive led Investment Group panel
- Scrutiny through the Senior Leadership Board
- Endorsed by Finance Committee
- Approved by Board

These cases and their rationale are summarised below. All investments will be subject to a rigorous post implementation review during 2023/2024 through the Investment Group process whereby benefits realisation is reviewed to ensure value for money is achieved as set out in the original case.

Investment Title	Description	Financial Impact	Rationale	Benefits
Acute Care Physicians to support the redesign of the Acute Medicine model	To secure 6 WTE additional consultant physicians in acute medicine to support the medical assessment unit, short stay medical patients with SDEC, MEACU and other SDEC models	**Recurrent** £0.943m	Significant pressure within the Acute and Emergency Unit at UHW has exacerbated post-pandemic and has led to increased waiting times, poor patient experience and risk of harm. The current Acute Medicine Model of Care is unsustainable and the increase in demand has not been matched by an increase in resources. Reviewing models across the UK it is clear to see that a successful service with appropriate and safe patient care is predicated on having acute care physicians (ACP) delivering and leading the care needed. Following options analysis, this was assessed as the only sustainable method of resourcing the service to ensure resilience and safety of services.	• Increased number of patients managed as same day patients • Reduction in LOS for ambulatory patients • Reduction in number of patients admitted > 24 hours • Improved ambulance turnaround times • Improved quality of care for ambulatory patients • Improved early decision making on the lower ground floor • Improved call handling to support scheduling of demand • Increased number of patients attending Hot Clinics and virtual wards • Potential reduction of medical outliers due to reduction in admissions
Phase Critical Care Expansion-Initial 3-Bed Expansion Saunders.Nathan 24/05/2023 15:05:05	Case for investment of 3 intensive care beds, to close the demand and capacity gap at Cardiff Intensive Care Unit	**2023/2024** £1.141m **Recurrent** £2.176m	The sickest patients in hospital are reliant on critical access to the critical care team and the Intensive Care Unit. Without this, their mortality is increased. The capacity of the ICU has a major impact on this early access. The main unit at UHW	• Improved survival rates • Improving timely clinical care and patient experience • Reduced LOS for survivors • Increased rehabilitation and recovery capability • Improved staff retention and workforce resilience • Safe environment

Investment Title	Description	Financial Impact	Rationale	Benefits
			has a recognised 31 commissioned ICU beds. The majority of these are tertiary commissioned beds that support major trauma, neurosurgery, tertiary cardiac, renal, CAR-T Therapy, heamatology and vascular, amongst others. There is a consilience of evidence from over a decade that makes the case that the ICU at UHW should have a bed base of closer to 50. It is the secondary care commissioned bed component of capacity that is the dominant contribute to the inadequate capacity. When compared to Wales and international data, this secondary care bed capacity is a distant outlier for the demand it services, and the result is limited access to critical care at the optimum point. The case supports phased expansion of intensive care beds, to close the gap.	• Improved patient flow
Phased Critical Care Expansion- 24/7 Patient at Risk Team	Case for investment in 24/7 Patient at Risk Team	**2023/2024** £0.433m **Recurrent** £1.1024m	Patients admitted from hospital wards to an intensive care unit (ICU) have a higher overall percentage mortality than patients admitted from other areas of the hospital. Despite being on a hospital ward, often	• Equity of service day and night • Specialised care delivered in the most appropriate setting

Investment Title	Description	Financial Impact	Rationale	Benefits
			for several days, a high percentage of these admissions receive cardiopulmonary resuscitation (CPR) before their ICU admission. Before cardiac or respiratory arrest, ward patients often have severe physiological abnormalities. Similarly, many patients admitted from the wards to ICU have abnormal physiological values in the hours preceding ICU admission. A 'patient-at-risk team' (P@RT), similar to the medical emergency team, was established in order to respond to these patients. The P@RT assess patients who fulfil certain physiological criteria, as well as other patients causing concern to medical and nursing staff. The P@RT objectives are aimed to improve care for these patients by providing advice and support to those responsible for them on the wards, by facilitating early ICU admission when appropriate, and by preventing unnecessary ICU admissions, thereby releasing valuable beds for use by patients in greater need. At present, the service provision is a 7-day daytime service only. As a result of this, gaps in P@RT have negative consequences on	• Out of hours discharge support from ICU • Workforce resilience • Compliance with national guidance and key recommendation made in external review of intensive care services in Cardiff and Vale UHB by the College of Anaesthetists in April 2019 • Compliance with national response times to the sickest ward patients

Investment Title	Description	Financial Impact	Rationale	Benefits
			the most important outcomes and experience for our patients, their families and our team, as well as the operational running and service development of those other specialties that rely on critical care.	
Case to fulfil gaps in Obstetric and Neonatal Service provision against the Ockenden Recommendations (Phase 1)	Improvement of quality and experience for mothers and babies in alignment with the Ockenden recommendations through investment in additional staff	**2023/2024** £1.441m **Recurrent** £2.727m	This investment will deliver a significant quality, training and governance improvement whilst realising system-wide benefits and longer-term financial savings. Becoming compliant with the Ockenden recommendations brings opportunity benefits such as full compliance with the Cwm Taf review recommendations, achieving BAPM (British Association of Perinatal Medicine) compliance in Neo-Natal Unit, and addresses the issues raised in a recent HIW inspection. It is of note that in the past financial year alone there have been three obstetric cases from Cardiff and Vale that have been settled via Welsh Risk Pool, the quantum of each of the cases ranges from 21 to 35 million pounds.	• Improvement in caesarean section rates towards the UK standard • Reduction in LOS, to improve patient experience and quality • Ambitions to reduce all still births, aligned to NHS England targets • A reduction in unplanned assumptions to neonatal critical care • The goal of longer-term financial savings from clinical negligence claims

Annex 4- Cost Improvement Plan Update

The Health Board has a 4% cost improvement financial plan ambition equating to £32m, which consists of a 1% general efficiency target and a 3% cost improvement from a number of value/Improvement themes.

The table below shows the cost improvement position as of Friday 12th May. £14.758m of Green/Amber schemes have been identified against the £32.0m target (46%).

Schemes will progress at pace with the aim of identifying 100% of schemes by the end of Q1 and a minimum of 75% by the end of May.

Progress will be monitored through both SLB and Clinical Board Performance Reviews.

2023-24 Savings Summary

2023-24 in-year plans

Clinical/Service Board	23-24 Target	Green	Amber	Total Green & Amber	Red	Shortfall on Total Target vs Green & Amber	% Target identified Green / Amber
	£'000	£'000	£'000	£'000	£'000	£'000	%
Capital Estates and Facilities	631	601	0	601	3	30	95%
Children and Women	869	356	222	578	318	292	66%

2023-24 full year impact recurrent schemes

Recurrent Target	Green	Amber	Total Green & Amber	Red	Shortfall on Total Target vs Green & Amber	% Target identified Green / Amber
£'000	£'000	£'000	£'000	£'000	£'000	%
631	694	0	694	328	-63	110%
869	10	0	10	249	859	1%

Clinical Diagnostics and Therapeutics	799	263	0	263	0	536	33%	799	66	0	66	0	733	8%
Corporate Executives	334	62	0	62	0	272	19%	334	52	0	52	0	282	16%
Medicine	919	919	0	919	0	0	100%	919	700	0	700	0	219	76%
Mental Health	719	0	225	225	0	494	31%	719	0	225	225	0	494	31%
Primary, Community and Intermediate Care	1,615	939	461	1,400	140	215	87%	1,615	1,277	605	1,881	582	-266	116%
Specialist Services	988	808	179	986	0	2	100%	988	186	422	608	0	380	62%
Surgical Services	1,126	670	170	840	0	286	75%	1,126	91	220	311	0	815	28%
Subtotal - Grip and Control	**8,000**	**4,618**	**1,256**	**5,873**	**461**	**2,127**	**73%**	**8,000**	**3,075**	**1,472**	**4,547**	**1,159**	**3,453**	**57%**
Length of Stay	3,000	896	145	1,041	450	1,959	35%	3,000	896	0	896	600	2,104	30%
Theatres Productivity	500	0	0	0	0	500	0%	500	0	0	0	0	500	0%
Income Generation	500	100	0	100	280	400	20%	500	0	0	0	280	500	0%
Medicines Management	2,000	0	243	243	0	1,757	12%	2,000	0	0	0	0	2,000	0%
Continuing Healthcare	1,500	0	0	0	0	1,500	0%	1,500	0	0	0	0	1,500	0%
Facilities and Estates	500	72	0	72	0	428	14%	500	86	0	86	0	414	17%
Procurement	5,000	1,465	125	1,591	360	3,409	32%	5,000	70	0	70	90	4,930	1%
Workforce Efficiencies	8,000	13	2,746	2,759	170	5,241	34%	8,000	0	2,746	2,746	170	5,254	34%

COVID Consequentials	3,000	0	3,000	3,000	975	0	100%	3,000	0	3,000	3,000	0	0	100%
Review of Investments		0	0	0	0	0	0%		0	0	0	0	0	0%
Commissioning		0	79	79	1,170	-79	0%		0	79	79	1,170	-79	0%
Subtotal Cost Improvement Themes	**24,000**	**2,546**	**6,339**	**8,885**	**3,405**	**15,115**	**37%**	**24,000**	**1,052**	**5,825**	**6,877**	**2,310**	**17,123**	**29%**
Total Savings Position	**32,000**	**7,164**	**7,594**	**14,758**	**3,866**	**17,242**	**46%**	**32,000**	**4,127**	**7,297**	**11,424**	**3,469**	**20,576**	**36%**

Total Savings Position as of 28th April	**32,000**	**5,064**	**7,370**	**12,434**	**4,634**	**19,566**	**39%**	**32,000**	**2,915**	**7,228**	**10,143**	**3,347**	**21,857**	**32%**
Progress		**2,100**	**224**	**2,324**	**-768**	**-2,324**			**1,212**	**69**	**1,281**	**122**	**-1,281**	

Report Title:	Supporting Information for Integrated Annual Plan Resubmission: NHS Planning Toolkit Resubmission			Agenda Item no.	7.7.1
Meeting:	Board	Public	X	Meeting Date:	25th April
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Abigail Harris, Executive Director of Strategic Planning				
Report Author (Title):	Ashleigh O'Callaghan, Head of Strategic Planning				

Main Report
Background and current situation:

The NHS Planning Toolkit (formerly named the Minimum Data Set) is a technical document designed to support organisations to articulate the planning assumptions that underpin the plan document and support triangulation between service, finance and workforce assumptions.

This data set is submitted to the NHS Wales Planning team alongside plan document submission and assumptions are updated each quarter.

The CAV NHS Planning Toolkit submission has been updated for the 31st May resubmission to reflect updated assumptions for planned care, dependent upon access to the Planned Care Recovery Fund, which are also reflected in the associated Ministerial Template for Planned Care (as articulated within the Board Paper- Annex 1).

Finance updates for the resubmission includes:

- Income assumptions following WG confirmation e.g. Real Living Wage 23/24
- In turn, updating expenditure forecasts
- Savings tracker based on latest position on identified savings
- Capital schedules (IFRS 16)

The CAV NHS Planning Toolkit is located in the Board **Supporting Documents Folder.**

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

It is important to note that the NHS Planning Toolkit is designed as a technical document to support organisations in planning.

The composition of the toolkit, including the measures included within it, has regularly changed over recent years and therefore comparisons with previous years can present challenges. Historically it's use within the Health Board has been limited. The Health Board continues to work with Welsh Government colleagues to refine the Toolkit to improve accuracy and usefulness for the organisation. For this year, related pertinent assumptions and associated plans are articulated within the plan document or supporting ministerial template documents

Recommendation:

The Board is requested to:

NOTE that the CAV NHS Planning Toolkit has been updated to reflect revised planned care assumptions and finance assumptions as outlined within the Integrated Annual Plan Board paper, and will be resubmitted on the 31st May.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
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*									
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
n/a
Safety: Yes/No
n/a
Financial: Yes/No
n/a
Workforce: Yes/No
n/a
Legal: Yes/No
n/a
Reputational: Yes/No
n/a
Socio Economic: Yes/No
n/a
Equality and Health: Yes/No
n/a
Decarbonisation: Yes/No
n/a

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
24/05/2023 15:05:05

Report Title:	Annual Review of Standing Orders and Standing Financial Instructions					Agenda Item no.	7.8
Meeting:	Board		Public	x		Meeting Date:	25 May 2023
			Private				
Status *(please tick one only):*	Assurance	x	Approval	x		Information	
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Corporate Governance						

Main Report
Background and current situation:

NHS Bodies in Wales must agree Standing Orders ("SOs") that, together with a set of Standing Financial Instructions ("SFIs") and a scheme of decisions reserved to the Board, a scheme of delegations to officers and others, and a range of other framework documents, set out the arrangements within which Welsh Health Bodies make decisions and carry out their activities.

The Health Board's SOs and SFIs are based upon the Welsh Government issued model Standing Orders and model Standing Financial Instructions. The model Standing Orders, Reservations and Delegation of Powers ("Model SOs") and model Standing Financial Instructions ("Model SFIs") were last reviewed by Welsh Government in March 2021 for Local Health Boards, Trusts, the Welsh Health Specialised Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC). On the 7 April 2021 the Welsh Government wrote to the Chair of the Health Board to inform him that the Health Board was required to incorporate and adopt the latest review of the Model SOs and Model SFIs into the Health Board's own SOs and SFIs. The updated version of the Welsh Government's Model SOs and Model SFIs was incorporated and set out in the Welsh Health Circular (WHC (2021) 010) which was issued on 16 September 2021.

In line with the letter issued by the Welsh Government in April 2021, and following formal Board approval in May 2021, the Health Board incorporated and adopted the Welsh Government's updated Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions.

SFIs

The SFIs detail the financial responsibilities, policies and procedures adopted by the Health Board.

On 7 November 2022 the Welsh Government wrote to the Welsh Health Boards and Trusts to inform them of an addendum made to the SFIs. The Addendum was reported to Board at its meeting in January for noting.

Since the review undertaken by Welsh Government in March 2021 and the Addendum issued in November 2022, the Welsh Government has not carried out any further reviews of the Model Standing Financial Instructions.

A review of the SFIs and the Health Board's accounting policies was considered by the Audit and Assurance Committee on 4 April 2023.

SOs

Since the review undertaken by Welsh Government in March 2021 and the instructions issued to the Health Board in April 2021 to update its SOs, the Welsh Government has not carried out any further reviews of the Model SOs.

Temporary variation to Standing Order 7.2.5

On 18 April 2023 the Welsh Government wrote to the Health Board, via email, in relation to a proposed temporary variation to Standing Order 7.2.5. By way of explanation:

a) Pursuant to Standing Order 7.2.5 the Health Board must hold an Annual General Meeting (AGM) in public no later than the 31 July each year.

b) In light of the Auditor General's request to delay certification of the annual accounts to 31 July 2023, the Welsh Government has confirmed that the Health Board's Final Annual Report and Accounts must be submitted to Audit Wales and HSSG Finance by 31 July 2023. Accordingly, the Health Board is unable to hold its AGM by 31 July this year.

c) The NHS Wales 2022-23 Manual for Accounts, Chapter 3 of the Financial Reporting Manual ("Chapter 3 Guidance") stipulates that "a public meeting must be held no later than *28 September 2023* (*date to be confirmed by Welsh Government*) at which the Annual Report and audited accounts are presented".

d) In accordance with paragraph xxx) of Section A of its SOs, the Health Board is able to vary or amend its own Standing Orders, provided that the variation is in accordance with the relevant statutory regulations (ie the Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009). It has been determined that this section of the SOs can be for local determination.

e) The Health Board has been given notice of this motion via email from Welsh Government on the 18 April 2023 which formally confirmed and acknowledged, as referred to within the recently revised Chapter 3 Guidance, that the Health Board's Annual General Meeting should take place no later than 28 September and not 31 July in 2023.

f) At its meeting held on 11 May 2023, the Audit and Assurance Committee recommended that the Board approves the temporary variation to Standing Order 7.2.5 in respect of the temporary arrangements for the AGM in 2023 so that the current wording "*The LHB must hold an AGM in public no later than the 31 July each year"* is temporarily amended to *"The LHB must hold its 2023 AGM in public no later than the 28th September. This variation from the date of July will be reviewed on the 31st March 2024".*

This temporary variation will be reviewed on the 31st March 2024 following the publication of the Manual for Accounts containing the Annual Report and Accounting Timetable for 2023-2024.

Save for the proposed variation to Standing Order 7.2.5, no further amendments to the Health Board's SOs are required by Welsh Government at present.

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

The Health Board's SOs and SFIs are based upon the model standing orders and model standing financial instructions issued by Welsh Ministers to Local Health Boards. There is a requirement to keep the SOs and SFIs under review to ensure they remain accurate and current, hence the purpose of this report.

It is understood that the Welsh Government plans to undertake a review of the Model SOs in the imminent future. An update report will be brought back to (i) the Audit and Assurance Committee and (ii) the Board once that review has been carried out.

Recommendation:

The Board is requested to:

a) **Note** the update, as set out in the body of this report, with regards to the Health Board's Standing Orders and SFIs; and

b) **approve** the proposed temporary variation to Standing Order 7.2.5.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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	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		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

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No

Financial: No

Workforce: No

Legal: No

The proposed variation to Standing Order 7.2.5 complies with the Standing Orders which permit variation and amendments to the Health Board's Standing Orders (ie paragraph xxx) of Section A to the Standing Orders). Further, as set out in the report Welsh Government has confirmed its agreement to the proposed variation.

Reputational: No

Socio Economic: No

Equality and Health: No

Decarbonisation: No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:
Audit and Assurance Committee	4 April 2023
Audit and Assurance Committee	11 May 2023

Report Title:	Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act (2016)			Agenda Item no.	7.9
Meeting:	Board	Public	X	Meeting Date:	25.05.2023
		Private			
Status *(please tick one only):*	Assurance		Approval X	Information	
Lead Executive:	Executive Nurse Director				
Report Author (Title):	Nurse Staffing Levels Lead				

Main Report
Background and current situation:

The Nurse Staffing Levels (Wales) Act (2016) became law in March 2016. 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. The process of determining the staffing levels of 25B wards across the Health Board is well established. In addition, the Executive Nurse Director requests all clinical areas outside of 25B&C to undertake a review of their staffing levels in line with this timetable to provide assurance of compliance with section 25A.

Section 25 B&C identifies wards where there is a duty to calculate nurse staffing levels using a prescribed methodology and maintain nurse staffing levels.

Section 25E requires Health Boards to submit an Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (2016). The assurance report enclosed covers the reporting period April 6th 2022 – April 5th 2023.

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

- A new digital platform, SafeCare has been introduced across CAVUHB primarily to 25B areas.
- The challenges associated with introducing a new digital platform during the reporting period is acknowledged. It is recognised that this platform will significantly improve the reporting ability and enhances operational decision making going forward.
- Internal creation of nurse staffing levels and patient acuity visualisers, enables the UHB to respond to trends and changes quickly and appropriately outside of the bi-annual audit period.
- In March 2023 the Internal Audit department undertook a formal review of the UHB's compliance with the Nurse Staffing Levels (Wales) Act (2016). The report provided reasonable assurance and an action plan has been agreed.
- A significant increase in hospital acquired pressure damage is reported during this reporting period. Previously only avoidable incidents had been reported in relation to hospital acquired pressure damage and this report contains both avoidable and unavoidable incidents. There has been a reduction in avoidable hospital acquired pressure damage during this reporting period.

The Annual Assurance Report 2022-2023 enclosed:

- Provides the Board with assurance of the progress through 2022-23 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.
- That the Designated Person has discharged their duty in calculating the number of nurses required in 25B areas 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
-

Recommendation:

The Committee is requested to:

Receive the report as assurance that the statutory requirements relating to section 25B of the Nurse Staffing Levels (Wales) Act (2016) have been fulfilled.

Note the funded nurse staffing establishments detailed in appendix A, undertaken as part of bi-annual recalculations.

Note the reasonable attempts to monitor and maintain nurse staffing levels at a time of significant organisational pressure.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	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

Prevention	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: Yes
As detailed in the report
Safety: Yes
As detailed in the report
Financial: No
Workforce: No

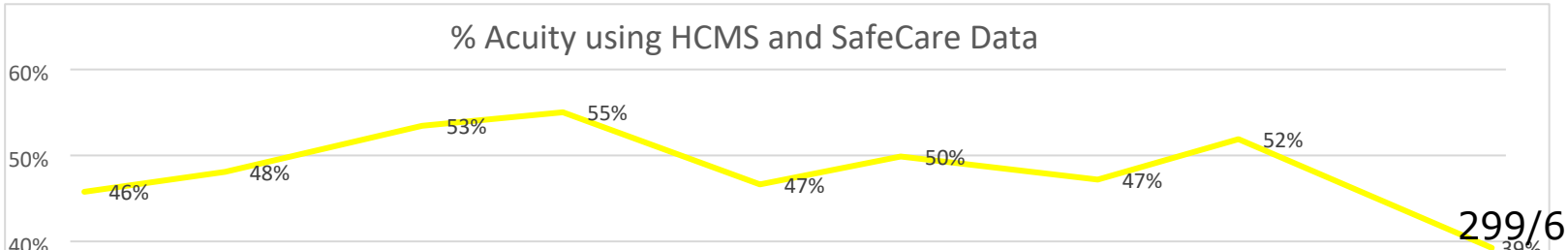
Legal: No	
Reputational: No	
Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board	Cardiff and Vale University Health Board		
Date annual assurance report is presented to Board	May 2023 Report includes data from April 6th 2022- April 5th 2023		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	18-19	22-23	2
During the last year the number of occasions (for section 25B wards) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	No areas required re-calculation outside of the bi-annual calculation period.	No areas required re-calculation outside of the bi-annual calculation period.	No areas required re-calculation outside of the bi-annual calculation period.
The process and methodology used to calculate the nurse staffing level.	The Nurse Staffing Levels (Wales) Act 2016 (the 2016 Act) Statutory Guidance requires the designated person (the Executive Nurse Director) to formally present to the Board, the nurse staffing requirements for adult in-patient medical, surgical and paediatric wards (Section 25B). Furthermore, Section 25A of the 2016 Act relates to the overarching responsibility placed upon each Health Board, to ensure they have robust workforce plans, recruitment strategies, structures and processes in place to ensure appropriate nurse staffing level across their organisation. This report provides the Board with a detailed summary of the nurse staffing levels for wards to which Section 25B pertains, in addition, it should be noted that the Executive Nurse Director conducts a review of nurse staffing levels across all clinical areas in line with the requirements of Section 25A of the 2016 Act. The agreed process for signing off the establishments on a bi- annual basis within Cardiff and Vale University Health Board (CAVUHB) is well established and has been followed within this reporting period. The triangulated methodology (Image 1) has been used to calculate the number of nurses required to provide care sensitive to patients' needs. This is derived from using professional judgement, patient acuity and quality indicators. The process for signing off the establishment includes the professional judgement and view of the Ward Sister/ Charge Nurse through to the Director of Nursing for the Clinical Board and includes the Executive Directors of Operations, Finance and Workforce. The Clinical Boards and Executive Nurse Director have agreed establishments that they consider will meet all reasonable requirements and provide care sensitive to patients' needs. A record of this process is documented for each clinical area using an All-Wales recording template. A summary of the current establishments is recorded on each Section 25B ward area using the Annual Assurance Report Appendix: Summary of Required Establishment (Appendix A). 		

CAVUHB has continued to see unprecedented demand on clinical services. This has resulted in a continual review and monitoring of nurse staffing to ensure the appropriate levels are maintained to meet the operational footprint. As a result, several establishment changes have occurred during the current reporting period as part of the bi-annual reviews. The reasons for these changes are indicated in the table below:

Ward	Reason for Establishment Change
B7	Change in skill mix, pilot of Band 4 Assistant Practitioner role.
Heulwen North	Ward Closure.
Heulwen South	Reduction in establishment as Heulwen North Closed.
LSW 1	Change to skill mix, pilot of Band 4 Assistant Practitioner role.
LSW 2	Change to skill mix, pilot of Band 4 Assistant Practitioner role.
Annex	Winter capacity, ward closure.
CAVOC	Increase in bed base from 27 to 35, returning towards previous activity.
Acute Surgical Ward A5	Reduction in establishment following a reduction in bed base on previous ward (previously on A1L 23 beds). Currently 19 beds.
C1	Bed base 23 with no decrease in capacity at weekends.
Island Ward	No change to establishment, but previous incorrect calculation, now corrected.
C7	Reduction in beds due to organisational change of footprint.
PolyTrauma Unit	Uplift to a 12-hour co-ordinator required 7 days a week

During recalculations, the acuity scores of patients informs decisions regarding the staffing establishments required. Using the national tool, 'The Welsh Levels of Care' patient acuity is scored twice daily using the scale of 1-5 (where Level 1 care is routine care with rising acuity to Level 5 care, i.e. 1:1 care). The graph below (Graph 1) highlights the increasing acuity across the organisation particularly in relation to the number of Level 4 and 5 patients and this appears to be a consistent trend that has been noted in other Health Boards across Wales. Training has been provided to clinical staff to ensure a consistent assessment of individual patients' acuity. This training has formed part of the initial SafeCare implementation and is ongoing. This will support CAVUHB having robust and consistent reporting ability.



	Throughout this report it should be noted that there has been a significant change to the way in which data has been collected across CAVUHB with the introduction of HealthRoster and SafeCare. Further details on the rollout of these systems can be seen in the reporting section below.
Informing patients	The statutory guidance states that "LHBs and Trusts must make arrangements to inform patients of the nurse staffing level". The Health Board is required to inform patients of the nurse staffing levels by ensuring that the most up to date information is displayed on wards in relation to the staffing levels agreed. In March 2023 the Health Board Internal Audit Department undertook a formal review of the Health Boards compliance with the 2016 Act and the report provided "reasonable assurance". The report highlighted that in most cases the nurse staffing levels were being displayed on the wards however the establishment templates forms were being used to display the nurse staffing levels and in some cases the information was of the previous establishment reviews. All- Wales bilingual poster templates are available and it is a key priority of the Nurse Staffing Levels Lead (a new role across CAVUHB) to ensure that all wards are compliant with this element of the 2016 Act. The Nurse Staffing Levels lead will ensure provision of the correct documentation to the ward areas including access to the frequently asked questions document. A further audit will be undertaken by the Nurse Staffing Levels Lead following this establishment review. Formal evidence will be provided on the outcome of this to the Executive Nurse Director.

Section 25E (2a) Extent to which the nurse staffing level has been 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.

		Period Covered May 2022- May 2023		
Extent to which the required establishment has been maintained within adult acute medical and surgical wards.		**Number of Wards:**	**RN (Wte)**	**HCSW (Wte)**
	Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle.	42	970.59	673.39
	WTE of required establishment of adult acute medical and surgical wards funded following first calculation cycle.	42	970.59	673.39
	Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle.	40	927.94	666.86
	WTE of required establishment of adult acute medical and surgical wards funded following second calculation cycle.	40	927.94	666.86
	The calculation of ward establishments are a collaborative process undertaken with nursing representatives, workforce, finance and the Executive Nurse Director. Consequently, the funding of all 25B wards is fully funded, including the 26.9% uplift to ensure the supernumerary status of the Ward Sister/ Charge Nurse. The overall bed occupancy across CAVUHB has increased during this reporting period with the introduction of areas such as Integrated Care Assessment Unit which do not meet the requirements of 25B under the 2016 Act. Other rehabilitation areas are also not included in these calculations as they are excluded under 25B of the 2016 Act. There has been scheduled de-escalation of wards which were opened to support winter pressures. For more details of individual wards and their calculated nurse staffing levels, please refer to Appendix A of this report.			

		Period Covered May 2022-May 2023		
Extent to which the required establishment has been maintained within paediatric inpatient wards		**Number of Wards:**	**RN (Wte)**	**HCSW (Wte)**
	Required establishment (WTE) of paediatrics inpatient wards calculated during first cycle	2	106.21	24.21
	WTE of required establishment of paediatrics inpatient wards funded following first calculation cycle	2	106.21	24.21
	Required establishment (WTE) of paediatrics inpatient wards calculated during second calculation cycle	2	106.21	25.02
	WTE of required establishment of paediatrics inpatient wards funded following second calculation cycle	2	106.21	25.02
	The 2 paediatric wards under 25B of the 2016 Act fully partake in the establishment reviews and receive a 26.9% uplift to ensure the supernumerary status of the Ward Sister/ Charge Nurse.			

Mental Health

Whilst there is no All-Wales requirement to report on areas outside of 25B of the 2016 Act, to provide assurance of Section 25A of the 2016 Act the Executive Nurse Director reviews all bi-annual establishment calculations across all clinical areas in CAVUHB. In the Mental Health Clinical Board there is ongoing work to ensure the professional, service and financial envelop are aligned. In the table below (Table 1) for 8 areas in mental health clinical board the professional, service and financial envelop are aligned. However, in 12 areas across the mental health clinical board, the professional and service requirements are being met for the working establishments and there is ongoing work being undertaken to align these clinical areas to the financial envelope. The number of clinical areas reporting alignment across professional, service and financial requirements has improved from previous reporting periods.

Table 1

Alignment of professional service and financial envelope		**Ongoing work to align these clinical areas to the financial envelope**		
Alder	St Barruc	Willow	Maple	East 18
Meadow	Pine	Beech	East 10	Daffodil
Park Road	Phoenix	Oak	East 12	Elm
Cedar	Ash	Hazel	East 14	East 16

In order to provide assurance that the areas remain safe, the Clinical Board maintains the working establishment of these areas through daily review of establishments, redeploying staffing resource across the service, use of temporary staff and redirecting financial resource from underspends elsewhere within the Clinical Board. However, whilst this approach supports the day to day working establishment of the wards, it is recognised that further work is required to meet the funded establishment.

It is acknowledged that currently there are no further plans to extend the Nurse Staffing Levels (Wales) Act 2016. Mental Health Clinical Board participated in the All- Wales professional judgment audit. Work is underway for Health Roster to be rolled out across Mental Health Clinical Board and SafeCare will be introduced following this. As with other areas across CAVUHB this will provide live information relating to nurse staffing and patient acuity and will support decision making related to establishment reviews.

Extent to which the planned roster has been maintained within both adult medical and surgical wards and paediatric inpatient wards

There has been a significant change in the way nurse staffing levels are reviewed and recorded in CAVUHB and some caution should be applied to the data produced during this reporting period. CAVUHB has moved away from using the HealthCare Monitoring System following the introduction of the Allocate software *SafeCare*. SafeCare is an additional ward management module that forms part of the e-rostering system, Health Roster. It provides a visual presentation of live data entered by operational staff relating to the acuity of patients and planned and deployed nurse staffing levels. SafeCare is the national system for use within Wales.

A pilot using SafeCare on four ward areas highlighted that for SafeCare to have a meaningful impact on decision making and mitigation of risk in relation to nurse staffing levels across CAVUHB the system needed to be introduced at pace. SafeCare implementation began at the end of January 2023 and has now been rolled out to 54 areas of which 43 areas are included under 25B of the 2016 Act. The final 25B area will begin using SafeCare in May 2023 following the introduction of Health Roster in that area. There are further plans to extend the SafeCare rollout to include areas such as Emergency Unit, Critical Care and additional areas in paediatrics.

Using SafeCare, acuity data will now be consistently available, which will support live staffing decisions but also will provide accurate and reliable data to track trends and support future planning in terms of nurse staffing.

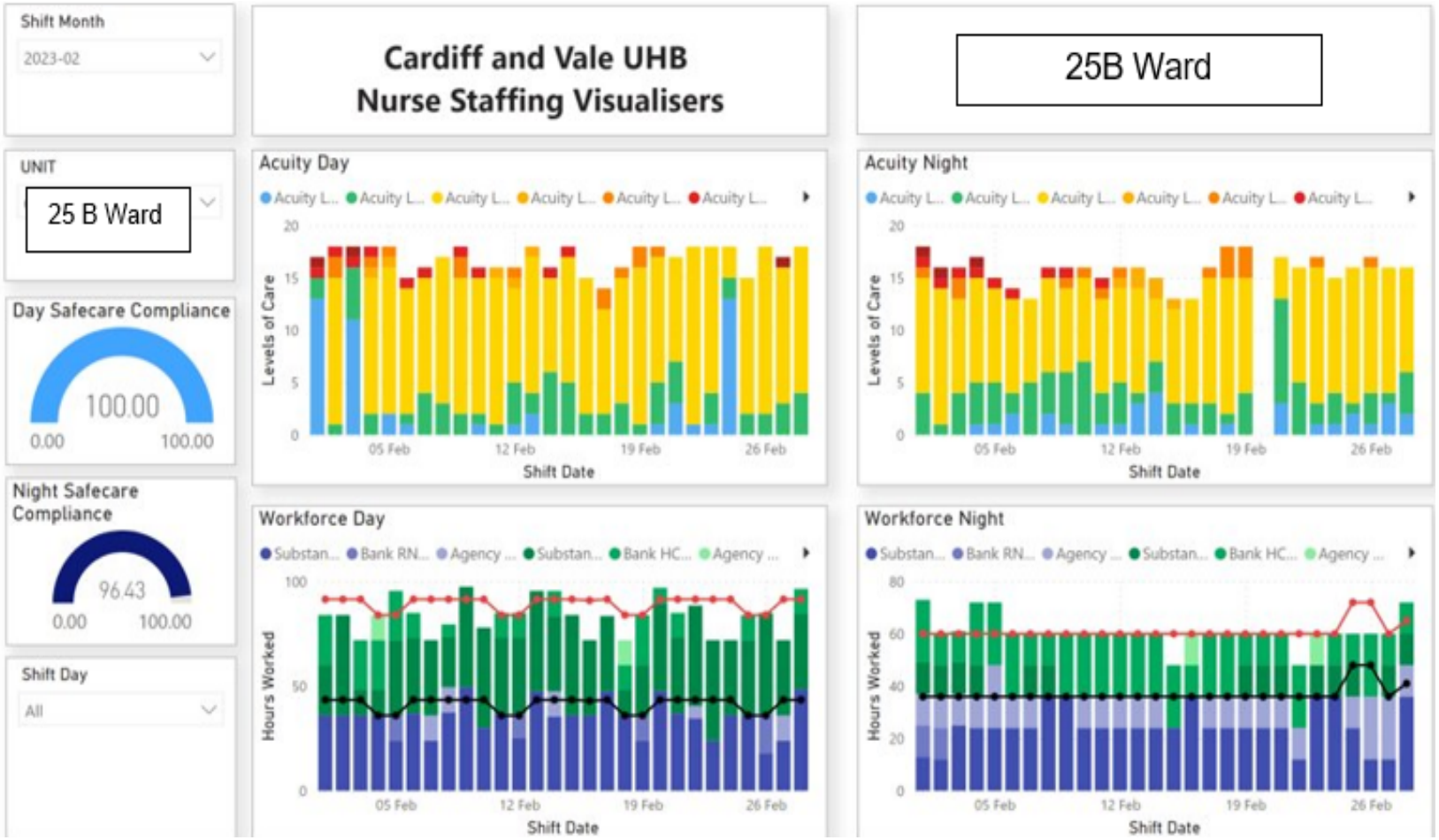
June 2022	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
Total	1466	65.69%	3.0%	6.96%	24.35%	56.8%

March 2023	Total Number of Shifts	Shifts where planned roster met	Shifts where planned roster not met	% of shifts where Red Flags Raised	Data Completeness
Total	2604	65.6%	34.4%	3.2%	100%

The data for June 2022 uses data produced using the HealthCare Monitoring System. Due to the changes in data capture using SafeCare, the complete data picture is not available for the most recent reporting period however the data available is provided in the table. The data also includes the number of red flags raised in SafeCare and these have been introduced following the All- Wales SafeCare Standard Operating Procedure. It is noted that other Health Boards have faced similar challenges with the change in reporting system and it is anticipated that this data will be available during the next reporting periods.

During previous reporting periods and in the first cycle of this reporting period HEIW developed a Power BI dashboard displaying visualisers of nurse staffing levels and patient acuity using information drawn from the Health Care Monitoring System. In the second cycle of this

reporting period previously developed dashboards were not available. Processes have been developed across CAVUHB to recreate the visualisers using SafeCare and going forward these will be available to clinical areas on a monthly basis. The visualisers will be available to all areas that have implemented SafeCare and not restricted to 25B areas under the 2016 Act. Furthermore, the visualisers will be available to inform any establishment reviews required outside of the bi-annual cycle.



This visualiser is a live example from one of the 25B wards in CAVUHB. It provides information regarding the planned and actual nurse staffing levels for both day shifts and the night shift together with patient acuity and patient flow data (not seen in this image). SafeCare compliance can also be seen displayed within this visualiser. This information has been included within the report to provide assurance that nurse staffing levels and patient acuity is being closely monitored despite the significant change through introducing the software SafeCare.

Extent to which the planned roster has been maintained within adult acute medical and surgical wards

June 2022	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
Total	1348	66.10%	3.26%	6.53%	24.11 %	54.8%

March 2023	Total number of shifts	Shifts where planned roster met	Shifts where planned roster not met	% of shifts where Red Flags Raised	Data completeness
Total	2480	67.7%	32.3%	3.2%	100%

Extent to which the planned roster has been maintained within paediatric inpatient wards

June 2022	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
Total	118	61.02%	0	11.86%	27.12%	98.3%

March 2023	Total number of shifts	Shifts where planned roster met	Shifts where planned roster not met	% of shifts where Red Flags Raised	Data completeness
Total	124	79.84%	20.16%	3.2%	100%

On the 1st October 2021 the second duty of the 2016 Act was extended to paediatric inpatient wards. The process and systems used within paediatric inpatient wards align to those used within the adult medical and surgical inpatient wards and use of HCMS and now SafeCare has enabled CAVUHB to capture the data required to inform the reporting requirements under section 25E of the 2016 Act.

Process for maintaining the Nurse staffing level	CAVUHB has an established process in place to review nurse staffing levels on a daily basis. Consideration of operational risk and mitigating actions associated with nurse staffing include: • Daily review of nurse staffing levels throughout each Clinical Board. • Staffing deficits escalated and reviewed by the Director of Nursing for each Clinical Board. • Escalation through daily operational site meetings. • Registered Nurses and Health Care Support Workers re-deployment when required. • A 'pool' roster created to provide high level of flexibility when there is short notice unavailability of substantive staff. • Senior Nurse Staffing Rota to provide weekday cover until 21:00hrs and weekend cover 07:00-21:00hrs. The SafeCare system allows live monitoring of patient acuity and nurse staffing and aids operational decision making and mitigation of risk in relation to nurse staffing. As CAVUHB adopts and implements SafeCare there is an opportunity to review the CAVUHB Operating Framework for the Nurse Staffing Levels (Wales) Act 2016 and consider the impact of using SafeCare operationally. The Operating Framework will be reviewed during Q1 23-24 and will be presented to the Directors of Nurses and the Executive Director of Nursing for agreement. In addition to these operational efforts, broader work is being undertaken to maintain nurse staffing levels, these include: • Over 400 nurses have joined the Health Board through the overseas nurse recruitment programme. • Recruitment events held across a range of settings including attendance at student streamlining events. • The development of the Nurse Retention Steering Group with 6 workstreams led by Senior and Lead Nurses. • A Director of Nursing responsible for Strategic Nursing Workforce Planning. • Development of the Assistant Practitioner role and an educational programme to support this. • Ongoing roll out of HealthRoster and SafeCare. • Introduction of Roster Review Panels to review and promote positive rostering practices. • The Clinical Standards and Innovation Group, with agenda items focusing on addressing the Chief Nursing Officer's Priorities. • The introduction of a Ward Accreditation Programme, an opportunity to promote and celebrate quality improvement strategies.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	**Total number of incidents/ complaints during last year**	**Number of closed incidents/ complaints during current year**	**Total number of incidents/ complaints <u>not closed</u> and to be reported on/during the <u>next</u> year**	**Increase (decrease) in number of closed incidents/ complaints between previous year and current year**	**Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained**	**Number of incidents/complain t s where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor**
Hospital acquired pressure damage (grade 3, 4 and unstageable)	25	44	2	+19	13	6
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	9	14	6	+5	5	1
Medication errors never events	0	0	0	0	0	0
Any complaints about nursing care	0	0	10	0	0	0

Reportable Pressure Damage (unstageable, Grade 3 and Grade 4)

There has been a total of 44 reports of pressure damage (unstageable, Grade 3 and Grade 4) which includes unavoidable and avoidable incidents. The data provided appears to indicate a significant rise from the previous reporting period. However, on investigation the pressure damage reported in 21-22 only focussed on avoidable incidents. Following a review of incidents in this reporting period there were 10 avoidable incidents and 34 incidents where the incident was unavoidable. This highlights a reduction in the number of avoidable pressure damage incidents across CAVUHB. The pressure damage collaborative was formed in April 2021 and is led by a Director of Nursing with the aims of:

- reducing the incidence of healthcare acquired pressure damage within the Health Board.
- speeding up adoption of innovation into practice to improve clinical outcomes and patient experience.

Measuring pressure damage per 1000 bed days, data available to the pressure damage collaborative now shows that in February 2023 for HealthCare Acquired Pressure Damage there has been a reduction of 27% since May 2021. It is noted and accepted that there has been a change to Datix systems during this time period. The collaborative continues to progress this work with the formation of 7 subgroups, focusing on different strategies to continue reducing pressure damage across CAVUHB.

Reportable Falls (resulting in severe harm or death)

There has been a total of 14 incidents of falls resulting in severe harm or death. All falls either those deemed avoidable or unavoidable have been included in this report. 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.

Reportable Medication Errors (Never events)

There has been no medication related never-events during this reporting period.

Reportable Complaints about Nursing Care

There are no closed complaints about nursing care during the reporting period. Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR). There are currently 10 complaints under investigation and these will be included in the next reporting period if the complaint is upheld.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Paediatric inpatient wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	**Total number of incidents/ complaints during last year**	**Number of closed incidents/ complaints during current year**	**Total number of incidents/ complaints not closed and to be reported on/during the next year**	**Increase (decrease) in number of closed incidents/ complaints between previous year and current year**	**Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained**	**Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor**
Hospital acquired pressure damage (grade 3, 4 and unstageable)	0	0	0	Same	0	0
Medication errors never events	0	0	0	Same	0	0
Infiltration/ extravasation injuries	0	0	0	Same	0	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	0	0	0	Same	0	0
Any complaints about nursing care	0	0	0	Same	0	0

There have been no reported incidents or complaints within paediatric in-patient wards during this reporting period.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	As noted in the previous annual assurance report, maintaining planned rosters during the reporting period has continued to be challenging. The UHB's bed capacity has increased, additional wards/units have opened and a rising level acuity has been noted. Additional demand across the Emergency Department and rising length of stay has further strained the ability of the nursing workforce to maintain established staffing levels. Actions taken in response to not maintaining established nurse staffing levels are varied. Within clinical boards, actions are captured as part of daily staffing 'huddles' and efforts to mitigate short staffing are shared across clinical board. SafeCare offers staff the opportunity to raise 'Red Flags' where there are concerns in clinical areas. These Red Flags are reviewed as part of the daily staffing huddles and Senior and Lead Nurse out of hours are able to quickly review and respond to these Red Flags. Wards are also supported with the provision of a senior/lead nurse out of hours who is available to make staffing decisions and provide professional judgement. Actions are recorded in daily staffing reports and shared with directors of nursing, the temporary staffing team and the patient access team. Actions taken when nurse staffing levels not maintained include: • Risk mitigation by redeployment of staff across clinical areas • Review of plans to increase capacity • Support of allied health professionals to meet patient needs • Provision of enhanced overtime to increase fill rate • Deployment of pool Health Care Support Workers • Review of enhanced supervision requirements • Number of beds are reviewed and closure considered if appropriate particularly across paediatrics. 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.

Conclusion & Recommendations	CAVUHB continues to experience significant challenges in maintaining nurse staffing levels. CAVUHB continues to provide assurance its' staffing calculations and reporting requirements have been fulfilled. Furthermore, across the organisation there are established processes in place to review changing acuity and nurse staffing levels. Appendix A provides a summary of the establishment reviews agreed by the designated person (Executive Nurse Director). **Highlights of this report include:** • Efforts of Workforce and Nursing teams to develop and strengthen recruitment and retention of both registered and unregistered staff. • Introduction of SafeCare ahead of schedule to all but one 25B areas and future plans for further rollout. • The acknowledged challenges associated with introducing a new digital platform during the reporting period but recognition that it is anticipated, this will be significantly improved going forward. • Internal creation of nurse staffing levels and patient acuity visualisers allowing CAVUHB to respond to trends and changes quickly and appropriately outside of the bi-annual audit period. • Internal Audit of compliance with the Nurse Staffing Levels Act (2016) found reasonable assurance with agreed action plan to be implemented. **The Board is asked to:** Receive the report as assurance that the statutory requirements relating to section 25B of the Nurse Staff Levels (Wales) Act have been fulfilled. Note the funded nurse staffing establishments detailed in appendix A, undertaken as part of bi-annual recalculations. Note the reasonable attempts to monitor and maintain nurse staffing levels at a time of significant organisational pressure.

Annual Assurance Report Appendix: Summary of Required Establishment

Health board/trust:	Cardiff and Vale University Health Board		
Period reviewed:	Start Date: April 2022	End Date: April 2023	
Number of wards where section 25B applies:	Medical:	Surgical: (Also includes Specialist CB)	Paediatric:
	18	22	2

To be completed for EVERY ward where section 25B applies

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment Adult Acute Medical inpatient wards**

Ward	Required Establishment at the start of the reporting period		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		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
A1 Link	16.58	17.06	Yes	16.58	17.06	Yes.	Yes	No	NA	No	NA	NA
A1 MDU	31.84	19.9	Yes	31.84	19.9	Yes	Yes	No	NA	No	NA	NA
B7	37.96	17.06	Yes	35.12	19.9	Yes.	Yes	Yes	Change in skill mix,	No	NA	NA

									pilot of Band 4 Assistant practitioner role.			
C6	27.04	23.86	Yes	27.04	23.86	Yes	Yes	No	NA	No	NA	NA
C7	27.6	20.71	Yes	26.58	21.71	Yes.	Yes	Yes	Reduction in beds due to organisational change of footprint.	No	NA	NA
C4 South	19.06	17.06	Yes	19.06	17.06	Yes	Yes	No	NA	No	NA	NA
Heulwen North	12.37	14.21	Yes	0	0	NA	NA	NA	Ward Closed	No	NA	NA
Heulwen South	14.21	11.37	Yes	12.37	11.37	Yes	Yes	Yes	Reduction in establishment as Heulwen North Closed	No	NA	NA
Lakeside Ward 1	21.91	28.43	Yes	15.21	35.11	Yes	Yes	Yes	Change to skill mix, pilot of Band 4 Assistant practitioner role.	No	NA	NA
Lakeside Wing Ward 2	15.21	20.18	Yes	12.37	23.02	Yes	Yes	Yes	Change to skill mix, pilot of Band 4 Assistant practitioner role.	No	NA.	NA

A7	28.84	19.44	Yes	28.84	19.44	Yes	Yes	No	NA	No	NA.	NA
Cystic Fibrosis Unit	12.11	2.78	Yes	12.11	2.78	Yes	Yes	No	NA	No	NA	NA
East 2	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No	NA	No	NA	NA
East 4	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No	NA	No	NA	NA
East 6	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No	NA	No	NA	NA
East 7	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No	NA	No	NA	NA
East 8	20.9	17.06	Yes	20.9	17.06	Yes	Yes	No	NA	No	NA	NA
West 2	20.9	19.9	Yes	20.9	19.9	Yes	Yes	No	NA	No	NA	NA
Annex	6.68	8.52	Yes	6.68	8.52	Yes	Yes	No	NA	No	NA	NA

Specialist Clinical Board

Ward	Required Establishment at the start of the reporting period		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)		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
West 6	20.9	8.53	Yes	20.9	8.53	Yes	Yes	No	NA			
B1	30.66	13.4	Yes	30.66	13.40	Yes	Yes	No	NA	No	NA	NA
A4Poly Trauma Unit	24.2	19.9	Yes	25.2	19.9	Yes	Yes	Yes	Uplift to a 12 hour co-ordinator required 7 days a week	No	NA	NA
T4	38.37	8.53	Yes	38.37	8.53	Yes	Yes	No	NA	No	NA	NA
B4N	36.35	25.18	Yes	36.35	25.18	Yes	Yes	No	NA	No	NA	NA
B4H	37.6	21.67	Yes	37.6	21.67	Yes	Yes	No	NA	No	NA	NA
Teenage Cancer Unit	18.22	5.69	Yes	18.22	5.69	Yes	Yes	No	NA	No	NA	NA
B5	29.89	18.32	Yes	29.89	18.32	Yes	Yes	No	NA	No	NA	NA

T5	30.7	13.64	Yes	30.7	13.64	Yes	Yes	No	NA	No	NA	NA
C4 Neurology	18.5	20.41	Yes	18.5	20.41	Yes	Yes	No	NA	No	NA	NA

Adult Acute Surgical inpatient wards

Ward	Required Establishment at the start of the reporting period		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		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
Duthie	22.17	14.21	Yes	22.17	14.21	Yes	Yes	No	NA	No	NA	NA
A2	31.46	17.06	Yes	31.46	17.06	Yes	Yes	No	NA	No	NA	NA
B2 Vascular	34.3	19.9	Yes	34.3	19.9	Yes	Yes	No	NA	No	NA	
CAVOC	22.93	16.24	Yes	26.99	19.09	Yes	Yes	Yes	Increase in bed base from 27 to 35, returning towards previous	No	NA	NA

									activity.			
West 3	15.21	12.79	Yes	15.21	12.79	Yes	Yes	No	NA	No.	NA	NA
West 1	20.90	19.9	Yes	20.90	19.9	Yes	Yes	No	NA	No	NA	NA
West 5	15.21	17.06	Yes	15.21	17.06	Yes	Yes	No	NA	No	NA	NA
B6	31.46	17.06	Yes	31.46	17.06	Yes	Yes	No	NA	No	NA	NA
A5 South	18.06	8.53	Yes	0	0	Yes	Ward closed		Ward closed			
A5 Acute Surgical Ward	20.09	11.37	Yes	17.24	11.37	Yes	Yes	Yes	Reduction in establishment following a reduction in bed base on previous ward (previously on A1L 23 beds). Currently 19 beds	No	NA	NA
A6 South	15.21	11.37	Yes	15.21	11.37	Yes.	Yes	No	NA	No	NA	NA
A6 North	19.32	14.21	Yes	19.32	14.21	Yes.	Yes	No	NA	No	NA	NA

C1	22.07	12.64	Yes	22.88	12.64	Yes	Yes	Yes	Bed base 23 with no decrease in capacity at weekends.	No	NA	NA

Paediatric inpatient wards

Ward	Required Establishment at the start of the reporting period		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		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
Island	52.17	10.56	Yes	52.17	11.37	Yes	Yes	No	No change to establishment, but previous incorrect calculation, now corrected.	No	NA	NA
Gwdihw	54.04	13.65	Yes	54.04	13.65	Yes	Yes	No	NA	No	NA	NA

Report Title:	Fire Safety Policy and Fire Safety Management Arrangements			Agenda Item no.	7.10
Meeting:	Board	Public	X	Meeting Date:	25.05.23
		Private			
Status *(please tick one only)*:	Assurance		Approval	X	Information	
Lead Executive:	Director of People and Culture				
Report Author (Title):	Head of Health and Safety				

Main Report

Background and current situation:

The Health Board is committed to ensuring that suitable fire safety arrangements are in place to minimise the risk of fire in line with the statutory requirements under the Regulatory Reform (Fire Safety) Order 2005 and the guidance laid out in the HTM Firecode suite of documents.

A Fire Safety Policy of Intent has been drawn up, in line with the H&S Policy Statement of Intent, this is underpinned by the Fire Safety Policy. This document is more streamlined than previous and details the high-level commitment of the UHB in terms of Fire Safety.

A new document titled Fire Safety Management Arrangements has been compiled which comprehensively details the specific arrangements in place for the safe management of the fire risk at Cardiff and Vale UHB.

The reviewed Fire Safety Policy and the new Fire Safety Management Arrangements were published for consultation with the assistance of the Corporate Governance team and no feedback was received following the same.

The reviewed Fire Safety Policy and the new Fire Safety Management Arrangements were received by the Health & Safety Sub-Committee on 18.04.23 where it was discussed and recommended to be received by the Board for approval.

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

This is an important policy review and the revised documents that include the Fire Statement Policy of Intent underline's the CEO and all Executive Directors commitment to fire safety at CAVUHB.

Recommendation:

The Board is requested to:

a) **Approve:**

(i) The Fire Safety Policy Statement of Intent;
(ii) The Fire Safety Policy (UHB 22); and
(iii) The Fire Safety Management Arrangements (UHB 504)

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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		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	
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*									
Prevention	X	Long term		Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes/No
No
Safety: Yes/No
Yes: It is the purpose of the documents to mitigate the fire risk to patients, staff, contractors and other stakeholders.
Financial: Yes/No
No
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
No
Socio Economic: Yes/No
No
Equality and Health: Yes/No
Yes
Decarbonisation: Yes/No
No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	25 May 2023

Saunders,Nathan
24/05/2023 15:05:05

IMS-06-01-CAV:
Fire Safety Policy

Reference Number: IMS-06-01-CAV (UHB 022) Version Number: 5	Date of Next Review: 25 May 2026 Previous UHB Reference Number: *Any reference number this document has been previously known as N/A*

IMS-06-01-CAV: FIRE SAFETY POLICY

Purpose

This document is the Cardiff and Vale University Health Board Fire Safety Policy.
At Cardiff and Vale University Health Board, fire safety responsibilities are core values, which means always acting and operating in a way that prevents harm to people, the environment and the communities in which we operate. We expect all our employees, contractors and volunteers to conduct themselves at all times in alignment with the values, commitments and principles in this policy. The policy provides an unambiguous statement of fire safety strategy applicable to Cardiff & Vale University Health Board (C&V UHB) and premises where NHS patients receive treatment or care, excluding a single private dwelling. This policy should be read in conjunction with IMS-06-02-CAV Fire Safety Management Arrangements.

Audience
The target audience for this document is all employees.
The policy is also applicable to our organisational partners (e.g. our contractors, suppliers and joint venture partners etc) when undertaking services for, or on behalf of CVUHB.

Health and Safety Committee
The Health and Safety Committee must approve the Fire Safety Policy and commit to its full implementation.

Board
The Board should agree the Fire Safety Policy and commit to its full implementation.

Policy Review
The Policy will be reviewed within three years of implementation or under significant Health Board or legislative change or significant fire incident. This will be determined by the Head of Health and Safety in collaboration with the Chief Executive.

Line Managers
Line managers **must** ensure that their employees and contractors understand the requirements of the Fire Safety Policy. All line managers should demonstrate the importance of the Fire Safety Policy by ensuring that their own behaviours actively promote and serve as a role model for the desired health and safety values and principles.

Communication to organisational partners.
Managers **must** ensure that the Fire Safety Policy is communicated to stakeholders and

other business partners and ensure that they actively cooperate with the Health Board to achieve compliance with the policy. **All employees** All our employees must ensure that they adhere to the policy and understand the implications for them. **Policy Commitment** The Chief Executive's commitment to this policy is underpinned by the Fire Safety Policy of Intent.
Supporting Documents • Fire Safety Policy Statement of Intent • IMS-06-02-CAV Fire Safety Management Arrangements

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and confirmed there is no adverse impact

Policy Approved by	Board
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Group
Accountable Executive or Clinical Board Director	Executive Director of People and Culture

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	November 2010	January 2011	Replace previous UHB version reference no 36
2	April 2013	May 2013	Policy reflects changes required to meet the requirements of the Enforcement Notice issued by South Wales Fire Service in relation to the management of smoking in Mental Health premises.

3	July 2015	July 2015	Policy reflects organisational structural changes. A review of the arrangements with regards to Deputy Fire Safety Managers for UHW. It reflects site closures and amendments and continues to reflect the requirements imposed by the Fire Service in relation to Whitchurch Hospital site.
4	July 2018	July 2018	Updated and reviewed in line with the UHB
5	TBC	TBC	Full review and update in line with the UHB. Inclusion of a policy statement.

Fire Safety Policy

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Fire Safety Policy of: -

Cardiff and Vale University Health Board
Woodland House
Maesycoed Road
Cardiff
CF14 4HH

Applicable to all Health Board Locations Including: -

- Woodland House
- Barry Hospital
- Cardiff Royal Infirmary
- Children's Hospital for Wales
- Community Premises/Health Centres and Clinics
- Rookwood Hospital
- St David's Hospital
- University Dental Hospital
- University Hospital Llandough
- University Hospital Wales

1.0 Aim

The aim of this Policy is:

- To minimise the risks and the impact on life to employees, contractors, patients, visitors and all those that may be at risk of fire arising out of our work activities
- Recognise the statutory requirements under the Regulatory Reform (Fire Safety) Order 2005.
- To discharge its fire safety responsibilities as a provider of healthcare by ensuring that suitable and sufficient arrangements are in place to manage all fire related subjects and matters that arise concerning fire safety across the Health Board.
- Where a fire occurs, this policy aims to minimise the impact of such occurrence on life safety, the delivery of patient care, the environment and property.

2.0 Objectives

- To minimise the number of fire related incidents. Should an outbreak occur ensure it is immediately detected, effectively contained and quickly extinguished by rapid intervention, and sound planning.
- To establish a culture of co-operation, communication, competency and control for fire safety.

- To communicate to all relevant persons and stakeholders the requirements placed on the UHB and them in adhering to this policy.
- To assess and provide appropriate levels of resource in relation to fire safety measures across the UHB
- To proactively support development of working partnerships initiatives with all relevant stakeholders and appropriate bodies to facilitate the provision of the fire safety where reasonably practicable.

3.0 Facilitation

- The Board has overall accountability for the activities of CAVUHB. The board discharges its responsibilities for fire safety through the Chief Executive as detailed in IMS-06-02-CAV: Fire Safety Arrangements

This includes;

- The provision of appropriate levels of investment in estate and personnel to ensure the implementation of robust fire safety precautions
- Development of partnership initiatives with stakeholders and other interested parties in the provision of fire safety where reasonably practicable

4.0 Implementation

Roles tasked with managing specific aspects of fire safety should;

- Implement their fire safety responsibilities in line with IMS-06-02-CAV
- Employ a clearly defined management structure for the delivery, control and monitoring of fire safety measures
- Have a programme in place for the assessment and review of fire risks
- Develop and implement appropriate protocols, procedures, action plans and control measures to mitigate fire risks, comply with relevant legislation and, where practicable, codes of practice and guidance
- Develop and disseminate appropriate fire emergency action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment
- Develop and implement a programme of appropriate fire safety training for all relevant staff
- Develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety

- Implement its responsibilities as a provider of healthcare to ensure that suitable and sufficient governance arrangements are in place to manage fire-safety related matters;
- Provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions
- Facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

5.0 Monitoring Review and Audit

The UHB will monitor the implementation of this policy through:

- Review of fire and false alarm incident reports;
- Review of fire safety training records;
- Review of fire service notices and communications;
- Fire safety audit reports;
- Submission of reports to Health and Safety Committee

Review of this policy is the responsibility of the UHB's Fire Safety Manager.

A full audit of the effectiveness of this policy and the associated Fire Safety Management System (FSMSY) should be carried out every three years.

Document Information

Version	Authors	Reviewers	Reason for review	Date	Approved
5	R Warren	R Warren F Barrett S Bennett B Perrett	Overdue	March 2023	

Change History

Version	Description of Change
5	Rewrite and simplification of the Fire Safety Policy. This has resulted in a Fire Safety Policy Statement of Intent and a new document, IMS-06-02-CAV Fire safety procedures to detail the procedures and processes required to fulfil the UHB statutory obligations under the requirements of The Regulatory Reform (Fire Safety) Order 2005;

Equality & Health Impact Assessment for

CVUHB Fire Safety Policy

Please read the Guidance Notes in Appendix 1 prior to commencing this Assessment

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required[1]
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	No service change, this is a review of a statutory policy.
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Robert Warren, Head of Health and Safety. Fire Safety. Health and Safety. People and Culture
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Statutory Requirement to implement and regularly review Fire Safety Policy. • Outline of the management of fire safety arrangements within the Health Board through the statement of intent, the organisation and structures. • To minimise the fire safety risks within the Health Board to all staff, patients and others.

[1] http://nww.cardiffandvale.wales.nhs.uk/portal/page?_pageid=253,73860407,253_73860411&_dad=portal&_schema=PORTAL

		• Recognise the obligation imposed under the Regulatory Reform (Fire Safety) Order 2005 and Welsh Health Technical Memorandum 05/01 to prepare an appropriate policy.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3]. Saunders,Nathan 24/05/2023 15:05:05	Statutory Policy. 2018 NHS Wales Staff Survey results for the UHB (health and wellbeing and engagement questions): ○ 63% of respondents had come into work in the preceding 3 months despite not feeling well enough to perform their duties (57& in 2016, 71% in 2013) ○ 25% have felt under pressure from their manager to come to work (31% 2016, 39% 2013) and 20% have felt pressure from colleagues (23% 2016, 29% 2013) ○ 50% of respondents believe the UHB is committed to helping staff balance their work and home life (45% 2016, 38% 2013) ○ 34% of respondents have been injured or felt unwell as a result of work related stress during the preceding 12 months (28% 2016, 35% 2013) ○ 22% had personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the pubic in the preceding 12 months (20% 2016, 19% 2013) ○ 18% had personally experienced harassment, bullying or abuse at work from managers/line managers/team leaders or other colleagues in the preceding 12 months (16% 2016, 21% 2013) • Gold and Platinum Corporate Health Standard assessments in September and October 2017 found the UHB to have robust data, evaluation and comprehensive and diverse health and wellbeing practices, to the extent that the UHB is now recognised as an exemplar organisation • A consultation has taken place between 14 March and 15 April 2019 via the UHB intranet site – views have been specifically sought from Clinical Board teams, Executive Directors, Staff Representatives, Equality Manager, Welsh Language Officer, Workforce and OD (People and Culture) and the Rainbow Flag Network.

[2] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[3] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		Re
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	The policy will benefit all staff, patients, visitors, contractors and stakeholders by setting out the commitment of the UHB to high standards of health, fire safety and welfare.

EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	This policy applies to all all employees and organisational partners (e.g. our contractors, suppliers and joint venture partners etc) when undertaking services for, or on behalf of CVUHB.		All applicable groups must adhere to and support the policy.
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	This policy applies to all all employees and organisational partners (e.g. our contractors, suppliers and joint venture partners etc) when undertaking services for, or on behalf of CVUHB. The policy applies equally to physical and emotional wellbeing.	Copies of the policy can be made available in alternative formats (e.g. large print) on request.	Specific policies and procedures exist to account for all disability groups and the necessity to make reasonable adjustments accounted for. Examples include potential protected disability characteristics through the wellbeing policy and safe access/egress through normal and emergency situations in the fire safety policy.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	This policy applies to all all employees and organisational partners (e.g. our contractors, suppliers and joint venture partners etc) when undertaking services for, or on behalf of CVUHB.		
6.4 People who are married or who have a civil partner.	This policy applies irrespective of whether individuals are married, in a civil partnership or not.		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	This policy applies irrespective of whether individuals are on maternity leave or have recently had a baby.		This is covered in the UHB Maternity Procedure which requires managers to complete a Maternity Risk Assessment for pregnant employees

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	This policy applies to all all employees and organisational partners (e.g. our contractors, suppliers and joint venture partners etc) when undertaking services for, or on behalf of CVUHB.		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	This policy applies to all all employees and organisational partners (e.g. our contractors, suppliers and joint venture partners etc) when undertaking services for, or on behalf of CVUHB.		
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	This policy applies irrespective of sexual orientation.		The UHB is committed to equal opportunities and is ranked on the Stonewall Index which indicates that the UHB is committed to making the workplace LGBT+ friendly in all its practices
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design	This policy applies irrespective of whether staff are Welsh speakers.	Copies of the policy and can be made available in Welsh.	

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A Wales of vibrant culture and thriving Welsh language			
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	This policy applies irrespective of of the income of the individual concerned.		
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	This policy applies irrespective of where the individual concerned lives.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	No evidence was found to suggest that any other groups or risk factors relevant to this policy have a negative impact. The policy has a positive impact by ensuring that the same processes are followed irrespective of the individual concerned.		

6. **HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?**

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	The policy has a positive impact by ensuring that the same processes are followed irrespective of access to services offered.		
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination,	No negative impact		Other procedures exist to cover this, including Stress at Work and Alcohol and Substance Misuse. The health and wellbeing agenda is apparent throughout the WOD 3-year workplan, which is used as the basis for the workforce aspects of each Clinical Board plan.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions Well-being Goal – A prosperous Wales	The policy has a positive impact by ensuring that the same processes are followed irrespective of the individual's income and employment status.		
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment	No negative impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No negative impact		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	This policy has a positive impact by ensuring that the same processes are followed irrespective of macro-economic, environmental or sustainability factors		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	The policy aims to ensure that the Health Board has appropriate policies, procedures and other written control documents to allow it to fulfil its responsibilities. There is an impact on service users whose first language is not English and those with visual impairment. The procedure developed in support of this document requires staff take responsibility of ensuring that the principles of the policies and written control documents are explained to service users via an interpreter, translated as appropriate or explained to them with the use of a hearing loop where available if they are aware that the publication of documents in English may cause a difficulty. Impact expected to be **positive.** The supporting procedure seeks to address any issues regarding language and disability. This review of the Fire Safety Policy not only reaffirms the previous commitment from the Chief Executive, but also the commitment of the Senior Management Team who support the implementation of it. The policy document is headed by a new policy statement of intent to confirm this. This revision will be rolled out to all employees, contractors and volunteers to ensure they are aware of their responsibilities and duties under the policy and confirm their commitment to it. It is assessed that the impact of this Policy will be overwhelmingly positive for all employees, contractors and volunteers and those who may be affected by the Health Board's activities such as patients, carers, service users, visitors, and members of the public

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Copies of the policy can be made available in alternative formats (e.g. large print) on request.	Line managers	Ongoing	Action to be taken as and when required
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No, as the overall impact is positive.			

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) o stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	The Policy and EHIA will be taken to the Health and Safety Committee meeting for agreement, and will require approval from the Board of Directors. The Policy will be published on the UHB internet and intranet sites. On publication, the policy will be communicated via a briefing for staff and managers advising of the key changes. This will be communicated via the Health and Safety internet pages and the monthly H&S Dashboard. The Policy and EHIA will be reviewed two yea after approval unless changes to legislation or best practice determine that an earlier review required			

Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Mission of 'Caring for People, Keeping People Well'

Guidance

The University Health Board's (the UHB's) Strategy 'Shaping Our Future Wellbeing' (2015-2025) outlines how we will meet the health and care needs of our population, working with key partner organisations to deliver services that reflect the UHB's values. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[4]

This explicit consideration of the above will apply to strategies (e.g. Shaping Our Future Strategy, Estates Strategy), policies (e.g. catering policies, procurement policies), plans (e.g. Clinical Board operational plans, Diabetes Delivery Plan), procedures (for example Varicella Zoster - chickenpox/shingles - Infection Control Procedure) and services /activity (e.g. developing new clinical services, setting up a weight management service).

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all UHB strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the UHB's Vision, 'a person's chance of leading a healthy life is the same wherever they live and whoever they are'. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the EHIA will identify if there is a need for a full impact assessment.

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

[4] http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[5]
- Equality Act 2010[6]
- Well-being of Future Generations (Wales) Act 2015[7]
- Social Services and Well-being (Wales) Act 2015[8]
- Health Impact Assessment (non statutory but good practice)[9]
- The Human Rights Act 1998[10]
- United Nations Convention on the Rights of the Child 1989[11]
- United Nations Convention on Rights of Persons with Disabilities 2009[12]
- United Nations Principles for Older Persons 1991[13]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[14]
- Welsh Government Health & Care Standards 2015[15]
- Welsh Language (Wales) Measure 2011[16]

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the UHB to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (ie their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.

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[5] http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en
[6] https://www.gov.uk/guidance/equality-act-2010-guidance
[7] http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[8] http://gov.wales/topics/health/socialcare/act/?lang=en
[9] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
[10] https://www.equalityhumanrights.com/en/human-rights/human-rights-act
[11] http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
[12] http://www.un.org/disabilities/convention/conventionfull.shtml
[13] http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
[14] http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
[15] http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
[16] http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information or if you require support to facilitate a session, please contact Susan Toner, Principal Health Promotion Specialist (susan.toner@wales.nh.uk) or Keithley Wilkinson, Equality Manager (Keithley.wilkinson@wales.nhs.uk)

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates[17]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[18]

[17] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)
[18] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

Appendix 2 – The Human Rights Act 1998[19]

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
13. Protocol 1, Article 1 Right to peaceful enjoyment of your property
14. Protocol 1, Article 2 Right to education
15. Protocol 1, Article 3 Right to participate in free elections
16. Protocol 13, Article 1 Abolition of the death penalty

[19] https://www.equalityhumanrights.com/en/human-rights/human-rights-act

Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seek views and opinions.

Fire Safety POLICY STATEMENT

Our Goal:
At Cardiff and Vale University Health Board (C&V UHB) we are committed to developing, embedding and maintaining the highest Fire Safety standards to ensure no harm comes from our actions to people, the environment or the communities in which we operate.

Our Values and Commitments: are based on the principles of;

- Strong visible leadership and the promotion of a positive Fire Safety Culture;
- Identifying and complying with corporate, voluntary and legal requirements;
- Improving performance through the promotion of positive Fire Safety values and behaviours;
- Providing a Safe working environment;
- Providing safe systems of work and associated Fire Safety equipment;
- Identifying and maintaining employee competence;
- Monitoring and reviewing our arrangements to ensure they remain effective;
- Applying sufficient expertise and resources to implement this policy;

Our Fire Safety Principles: These principles are for all – Fire Safety is a key component of quality healthcare as well as an essential enabler to a high-quality workplace and team experience.
We are united in the assessment that;

1. All fires and fire related incidents and injuries are preventable.
2. Fire Safety is a line management accountability.
3. We are responsible for our own Fire Safety and that of others around us.
4. Our employees and contractors are obliged to suspend a task or refuse to continue the task if it compromises fire safety.
5. All Fire alarm activations and Fire incidents must be reported to enable investigation and learning outcomes to be completed and submitted to the relevant authority.
6. Our commitment and efforts in Fire Safety will improve performance.
7. Acting safely is a condition of employment and supplier contracts.

We expect our employees, contractors and partners to embrace these principles and reflect them in every aspect of work they perform.

This policy is integral to the C&V Fire Safety Strategy. The Health and Safety Committee and Executive leadership is fully committed to the entire implementation of this policy.

Signed:
Chief Executive Officer Date:

IMS-06-02-CAV: Fire Safety Management Arrangements

Reference Number: UHB 504 Version Number: 1	Date of Next Review: 25 May 2026 Previous Trust/LHB Reference Number: *Any reference number this document has been previously known as N/A*

IMS-06-02-CAV: FIRE SAFETY MANAGEMENT ARRANGEMENTS

Purpose

This document details the management arrangements for fire safety at Cardiff and Vale University Health Board.

At Cardiff and Vale University Health Board, fire safety responsibilities are core values, which means always acting and operating in a way that prevents harm to people, the environment and the communities in which we operate. We expect all our employees, contractors and volunteers to conduct themselves at all times in alignment with the values, commitments and principles in this policy. The policy provides an unambiguous statement of the arrangements put in place to manage the risk of fire at Cardiff & Vale University Health Board (C&V UHB) and premises where NHS patients receive treatment or care, excluding a single private dwelling. This policy should be read in conjunction with IMS-06-01-CAV Fire Safety Policy.

Audience

The target audience for this document is all employees.
The policy is also applicable to our organisational partners (e.g. our contractors, suppliers and joint venture partners etc) when undertaking services for, or on behalf of CVUHB.

Health and Safety Committee

The Health and Safety Committee should agree the Fire Safety Management Arrangements and commit to its full implementation.

Board

The Board **must** approve the Fire Safety Management Arrangements and commit to its full implementation.

Procedure Review

The Procedure will be reviewed within three years of implementation or as the Health Board changes and/or when legislation, codes of practice and official guidance dictate, by the Head of Health and Safety in collaboration with the Chief Executive.

Line Managers

Line managers **must** ensure that their employees and contractors understand the requirements of the Fire Safety Management Arrangements. All line managers should demonstrate the importance of this document by ensuring that their own behaviours

actively promote and serve as a role model for the desired health and safety values and principles.

Communication to organisational partners.
Managers **must** ensure that the Fire Safety Management Arrangements is communicated to stakeholders and other business partners and ensure that they actively cooperate with the Health Board to achieve compliance with this procedure.

All employees
All our employees must ensure that they adhere to the procedure and understand the implications for them.

Procedure Commitment
The Chief Executive's commitment to this procedure is underpinned by the Fire Safety Policy and Fire Policy Statement of Intent.

Supporting Documents

- Fire Safety Policy Statement of Intent
- IMS-06-01-CAV Fire Safety Policy
- IMS-14-01 CAV Contractor Control Policy

The Health and Safety Sub-Committee maintains a schedule of all supporting policies and documents.

Other References:
See Section 36

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed for the Fire Safety Policy and confirmed there is no adverse impact
Policy Approved by	Board
Group with authority to approve procedures written to explain how this policy will be implemented	Operational Health and Safety Group Fire Safety Group
Accountable Executive or Clinical Board Director	Executive Director of People and Culture

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1			New document to support the Fire Safety Policy

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1. Introduction

The Regulatory Reform (Fire Safety) Order 2005 (FSO) provides the legislative framework to promote, stimulate and encourage high standards of Fire safety at work. It places a duty upon the employer to safeguard so far as is reasonably practicable, the health, safety and welfare of all employees, including the provision and maintenance of safe plant and systems of work. In addition, a number of other related laws have relevance within the Health Board. These are also designed to ensure that work is conducted in a safe and healthy manner.

Although the main responsibility for compliance with the FSO rests with the employer, the owner and occupiers, every employee also has a responsibility to ensure that no one is harmed as a result of their acts or omissions during the course of their work.

This document defines how management responsibilities are set for all management position within CAVUHB and details specific responsibilities for fire safety. This document should be read in conjunction with IMS-06-01-CAV Fire Safety Policy

2. Aim

The aims of this document are to:

- Outline the arrangements for managing fire safety throughout CAVUHB
- Identify roles and personnel with specific duties and responsibilities, and to detail what those duties and responsibilities are
- To provide a clearly defined management structure for the delivery of and maintaining suitable and sufficient controls and monitoring measures for all fire safety related subjects throughout the Health Board.

3. Scope

The target audience for this document is all line managers responsible for setting priorities and assigning resources.

4. Objectives

- To secure the fire safety and welfare of people at work
- To protect patients and people other than those at work against risks to their fire safety arising out of work activities
- To minimise the number of fire related risks and incidents within the UHB
- To establish a culture of co-operation, communication, competency and control for fire safety.
- Explain the structure of the organisation and how fire safety will be managed and communicated
- Define how fire management responsibilities are set throughout the UHB

5. Statutory Requirements

5.1 Current Statutory Compliance

The Chief Executive, Executive Management, Service Board and Department Heads i.e. Responsible Persons (RP's) shall ensure that all aspects of current fire safety legislation are met in their areas of jurisdiction.

The Chief Executive Officer is responsible for ensuring that all fire risk assessments are in place in all premises falling within their remit.

The UHB Responsible Person's will ensure that the duty of care towards all patients and occupants of premises within its remit is met with respect to the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations 1999 in so far as these statutes and enactments relate to fire safety.

All employees of the UHB (including contracted staff) are required to comply with the procedures associated with this policy and IMS-06-01-CAV Fire Safety Policy.

5.2 Changes to Fire Safety Legislation

The UHB Fire Safety Manager shall monitor changes in fire safety legislation and adapt this Policy (and any Supporting Procedures); to suit any such amended requirements

6. Fire Safety Management

C&V UHB Fire Safety Management System (FSMSY)

C&V UHB undertakes to meet the requirements for fire safety legislation by the implementation of the Fire Safety Management System which is integrated into the framework of the Health and Safety Management System.

The system also sets out the requirement of the UHB in terms of the management framework and responsibilities for fire safety and the procedures and responsibilities for dealing with fire alarm activations, actual fires and the level, frequency and methods of fire safety training.
The framework of Fire Safety Management for the UHB aligns with: Statutory Regulation, and British Codes of Practice, Welsh Health and Technical Memoranda.

7. Roles and Responsibility

7.1. Health Board Profile

The Board has overall accountability for the activities of CAVUHB which includes fire safety. The board should ensure that it receives appropriate assurance that the requirements of current legislation are being met.

Operational management for Fire Safety within the Health Board has been devolved to the Clinical/Service Boards; they are supported in the management of Fire safety by the Directorates. The duty of implementing these requirements has, however, been delegated to: -

Each Directorate Manager/Head of Department or equivalent level of manager, who is responsible within their own area.

The UHB has duties as controller of premises and provides care at a number of sites including but not limited to Barry Hospital, Cardiff Royal Infirmary, Children's Hospital for Wales, University Hospital Llandough, St Davids Hospital, University Dental Hospital, University Hospital of Wales, Rookwood and Community Premises. In addition, the Health Board has administration offices and support facilities at a number of other locations. The UHB also shares its sites with Cardiff University and other external organisations.
Each site shall have arrangements to ensure that fire safety risks are appropriately managed, with an identified senior person to whom concerns can be raised.

7.2. Roles and Responsibilities for implementation

The "Appropriate "level of management for Cardiff and Vale University Health Board is based on the recommendations of WHTM 05–01 where the management of central functions conform to the management level appropriate for the most complex premises and/or highest dependency of patients in the organisation's portfolio.

8. Role of the Board

The Board has overall accountability for the activities of CAVUHB which includes fire safety. The board should ensure that it receives appropriate assurance that the requirements of current legislation are being met.

The Board discharges the responsibility for fire safety through to the chief executive.

8.1. The Chief Executive

Responsibility for the organisation of fire safety arrangements within the Health Board rests with The Chief Executive in respect of all premises within the Health Board. They are the Duty Holder as defined in the Regulatory Reform (Fire Safety) Order 2005.

The Chief Executive has nominated the Executive Director of People and Culture as the Senior Responsible Officer for Fire Safety, and is responsible throughout the UHB for the implementation of the Fire Safety Policy and for presenting Fire Safety issues to the Health Board.

8.2 Executive Director of People and Culture

The Executive Director is responsible for ensuring that fire safety issues are highlighted at Board level. This responsibility will extend to the proposal of programmes of work relating to fire safety for consideration as part of the business planning process.

Operationally the Executive Director will;

- Assist the Chief Executive with Board level responsibilities for fire safety matters
- Ensure that the Health Board has in place a clearly defined fire safety policy and relevant supporting protocols and procedures
- Ensure that all work that has implications for fire precautions in new and existing trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements
- Ensure cooperation between other employers where two or more share trust premises
- Ensure through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained
- Ensure that agreed programmes of investment in fire precautions are properly accounted for in the Health Boards annual business plan
- Ensure that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Board
- Fully support the Fire Safety Manager function in line with delegated authority
- Ensure Cardiff and Vale University Health Board has a “suitable and sufficient” Fire Safety Management System with appropriate levels of management available to enable “effective management” decisions to be made regardless of the time of day

The Executive Director of People and Culture has devolved day-to day fire safety duties to the Head of Health and Safety who is the Fire Safety Manager for the Health Board.

8.3. Head of Health and Safety - Fire Safety Manager

The Head of Health & Safety is also the recognised University Health Board Fire Safety Manager and supports the Director of People and Culture with assurance that fire legislation is complied with. An additional function of this role is to support strategic direction in fire safety management in liaison with the Assistant Head of Fire Safety.

Fire safety manager responsibilities include:

- The day-to-day implementation of the fire safety policy
- Reporting of non-compliance with legislation, policies and procedures to the Executive responsible for fire
- Obtaining appropriate and professional advice on fire legislation
- Obtaining expert technical advice on the application and interpretation of fire safety guidance, including Fire code

- Raising awareness of all fire safety features and their purpose throughout the University Health Board
- The development, implementation, monitoring and review of the organisation's fire safety management system, fire safety policies and protocols
- Ensuring that fire risk assessments are undertaken, recorded and suitable action plans devised
- Ensuring that risks identified in the fire risk assessments are included in the clinical boards relevant risk registers as appropriate
- The development, implementation and review of fire emergency action plans
- Ensuring that requirements related to fire procedures for less-able staff, patients and visitors are in place
- The development, delivery and audit of an effective fire safety training programme for all staff appropriate to their duties and place of work
- The reporting of fire incidents in accordance with UHB policy and external requirements
- Monitoring, reporting and initiating measures to reduce false alarms and unwanted fire signals
- Liaison with external enforcing authorities, UHB managers and the Authorising Engineer (NWSSP)
- Monitoring the inspection and maintenance of fire safety systems to ensure it is carried out
- Ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported
- Provide a link to the relevant UHB committees
- Ensuring the organisation's management arrangements support the day-to-day implementation of the fire safety policy
- In conjunction with the Emergency Preparedness Resilience and Response Department and local directorate managers establish the necessity for fire Response Teams across the organisation's sites. Local site circumstances will best determine the quality of people and skill profile required; consideration must also be given to the availability of staff outside of daytime operating hours.

8.4. Director of Nursing

The Director of Nursing will be responsible for:

- Ensuring that the fire safety aspects pertinent to patient safety are integrated throughout the Health Board.
- Providing advice with regards to patient safety.

8.5. Chief Operating Officer (COO)

The Chief Operating Officer will make suitable arrangements to;

- Ensure appropriate arrangements for fire safety are in place within each of the Clinical Boards.
- Ensure that they provide appropriate support to Clinical Board Directors where matters arise that require their intervention.

- Ensure they advise the Chief Executive of any fire related issues which require their attention which cannot be resolved or is of an organisation wide significance.
- Monitor fire, health and safety performance against agreed targets within the Clinical Boards.
- Ensure that there are nominated leads at each site so as to provide a focus for each site outside of the management accountability structure that will provide staff with an identified senior person to whom concerns can be raised.
- Establish arrangements for each site to support the site nominated lead function.

8.6 Director of Capital Estates and Facilities

The Director of Capital Estates and Facilities is:

- Responsible for ensuring building services and maintenance is undertaken on a regular and systematic basis for those building elements, engineering services and equipment which have a direct implication on fire safety
- Responsible for managing a team ensuring all physical and structural elements of fire protection systems are maintained in accordance with WHTM's and statutory legislation.
- Required to ensure that sufficient arrangements are in place to respond to fire alarm incidents through the Estates and Facilities management arrangements.
- Responsible for ensuring that the Mandatory Code of Conduct for Contractors is observed for all penetrations and breaches of fire compartmentation and the appropriate controls are applied throughout, during and on completion of the works; including temporary fire stopping where works are suspended overnight, weekend periods etc.
- Responsible for ensuring that suitable management of any fire related components required by the capital programme and future allocation of funding is realised
- To ensure all proposals, for new buildings and alterations to existing buildings, are referred to the Assistant Head of Fire Safety for comments before Building Control approval is sought
- Ensure that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records maintained
- In liaison with the Head of Health and Safety, assess and provide appropriate levels of investment in relation to fire safety measures across the estate and personnel to facilitate the maintenance to existing fire safety arrangements and support the implementation of suitable fire safety precautions as required
- To ensure all work which has implications on fire precautions in new and existing Health Board buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety legislation (including current HTM's, British and EU standards)
- To ensure project teams include relevant and competent persons to provide advice, information and guidance on both statutory and best practice standards as well as practical application to attain best whole life value

8.7. Assistant Head of Fire Safety (Authorised Person)

The Assistant Head of Fire Safety is accountable to the Fire Safety Manager for matters of fire safety. They provide competent fire safety advice and are responsible for;

- Ensuring the undertaking, recording and reporting of fire risk assessment
- Providing expert, technical advice on fire legislation and the application and interpretation of fire safety guidance, including Firecode
- Assisting with the review of the content of the Health Board's fire safety policy and associated suite of fire safety documents
- Assisting with the development and delivery of a suitable and sufficient training programme for staff
- The investigation of all fire-related incidents and fire alarm actuations
- Liaison with managers and staff on fire safety issues
- Liaison with Estates Management in the outcome of fire risk assessments, audit and change of use in order to achieve compliance with fire precautions in new and existing premises.
- Liaison with the Authorising Engineer for fire (NWSSP)
- Liaise with the Enforcing Authority (Fire & Rescue Service) and Building Control Inspectors to achieve compliance with the fire precautions in new and existing premises.
- Ensure "Live" fire exercises area carried out throughout Cardiff and Vale University Health Board premises.
- Developing and implementing C & V UHB site fire safety manuals and action plans
- Completion of the programme of on-line fire audits as directed by NWSSP-SES.
- Monitor the existing fire risk assessment methodology and application to ensure compliance and consistency.
- Provide specialist / technical advice and support to the Fire Safety Advisors.

8.8. Fire Safety Advisor

The Fire Safety Advisors are operationally responsible to the Fire Safety Manager and Assistant Head of Fire Safety for matters of fire safety. They liaise with the Assistant Head of Fire Safety in relation to professional, technical and strategic matters and for monitoring the condition of fire precautions in Health Board premises. They provide competent fire safety advice and in addition will be responsible for:

- Undertaking, recording and reporting fire risk assessments within premises owned, occupied or under the control of the organisation, updating records accordingly and reviewing as necessary. Informing managers of any significant findings.
- Providing appropriate advice on application, interpretation and provision of Firecode and other relevant legislation and guidance.
  Providing advice to management in respect of their initial and continuing responsibilities in respect of Health Board premises falling within the scope of the Regulatory Reform (Fire Safety) Order 2005.

- Ensuring all recorded information in relation to Fire Risk Assessments is sent to the relevant person to record on the Fire Risk Register, updating and reviewing as necessary
- Assisting with the review of the content of the organisation's fire safety suite of policy documents
- Assisting with the preparation, development, maintenance and delivery of a suitable and sufficient training programme for staff, in conjunction with the Assistant Head of Fire Safety and the Training Needs Analysis.
- Planning, developing and organising regular Fire Evacuation exercises and staff training, witnessing their effectiveness or otherwise and recording accordingly. Ensure accurate records of fire exercises are produced and maintained.
- Maintain accurate records of all fire incidents and investigate fires as appropriate. Ensure the reports are entered on the NWSSP - SES
- Preparation of fire prevention and emergency action plans
- Reporting, monitoring and investigation of all Unwanted fire alarm actuations

8.9. Local Management

Fire Risk Assessments are held centrally but managers are provided with a copy. Identified non-conformances must be actioned and worked through on a risk prioritised basis.

All management have responsibility for;

- Monitoring fire safety within their respective areas of responsibility and ensuring that contraventions of fire safety precautions relating to statutory duties and UHB fire safety policy do not take place
- Operational management and communication of fire safety risks identified by the risk assessments
- Ensuring local fire risk assessments are undertaken and maintained up-to-date
- Notifying the Assistant Head of Fire Safety or Fire Safety Advisor of any proposals for "change of use", including temporary works that may impact on the risk assessment, within their area
- Reporting any defects in the fire precautions and equipment within their area of control and ensuring that appropriate remedial action is taken
- In the event of a fire, taking control and directing staff as the situation dictates
- Ensuring that local fire emergency action plans are developed, brought to the attention of staff and adequately rehearsed to ensure sufficient emergency preparedness
- Ensuring that local fire emergency action plan is revised in response to any changes, including temporary works, which may affect response procedures
- Ensuring the availability of a sufficient number of appropriately trained staff at all times to implement the local fire emergency action plan to ensure the safe evacuation of all relevant persons including those with disabilities
- Ensuring that every member of their staff is provided with fire safety training as set out in the organisation's fire safety training matrix

- Ensuring that all new staff, on their first day in the ward/department, are given basic familiarisation training within their workplace, to include:
  - Local fire procedures and evacuation plan
  - Means of escape/secondary means of escape
  - Location of fire alarm manual call points
  - Fire-fighting equipment
  - Any fire risks identified;
  - Oxygen shut off (where applicable)
- Ensuring records are retained of staff induction and attendance at fire safety training
- Ensuring staff at all levels understand the need to report all fire alarm actuations and fire incidents as detailed in the fire safety protocols
- Ensuring that sufficient Fire Wardens are identified and appointed for their specific areas of responsibility (where applicable)

8.10. Deputy Fire Safety Manager (DFSM)

Deputy Fire Safety Manager together with one or more deputies will be appointed to ensure that there is adequate co-ordination and control of the fire arrangements on each of the main sites as follows:

- Each Clinical Board will appoint a Deputy Fire Safety Manager for areas under their control.
- Capital Estates and Facilities Departments will appoint DFSM(s) for areas under their control including refurbishments, capital projects and public areas
- Community premises- The Clinical Board with the major presence will be responsible for nominating a DFSM for each Community premises. However, actions identified relating to specific Clinical/Service Board activities within the premises will still remain be the responsibility of that Clinical/Service Board DFSM

Deputy Fire Safety Managers will be supported as necessary by Health and Safety Advisors and Fire Safety Advisors.

The Deputy Fire Safety Manager will be appointed to:

- Monitor the effectiveness of the day-to-day upkeep of the Fire Safety Policy; IMS-06-01-CAV and Fire Safety Management Arrangements; IMS-06-02-CAV.
- As the Deputy Fire Safety Manager may not be “onsite” on a day-to-day basis, this responsibility will be delegated to a relevant Line Managers/Heads of Department
- Ensure that for all areas within their control, emergency evacuation procedures are in place.
- Verify that for all patient areas, appropriate fire response teams are established, this is detailed in the relevant site fire procedure.
- Verify, via relevant Heads of Department/Line Managers, that for all patient areas within their control, mechanisms are in place for adequate staff to be available at all times to aid with patient evacuation in a fire emergency.

- Establish that appropriate training is given to the fire response team and other staff who are involved in patient evacuation in their place of work.
- Be responsible during office hours for the co-ordination and direction of staff actions at a serious fire incident in accordance with the emergency plan. Out of hours response, being provided via agreed arrangements established with the relevant line managers or in line with the normal out of hours on site escalation procedure.
- Ensure that Fire Risk Assessments are reviewed and remain relevant.
- Receive reports of all fire incidents within their remit and support the arrangement of any actions required.
- Appointed Deputy Fire Safety Manager will receive appropriate training on their role requirements.

8.11. Fire Wardens

The Fire Wardens essentially will be the “eyes and ears” within that local area but will not have an enforcing role. They will rectify simple problems and report other issues identified to their head of service or departmental managers and if necessary to the Fire Team.

The Fire Warden should;

- Act as the focal point on fire safety issues for the local staff
- Organise and assist in the fire safety regime within local areas
- Raise issues regarding local fire safety with their line management
- Support line managers in their fire safety issues.

8.12. Staff Employees, Students and Contractors

All persons employed or undertaking paid or voluntary work on behalf of Cardiff and Vale University Health Board have a legal responsibility to co-operate with the Health Board to provide and maintain fire safety in the workplace.
All staff, contractors and volunteers must:

- Comply with the organisation’s fire safety protocols and fire procedures;
- Participate in fire safety training and fire evacuation exercises in accordance with the organisations training needs analysis;
- Report deficiencies in fire precautions to line managers and Fire Wardens
- Report fire incidents and false alarm signals in accordance with organisation’s protocols and procedures

8.13. Fire Safety Team

The Fire Safety Team consists of Assistant Head of Fire Safety and the Fire Safety Advisors. The team meets regularly and report into the Head of Health and Safety (Fire Safety Manager). Its function is to discuss any fire safety related matters that

may affect the Health Board in its ability to maintain compliance with current legislation.

8.14. Authorising Engineer (Fire) [External Specialist]

The Authorising Engineer (Fire) will act as an independent professional adviser to the healthcare organisation. This role is provided by NWSSP – SES as detailed in FSN11/14.

In brief, the Authorising Engineer (Fire) will fulfil the following duties on behalf of appointing NHS Organisation:

- Provide independent professional advice on all aspects of healthcare fire safety.
- Undertake reviews of systems and installations.
- Support and improve competency levels of NHS staff.
- Maintain a distribution system to ensure that any adverse incidents and other relevant information is circulated to the appropriate individuals.
- Provide advice and support on the development of fire strategies through the design, installation and commissioning of new schemes, extensions and refurbishment projects.

9.0. Contractor Management

Contractors carrying out any work have a duty to ensure that the work they do relating to fire safety matters within their controls are carried out in good order.
Managers responsible for contractors must;

- Ensure only approved contractors are used and adherence to the Health Board Contractor Control policy IMS-14-01-CAV is maintained including measures implemented by means of safe systems of work

10. Organisation for Fire Safety

10.1. Fire Safety Strategy

The Fire Safety Strategy will be consistent, proportionate and targeted and shall aim;

- To encourage strong leadership in championing the importance of a pragmatic approach that will motivate and focus on core aims to distinguish between real and trivial issues, driving an overall positive fire safety culture
- To increase competence and reinforce promotion of worker involvement.
- to undertake a base line assessment and set realistic targets and priorities on key fire safety issues

10.2. Safe Systems of Work

Each Directorate/Department is required to have fire safety arrangements and procedures specific to that area.

The Directorate/Department Manager is responsible for ensuring that Policies/Safe Systems of Work/Standard Operating Procedures are operational for all procedures undertaken within the Department.

Following risk assessment, the Directorate Managers/Heads of Department are responsible for devising, documenting and implementing any safe systems of work/safe operating procedures necessary in areas under their control, to eliminate hazards or minimise any risk to the health and safety of employers (and others).

10.3. Reporting and Investigation

- All fires no matter how small, even if extinguished, must be reported to the Fire Safety Advisor for investigation and action.
- Incidents of fire must be reported. A report is to be logged by the Fire Safety Advisor and must reach NHS Wales Shared Services Partnership – Specialist Estates Services within 48 hours of the incident.
- When an incident is entered onto the online fire system portal an automatically generated email is sent via whe.fireaudit@wales.nhs.uk
- In the event of a serious fire incident developing where disruption to services and patient care are likely, the senior person present should consider whether to initiate the “Health Board Major Incident Plan”.
- In addition, fires involving multiple deaths, multiple injuries or damage on a very large scale are to be notified immediately to the Director of the NHS in Wales, National Assembly for Wales, Health Service and Management Division, Cathay’s Park, Cardiff, CF1 3NQ by the Health Board Chief Executive Officer or Executive Director on call, depending on availability. The Health and Safety Executive must also be advised in the nearest regional office.
- Details of all false alarm calls to which the fire service is called must also be reported to NHS Wales Shared Services Partnership – Specialist Estates Services. This is completed by the Fire Safety Advisor
- Switchboard operators will complete a Fire Call Report Form for every fire call (including false alarms) received. These will be forwarded to the appropriate Fire Safety Officer
- Other users of Health Board premise such as CU, Public Health Wales (PHW), Concourse Units etc. will be informed of fires in their areas of responsibility
- The Assistant Head of Fire Safety will maintain the fire statistics for the Health Board and will compile quarterly reports for submission to the Health and Safety Committee

11. Cancelling of Fire Alarms

No fire alarms are to be silenced until the situation is assessed as safe by the Senior person in charge / Fire Safety Advisor. If the situation is a non-fire activation the Senior

person in charge should contact switchboard using 3333 and ask them to contact the F&RS and detail the activation. If the F&RS attend they take the decision to silence the alarms in conjunction with the Senior person in charge. Re-setting of the fire alarm system should be authorised in agreement with the F&RS (if in attendance) and only actioned by a competent person familiar with this process. For stand-alone buildings with a single alarm, cancellation and reoccupation of the building is the responsibility of the senior person on site.

12. Fire Safety Training

It is the responsibility of the Chief Executive to provide training for each category of staff. However, Line Managers are responsible for ensuring that fire safety policies and particular instructions are brought to the attention of their staff. Fire safety training will be included as part of both local and corporate staff induction. Departmental induction should include fire safety issues such as location of fire exits, fire alarms, location of fire assembly points and oxygen isolation valves etc.

A mandatory Training E Learning Package has been developed which is utilised in accordance with the guidance given in HTM management Document 05-01. The frequency and method of training will be based on the level of risk and responsibilities of employees in their workplace.

Ward based training sessions may be offered to staff, these will be initially undertaken by the Fire Safety Advisor but may be cascaded down to staff by other competent trainers approved by the Fire Safety Team.

Fire Drills should be conducted regularly in accordance with the evacuation exercise programme. Local management are responsible for ensuring that these drills take place and ensuring that all areas throughout the hospital have been involved.

Part-time staff, agency staff, students and ancillary workers will be included in the training. Additional training will be provided for key staff e.g. Deputy Fire Safety Manager, staff involved in maintenance of fire alarms and so on.

Major Fire Emergency Exercises will be run periodically by the Emergency Preparedness Resilience and Response Department in collaboration with the Fire Safety team to practice the Emergency Fire Procedures. This will allow key personnel to practice their roles.

Permanent records of instruction training received will be kept on the Electronic Staff Record database maintained by the Learning Education & Development Department and made available to each departmental area as appropriate.

Compliance to fire training will be monitored at the Fire Safety Group, Operational Health and Safety Group and other relevant Clinical Board/Departmental meetings. Assurance of compliances will be given to the Board via regular reports to the Health and Safety Committee.

13. Discipline

Disciplinary action under the terms of the Health Board's Disciplinary Policy will be taken against any employee, regardless of status, who shows wilful disregard for safe working practices. No disciplinary action will be taken against an employee until the case has been appropriately investigated. Where the total disregard for Safe Working Practices seriously affects the health and safety of themselves or that of any other employees, the employee may be summarily dismissed and the employer and their employees may be subject to prosecution under the Health and Safety at Work Act etc 1974 and Corporate Manslaughter legislation.

14. Emergency Situations

Due to the wide variety of work undertaken within the Health Board, it is not possible to produce valid and detailed instructions to cover every emergency situation which may arise. Therefore, each Directorate/Department must ensure that it has adequate plans in place to deal with foreseeable emergencies, incidents and failures in systems.

The Major Incident Plan supports mechanisms for perceived significant health and safety events such as fire which is supported by the Emergency Preparedness Resilience and Response Department.

15. Health Board Fire Safety Meetings

The Deputy Fire Safety Manager (DFSM) Group aim is to provide assurance to the Executive Director for Fire Safety and the Health and Safety Committee that the risks associated with fire are controlled. This includes ensuring actions identified as a result of Fire Inspections and Fire Risk Assessments are progressed and implemented. The group will monitor the status of management of Compliance, Estates and Management actions. The group will include representatives appointed as Deputy Fire Safety Managers for each of the agreed fire areas.

The meeting reports as a sub group of the Health and Safety Committee

The terms of reference of the Deputy Fire Safety Group will include:

- Overseeing the effectiveness of fire training
- Maintaining contact with Line Managers on fire precautions
- A review of the Status of the Fire Risk Assessment and any actions arising
- Review the Status of any management actions identified as a result of the Fire Service Inspections or Audits
- Agree responsibilities for areas of multiple occupancy
- Developing an action plan to deal with a fire emergency.
- Review the status of fire training and develop actions for enhanced compliance.

The Fire Safety Manager will chair the Group and membership will comprise of:

- Assistant Head of Fire Safety (Deputy Chair)

- Deputy Fire Safety Managers
- Cardiff University Representative
- Fire Safety Advisors
- Trade Union/Staff Representatives
- Strategic Emergency Planning Officer
- Estate Management

16. Resources

It is likely that issues will arise as a result of implementation of the policy, which may require resources to monitor effective standards of fire safety. This resource need will be considered at the Fire Safety Group and taken to the lead Executive Director for fire for resolution or progression, on to the relevant Board Committee.

17. Maintaining Adequate Levels of Physical Fire Precautions

The Health Board needs to ensure it has an extensive programme for installing and satisfactorily maintaining an adequate level of physical fire precautions designed to prevent the occurrence, ensure the detection, and stop the spread of fires. Specialist advice in the preparation of this programme will be obtained from the Fire Safety Advisor.

The Assistant Head of Fire Safety must be consulted prior to any changes to the structure, use/function, layout, furniture, fittings or decoration, or to procedures and staffing levels to determine if such changes will have a bearing on fire safety.

The Assistant Head of Fire Safety will arrange for systematic inspections, at prescribed intervals, to be undertaken by the Fire Safety Advisors of all areas of the Health Board.

Site Fire Plans are to be kept by the Head of Discretionary Capital and Compliance showing the following:

- Fire resisting construction.
- Periods of fire resistance.
- Location of Compartments and sub-compartments
- Location of firefighting equipment.
- Location of fire alarm call points, detectors, sounders and fire panels.
- Fire locks and mechanisms.
- Location of fire action notices.
- Arrangements for means of escape.
- Location of exit signs.
- Location of Emergency lighting luminaries.
- Location of all fire suppression systems and their type

18. Maintenance and Testing of Fire Equipment, Services including Fire Alarm and detection Systems etc.

The maintenance of all premises fire services such as fire alarm and detection systems, fire resisting door sets, emergency lighting systems, mechanical ventilation, fire suppression systems and smoke control systems etc. is a legal requirement under the Regulatory Reform (Fire Safety) Order 2005 and is the responsibility of the Director of Capital Estates and Facilities as implemented by designated competent and qualified engineers. Equipment is to be maintained and tested by the staff of Estates Management in accordance with the following standards:

- Portable fire extinguishers BS 5306
- Part 3 Fire blankets BSEN 1869
- Firefighting systems BS 9990:2015
- Fire detection and fire alarm systems BS 5839
- Emergency lighting BS 5266-1
- Sprinkler systems BSEN 12845
- Lightning protection systems BS 6651:
- Mechanical ventilation systems and Fire Dampers BS 9999:
- Fire doors BS 8214
- Powered smoke and heat exhaust ventilators BS 7346-2

The results of tests and examinations of this equipment, together with any subsequent remedial actions, are to be recorded. The Head of Estates and Facilities will maintain the register and make it available for inspection by the Fire Safety Group, the fire safety management team and the Fire Authority. These records are to be retained for seven years.

19. Major Capital Project Design/ Building Works

The Project Design Protocol is to be followed for all Capital and Revenue projects and schemes undertaken by the Design Group, Facilities Management, and Cardiff University (See Appendix i)

The Health Board Assistant Head of Fire Safety should be consulted during the design and construction of all Private Finance Initiative (PFI) Design and Build schemes to ensure that compliance with Fire code and the Health Board Fire Safety Strategy.

19.1. Fire Safety During building works:

- The site of the activities must be strictly supervised and controlled, even during small works and sporadic maintenance visits.
- Capital & Asset Management and Estate Maintenance staff must ensure that all necessary precautions against fire are taken.

- The Fire Safety Advisor will give guidance where necessary and keep in regular contact with such activities to check compliance with fire safety policy.
- The 'permit to work' and 'hot work permits' policy must be followed for removal/covering of fire detectors, and use of flame producing equipment for cutting, welding and grinding.
- The use of open waste skips is not permitted unless authorised by the Fire Safety Advisor. Enclosed lockable skips will be used and positioned in safe areas away from buildings and boundaries.

20. Fire Alarm Systems

All new Health Board installations will be protected by analogue addressable fire alarm systems designed to the current BS 5839: Fire Detection and Alarm Systems for Building Category L1 standard as supplemented by the current Firecode WHTM 05-03 Operational Provisions Part B-Fire Detection and Alarm Systems. Some deviations from this policy exist on older installations.

21. Maintaining Escape Routes

The duty to maintain escape routes, which includes corridors, staircases, lobbies and doors, is laid down in the Regulatory Reform (Fire Safety) Order 2005. They must be adequate, clearly marked and free from obstruction. A simple outline plan is to be displayed in each area as appropriate, showing the relevant escape routes and fire barriers.

It is the responsibility of individual managers – or persons delegated on their behalf to ensure that escape routes are maintained. These include external fire routes, which are the responsibility of the Estates Department.

A visual inspection at the start of the working day or shift should be made by staff working in a given area and any obstruction or defect found must be dealt with immediately.

A further check should be made at the end of the working period to ensure that appropriate doors are shut, locked or secured as appropriate and the site cleared.

22. Fire Safety Signage

Fire Action Notices detailing the action to be taken on discovering a fire and on hearing the fire alarm are to be displayed throughout the sites adjacent to each manual fire alarm call point. The information contained in the notices will identify the methods of:

- Raising the alarm.
- Informing the switchboard by emergency number.
- Controlling the fire.
- Evacuation procedure – assembly point (where appropriate)
- Stages of the fire alarm.

Fire Safety Signs meeting the requirements of The Health and Safety (Safety Signs and Signals) Regulations 1996 will be displayed to indicate locations of fire exits, and fire alarm and firefighting equipment, where required.

23. Emergency Access

Access for the Fire Service is to be kept available at all times and fire hydrants and dry riser inlets are not to be obstructed. A copy of the Site Fire Plans and Evacuation Procedures are to be given to the Fire Service so that, where possible, the routes to be used by the service for firefighting do not conflict with escape routes. The Fire Service is to be made aware of any special hazards on site e.g. radiation and biological hazards, during inspections made by them and they are to be kept up to date with any developments in this field by the Fire Safety Advisors.

24. Smoking Policy

The Smoke-free Premises and Vehicles (Wales) Regulations 2020 came force on 1st March 2021 and prevents smoking anywhere within or on all UHB premises. The Regulations cover all workplaces including mental health and remote health-care premises. All staff, visitors and patients are expected to comply with the Regulations and Smoking Policy.

25. Furniture and Textiles

It is essential that the contents of premises comprising furniture, textiles, fixtures and fittings, including mechanical and electrical equipment, receive careful consideration and selection in order that they fulfil the aims of the fire strategy.

All Furniture & Textiles satisfy tests specified in BS5852 1990 (Ignitibility test), the requirements of the Furniture & Furnishings (Fire Safety) Regulations 1988 & HTM 05-03 Part C.

Damaged furniture and textiles must be removed and repaired or replaced to meet the above guidance.

Donated furniture or textiles from whatever source must comply with the above standards. The Assistant Head of Fire Safety should be consulted if there is any doubt about the suitability of any item.

All soft toys in Paediatric Wards and Children's Centres should comply with the above guidance. Commercially produced toys should already meet the requirements; however, donations of homemade toys and other donations must not be accepted if they do not comply with the requirements.

26. Staffing Levels

The level of trained, competent staff provided should be appropriate for the building concerned, including its use, nature of the occupants, management system in place and active and passive systems provided.

It is the responsibility of management to achieve an agreed safe level of staffing sufficient to deal with the consequences of fire in its early stages and ensure that there are sufficient staff available to ensure effective evacuation can be carried out.

27. Communications

All emergency calls from major UHB installations are routed to the switchboard which is manned 24 hours a day however, some smaller external sites such as health centres are required to call 999 direct. This is detailed in local emergency plans and fire notices.

28. Arson

Hospitals and their externally and internally located storage areas are vulnerable to arson attacks from intruders, patients with disturbed patterns of behaviour, employees and others who may enter sites, including contractors. Stores, including those with pharmaceuticals, may be targets for theft and fires may be started to conceal the theft. Attention to housekeeping, for example management of waste collection, storage and disposal, and security arrangements are controls in the prevention of arson.

Security systems and procedures are in place to keep unauthorised persons out of vulnerable areas e.g. lower ground floor at UHW. These systems must not be abused by personnel taking or allowing unauthorised persons into restricted areas without the necessary authority.

Identification badges must be worn at all times, including contractors and servicing personnel.

All fire incidents that are staff related, either by accident or intent, will be investigated in accordance with the Health Board Disciplinary Procedure.

29. Car Parking

The designated fire roads on all Health Board premises are maintained clear of obstruction by a site-specific car parking procedure.

30. Portable Electrical Equipment Safety

Electrical equipment provides a high risk in starting fires where they are faulty, overloaded or used in inappropriate areas. Portable appliance testing will be conducted for all portable equipment to ensure that basic electrical safety checks are maintained.

Electrical installations and testing are managed by Estates. The following points should be adhered to:

- Multi socket plug adaptors are not to be used. Extension leads are authorised for use where they have been subject to Portable Appliance Testing.
- All personal electrical equipment brought into buildings such as mobile chargers should be fit for purpose, compatible and not introduce hazards into the workplace.
- No alterations and additions to wiring or fittings may be conducted apart from those carried out by authorised electricians
- Electrical equipment brought in by patients should be visual checked by ward staff for defects and if unsure items must be removed. Staff should report defective electrical equipment and remove them from supply by switching off and unplugging any electrical equipment that they find defective.

31. Waste Management

It is important to keep all circulation areas clear of storage and combustible materials, to maintain the means of escape provisions and reduce the risk of arson attacks.

The collection, storage and disposal of waste will be undertaken on a regular basis according to the need and in accordance with the Waste Management Policy UHB038.

32. Audit and Monitoring

The Chief Executive is required to ensure that the management policies regarding fire safety comply with the provisions laid out in Firecode Fire Safety in the NHS WHTM 05-01: Managing Healthcare Fire Safety Section 4. To assist with this requirement, an annual fire safety audit is conducted covering all Health Board in-patient care premises. The Fire Audit Information System has been developed independently by Welsh Shared Services Health Estates.

33. Resources

With respect of resource implications identified within this policy, the policy reflects current arrangements and as such identifies no additional resource need.

In respect of resources, the Health Board will identify designated budgets for fire safety across the organisation. If any additional resources are required, this will be considered as part of the risk management and profiling arrangements within the Health Board.

34. Communications and Implementation

- The Fire Safety Policy Statement should be disseminated to all staff and be made freely available to all stakeholders.

- A copy of the Health Board Fire Safety Policy is available on the Health Board's Intranet site. For those staff without access to the intranet, it will be the responsibility of the local manager to post a hard copy of the Policy in a prominent location.
- A register of all current Fire Safety Policies and Procedures will be maintained by the Health and Safety Department
- Local Procedures and Protocols will be approved and reviewed by the Fire Safety Advisor in conjunction with the department manager
- It is the responsibility of all employees to read and understand the relevant sections

35. Arrangement's/Committee's and Sub Groups

The Health Board has established a Health and Safety Committee as a Committee of its Board, Chaired by an appointed Independent Member.

The Sub Groups reporting to the Health and Safety Committee are: -

- Operational Health and Safety Group, Chaired by the Executive Lead.
- Anti-Violence Group (Personal Safety Strategy Group) Chaired by an appointed Senior Manager
- The Deputy Fire Safety Managers Group, Chaired by the Head of Health and Safety as the appointed responsible Fire Safety Manager under the fire safety policy.
- The Water Safety Group, Chaired by a Senior Manager.
- Each Clinical/Service board has established a local health and safety group, which reports to the Operational Health and Safety Group.

36. Associated Reference Material

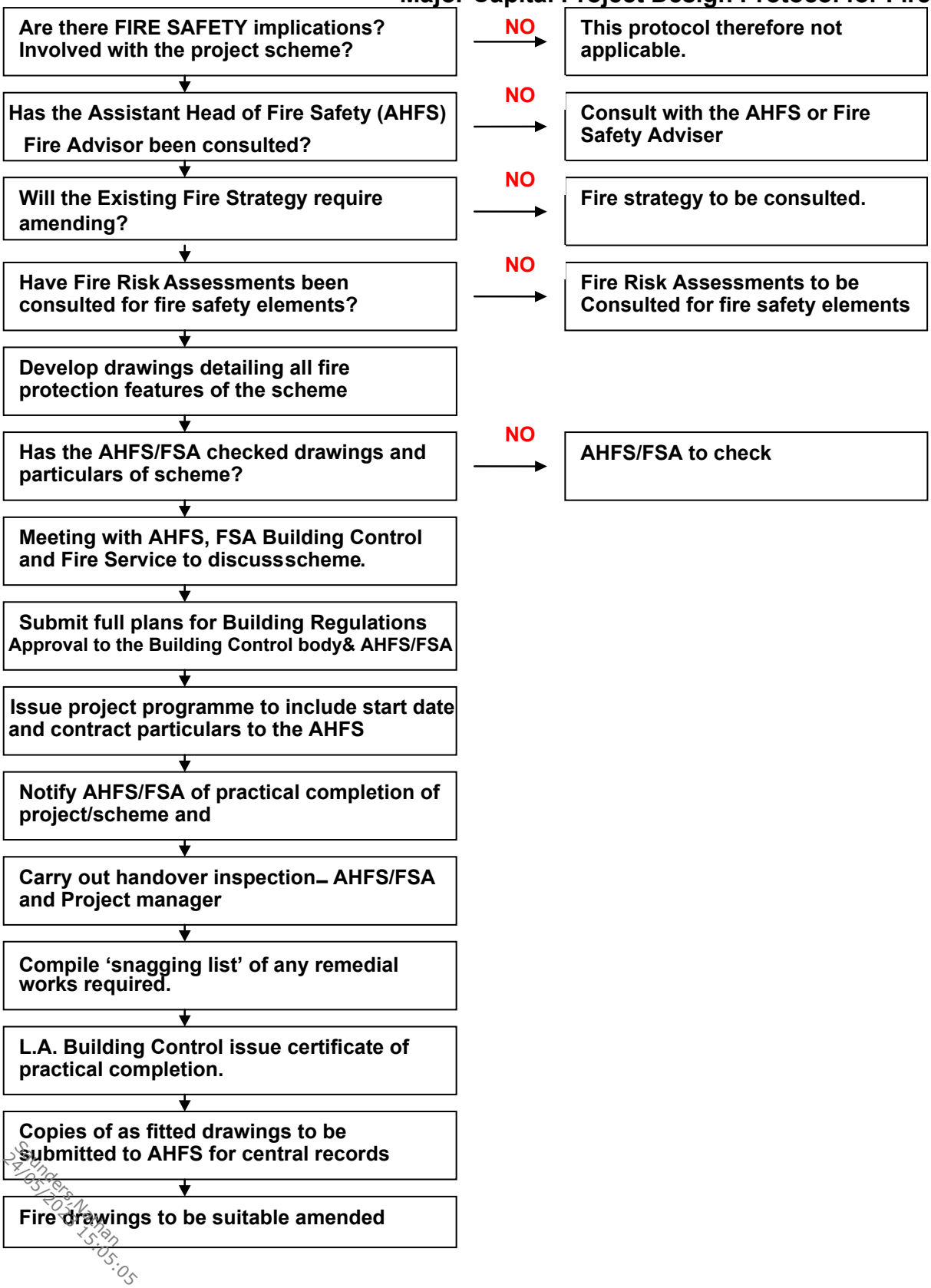
The relevant evidence base for this document is listed below:

- The Regulatory Reform (Fire Safety) Order 2005
- Fire Services Act 2004
- Building Act 1984
- Building Regulations 2000
- Fire Safety Act 2021
- The Building Safety Bill 2021
- Welsh Health and Technical Memorandum 05-03 (Firecode) Suite of Documents
- Department for Communities and Local Government Publications – fire safety risk assessment in Healthcare Premises
- Furniture and Furnishings Fire Safety Regulations 1988 (Amended);
- The Health & Safety (Safety Signs and Signals) Regulations 1996;
- The Equalities Act (2010)
- The Construction (Design and Management) Regulations 2007;
- The Dangerous Substances and Explosive Atmospheres Regulations 2002 (DSEAR)
- Health and Safety at Work etc. Act 1974
- The National Health Service & Community Care Act 1990

- The Management of Houses in Multiple Occupation (Wales) Regulations 2006
- The Management of Health and Safety at Work Regulation 1999

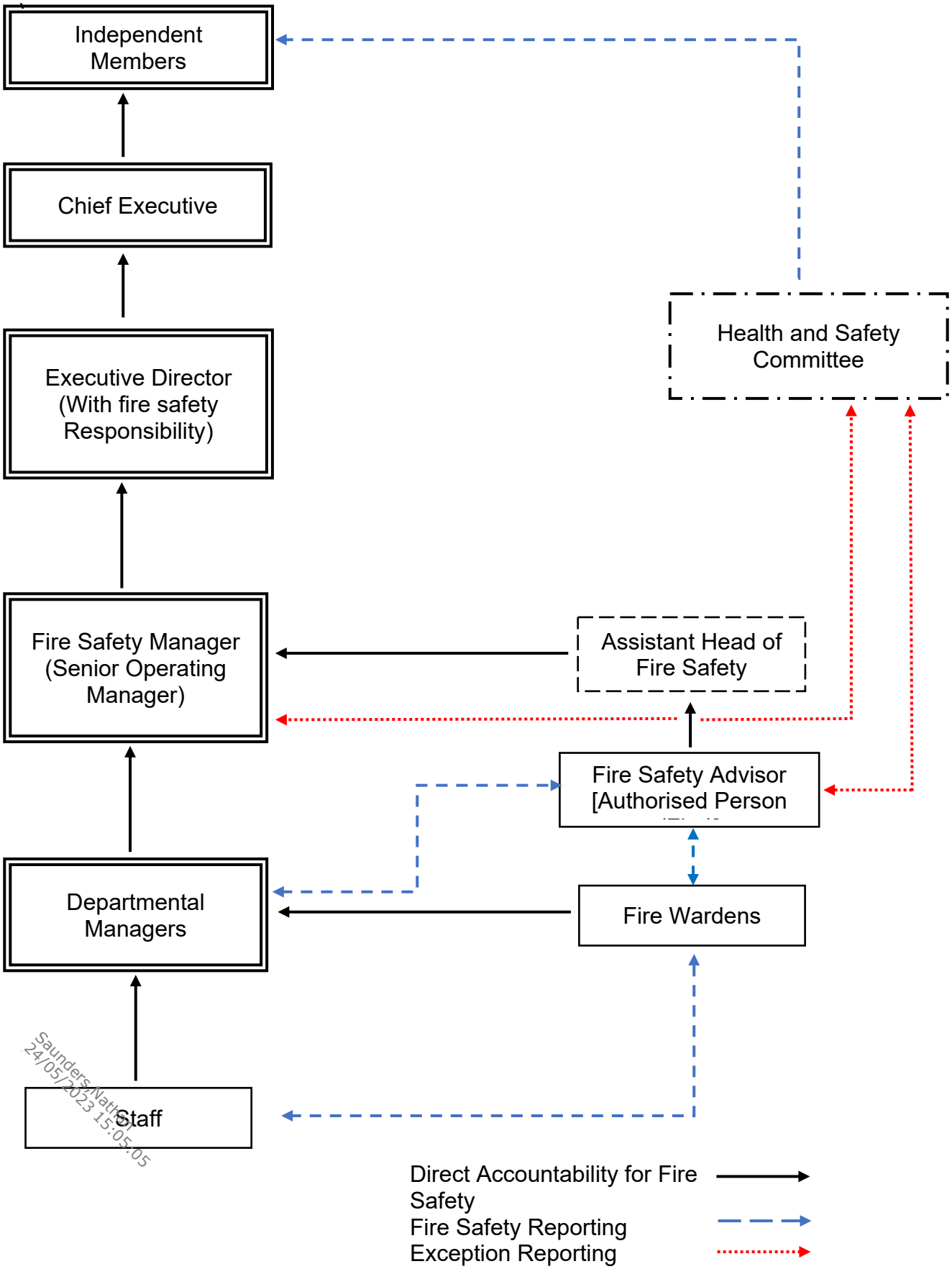
Appendix i

Major Capital Project Design Protocol for Fire Safety



Appendix ii

Fire Safety Management Structure



Version	Reviewers	Reason for review	Date	Approved
1.0	R Warren F Barrett S Bennett B Perrett	New Document	March 2023	

Change History

Version	Description of Change
1.0	Simplification of the Fire Safety Policy has resulted in a new document to detail the management arrangements required to fulfil the UHB statutory obligations under the requirements of The Regulatory Reform (Fire Safety) Order 2005;

Confirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 7 February 2023 at 9:30am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair
Present:		
Mike Jones	MJ	Independent Member for Trade Union
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
Rhian Thomas	RT	Independent Member for Capital and Estates
In Attendance:		
Catherine Phillips	CP	Executive Director of Finance
Ian Virgil	IV	Head of Internal Audit
Wendy Wright-Davies	WW	Deputy Head of Internal Audit
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Aaron Fowler	AF	Head of Risk and Regulation
Urvisha Perez	UP	Audit Wales
Huw Richards	HR	Deputy Director Specialist Services Unit
Rachel Gidman	RG	Executive Director of People & Culture
Ceri Phillips	CP	UHB Vice Chair
James Quance	JQ	Interim Director of Corporate Governance
Andrew Crook	AC	Head of People Assurance & Experience
Sion O'Keefe	SO	Directorate Manager
Charles Janczewski	CJ	UHB Chair
Anthony Veale	AV	Audit Wales
Observers:		
Tim Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Alex Painting	AP	Cardiff and Vale Finance Trainee
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		

Item No	Agenda Item	Action
AAC 7/2/23 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 7/2/23 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	

AAC 7/2/23 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	
AAC 7/2/23 004	**Minutes of the Meeting Held on 8th November 2022** The Minutes were received. **The Committee resolved that:** a) The draft minutes of the meetings held on 8th November 2022 were a true and accurate record of the meeting.	
AAC 7/2/23 005	**Action Log – Following Meeting held on 8th November 2022** The Action Log was received. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 7/2/23 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 7/2/23 007	**Internal Audit Progress Report** The Head of Internal Audit (HIA) presented the Internal Audit Progress Report and highlighted the following: <u>Section 2</u> - Table 4 noted the audits which had been planned to be reported to the September Audit Committee but had not met that deadline. <u>Section 3</u> - 10 audits were finalised since the last Committee meeting. - 8 were awarded Reasonable Assurance. - 1 audit was awarded Limited Assurance. - The full reports were included in section 9 of the papers. <u>Section 4</u> There was a total of 40 reviews within the 2022/23 Internal Audit Plan which included:	

	- 19 finalised - 2 draft stage - 6 work in progress - 11 planning stage - Appendix B summarised the timescale of Management responses. - The HIA commented that there were a number of audits that had not received Management responses within the timeframe. - However, given the Christmas period, Winter pressures and strikes, the delays were understandable. The UHB Chair expressed concern that nothing was "lined up" for the time lost with the audits. It would be useful if Internal Audit worked with the Executive team to obtain realistic timescales to deal with the recommendations. The HIA responded that he looked forward to working with the Executives. <u>Section 5</u> - Described the changes to the Internal Audit plan. - At the November 2022 meeting, the Committee had agreed an initial list of four audits to be rescheduled to the end of the 22/23 plan, but with the possibility that they could be removed or deferred into 23/24 if required. - As the Winter period had progressed and operational pressures had intensified, discussions with the relevant managers and Executives had highlighted that the identified audits would need to be removed from the plan. - As part of those discussions, an additional four audits had also been identified for removal from the plan. The details of all the audits were included within the papers. The UHB Chair queried what the overall opinion of the Health Board was likely to be. The HIA responded that only one audit was awarded limited assurance so far and another was in draft. Therefore, the overall opinion was likely to be Reasonable Assurance. The EDPC advised that several audits had been completed regarding inclusion and retention. Next year would be a better time to understand how the People and Culture Plan was embedded into the Health Board. <u>Section 6</u>	**HIA**

	The HIA advised that he was currently working on developing a plan for the 2023/24 audits and would bring that to the meeting in April. <u>Section 7</u> 7.1 Development of Genomics Partnership in Wales - The audit was undertaken to review the delivery and management arrangements in place to progress the Genomics Partnership Wales project, and the performance, against its key delivery objectives i.e. time, cost, and quality - An overall Reasonable Assurance had been determined. 7.2 Capital Systems Management - The audit was undertaken to provide assurance on the application of the plan and to identify any enhancements to existing operational procedures working practices. - A number of key matters were identified which were included in the paper. - Reasonable Assurance was awarded. - It was proposed that a further follow up audit would be undertaken during March/April 2023 to test further UHB projects in order to ensure ongoing compliance with established procedures. 7.3 Core Financial Systems (Treasury Management) - The overall objective of the audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Core Financial Systems – Treasury Management'. - Two medium matters were highlighted. - Overall Reasonable Assurance was awarded. • 7.4 Management of Locum Junior Doctors (Women & Children's CB) - The purpose of the audit was to review the system for agreeing and booking locum junior doctors. - Reasonable Assurance was awarded. • 7..5 UHL Engineering Infrastructure - The purpose of the audit was to review the delivery and management arrangements for the University Hospital Llandough (UHL) Engineering Infrastructure Project, and the performance, against its key delivery objectives i.e., time, cost, and quality. - Recommendations were noted within the detail of the report. - Reasonable Assurance was awarded.	

- 7.6 Endoscopy Insourcing (Medicine Clinical Board

- The audit focussed on the governance and operational arrangements in place to manage the Endoscopy Insourcing Contract.
- Six medium recommendations had arisen.
- Reasonable Assurance was awarded overall.

- 7.7 Access to In-Hours GMS Service Standards (PCIC Clinical Board)

- The purpose of the audit was to review the processes and procedures in place for assessing GP practices achievement against the 'Access to In-Hours GMS Service Standards'.
- Two medium key matters had arisen.
- Reasonable Assurance was awarded.

- 7.8 New IT Service Desk System

- The purpose of the audit was to review the set-up and implementation of the new system, and to assess the extent to which the new system had been able to drive improvements.
- The audit had followed on from a previous audit regarding IT service management.
- Reasonable Assurance was awarded.
- One high recommendation and three medium recommendations had been made.

- 7.9 Medical Records Tracking (CD&T Clinical Board)

- The purpose of the audit was to review the effectiveness of the mechanisms for tracking medical records both inside and outside of the Health Records department.
- Four high priority recommendations and two medium priority recommendations were made.
- Limited Assurance was awarded overall.

- 7.10 Assurance Mapping

- The report was an advisory review to support management, rather than an assurance report and, therefore, there was no assurance rating.
- It was noted that the Health Board's Assurance Strategy 2021-24 aligned to recommended best practice and the Assurance Map Template captured appropriate assurance and risk information.
- There was a defined governance structure which underpinned the Assurance Strategy and an action plan was in place for its implementation.

	In relation to the Medical Records Tracking (CD&T Clinical Board) Internal Audit Report, the Directorate Manager (DM) advised the Committee on the following: - The Director of Operations for CDT Clinical Board had discussions with other Director of Operations regarding the audit outcome. - There was a plan to put structure around the governance arrangements. - There had been dialogue with colleagues in Digital Health and Intelligence. - It linked closely with Clinical Board Directors and the QSE group that each board had. - The team were also looking at how records were stored on a daily basis. - Estate was also another element because the teams were spread across lots of different places. The Clinical Board would work with Estate colleagues to set up a programme of work. The UHB Chair requested that setting up the governance arrangements was co-ordinated through the Corporate Governance Office. The UHB Vice Chair emphasised the importance of getting the medical records tracking right. The error rates were directly related to records and data. If information systems could be improved then it would improve quality and safety and minimise errors that occur in patient management. The DM responded that the Clinical Board had already started to scan concerns. The Independent Member for ICT and Committee Vice Chair (IMI) stated that the current digital systems were not being leveraged to their full extent. The DM responded that the Clinical Board would like to push for more electronic practice. The EDPC stated that electronic practice would take time and queried whether standardisation could be built in. The DM responded that location-based filing could be restricted. The Clinical Board would also like to develop a app. A large communications campaign on the importance of tracking would be needed. The DIA stated that there would be a follow up audit and it would also be picked up on the Internal Audit tracker. **The Committee resolved that:** a) The Internal Audit Progress Report, including the findings and conclusions from the finalised individual audit reports were considered.	**IDCG/DM** **Internal Audit**

	b) The proposed adjustments to the 2022/23 plan were approved.	
AAC 7/2/23 008	**Audit Wales Update to include:** Anthony Veale (AV) advised the Committee on the following: • The Charitable Funds accounts would be signed by the Auditor General that week. There had been some challenges with the accounts this year. • The planning for next year had started. Progress had been slightly slower due to the huge number of requests from Health Boards Urvisha Perez (UP) advised the Committee on the following: • The Structured Assessment work was completed. • Exhibit 3 showed the work that was underway. • The Structured Assessment report was positive overall. - The Health Board's approach to planning was generally effective and inclusive, with good Board-level oversight and stakeholder involvement. - Refreshing its long-term strategy and producing an approvable IMTP should remain a key priority for the Health Board. - The Health Board was generally well led and well governed. Plans to refresh governance structures and align them to revised strategic objectives would provide opportunities to further enhance Board and Committee effectiveness. - Systems of assurance continued to mature at a corporate-level, and work was underway to strengthen arrangements at an operational-level. - There were reasonably appropriate arrangements in place to support financial planning, management, and control. Whilst finances were well scrutinised, improving its longer-term financial position should remain a key priority. - Whilst the Health Board had achieved its financial duties for 2021-22, it risked not breaking-even at the end of 2022-23 due to growing cost pressures. - Financial reports were clear and the Health Board was open about financial challenges and risks which were regularly scrutinised by the Finance Committee. - There was good Board-level oversight of staff well-being support arrangements. - The Board should seek greater assurances it was making a positive difference. The UHB Chair stated that it was well balanced report, although he did not get the opportunity to run through it in	

	draft with Audit Wales. He requested that he be given that opportunity next year. He also added that “generally” was used a lot in the Structured Assessment report and he did not think that was a helpful quantifier. He suggested that a matter was either effective or ineffective. UP responded that there were a few recommendations from last year that had not been picked up by the Health Board. The EDPC commented that the People and Culture Committee would give more time to the People Strategy. Wellbeing and estate matters also do not currently have a “home”. The EDF advised that her team was considering how to engage the Board on Estate matters. **The Committee resolved that:** a) The Audit Wales Update, including the Structured Assessment, was noted.	
AAC 7/2/23 009	**Declarations of Interest, Gifts and Hospitality Report** The Head of Risk and Regulation (HRR) presented the Declarations of Interest, Gifts and Hospitality Report and highlighted the following: • Following the November 2022 Committee meeting, additional software had been procured to assist with the analysis of data held with ESR and, for the first time, an accurate Register had populated the live staff information held within the ESR system. • As of the 12th January 2023 ESR held the following records: - 234 Declarations of Interests, Gifts, Hospitality and Sponsorship - 619 entries recording ‘No Interest’ be declared. • The next steps were to work with the ESR and the HR teams to improve return rates. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The proposals to improve Declaration of Interest reporting across the Health Board was noted.	
AAC 7/2/23 010	**Internal Audit Tracking Report** The HRR presented the Internal Audit Tracking Report and highlighted the following:	

	• The Risk and Regulation team continued to meet with Internal Audit colleagues. • Of the 140 recommendations listed within the Tracker, 58 were recorded as complete, 54 were listed as partially complete and 28 were listed as having no action taken or reported since the last Committee meeting. • Of those actions where no action was reported, 2 were recorded as High Priority and would be flagged with relevant Executive Leads for updates prior to the next Committee meeting. • One of these recommendations related to the Chemo Care IT System Audit Review which had received a Limited Assurance rating during 2021-22. • No update had been shared by Executives or Operational leads for any of the outstanding recommendations for this Audit. The UHB Chair advised that an Executive should be invited to the next Committee meeting to give an update on the Chemo Care IT System. The HIA advised that all previously Limited Assurance audits would be followed up as per Internal Audit's plan. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit, was noted. b) The progress which had been made since the previous Audit and Assurance Committee Meeting in November 2022, was noted. c) An update on progress made against the Chemo Care IT System Audit Review would be shared at a future Committee Meeting.	**IDCG/DDHI**
AAC 7/2/23 011	**Audit Wales Tracking Report** The HRR presented the Audit Wales Tracking Report and highlighted the following: • There were 35 external audit recommendations. • Out of those, 4 were recorded as complete, 24 were partially complete and 7 indicated that no action had been taken. • The HRR would be looking to have a year end clean-up of those audits. • The HRR would have a meeting in February with Audit Wales. **The Committee resolved that:**	

	a) Assurance from the progress which had been made in relation to the completion of Audit Wales recommendations, was noted. b) The continuing development of the Audit Wales Recommendation Tracker, was noted.	
AAC 7/2/23 012	**Regulatory Compliance Tracking Report** The HRR presented the Regulatory Compliance Tracking Report and highlighted the following: • The Health Board was currently Non-Compliant with the two Patient Safety Alerts and continued to be monitored by the Patient Safety teams and reported to QSE meetings. • One recommendation had been fully closed. • There was regular interaction with Executive leads to ensure those were progressed and moved forward. The UHB Vice Chair queried the non-inclusion of WHSCC services and their escalation status. The HRR responded that he was happy to work with colleagues to get that included. The EDPC stated that the manual handling case had been closed down. The EDPC was also the responsible Executive for health and safety. **The Committee resolved that:** a) The updates shared and the continuing development and review of the Legislative and Regulatory Compliance Tracker were noted.	
AAC 7/2/23 013	**Review of Risk Management System** The IDCG presented the Review of Risk Management System and highlighted the following: Internal Audit had undertaken an Audit of the Health Board's Risk Management procedures in June 2022 which had received an overall Reasonable Assurance rating. As of February 2023, all 3 recommendations were reported as complete with appropriate actions being embedded into Risk Management practice. **The Committee resolved that:** a) The update on the Review of the Health Board's Risk Management Systems and ongoing developments in this area, were noted.	

AAC 7/2/23 014	**Assurance Strategy and Risk Management Strategy** The IDCG presented the Assurance Strategy and Risk Management Strategy. The IDCG stated that an action plan had been prepared and agreed internally to ensure that the Assurance Strategy was embedded across the Health Board. **The Committee resolved that:** a) The progress made against the Advisory Recommendations made by Internal Audit were noted. b) The updated Assurance Strategy 21-24 and Risk Management and Board Assurance Framework Strategy were approved and recommended for referral to Board for ratification. c) The updated draft Assurance Map that will be formalised and shared with Board in March 2023 was noted. d) The updated Action Plan prepared to ensure that the Assurance Strategy was embedded across the Health Board was noted.	**IDCG**
AAC 7/2/23 015	**Single Tender Actions** The EDF presented the Single Tender Actions report. It was noted that it was a routine report. The CC queried the locum amount for Gastroenterology and queried whether it would follow normal HR policy. The EDF would take this offline with the EDPC. The UHB Chair queried the no procurement engagement comment in the reason column for non-compliance. He queried how learnings were being taken forward to prevent those errors from happening again. The EDF responded that the systems had lost robustness during Covid times. Her team was trying to ensure that matters/items that were procured went through the Procurement department. **The Committee resolved that:** a) The contents of the Report were noted. b) The contents of the Report were approved.	**EDF/EDPC**
AAC 7/2/23 016	**Procurement Compliance Report – Chairs Action Review** The EDF stated it was the wrong version of report and requested to remove it.	

	The UHB Chair stated Chairs Actions were an important part of the Chair's work. He received too many requests for Chairs Actions and the relevant teams needed to plan work properly to avoid this. It was agreed that there would always be exceptions. **The Committee resolved that:** a) The Procurement Compliance Report was not considered and would be brought back to the next Committee.	
AAC 7/2/23 017	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LLCFS) presented the Counter Fraud Progress Report and highlighted the following: • There were two fraud prevention notices. • The Counter Fraud team continued to receive a steady stream of referrals. • Fraud awareness week had taken place. **The Committee resolved that:** a) The content of the report was noted.	
	Items for Approval / Ratification	
AAC 7/2/23 018	**Audit Wales Annual Audit Report** Anthony Veale (AV) presented the Audit Wales Annual Audit Report and highlighted the following: It was a summary of all the work undertaken in the year. It summarised the account work and Audit Wales view of Health Boards arrangements. **The Committee resolved that:** a) The content of the report was noted.	
AAC 7/2/23 019	**Timetable for the Production of the 2022-2023 Annual Accounts and Annual Report** The IDCG stated that the report detailed the plan for the Health Board Annual Accounts and Annual Report. It was based on draft guidance. It would be reported and presented to the public in the AGM. The UHB Chair stated that although there is no requirement to do an Annual Quality Statement, he was not comfortable with that due to the quality of service being a top priority. He stated it would be beneficial to produce an Annual Quality Statement this year.	

	The Committee resolved that: a) The proposed timetable and approach, as set out in the report, for the Annual report 2022-22 prior to the same being presented to full Board in March for formal approval, was ratified.	
AAC 7/2/23 020	**Audit Committee Annual Report 2022-23** The IDCG stated that the Annual Report from the Committee was produced to demonstrate the Committee's activities for the past year. The final version would be added to the Health Board's Annual Report. **The Committee resolved that:** a) The draft Annual Report 2022/23 of the Audit Committee was reviewed. b) The Annual Report was recommended to the Board for approval.	
AAC 7/2/23 021	**Audit Committee Terms of Reference and Annual Work Plan** It was noted that the agenda item provided Members of the Audit and Assurance Committee with the opportunity to review the Terms of Reference and Work Plan 2023/24 prior to submission to the Board for approval. **The Committee resolved that:** a) The Terms of Reference and Work Plan 2023/24 for the Audit and Assurance Committee was reviewed. b) The Terms of Reference and Work Plan for the Audit and Assurance Committee 2023/24 was reviewed and the changes were recommended to the Board for approval on 30th March 2023.	
AAC 7/2/23 022	**Internal Audit reports for information:** i. Genomics Partnership Wales – Reasonable Assurance ii. Capital Systems Management - Reasonable Assurance iii. UHL Engineering Infrastructure - Reasonable Assurance iv. Core Financial Systems (Treasury Management) - Reasonable Assurance v. Assurance Mapping (Advisory) – Assurance not applicable vi. IT Service Desk System – Reasonable Assurance vii. Access to In-Hours GMS Service Standards (PCIC Clinical Board) - Reasonable Assurance viii. Endoscopy Insourcing (Medicine Clinical Board) - Reasonable Assurance ix. Medical Records Tracking (CD&T Clinical Board) – Limited Assurance	

	x. Management of Locum Junior Doctors (Children & Women's Clinical Board) - Reasonable Assurance	
AAC 7/2/23 023	**Agenda for Private Audit and Assurance Committee** i. Private Audit Minutes – 8 November 2022 *ii.* Counter Fraud Progress Update (*Confidential – ongoing investigations)* iii. Workforce and Organisational Development Compliance Report (*Confidential – this report contains sensitive information and/or (potentially) personal data*) iv. Overpayment of Health Board Salaries v. Learning from Cyber Attacks (*Confidential Report*) Losses and Special Payments Panel Report (*Confidential – sensitive information)*	
AAC 7/2/23 024	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
AAC 7/2/23 025	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
	Date and time of next committee meeting Tuesday 4 April 2023 at 9:30 am via MS Teams	

Confirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 4th April 2023 at 9:30am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair
Present:		
Mike Jones	MJ	Independent Member for Trade Union
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
Rhian Thomas	RT	Independent Member for Capital and Estates
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Ian Virgil	IV	Head of Internal Audit
Lucy Jugessur	WW	Internal Audit Manager
Robert Mahoney	RM	Interim Deputy Director of Finance (Operational)
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Claire Salisbury	CS	Head of Procurement
Aaron Fowler	AF	Head of Risk and Regulation
Urvisha Perez	UP	Audit Wales
Mark Jones	MJ	Audit Wales
James Quance	JQ	Interim Director of Corporate Governance
Lianne Morse	LM	Assistant Director of Workforce
David Thomas	DT	Director of Digital & Health Intelligence
Observers:		
Timothy Davies	TD	Head of Corporate Business
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Rachel Gidman	RG	Executive Director of People & Culture
Catherine Phillips	CP	Executive Director of Finance

Item No	Agenda Item	Action
AAC 4/4/23 001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 4/4/23 002	**Apologies for Absence** **The Committee resolved that:** a) Apologies were noted.	
AAC 4/4/23 003	**Declarations of Interest** **The Committee resolved that:** a) No Declarations of Interest were noted.	

AAC 4/4/23 004	**Minutes of the Meeting Held on 7th February 2023** The Minutes were received. Mark Jones (MJ) commented that Anthony Veale (AV) had presented the Audit Wales Report and not Huw Richards. **The Committee resolved that:** a) Pending the above amendments, the draft minutes of the meeting held on 7th February 2023 were held to be a true and accurate record of the meeting.	**MJ**
AAC 4/4/23 005	**Action Log – Following Meeting held on 7th February 2023** The Action Log was received. The Head of internal Audit (HIA) commented that the timing of the Medical Records Tracking report was yet to be agreed and would come to a meeting later on in the year. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 4/4/23 006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 4/4/23 007	**Internal Audit Progress Report** The HIA presented the Internal Audit Progress Report and highlighted the following: <u>Section 2</u> • The Audits planned for the April meeting had not been finalised due to delays. Those would be brought to a future Committee meeting. <u>Section 3</u> • Four reports were finalised in time for today's meeting. • The Cyber Security report would be discussed in the Private meeting. <u>Section 4</u> • There were 38 Audits within the 2022/23 Internal Audit Plan.	

- 23 Audits had been finalised so far. Of the remaining 15 Audits, 10 were at draft report stage. A number of those Audits would be finalised in time to feed into the end of year opinion.
- Appendix C highlighted performance against key performance indicators.

The CC queried whether there were concerns that some reports would not be completed in time and would that affect the end of year opinion.

The HIA responded that so far only one draft Audit had been awarded limited assurance. Even if that draft Audit remained as limited, only 3 Audits would have limited assurance overall.

It was noted that the HIA opinion for the end of year was likely to be reasonable assurance.

<u>Section 5</u>

- It was agreed with the Assistant Director of Quality & Safety that the QSE Governance advisory review audit would be moved to Q1 23/24 to allow for coverage of developments around the Duty of Quality.
- It was proposed that the ChemoCare IT System Follow-up Audit would be deferred into the 23/24 plan due to delays with implementation of the new system.

The Independent Member for Capital and Estates (IMCE) queried whether the reasons for the delay in the Audits were typical or should they be concerned and dig deeper into the lack of resources or delays in management responses.

The HIA responded that the lack of resources would be addressed going into the new year as Internal Audit were looking into creating a recruitment drive. The engagement from the Health Board was not overly concerning. There had been many pressures and the Winter period had impacted the ability to engage.

<u>Section 6 – Final report summaries</u>

1. 6.1 Financial Reporting & Savings Targets

- The purpose of the Audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Financial Reporting and Savings Targets'.
- Substantial assurance was issued in this area.
- The report made three low priority recommendations which included:

- The creation of a desktop procedure to support the resilience of completing the Monthly Monitoring Return to Welsh Government and associated Finance Reports;
- Greater transparency of the data sources which informed the monthly Finance Report; and
- Clarity of the Saving Scheme 'RAG' rating system, used within the publicly available Finance Report.

2. 6.2 Nurse Staffing Levels Act

- The purpose of the Audit was to review the processes in place to ensure compliance with the requirements of the Act, with a focus on Paediatric arrangements, which was a new part of the Act.
- Reasonable assurance was issued in this area.
- The matters which required management attention included:

- The Health Board's Nurse Staffing Levels Operating Framework' was not available on the Intranet and also required updating.
- The Workforce Planning templates were not all signed off by the Designated Person and the recorded staffing levels were not always reflected within the ward's funded establishments.
- The Nurse staffing levels were not always being displayed on the wards or the information was incorrect.

3. 6.3 Decarbonisation

- Audits were planned to be undertaken simultaneously across NHS Wales to provide assurance to respective NHS Wales bodies on their arrangements to reduce carbon emissions and control climate change.
- Having reviewed all the information for most NHS Wales bodies and fully concluding the fieldwork at five of 11 Audits, it was clear that in each instance the implementation plans had not been sufficiently developed to allow meaningful testing and to provide an assurance rating to respective Audit Committees.
- Accordingly, the decision was taken to affirm common themes to provide an overview of the overarching position across NHS Wales. The details were contained within the report.

The Committee resolved that:

a) The Internal Audit Progress Report was noted.

AAC 4/4/23 008	**Chemo Care IT System Update** The Director of Digital & Health Intelligence (DDHI) advised the Committee on the following: • This was an update on the management action plan relating to the Chemo Care IT system. • Internal Audit had previously made 8 recommendations. <u>Section 1.1</u> • No breaches had occurred since the Audit had been undertaken. <u>Section 1.2 - 1.3</u> • The Digital Team was awaiting version 6 of the system which was scheduled for April 17th. Paediatrics would be completed in May. <u>Section 2.1 - 2.6</u> • The recommendations were already in place. • The Digital Team was waiting for version 6 to be implemented in April and May 2023. <u>Section 3.1</u> • Training was being undertaken. <u>Section 4</u> • The recommendations had been undertaken and completed. <u>Section 5</u> • The password control recommendation had been completed. <u>Section 6</u> • The Digital Team was waiting for version 6 in April. <u>Section 7.1</u> • The recommendations had been completed. <u>Section 7.2</u> • The back-up schedule was in place.	

	Section 8.1 • This would be completed once version 6 of the system was in place. The HIA advised that a detailed follow up report would be completed in 2023-24. **The Committee resolved that:** a) The Chemo Care IT System Update was noted.	
AAC 4/4/23 009	**Audit Wales Update to include:** MJ advised the Committee that the Financial Audit work had commenced last month. Urvisha Perez (UP) advised the Committee on the following: • The Orthopaedics Services Follow Up Review was published in March 2023. Links to both reports were provided in exhibit 3. • Audit Wales was at the latter stages of the fieldwork for the Unscheduled Care Review. • Audit Wales would begin the follow up review of the Primary Care Services. • Exhibit 3 provided information on other relevant examinations and studies published by the Auditor General in the last six months. The UHB Vice-Chair queried how much of the Unscheduled Care Review would feed into the Six Goals work. UV responded that the review had been completed and a blog was published last year. The current review was looking at the “back door”. Later in the year Audit Wales would look at the “front door”. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 4/4/23 010	**Declarations of Interest, Gifts and Hospitality Report** The Head of Risk and Regulation (HRR) presented the Declarations of Interest, Gifts and Hospitality Report and highlighted the following:	

	• 417 Declarations of Interests, Gifts, Hospitality and Sponsorship were held on ESR (an increase of 183 from the 234 reported in January 2023). • 2,504 entries were recording 'No Interest' to be declared (an increase of 1,885 from the 619 reported in January 2023). • 97.5% of Declarations received were rated Green (407 Declarations). 2% of Declarations received were rated Orange (8 Declarations). 0.5% of Declarations were rated Red (2 Declarations). • The HRR was in contact with managers of individuals who had declarations rated red. • A meeting with Shared Services would take place shortly to understand whether ESR could be made more functional. The Independent Member for Trade Union (IMTU) commented that it was a massive improvement since last year. He queried how it compared with declarations in other Health Boards. The HRR responded that the Health Board was held as an exemplar in this area. However, he did not have much information available. Other Health Boards were using a purchased package instead of ESR. The CC queried whether responses were completed by banding. The HRR responded that staff on higher bands usually made the declarations. However, his team had targeted the whole Health Board. **The Committee resolved that:** a) The ongoing work being undertaken within Standards of Behaviour was noted. b) The proposals to improve Declaration of Interest reporting across the Health Board was noted.	
AAC 4/4/23 011	**Internal Audit Recommendation Tracking Report** The HRR presented the Internal Audit Tracking Report and highlighted the following: • There were 130 recommendations noted on the Tracker. • Of the 130 recommendations listed within the Tracker, 28 were recorded as completed (3 of which related to the advisory Assurance Strategy Audit), 73 were listed as partially complete and 29 were listed as having no	

	action taken or reported since the last Committee meeting. • The HRR had met with the HIA since the last meeting to discuss recommendations on the tracker. • A full review of all outstanding recommendations had been undertaken since the last meeting of the Committee where the internal audit tracker was presented (February 2023). • Each Executive Lead had been sent the recommendations made by Internal Audit which fall into their remits of work. • The aged entries would be targeted and most would be closed off by the July meeting. **The Committee resolved that:** a) The tracking report for tracking audit recommendations made by Internal Audit was noted. b) The progress which had been made since the previous Audit and Assurance Committee Meeting in February 2023 was noted and provided assurance.	
AAC 4/4/23 012	**Audit Wales Recommendation Tracking Report** The HRR presented the Audit Wales Tracking Report and highlighted the following: • The Risk and Regulation team was looking to collaborate with colleagues in Audit Wales to progress recommendations. • The tracker recorded a total of 34 recommendations, 3 of which were reported as complete, 25 had been partially completed. There were also 6 entries where no further action had been reported since the February 2023 Committee meeting. **The Committee resolved that:** a) the progress which had been made in relation to the completion of Audit Wales recommendations had been noted and assurance in relation to the same had been received. b) The continuing development of the Audit Wales Recommendation Tracker had been noted.	
AAC 4/4/23 013	**Regulatory Compliance Tracking Report** The HRR presented the Regulatory Compliance Tracking Report and highlighted the following:	

	• The Risk and Regulation team would continue to monitor those areas of compliance whilst working with external regulators. • The tracker highlighted one recommendation which was closed off as being complete. • Significant progress had been made with the trackers. The IMCE queried how the recommendations were prioritised. The HRR responded that each individual recommendation was dealt with as a high priority, especially where there were legal implications. The Executives would lead to push the team to escalate the recommendation. The CC queried timescales for the patient safety alerts. The HRR responded that one patient safety alert was reliant on an all Wales solution. That should be updated in the QSE Committee meetings. **The Committee resolved that:** a) Updates shared were reviewed and assurance was taken from the continuing development and the Legislative and Regulatory Compliance Tracker was reviewed.	
AAC 4/4/23 014	**Scheme of Delegation and Shared Services Governance Structure** The Interim Deputy Director of Finance (Operational) (DDFO) presented the Scheme of Delegation and Shared Services Governance Structure and highlighted the following: • Page 1 detailed an organisation map of Shared Services which was provided for information purposes. • Page 2 listed the services provided by Shared Services. • Page 3 highlighted the leads in Shared Services and their peers in the Health Board. **The Committee resolved that:** a) The Scheme of Delegation and Governance Structure of NHS Wales Shared Services was noted.	
AAC 4/4/23 015	**Review changes to Standing Financial Instructions (SFIs) and Accounting Policies**	

	The DDFO presented the Review changes to Standing Financial Instructions and Accounting Policies and highlighted the following: • The report detailed whether there had been any changes made to SFIs. • The SFIs were periodically revised by WG. • One small amendment had been made and the Finance team was already working to that. • The Finance team was also obliged to report to the Committee any major changes to the Health Board's accounting policies. This year there was the IRFS 16 Leases amendment. • The Finance team had implemented IRFS rules in the 2022/23 accounts. **The Committee resolved that:** a) The update, as set out in the body of the report, with regards to the Health Board's Standing Financial Instructions and Accounting policies was noted.	
AAC 4/4/23 016	**Procurement Compliance Report including Single Tender Actions** The Assistant Director of Procurement Services and Executive Procurement Lead C&V (ADPS) presented the Report and highlighted the following: • The Health Board's Standing Orders & Standing Financi Instructions required that the purchase of all goods and services were subject to competition in accordance with good procurement practice, referred to minimum thresholds for quotes and competitive tendering arrangements. • There were some situations where that was not always practical and requests for Single Quotation Actions (SQA) or Single Tender Actions (STA) were made in accordance with the Procedure for the Approval of Single Tender Actions. • There were times where individuals acted outside Procurement Regulations and Standing Financials Instructions and that needed to be reported as a non-compliant process, which was a direct breach, and could compromise competition and value for money. The IMCE queried whether they needed to look at the governance processes because the amount of breaches was concerning.	

	The ADPS responded that there was a total of 30 non-compliant activities. Those were mainly due to inexperience or urgency from clinicians. The ADPS added that a letter was issued to the Clinical Boards when there was a breach. The Clinical Board would write back and formally confirm any lessons learnt. There were 31 non-compliant breaches this year which was a drop from last year. The IMCE queried whether there were persistent breaches and if so what would happen. The ADPS responded that the individual was named in the letter and Clinical Director would need to address that.. The Health Board had not had a continuous offender to date. **The Committee resolved that:** a) The contents of the Report were noted and approved.	
AAC 4/4/23 017	**Review of Chair's Actions** The ADPS presented the Review of Chairs Actions Paper. It was noted that there was a concern in relation to the number of Chairs Actions. In 2023, there had been 34 Chairs Action and only 2 Board meeting approvals. The reasons were contained in the paper. A lot of Chairs Actions were due to unforeseen emergency situations. **The Committee resolved that:** a) The contents of the report were noted.	
AAC 4/4/23 018	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LLCFS) presented the Counter Fraud Progress Report and highlighted the following: • The Report provided details on activity during Quarter 4. • The Counter Fraud department had been under resourced. • Work had continued to develop better infrastructure. • It had been a busy period for referrals. • The Counter Fraud department had finished the thematic assessment.	

	• Ongoing investigations would be reported in the Private session. **The Committee resolved that:** a) The content of the report was noted.	
AAC 4/4/23 019	**Review Draft UHB Annual Report** The IDCG presented the Review of the Draft UHB Annual Report. It was noted that the Health Board was on track to deliver the Report in May. There was still a lot to be finalised in the draft, in particular in relation to the Health Board's accounts. **The Committee resolved that:** a) The progress made in relation to the drafting of the 2022-23 Annual Report was noted. b) Any comments with regard to the content of the draft report attached as Appendix 2 were provided and reviewed.	
AAC 4/4/23 020	**Audit Committee Effectiveness Survey 2022-23** The IDCG presented the Audit Committee Effectiveness Survey 2022-23 and highlighted the following: • It was noted that 8 responses were good. Overall it was a positive picture. • There were several persistent "ambers" and that could be looked into. • The Corporate Governance team would look at consistent actions that should to be put in place. • It was important to make sure that everyone was supported when moving to the new Committees structure. The IMCE suggested that induction pack should be circulated to all Independent Members (IMs). **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Audit and Assurance Committee were noted.	
	Items for Approval / Ratification	
AAC 4/4/23 021	**Annual Internal Audit Plan 2023/24**	

	The HIA presented the Annual Internal Audit Plan 2023/24 and highlighted the following: The Plan detailed the proposed audits to be undertaken along with the analysis of resources. The Internal Audit Charter was updated in April 2023 and set out the purpose, authority and responsibility of the Internal Audit service along with the relationships with the Health Board, its officers and other assurance providers <u>Section 2</u> • The draft Internal Audit plan for 2023/24 had been developed following review of the Health Board's key objectives, Corporate Risk Register, relevant Committee papers, previous audits undertaken and other key papers and documents. • Individual planning discussions were held with each of the Executive Directors, the Chief Executive and Chair to inform development of the plan. • The plan covered the whole of the 2023/24 audit year but would be subject to regular on-going review and adjustment as required to ensure that the audits reflected the Health Board's evolving risks and changing priorities and therefore provided effective assurance. The IMI stated that he had a concern and would discuss this in the Private meeting. **The Committee resolved that:** a) The Internal Audit plan for 2023/24 was approved. b) The Internal Audit Charter as at March 2023 was approved. c) The associated Internal Audit resource requirements and Key Performance Indicators was noted.	
AAC 4/4/23 022	**Audit Wales - Outline 2023 Audit Plan** MJ presented the Audit Wales - Outline 2023 Audit Plan and highlighted the following: • The Plan listed the team. • It also flagged a few conflicts that were being mitigated.	

	• The WG deadline for accounts to be audited had been changed to 31st of July. • There was a link to the Audit Quality Report for 2022. **The Committee resolved that:** a) The Audit Wales - Outline 2023 Audit Plan was noted.	
AAC 4/4/23 023	**Counter Fraud Annual Plan 2023/24** The Lead Local Counter Fraud Specialist presented the Counter Fraud Annual Plan 2023/24 and highlighted the following: • The Counter Fraud Annual Plan 2023/2024 – annual plan outlined the work proposed to be undertaken in order to meet the Counter Fraud requirements for the Health Board for the forthcoming year. • The plan aligned with the NHS Counter Fraud Authority Functional Standard requirements. • Last year had involved developing the infrastructure in Health Board. • This year there was a big push on improving awareness for staff and structure processes for fraud risk assessment. **The Committee resolved that:** a) The Counter Fraud Annual Plan 2023 – 2024 was reviewed, discussed and approved.	
AAC 4/4/23 024	**Agenda for Private Audit and Assurance Committee** i. Private Audit Minutes – 7th February 2023 ii. Counter Fraud Progress Update (Confidential – ongoing investigations) iii. Workforce and Organisational Development Compliance Report (Confidential – this report contains sensitive information and/or personal data) iv. Procurement Improvement Plan (confidential discussion) v. Cyber Security – Internal Audit Report (confidential discussion)	
AAC 4/4/23 025	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	

AAC 4/4/23 026	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
	Date and time of next committee meeting Thursday 11th May 2023 at 9:00 am via MS Teams	

Confirmed Minutes of the Public Strategy and Delivery Committee Meeting
Held On 24th January 2023 at 09:00am
Via MS Teams

Chair:		
Michael Imperato	MI	Independent Member – Legal/ Committee Chair
Present:		
Rhian Thomas	RT	Independent Member - Capital & Estates
In Attendance:		
Abigail Harris	AH	Executive Director of Strategic Planning
Ceri Phillips	CP	Vice Chair of the UHB
Jason Roberts	JR	Executive Director of Nursing
Rachel Gidman	RG	Executive Director of People and Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Ed Hunt	ED	Programme Director – Redevelopment
James Quance	JQ	Interim Director of Corporate Governance
Paul Bostock	PB	Chief Operating Officer
Cath Doman	CD	Programme Director
Dr Sian Griffiths	SG	Consultant in Public Health Medicine
Lianne Morse	LM	Assistant Director of Workforce
Observers:		
Marcia Donovan	MD	Head of Corporate Governance
Timothy Davies	TD	Head of Corporate Business
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
David Edwards	DE	Independent Member - ICT
Sara Moseley	SM	Independent Member - Third Sector
Nicola Foreman	NF	Director of Corporate Governance
Meriel Jenney	MJ	Executive Medical Director

Item No	Agenda Item	Action
S&D 24/01/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
S&D 24/01/002	**Apologies for Absence** Apologies for absence were noted.	
S&D 24/01/003	**Declarations of Interest** There were no Declarations of Interest.	
S&D 24/01/004	**Minutes of the Meeting Held on 15 November 2022** The minutes of the Committee meeting held on 15 November 2022 were received.	

	The Committee resolved that: a) The minutes of the Committee meeting held on 15 November 2022 were approved as a true and accurate record of the meeting.	
S&D 24/01/005	**Action Log following the Meeting held on 15 November 20022** The Action Log was received. **The Committee resolved that:** a) The Action Log from the meeting held on 15 November 2022 was noted.	
S&D 24/01/006	**Chairs Action** There were no Chairs Action taken.	
	Items for Review and Assurance	
S&D 24/01/007	**Strategic Delivery Programme updates - Flash Reports** The Executive Director of Strategic Planning (EDSP) presented the Strategic Delivery Programme updates - Flash Reports and highlighted the following: 1. Shaping our Future Population Health • That was currently at a green status. 2. Shaping our Future Community Services • That was currently at a green status. 3. Shaping our Future Clinical Services • That was currently at an amber status. 4. Shaping our Future Hospital • Work was progressing. However, there was no Programme Business Case endorsed yet. • The Health Board had asked for resource from Welsh Government (WG) in order to build a team and hire specialist technical staff. • The Minister had asked for a clinical review of the model. **The Committee resolved that:** a) The Strategic Delivery Programme updates - Flash Reports were discussed and noted.	

S&D 24/01/008	**Key Workforce Performance Indicators** The Assistant Director of Workforce (ADW) presented the Key Workforce Performance Indicators and highlighted the following: • The KPIs showed a very challenging recruitment environment. • The turnover rate remained at 13% since March, despite efforts made by managers. A healthy turnover rate is between 7 – 9% • The sickness absence rate was similar. It was fluctuating between 6-7%. However, it was higher than pre -Covid rates. • Formal disciplinary investigations continued to reduce month by month due to the People and Culture team focus (the PC Team) and Trade Unions. • There had been positive improvements in VBA and statutory and mandatory training All with a target of 85% compliance • Benchmarking workforce key performance targets across Wales had been completed. The comparison data was out of date from August 2022 However, it showed that the Health Board was in the middle range. There was clearly a challenging workforce environment across Wales. • The PC Team had started to look at the data in England but more work was required in readiness for the May committee • The Health Board was not an outlier in terms of KPIs. The Independent Member - Capital & Estates (IMCE) queried what practical learning was being gained from other Health Boards since their KPIs were better. Also, how was the impact of initiatives being measured. The ADW responded that the PC Team was constantly speaking to colleagues in other Health Boards. From discussions, it was apparent that the Health Board was not doing anything different to other Health Boards. The Chief Operating Officer (COO) advised that there was still an upward trajectory. There was not enough focus initially. However, since August/September last year he was going through the KPIs with the Clinical Boards every month. Some Clinical Boards were doing better than others. The ADW stated that all interventions were measured to understand how effective those interventions were. Sometimes the impact of the managers' work might not be seen in KPIs due to the size of the organisation. **The Committee Resolved that:** a) The contents of the report were discussed and noted.	
S&D 24/01/009	**People and Culture Plan Update** The EDPC presented the People and Culture Plan Update and highlighted the following:	

	• It had been one year since the launch of the People and Culture Plan. • It was a 3-year plan and the second year would be focusing embedding the plan into the clinical boards • Next year there would be a focus upon the impact of the People and Culture Plan. • The King's Fund Report highlighted the importance of worker closer with the Social Care sector. • The highest sickness rates category were due to stress, anxiety and depression. Those reasons did not sit in isolation and a wellbeing strategy needed to be developed. • The creation of the new People and Culture Committee with the alignment twith health and safety, and quality and safety would give a broader insight and impact of the people agenda • Going forward, Clinical Boards needed to own the People and Culture Plan and incorporate the 7 themes within the Clinical Boards' own plans. The COO stated that an external review had been commissioned. **The Committee Resolved that:** a) The contents of the report were discussed and noted.	
S&D 24/01/010	**Key Operational Performance Indicators** The COO presented the Key Operational Performance Indicators and highlighted the following: • There had been progress regarding ambulance handover. The 3-hour waiting time needed to be reduced. • The Health Board was doing better this Winter than originally envisaged. However, there was still a lot of work to do. • His team had met with the Fracture, Neck and Femur team to set clear objectives and to benchmark against the hip and fracture database. • Stroke services remained a concern. There was Stroke summit recently and the UK benchmarking scores were considered. At the moment the Health Board was rated "D", with "A" being the best score. There was a follow up meeting next week. • Planned care elective work had not been cancelled because of pressures. • The 8-week diagnostic waits might increase. • Primary Care was managing this Winter. The Health Board was providing urgent Primary Care from five locations. The third urgent centre was opening next week. *a) General Update on Cancer Services including rapid diagnostic centres* • The standard says every Cancer patient should have treatment commenced by day 62 of being referred.	

- A key milestone that would be used was that as many patients should be diagnosed of cancer or not, by day 28.
- The standard was for 75% of patients to start definitive treatment within 62 days of the point of suspicion.
- The main task was to eradicate the number of patients who had already waited 62 days.
- The Health Board approved a business case in April 2022 to establish a Rapid Diagnosis Clinic for patients referred as having suspected cancer as part of the Vague Symptom Pathway.
- There were 2,062 active patients.

The IMCE queried what the ambitions were for the new General Manager for Cancer services.

The COO responded that he/she would (i) continue the work done to date and (ii) move forward to develop a clear strategy for Cancer treatment.

The IMCE stated it would be useful to get the new General Manager's insight when he/she has had 6 months in the role.

b) Medically fit for discharge

- 363 patients were deemed medically fit for discharge.
- The position had stabilised but that figure represented a lot of people occupying an acute hospital bed.
- A lot of people were waiting for a Social Worker to be allocated.
- A forensic review was completed in October.
- 37% of patients were waiting for Social Services admission.
- 50% of patients spent 24 hours in EU. That was causing more harm to patients.
- It was recognised that the Local Authority partners had challenging issues with recruiting Social Workers. One option being considered was to have trusted assessors to carry out social worker assessments.
- Work was currently underway with the END to cohort some patients into the Lakeside facility and to make that facility more conducive to a residential space for that medically fit for discharge patients. Plans were being worked up, however, there were some risks.

The IMCE queried what else could the Local Authority partners do to support the welfare of people.

The COO responded that the benefit of maximising Lakeside estate was to centralise and maximise the available resource.

The EDSP stated that focus should be on the pathway to get patients out of hospital as not all patients required an intensive package of care and/or a full care assessment. One issue was about changing the culture and getting people out of the hospital and then doing the comprehensive assessment after hospital discharge. Work was required to consider how that could be carried out safely.

	The EDPC stated that the Health Board needed to be more efficient with workforce plans and noted that there was ongoing work with regards to developing Band 4 staff to assist in that area. The END stated that he had spoken to the Chief Nursing Officer with regards to remodelling the nursing workforce in those areas. The UHB Vice Chair stated that the demand was continuing to increase. The Health Board was going to see pressures unless it could address issues in Social Care and he queried whether discharge could be facilitated with additional support in the community. The COO responded that a lot could be done to support Social Care. The Six Goals programme placed a big emphasis on “at home care”. If people were unable to stay home then they should be signposted to the correct place. c) *Deep Dive - Cost of living crisis impact upon Mental Health Services* • There had been a significant impact on patients and staff. • There were actions included in the documents presented to the Committee. The EDPC stated that staff were struggling with the cost of living. There was a cost of living page that staff were signposted to. There was also a financial wellbeing offering by several other Health Boards called “Wage Stream” and discussions had taken place in Management Executive about adopting that. **The Committee Resolved that:** a) The year to date position against key organisational performance indicators for 2022-23 and the update against the Operational Plan programmes was noted.	
S&D 24/01/011	**Strike update** The COO presented the Strike Update and highlighted the following: • The Health Board had the lowest number of derogation requests. • The rights of individuals who wished to strike were accepted, whilst making areas safe. • The use of Corporate department support was not well received by staff who were striking. • The first two strike days had involved cancelling 1,000 outpatients, of which 500 outpatient appointments were cancelled the next day. • Cancer patient appointments were not cancelled. • There were no additional issues with Ambulance handover as a result of the strikes.	

	• The first Ambulance strike saw a reduction in ambulances but not as many as they thought it would be. • More strikes were planned for the 6-7th of February. • Teachers were also striking and it was noted that such strikes could have an impact on Health Board staff (for example, it could affect child care). The IMCE queried the impact of indirect strikes and how they planned to compassionately support staff. The EDPC responded that the Health Board encouraged compassion to our people throughout the industrial action strikes. The END stated the Health Board would be impacted by the WAST strike action. **The Committee Resolved that:** a) The Strike Update was noted.	
S&D 24/01/012	**IMTP Quarter 3** **The Committee Resolved that:** a) The IMTP Quarter 3 Update was noted.	
S&D 24/01/013	**2023/24 Decarbonisation Action Plan** The Programme Director – Redevelopment (PDR) presented the 2023/24 Decarbonisation Action Plan and highlighted the following: <u>Context</u> • The Health Board had emitted 202,000 tonnes of CO2. • WG had set a target for reducing carbon emissions by 16% by 2025 and 34% by 2030. • Audit Wales have produced “5 actions” for Public Bodies to address. • There was currently no line of sight to the 16% emission reduction target by 2025. <u>Vision and leadership</u> • Decarbonisation should be included as a central pillar of decision making. • Leadership should commit to owning and impacting positively on carbon emissions, encouraging their teams to deliver change. • Climate Champions should be sponsored across the organisation for specific and relevant work. • A decarbonisation behaviour change programme needed to be sponsored.	

	• Grant funding available (for example, Re:Fit) to understand energy savings opportunities should be maximised. • There needed to be actions at a working level i.e. Clinical, travel, estates, people, procurement. <u>Next steps</u> • To mature actions, estimate cost and back off with owners. • The first draft of action plan was submitted on 31st January. • It was due to go to Board Development in February. The IMCE queried what else should the Board be doing to implement the actions and move the decarbonisation matter forward. The EDSP responded that there should be a section on decarbonisation in Board reports. There should also be a clear action plan. The PDR stated Internal Audit have said the decarbonisation agenda should go to meetings and he would pick this up with the Interim Director of Corporate Governance (IDCG). Board level training on the topic could be considered. The IMCE stated that Board champions could be something they could do. **The Committee Resolved that:** a) The content of the report, including the timetable to completion, was noted.	ED/JQ
S&D 24/01/014	**Board Assurance Framework** The IDCG presented the Board Assurance Framework (BAF) and highlighted that it was part of the reporting cycle. There are 3 risks being reported which included Capital Assets, IMTP and Staff Wellbeing. **The Committee resolved that:** **a)** The attached risks in relation to Capital Assets, IMTP 22-25 and Staff Wellbeing were reviewed. **b)** Assurance was provided to the Board on 26th January 2023 on the management /mitigation of those risks.	
	Items for Approval / Ratification	
S&D 24/01/015	**King's Fund Report – Early Intervention** The Executive Director of Public Health (EDPH) presented the King's Fund Report – Early Intervention and highlighted the following:	

- The Report followed work previously completed with the King's Fund in 2021.
- It addressed ways to create sustainable systems which supported and improved the health of populations and tackled inequalities.
- The Report was commissioned to find scrutiny of the status of the Health Board with regards to prevention, early intervention and strengthened integrated social care.
- There would be a follow up piece of work.

The Programme Director (PD) highlighted the following:

- There were two reports which had focussed upon (i) Creating a more integrated health and care system and (ii) Embedding a more preventative approach within primary and community services. It was noted that the two reports were interlinked.
- The aim was to get an objective, independent and credible view of the Health Board's strategy.
- The reports provided an independent perspective on the progress to date, and added to the information and evidence for consideration as the Health Board developed strategic and operational plans.

The Consultant in Public Health Medicine (CPHM) highlighted the following:

- There was an overlap between the two reports.
- A culture of innovation was identified in both reports.
- The integrated health and care system report had identified that the Health Board had made significant progress towards delivering a more integrated care system.
- The preventative report found that the Health Board had made significant progress towards delivering preventive approach in primary and community services.

<u>Recommendations</u>

- Opportunities for further progress included strengthening a culture of innovation. Doing more with data. Closer working with patients and communities and managing resource collectively.

The IMCE queried how the recommendations would be weaved into the day to day activities of the Health Board.

The PD responded that the Regional Partnership Board (RPB) was in the process of putting together a 5-year plan. The timing of the reports had been useful to input into that plan.

The ESDP advised that the recommendations from the reports should form part of the Health Board's core business and should be reflected in the Health Board's Strategy refresh, and the IMTP.
The recommendations from the Kings Fund would enable to continue to further integrate across health and social care and work more closely with the third sector.

	The COO stated that the reports had been discussed at the Senior Leadership Board and the positive comments about the strength of the third sector relationship had been noted. The COO advised that he was Interested in how the reports' recommendations would be taken forward. **The Committee resolved that:** a) The content of the two reports were noted; and b) The application of identified priorities in planning and strategy development, were endorsed.	
S&D 24/01/016	**Policies** The Committee noted that there were no policies on the agenda.	
	Items for Information and Noting	
S&D 24/01/017	**Corporate Risk Register** The IDCG presented the Corporate Risk Register (CRR) and highlighted the risks which were in the Committee's remit to oversee. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Strategy and Delivery Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates, was noted.	
	Review and Final Closure	
S&D 24/01/018	**Any Other Business** No Other Business was discussed.	
	Date & time of next Meeting 14 March 2023 at 9am via MS Teams	

Confirmed Minutes of the Public Strategy and Delivery Committee Meeting
Held On 14th March 2023 at 09:00am
Via MS Teams

Chair:		
Michael Imperato	MI	Independent Member – Legal/ Committee Chair
Present:		
Rhian Thomas	RT	Independent Member - Capital & Estates
Sara Moseley	SM	Independent Member - Third Sector
In Attendance:		
Abigail Harris	AH	Executive Director of Strategic Planning
Ceri Phillips	CP	Vice Chair of the UHB
Jason Roberts	JR	Executive Director of Nursing
Rachel Gidman	RG	Executive Director of People and Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Ed Hunt	ED	Programme Director – Redevelopment
James Quance	JQ	Interim Director of Corporate Governance
Richard Skone	RS	Critical Care Consultant
Andrew Hall	AH	Performance and Planning Manager
Mitchell Jones	MJ	Equity & Inclusion Senior Manager
Observers:		
Timothy Davies	TD	Head of Corporate Business
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Meriel Jenney	MJ	Executive Medical Director
Lianne Morse	LM	Assistant Director of Workforce
Paul Bostock	PO	Chief Operating Officer

Item No	Agenda Item	Action
S&D 14/03/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
S&D 14/03/002	**Apologies for Absence** Apologies for absence were noted.	
S&D 14/03/003	**Declarations of Interest** There were no Declarations of Interest.	
S&D 14/03/004	**Minutes of the Meeting Held on 24 January 2023** The minutes of the Committee meeting held on 24 January 2023 were received.	

	The Executive Director of People and Culture (EDPC) commented that she would like to make changes to page 6. She would send the amendments to the Corporate Governance team. The Independent Member – Third Sector (IMTS) requested information on the Stroke situation. The Performance and Planning Manager (PPM) responded that he would provide an update on that within the operational update later in the meeting. The Executive Director of Strategic Planning (EDSP) requested that the fourth bullet point on page 7 should read "The recommendations from the Kings Fund Report would allow the Health Board to continue to further integrate across health and social care and work more closely with the third sector." The Executive Director of Public Health (EDPH) requested that page 8 was amended to "The report was commissioned to find scrutiny of the status of the Health Board with regards to prevention, early intervention and strengthened integrated social care." **The Committee resolved that:** a) Pending the above amendments, the minutes of the Committee meeting held on 24 January 2023, were approved as a true and accurate record of the meeting.	
S&D 14/03/005	**Action Log following the Meeting held on 24 January 2023** The Action Log was received. **The Committee resolved that:** a) The Action Log from the meeting held on 24 January 2023 was noted.	
S&D 14/03/006	**Chairs Action** There were no Chairs Action taken.	
	Items for Review and Assurance	
S&D 14/03/007	**Shaping Our Future Wellbeing Strategy** 2.1.1 – Strategic Portfolio Update The EDSP presented the Strategic Portfolio Update and highlighted the following: • The flash reports were reviewed by the Management Executive Strategic Meeting a few weeks ago. • The Shaping Our Future Population Health had a green status. • The Shaping Our Future Community Services also had a green status. The activities were being completed in a timely manner.	

	• The Shaping Our Future Clinical Services had an amber status. Due to capacity issues, the programme had been reshaped. Additional resource had been requested to prepare the Strategic Outline Case for submission to Welsh Government (WG). • The Shaping our Future Hospitals had an Amber status. - The Minister wanted to be assured of the clinical models described in the programme business cases. - It had been discovered that a hospital programme would take a long time to deliver and running a Clinical services plan alongside it was appropriate. The challenge would be making sure that it was flexible because things could change. - The Minister had received advice on the request for resources. - The Strategic Planning team was preparing to develop an Outline Strategic Case and was going to tender for a strategic partner who would work all the way through the programme. - Since the Programme Business Case had been completed, interest rates had gone up. However, the funding aspect was a WG issue. • The EDSP advised that the Health Board would need to think about strategy programmes that would drive longer term strategy delivery and consider operating models during the Strategy refresh. The IMTS queried the link between the Shaping Our Future Clinical Services and the new hospital. A lack of clarity was identified which caused confusion and there seemed to be a lack of engagement with the programme. The IMTS stated that was concerning and requested assurance that more attention would be given to that. The EDSP responded that she would bring an update to the Board Development session and would work with the Interim Director of Corporate Governance (IDCG) and the UHB Chair to attend to that. The EDSP added that she was hoping to receive a positive response from the Minister. She had agreed a series of workshops with Clinicians to shape the plan with the Chief Operating Officer (COO) and the Executive Medical Director (EMD). A programme which would include the work done to date by Grant Thornton, had been agreed. There had also been learning from national pieces of work that had been completed. <u>*2.1.2 - Strategy* Refresh Update</u> The EDSP presented the Strategy Refresh Update and highlighted the following: • The update was written a few weeks ago and was therefore slightly out of date. • The Strategic Planning team was working towards a launch date to coincide with the Health Board's Annual General Meeting. • The engagement process was currently a month behind.	**EDSP/IDCG**

	• A number of online staff events had been completed. The feedback was instantaneous and anonymous. • The CEO and the Deputy Director of Planning (DDP) had completed a staff session in UHL and another session was completed at UHW. • A series of public sessions had also been completed. • The Strategy refresh would need to take account of the feedback contained in the 400 completed surveys received. An analysis of the data would also need to be completed. The Independent Member - Capital & Estates (IMCE) queried what role the Youth Forum played. The IMCE also queried how the volunteers and staff network groups were being included in the Strategy refresh. The EDSP responded that her team was small and she would expect others to cascade the Strategy refresh out to their staff and other key groups. She also hoped that the networks were having the relevant conversations. The EDSP added that funding was provided to the Third Sector to allow engagement with groups in the community. A range of sessions had been held and the feedback had now been received. The UHB Vice Chair commented that he sat on the working group for the Strategy refresh and the Strategic Planning team had done a really good job, considering the constraints. The working group had highlighted new groups to reach out to and the process had been rigorous. He added that a lot of good work had been completed under the radar. **The Committee Resolved that:** a) The progress and risks described in the Strategic Portfolio Flash Report were noted. b) The progress and risks described above and the proposed Strategy Launch date of 18th July 2023 subject to formal Board approval at 27th July Board meeting, were noted.	
S&D 14/03/008 Saunders.Nathan 24/05/2023 15:05:05	**Key Workforce Performance Indicators** The EDPC presented the Key Workforce Performance Indicators and highlighted the following: • The People and Culture team (the P&C team) would be maturing the data to highlight both the Health Board and Clinical Boards' KPIs. • The team was still focusing on benchmarking against larger Health Trusts nationally. • There had been a slight reduction in turnover rates. The current rate was 13%. The ideal turnover rate was 7-9%. The team was obtaining the themes that had arisen from the exit and starter questionnaires. • Turnover rates had risen for all of the Clinical Boards in the last year, with the exception of Capital, Estates & Facilities (CEF),	

	where the rate had fallen from 15.19% in January 2022 to 14.49% in January 2023. • The P&C team have supported Value Based Appraisals (VBAs). A meeting had taken place with the Head of Capital Planning to discuss KPIs.. • The PCIC turnover rates had fallen from 28.44% to 23.12%. There had been a lot of fixed term contracts as a result of the Mass Vaccinations Programme. There would be a new redeployment model going forward which meant that all roles would not be retained. The P&C team was actively helping individuals regarding their choices for redeployment. • The District Nursing turnover rates was at 16%. A reason for that was that a lot of the workforce were from an aging cohort. • The turnover rate was improving in the Specialist and Mental Health Clinical Boards. It had decreased by 1%. Those Clinical Boards were not in the “green area”, but there was a focus to help and support them in those areas. • Sickness absence rates remained high. All areas had seen a significant reduction between December and January. Since the papers were published, the sickness rates have come down even further to 5.8%. • There had been conversations with Clinical Boards regarding performance reviews/ trajectories in relation to sickness rates and VBAs. • Clinical boards had been asked to get to 60% by the end of March and to hit a target of 85% by June. CEP had reached 74.2% already. CD&T was at 65% and PCIC was at 59%. • The EDPC advised that it was mainly about checking in and having conversations with employees rather than the exercise. • There was a real focus on achieving statutory and mandatory training. The compliance rate had risen to 76.06% in January 2023 which was 8.94% below the overall target. The IMTS queried the hotspot areas which were problematic and the reasons for that. The IMTS also queried whether different roles and grades within the organisation made a difference. The EDPC responded that the P&C team was working with PCIC to complete a deep dive. The data would be brought back to the new People and Culture Committee.. The EDPH added that a number of high-grade vaccination staff were made permanent. A number of lower grade staff were not made permanent. A proposal for health protection services had gone to the Investment Group and the Senior Leadership Board (SLB) to create a permanent sustainable model. The EDPH added that there would be more stability going forward. Her team was going through the process to ensure that all staff in mass vaccination centres, including lower banded staff, were made permanent.	**EDPC**

	The Vice UHB Chair commented that the variable pay trend seemed to be static. The paper stated there was a reduction in Corporate areas and PCIC which implied that other Clinical Boards were seeing an increase. He queried whether that could be attributed to the turnover and sickness issues or were there other factors. The EDPC responded that a piece of work was being completed with each Clinical Board to reduce the requirement for agency and locum staff and to increase workforce sustainability. The EDPC added that there was a workforce efficiency group in place. The EDPC added that the P&C team had carried out some benchmarking in relation to staff wellbeing. The P&C team had found that a traditional method of using Counsellors and lower level practitioners to support staff was used pre-pandemic. That structure would be kept through the wellbeing service. **The Committee Resolved that:** a) The contents of the report were discussed and noted.	
14/03/009	**Key Operational Performance Indicators** The PPM presented the Key Operational Performance Indicators and highlighted the following: • In February, there had been a small drop in attendances. • There were improvements in the 12-hour breaches and the 4-hour compliance performance. • There were still pressures in high occupancy and delayed discharges. That had continued to be monitored and the Winter Plan was still progressing to address discharges and additional beds. • The number of ambulance handovers more than 4 hours had reduced from 230 in September to 33 in December and 12 in January. • There had been a small improvement in the fractured neck of femur admissions. In December 2022, 1.7% of patients were admitted to a specialist ward with a nerve block within 4 hours. • Since the last meeting, there was a summit with the surgery team and Emergency Unit (EU) team to improve that pathway. • In December, 59.2% of patients had received surgery within 36 hours. That was reflective of the general trend during 2022 but was a reduction when compared to October 2021 performance (64.6%). The performance was above the national average of 56% over the last 12 months. • The Health Board had held two internal Stroke summits and a number of improvements to the Stroke pathway were now being implemented. • There continued to be an improvement against the Single Cancer Pathway and the backlog trajectories agreed with the Delivery Unit.	

- December had seen another improvement of 4% compared with October with 58.5% of patients receiving treatments within 62 days. Since December, 55% had been reported to WG.
- There would be a focus on work to treat the longest waiting patients.
- There were currently 69 patients as of Monday who have waited over 104 days for treatment to begin and 235 patients who have waited over 62 days.

- The waiting list for the total number of patients waiting for planned care and treatment was 121,687 at January 2023. The Urgent Primary Care Centres were now operating in Cardiff and the Vale.
- The volume of greater than eight-week Diagnostic waits had increased to 5,247 at the end of January 2023 from 3,654 in November 2022, largely driven by increased waits in Radiology (MRI).
- The number of patients waiting over 14 weeks for Therapy had slightly increased to 1,220 from 1,209 in November 2022, as reported at the December Board Meeting.
- The Health Board was 100% compliant in January 2023 against the standard of 100% for 'Emergency' GP out of hours patients requiring a home visit within one hour, with 7 of 7 patients receiving their visit with one hour.
- The percentage of Mental Health assessments undertaken within 28 days was 98.1% in January 2023. That had reduced from 98.5% in December 2022. For CAMHs services, compliance reduced from 93.2% in December to 90.7% in January.

The IMCE queried what measures had been taken to reduce the ambulance handover from 230 in September to 12 in January.

The PPM responded that performance had been improving over the past few months. The measures taken included ring fencing of beds in EU, consultant reviews regarding bringing patients into the EU. There was also an escalation policy of 3 hours of search beds. That had been a real area of focus.

The EDPH responded that it was also a result of the strategic and operational leadership approach taken. It was not acceptable to have that level of risk in the community. There was also a constant mix of movement in the inpatient setting. The COO would have balanced the risk internally with the desire to decrease the community risk.

The EDSP stated it was a combination of actions undertaken. Taking a zero-tolerance approach towards the issue and working with Clinical teams had been vital.

The UHB Vice Chair stated that it was not about just getting patients out of hospital but enhancing their quality of life.

	The Committee Resolved that: a) The year to date position against key organisational performance indicators for 2022-23 and the update against the Operational Plan programmes was noted.	
S&D 14/03/010	**Strategic Equality Plan Update** The Equity & Inclusion Senior Manager (EISM) presented the Strategic Equality Plan Update and highlighted the following: • The Health Board achieved a Disability Confident Level 3 status. A lot of work had gone into that and it could now be added onto the Health Board website. • Activity around LGBTQ+ inclusion had resulted in the Health Board maintaining its Gold Award as part of Stonewalls Workplace Equality Index (WEI) and being ranked as the 80th most LGBTQ+ inclusive employer in the UK by the charity. • The organisation had continued to support the three staff networks. • Progress had been made in organisational compliance with the Welsh Language Standards and the Health Board reported compliance with 81 out of the 121 standards. The use of translation memory software led to an 11% increase in the number of words translated in 2022 in comparison with 2021, with the Welsh Translation team translating 1,158,688 words last year. • There would be a focus on improving data collection and compliance. The IMTS commented that she was glad to see the disability status. She queried the Anti-Racist Wales Action Plan and queried whether the Health Board had the right data collection in place. Also, was enough being done to value and support the staff networks and was there more that could be done. The EISM responded that the workforce equality standards were used as a workforce indicator measure in England. WG was currently scoping that for Wales and it was anticipated that the final version would be received towards the end of the year. His team did have sight of the proposals and have started to map the Health Board against the indicators. There are gaps and some of the information would be collected through the NHS Staff Survey. The EISM also added that more could be done to support the staff networks. The EDPC stated that part 2 of the Anti-racist Wales Action Plan would be discussed in Board Development to understand what more could be done. The IML queried how would they know whether the Health Board was on the right trajectory based on the outcomes. The EISM responded that the objectives sat under the outcomes and the objectives would need to be met. Some of these objectives rolled on	

	annually. As long as they were meeting the objectives under the plan, the Health Board could demonstrate that it was working towards meeting the outcomes. The EDPH stated that outcome 3 was about the interfaces between equality, equity, safety and patient experience. The specific actions would be worked on. **The Committee Resolved that:** a) The contents of the report were noted and discussed.	
S&D 14/03/011	**Board Assurance Framework** The IDCG presented the Board Assurance Framework (BAF) and highlighted the following: • There were two risks reported at today's meeting: - Urgent and Emergency Care - Exacerbation of Health Inequalities • Those risks were last reported to the Board at the end of November 2022 and agreed, along with other risks on the BAF, to be the risks to the Strategic Objectives. • The risks would go to the Board meeting at the end of month. **The Committee resolved that:** **a)** the attached risks in relation to Urgent and Emergency Care and Exacerbation of Health Inequalities were reviewed. **b)** Assurance could be provided to the Board on 30th March 2023 on the management /mitigation of these risks.	
S&D 14/03/012	**Anti-Racist Wales Action Plan Update** The EISM presented the Anti-racist Wales Action Plan Update and highlighted the following: • The Anti-Racist Wales Action Plan was published in June 2022. • The aim was to create an anti-racist Wales by 2030. • One of the primary actions was to develop an organisational Anti-Racist Action Plan in Cardiff and Wales. • A draft version had been completed alongside the One Voice Staff Network and Trade Union partners and was due to go to SLB on the 19th of April. • The Health Board's approach was presented to the WG steering group responsible for the delivery of health actions under the Anti-racist Wales Action Plan. The group was pleased with the Health Board's proactive approach. • It was intended that the action plan would go to Board for approval in May 2023.	**EDPC**

	• In the meantime, work had already begun to take forward some of the key actions with plans in place to progress others. Some of the key areas of focus over the coming months would be: - Improving data collection - Continuing to develop the Inclusion Ambassador programme - Continuing to deliver anti-racist sessions for Board through Race Equality First - Supporting the One Voice Staff Network - Undertaking an organisational listening exercise to better understand the experiences of colleagues from ethnic minority communities - Developing a Health Equality, Equity, Safety and Experience Framework The IMTS stated that on previous listening exercises, people had shared very painful experiences. It was important to communicate how the Health Board would address those experiences. The EDSP stated that there were a high number of still birth rates across the BME population and it was important to understand the reasons for that. The EDPH advised that the issues around mortality had been discussed at the Quality, Safety and Experience (QSE) Committee meetings and one of the elements was that the Health Board had delivered a lot of complex births in Wales. There was further work to do in relation to this issue. The END advised that women from BAME backgrounds go through more maternity issues, which included a lack of translation facilities. The END added that his department was in the process of employing midwives to lead on that. That issued had been picked up in the HIW report which would be taken to the QSE Committee meeting and then to Board. The EDPC stated it was about everyone "owning" the Anti-Racist Wales Action Plan. There were plans to co-produce a workshop with the Clinical Boards so that they understood it. There was also work to be done in supporting the international nurses. **The Committee Resolved that:** a) The contents of the report were noted and discussed.	
S&D 14/03/013	**Decarbonisation Plan** The EDSP presented the Decarbonisation Plan and highlighted the following: • The Board had declared a climate emergency in January 2020. Since then two Sustainability Action Plans have been implemented. The third action plan was now being developed.	

	• NHS Wales had set a target of a 16% reduction in emissions by 2025 and a 34% reduction by 2030, from a 2018/19 baseline. • The plan had been developed by a working group which included key departments across the organisation. That work was overseen by a Decarbonisation Delivery Group which included key Executives. • The largest contributor to the carbon footprint was procurement. • The plan described what needed to be done at Board level, what needed to be done at Clinical Board level and actions that every front-line team could be taking. • Any future estates development would need to have carbon zero built into it from the start. • At the moment there was no line of sight for the 2030 target and there was a lot to be done. • WG was currently reviewing the targets. The Health Board was required to submit the plan after Board approval. The UHB Vice Chair stated more could be done about the way the plan was being developed. For example, integrated working and the way District Nurses were avoiding patients coming to hospital and being managed in the community could be factored in. Clinicians running clinics in communities instead of patients attending outpatient appointments could also be considered. The EDSP responded that the sustainable travel element and doing as much as possible digitally was really important and would be included in the action plan. **The Committee Resolved that:** a) The 2023/24 Decarbonization Action Plan was reviewed. b) The 2023/24 Decarbonization Action Plan was recommended to Board for approval.	
S&D 14/03/014	**Committee Self Effectiveness Survey** The IDCG presented the Committee Self Effectiveness Survey. It was noted that there were three responses to the survey. One of the key feedbacks was the timeliness of papers which would be taken away and incorporated into the team and organisation. The IDCG commented that it was important to ensure that everything was at the right level and flowed properly. **The Committee Resolved that:** a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Strategy and Delivery Committee were noted.	
	Items for Approval / Ratification	

S&D 14/03/015	**Annual Equality Report 2021/22** The EISM presented the Annual Equality Report 2021/22 and highlighted the following: • The report discharged the Health Board's legislative duty under the Equality Act 2010. • The report covered the period April 2021 – March 2022. • The report would be published in the Summer. • The final version would go to Medical Illustration team to reformat and it would also be translated into Welsh. The IMTS stated that the gender pay gap was worrying and queried how that would be resolved. The IMCE also queried whether men undertaking more overtime compared to women was a factor. The EISM responded that it was disappointing. He would need to collect the information and create an action plan to address the gender pay gap. The EDPC stated that would be looked into more as part of the People and Culture Committee. The UHB Vice Chair suggested that the percentage of males within the Medical and Dental sectors was higher than the percentage of women. The earnings in that area could be higher. **The Committee resolved that:** a) The contents of the report were noted and approved.	**EDPC**
S&D 14/03/016	**Strategy & Delivery Committee Annual Report 2022-23** The IDCG presented the Strategy & Delivery Committee Annual Report 2022-23. The report was produced to demonstrate that the Committee had undertaken the duties set out in its Terms of Reference and to provide assurance to the Board that was the case. **The Committee Resolved that:** a) The draft Annual Report 2022/23 of the Strategy and Delivery Committee was reviewed and recommended to the Board for approval.	
	Items for Information and Noting	
S&D 14/03/017	**Corporate Risk Register** The IDCG presented the Corporate Risk Register.	

	It was noted that the register highlighted the risks which were in the Committee's remit to oversee. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Strategy and Delivery Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates, was noted.	
	Review and Final Closure	
	Any Other Business It was noted that this was the last Strategy and Delivery Committee meeting. The Committee thanked the Chair.	

Confirmed Minutes of the Public Finance Committee Meeting
Held On 15th February 2023 at 2 pm
Via MS Teams

Chair:		
Rhian Thomas	RT	Independent Member - Capital and Estates
Present:		
John Union	JU	Independent Member – Finance
David Edwards	DE	Independent Member – ICT
Keith Harding	KH	Independent Member – University
In Attendance:		
Charles Janczewski	CJ	UHB Chair
Suzanne Rankin	SR	Chief Executive Officer
Abigail Harris	AH	Executive Director of Strategic Planning
Catherine Phillips	CP	Executive Director of Finance
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Andrew Gough	AG	Deputy Director of Finance (Strategy)
Paul Bostock	PB	Chief Operating Officer
Jason Roberts	JR	Executive Nurse Director
James Quance	JQ	Interim Director of Corporate Governance
Observers:		
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		

Item No	Agenda Item	Action
FC 15/02/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FC 15/02/002	**Apologies for Absence** **The Finance Committee resolved that:** a) No Apologies were noted.	
FC 15/02/003	**Declarations of Interest** **The Finance Committee resolved that:** a) No Declarations of Interest were noted.	
FC 15/02/004	**Minutes of the meeting Held on 18 January 2023** The minutes of the meeting held on 18 January 2023 were received.	

	The Finance Committee resolved that: a) The minutes of the meeting held on 18 January 2023 were held as a true and accurate record of the meeting.	
FC 15/02/005	**Action Log following the meeting held on 18 January 2023** The Action Log was received. FC18/01/007 - The Executive Director for Finance (EDF) stated that the Finance team would incorporate a workforce efficiency element into the savings plan and savings development which would be discussed in today's IMTP discussions within the Private meeting. FC 14/12/007 and FC 18/01/007 – The EDF emphasised the connection between the cost pressures and the lessons learnt. She requested Independent Members to provide feedback in the Private session. FC 14/12/007 and FC 18/01/007 – The deadline should be changed to April 2023. **The Finance Committee resolved that:** a) The Action Log was up to date.	**Action log**
FC 15/02/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance	
FC 15/02/007	**Financial Report – Month 10** The Deputy Director of Finance (Operational) (DDFO) presented the Financial Report – Month 10 and highlighted the following: At month 10 the Health Board was reporting an overspend of £22.417m. That was comprised of £8.167m of operational overspend and the planned deficit of £14.250m (ten twelfths of the annual planned deficit of £17.1m set out in the 2022/23 financial plan). The Health Board had forecast a £26.9m deficit for the end of 2022-23. <u>Key Performance Indicator Dashboard at January 2023</u> • That remained unchanged from previous months.	

Financial Performance of Clinical Boards

- The operational deficit of £12.203m against delegated budgets was offset by a £4.036m underspend against central budgets.
- That left a total operational and Covid overspend of £8.167m before the addition of the cumulative £14.250m planned deficit. That resulted in a total overspend of £22.417m.
- Table 4 provided details of some of the cost pressures impacting operational positions.
- The cost pressures had the effect of removing budgetary surpluses that the Health Board had partially relied on to achieve break even positions in previous financial years.

Planned versus current EOY Trajectory 2022-2023 Month 1

It was noted that enhanced action had been taken at Month 7 which had broken the trend.

The CC queried the type of enhanced actions taken since month 7 to ensure the Health Board was on the grey line trajectory as opposed to the orange line. The CC also queried whether those actions were sustainable or not.

The DDFO responded that the Finance team had asked the Clinical Boards to firm up forecasts and look for all opportunities. The Finance team had also set a number of control totals.

The COO explained that having control totals would be really helpful and should set the Health Board up in the right direction for next year.

The CC queried the reason why some of the Clinical Boards were breaching the control totals.

The COO responded that some of the Clinical Boards needed extra help and support in meeting their control totals.

The UHB Chair queried whether the approach would be looked at when deciding the overall situation of the control totals.

The Deputy Director of Finance (Strategy) (DDFS) stated that next year would be the first year that a differential cost improvement target would be applied across the Health Board. Opportunities were not equal across different Clinical Boards. Going into next year, it was important that budgets were aligned to the plan that was agreed for 2023-24. The targets also needed to be agreed at the outset.

The CEO commented that work was required with regards to the maturity of the organisation to embrace that approach. There should also be rigour with setting and applying the control totals.

The EDF stated that the control totals needed to be both individual and collective. All the problems due to the pressures of Covid which had led to activity that was not fully understood also needed to be flushed out. The control totals were important to understand what the cost drivers were. It would also allow for solutions that dealt with the core problem which was the layering on of costs. The EDF added that the Finance team also wanted people to own their targets.

Exceptional Costs

It was noted that Welsh Government funding to support the National Insurance Levy and Social Care Providers had been confirmed.

Welsh Government had also confirmed that funding for the exceptional costs of Energy was no longer at risk.

Covid 19 expenditure and funding

- It was noted that there had been a slight decline.
- The forecast local Covid response costs and Cleaning Standards was £35.492m, which was a decrease of £1.327m against the comparable £36.819m forecast costs reported at month 9.
- Welsh Government had also acknowledged the assumption of financial support for Covid Response costs by Health Boards in the 2022-23 financial year but had been consistent in stating that assumption was carried at risk.
- Welsh Government had recently reviewed guidance and had indicated to Health Boards that funding support would be capped at a maximum of Month 8 reported costs for each Healt Board.

Risk Register at January 2023

- It was noted that two risks were green.
- Welsh Government had confirmed Exceptional Costs funding in 2022-23.
- Welsh Government had also confirmed the basis of Covid Response funding in 2022-23. The Health Board had currently forecast Covid Response costs below the confirmed claimed amount.

Public Sector Payment Compliance

- The Health Board's public sector payment compliance performance remained below the target of 95%.
- Performance for the 10 months to the end of January was 94.4%. That remained below the target following a deterioration of 0.2% in month.
- The below target performance was due to the high number of invoices which were on hold and subsequently cleared following work by the Procurement department with those placing orders to clear the backlog of "holds".
- However, that had contributed to the performance remaining below target, as any "holds" exceeding 30 days had been resolved and paid.
- Performance was expected to improve and work was ongoing with departments within the Health Board, including training, to address the level of orders not receipted, and the high number of workforce and nursing "holds", which should improve the Health Boards position.

<u>Capital Resource Limit</u>

- The Health Board had an approved capital resource limit of £51.675m, in line with the latest capital resource limit received from Welsh Government, which comprised of £10.263m discretionary funding and £41.412m towards specific projects.
- 53% had been expended to date of the Health Board's approved Capital Resource Limit.

The CC queried what the Capital Resource Limit profile looked like with two months left.

The DDFO responded that the profile would be to expend the remaining amount.

The Finance Committee resolved that at Month 10:

a) The reported year to date overspend of £22.417m and the forecast deficit of £26.900m, was noted.
b) The year to date financial impact of forecast COVID 19 costs which was assessed at £47.914m with assumed Welsh Government funding of £47.914m, was noted.
c) The financial impact of year to date Exceptional Inflationary Pressures which was assessed at £16.453m with assumed Welsh Government funding of £16.453m, was noted.
d) The forecast deficit of £26.900m, which comprised of the £17.1m planned deficit identified in the Final Financial plan and £9.800m of additional operational pressures recognised by the Health Board, was noted.

	Items for Approval / Ratification	
FC 15/02/008	**Finance Committee Annual Report 2022/23** The Interim Director of Corporate Governance (IDCG) presented the Finance Committee Annual Report 2022/23 and highlighted the following: • The report summarised the activity of the Committee during the past year. • All of the Committees' Annual Reports would be combined and summarised to go into the Health Board's overall Annual Report as part of the Health Board end of year process. The CC stated that the January update was missing from the Committee's draft Annual Report. The CEO congratulated the independent members on their excellent attendance rate. **The Finance Committee resolved that:** a) The draft Annual Report 2022/23 of the Finance Committee was reviewed. b) The Annual Report was recommended to the Board for approval.	
	Items for Information and Noting	
FC 15/02/009	**Financial Monitoring Return – Month 10** The Financial Monitoring Return – Month 10 was received. It was noted that it had been updated since the paper was published. The updates would be discussed in the Private session of the Committee meeting. **The Finance Committee resolved that:** a) The extract from the UHB's updated Monthly Financial Monitoring Return would be noted at the next public Committee meeting.	
	Agenda for Private Finance Committee Meeting	
FC 15/02/0010	i. Approval of Private Minutes ii. IMTP Financial Plan Update (confidential discussion)	
FC 15/02/011	**Any Other Business**	

	No Other Business was discussed.	
	Review and Final Closure	
FC 15/02/012	**Items to be referred to Board / Committee** No Items to be referred to Board / Committee.	
	Date & time of next Meeting Wednesday 22nd March 2023 at 2pm Via MS Teams	

Confirmed Minutes of the Charitable Funds Committee
6 December 2022 09:00am
Via Microsoft Teams

Present:		
Akmal Hanuk	AH	Committee Chair / Independent Member – Community
Susan Elsmore	SE	Independent Member – Local Authority
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Mike Jones	MJ	Vice Chair / Independent Member – Trade Union
Catherine Phillips	CP	Executive Director of Finance
In Attendance:		
Alex Dow	AD	Investment Manager for Rathbones
Joanne Brandon	JB	Director of Communications
Nicola Foreman	NF	Director of Corporate Governance
Rob Mahoney	RM	Deputy Director of Finance
Suzanne Rankin	SR	Chief Executive Officer
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Observers:		
Timothy Davies	TD	Head of Corporate Business
Marcia Donovan	MD	Head of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience (Left at 10.55am)
Apologies:		
Rachel Gidman	RG	Executive Director of People and Culture
Sara Moseley	SM	Independent Member – Third Sector

CFC22/12/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	Action
CFC22/12/002	**Apologies for Absence** Apologies for Absence were noted.	
CFC22/12/003	**Declarations of Interests** No declarations of interests received.	
CFC22/12/004	**Minutes of the Committee Meeting held on 20 September 2022** The Committee reviewed the minutes of the meeting held on 20 September 2022. **The Committee resolved that:** a) The minutes of the meeting held on 20 September 2022 were approved as a true and accurate record.	

CFC22/12/005	**Committee Action Log** The Committee reviewed the Action Log. The Executive Director of Finance (EDF) advised the Committee that in relation to action CFC22/06/008 and CFC22/06/014 regarding the wellbeing service, email correspondence had been sent out via the Corporate Governance team to confirm that the employee wellbeing service bid would be picked up as Health Board revenue. She added that the service was expected to go to the Business Case Review Group for the Health Board as opposed to the Health Charity, and that any recurrent commitment would be picked up in the Health Board's underlying position going into next year. It was noted that the Charitable Fund Committee had signed off the action. The Head of Corporate Governance (HCG) advised the Committee that the action would be marked as completed. **The Committee resolved that:** a) The Action Log was noted.	
CFC22/12/006	**Chair's Action** No Chair's Actions to note.	
CFC22/12/007	**Rathbones Investment Update** The Rathbones Investment Update was received. The Investment Manager for Rathbones (IMR) advised the Committee that the presentation would update the Committee on the performance of the investment from its inception in February 2022 until the 27th November 2022. He added that the presentation would focus on 5 areas which included: • Performance • Asset Allocation • Responsible Investment • Market Review • Any Other Business. It was noted that the period February 2022 until November 2022 had been very challenging for investors driven by three factors which included: • High inflation driven by the Covid-19 pandemic and exasperated further by the war in Ukraine. • Rising interest rates in response to the high inflation. • Risk of recession due to both the squeeze on real incomes, as inflation had outstripped wage growth, and the impact on growth over the longer term from higher interest rates. It was noted that the Charity's investments were exposed to the global economy rather than the UK economy and that the UK was likely to see a deeper recession than the US's economy. The IMR advised the Committee that the chance of recession in the UK and Europe was far higher than in the US for reasons such as, (i) the UK have seen a much more substantial energy crisis and (ii) the UK did not have the same level of accumulated savings. It was noted that for the period, equities were posted as a mild positive return but it was identified that the asset class that had suffered was government bonds down by almost 16%.	

	The Committee was advised that as of the 27th November 2022, the Charity's portfolio was worth just under £5.6m, with income of approximately £134k being paid out to the Charity on a quarterly basis. The IMR noted that the risk levels of the investment portfolio ran from level 1 to 6 and that the Health Board's portfolio was managed at a risk level of 3 (which was a lower end of medium risk). He added that the Health Board's Asset allocation consisted of 4 areas which included: • Equities UK • Equities – Overseas • Fixed Interest • Alternatives The Committee was advised that Rathbones had been investing responsibly in "greener" companies (ie those with Environmental, Social and Governance (ESG) issues higher on their agendas). It was noted that companies with good ESG policies and actions represented better run companies and that better run companies tended to produce better returns on investment. The IMR presented the Committee with some of the areas in which Rathbones had engaged with companies with ESG values. That included various areas such as: • An ambition to reach net zero across the wider business by 2050 or sooner; • Voting for a report on efforts to prevent harassment and discrimination in the workplace; • Supporting a shareholder proposal for the US streaming company Netflix to produce a report on it's lobbying of policies and payments. He concluded that those were all examples of Rathbones commitment to responsible Investment. The Independent Member – Local Council (IMLC) asked how responsive individual companies were with responsible investment and how timely were their responses to Rathbones. The IMR responded that more positive feedback was received by companies based in the UK than the US and they understood the reasoning behind shareholder engagement on the "green" matter. He added that a dramatic change had been seen in quite a short amount of time which showed improving dialogue between companies and the green agenda. The CEO suggested that the Health Board's Charity should undertake a review, in conjunction with Rathbones, on the Charity's risk appetite in order to maximise better returns whilst safeguarding the charitable donations, as well as to carry out benchmarking against other Health Boards in relation to their risk appetites. She added that as part of that review, the potential to invest further with ESG companies could also be considered. It was noted that a conversation would be held offline between the EDF, the CEO and the IMR. The EDF added that the risk-based assessment could form part of the strategy work. She asked the IMR if they had any understanding on the timeframe for a UK recession and a level of insight for that in regards to helping the Charity to know when the best time would be to "cash in" its investments. The EDF also asked if the Charitable Funds Committee or Trustees had confirmed with Rathbones the ESG rating that the Health Board wanted to achieve.	SR/CP/IMR

	The IMR responded that Rathbones could undertake some benchmarking in relation to the portfolio on ESG perspective versus the index. He added that Rathbones' job was also to ensure what was best for the Health Board Charity because if the Charity excluded too much of the market, then that could either reduce returns or increase the risks. The IMR concluded that in terms of the recession, considering the Bank of England's predictions, it could be long recession in the UK. He added that the Charity's investment portfolio had relatively low levels of exposure to the UK economy. The CC reiterated that an action would be taken for a conversation to be held offline between the CEO, the EDF and the IMR to discuss the Health Board's ESG rating and risk appetite. **The Committee resolved that:** a) The Rathbones Investment Update was noted.	
CFC22/12/008	**Health Charity Financial Position & Detailed Investment Update** The Health Charity Financial Position Update was received. The Deputy Director of Finance advised the Committee that the report contained slightly older data than that presented by the IMR earlier in the meeting and noted that since the report had been written, there had been a slight pick up in the investment market. He added that there had been no great changes in the financial position that had been previously reported to the Committee. The Committee was advised that the financial position of the Charity for the period to 31st October 2022 showed outgoing resources of £432k. There was a negative movement of funds of £875k based on net over expenditure against income and a reduction in the value of portfolio. The DDF presented the Committee with the summary balance sheet as at 31st October 2022 which showed where the Charity's assets were which included: • Investment Portfolio • Fixed Costs Rookwood Hospital • Net Current Assets/Liabilities – Cash and Bills to pay He added that the investment portfolio had started the financial year with a market value of £6.569m. That figure had decreased to £5.426m for the period ending October 2022, and had included two cash withdrawals totalling £0.700m in the current financial year. That had resulted in a market value loss of £0.443m for the period ending October 2022, compared to the opening balance of £6.569m. It was noted that the Finance team had been working on a cashflow forecast. He highlighted that it was difficult to do for charities, but the Finance team would continue to work on that because there was an ambition to have a multi-year cashflow forecast. The DDF added that the cash forecast for the current year had been looked at alongside whether the Charity would need to call on cash again from the investment portfolio. It was noted that it was not something that the Charity wanted to do in a period where the markets were so unstable, but at the moment, the forecast was that the Charity should not need another cash call from the investment portfolio. The DDF reminded the Committee that they had approved the decision to freeze new applications to the general fund which was made up of the spare asset value within the overall remit of the Charitable Funds which could be used for general purposes. He added that the general reserve was overcommitted by £1.205m and that a key driver for that was the year to date performance of the investment portfolio, which had achieved losses of £0.443m for the period ending October 2022.	

	It was recommended that the freeze on new applications remained. It was noted that the Finance Charity team would continue to monitor dormant funds and would transfer those to general reserve, where appropriate, in line with the financial control procedure. The DDF advised the Committee that the next review was due to concluded in January 2023 for the period ending March 2022. He added that the Charity should not let those dormant funds languish and noted that there was a process whereby all fund holders were contacted to seek their intentions for their dormant funds. The EDF noted that a deficit of £1.2m was not a position the Charity should continue to tolerate. She suggested that a piece of work should be undertaken by herself, the Director of Communication (DC) and the DDF with regards to a forecast of the general fund in order to understand at what point the Charity could recover the position. She added that a plan was required for the next financial year which would include: • The status of the General Fund • All of the Charity's other funds • Fundraising activities being planned It was noted that could then be used to inform Rathbones how much cash the Charity wanted to withdraw at the start of the year and then the Charity could let them choose when was a good time to sell. The Director of Corporate Governance (DCG) noted that it was unclear how much was in the dormant funds altogether and asked what was being communicated to encourage people to use their funds. The DDF responded that it was difficult to define was constituted a dormant fund and that was part of the problem. He added that if there had been no expenditure for approximately 18 months, the Finance team considered it to be dormant and so they would write to the fundholder to gage their expectations on how the funds would be used. The CC asked if the DDF knew how much was outstanding from the last review exercise. The DDF responded that it did not illicit more than £20k to £30k and noted that that even with good housekeeping, it would not bring major funds back to the general fund. The Assistant Director of Patient Experience (ADPE) asked whether the Charity should change its approach on endowment funds so that when people put bids in, the Charity would then say it expected a percentage to be paid from the endowment fund where there was one. The EDF responded that it was important how to communicate with people placing bids and that the Charity should be encouraging them to spend their money rather than take dormant funds away because that would not be the right thing to do in terms of the set of values for the Charity. She added that the Charity had overspent on the general fund because they had not encouraged people to spend their own money above the general funds and too many bids had been accepted. The EDF concluded that the point was that the Charity needed to spend money from all of everybody's funds rather than from the general fund. **The Committee resolved that:**	CP/JB/RM

	a) The financial position of the Charity was noted b) The performance of the investment portfolio was noted c) The over commitment of the general reserve was noted	
CFC22/12/009	**Charitable Funds Draft Strategy** The Charitable Funds Draft Strategy was received. The DC advised the Committee that a lot of work had been undertaken in relation to the Charitable Funds Strategy. It was noted that the Charity's Strategy for the period 2019 – 2024 was approved in principle by the Charitable Funds Committee (CFC) in September 2019, and was subsequently endorsed for publication by the Board of Trustees in July 2020 (where it was revised to cover the period 2020 – 2025). The DC advised the Committee that in the CFC meeting held on 21st June 2022, the Committee had discussed the requirement for a review of the Charity's Strategy, following on from the Covid-19 pandemic and all of the learnings and change following the same. It was noted that the Strategy Review Session was held on 20th September 2022 and that actions from the session were written up to take forward to the Task and Finish Group meeting held on the 22nd November 2022. It was noted that a CFC meeting was held following the review of the strategy session where the Committee had concluded that the new Charity Strategy should be finalised by the new financial year and that there would be a focus on the cost of living crisis over the winter months. The DC advised the Committee that the first draft of the Charity's Strategy had been completed and would be presented to the CFC at their March 2023 meeting, before it was presented to the Board of Trustees. She concluded that the request for the Committee was to note the progress of the Task and Finish Group and to ask the CFC if there were any additional comments to be made in drawing together the new Strategy. The CEO noted that based on the discussion held with the IMR during the Rathbones Investment Update earlier in the meeting, she could not see anything in the report about describing the Health Board's approach to the strategy and how to optimise and safeguard those who donated into the Charity. She added that it was important to ensure that that the Charity's Strategy aligned with the Health Board's overarching Shaping our Future Services Strategy. The EDF added that it was too early to provide the Committee with a draft of the Charity's new Strategy but that it would be circulated prior to being formally received in March 2023. The CC noted that he had always been keen to add in information to the strategy regarding the various focussed teams working on matters, such as the cost of living crisis, staff wellbeing as well as other areas identified during the strategy review session. The DC responded that the CC's comments were something the Task and Finish Group had been aware of and noted that it fell in line with the comment made by the CEO on strategic alignment. The Executive Director of Therapies and Health Sciences (EDTHS) noted that discussions were ongoing around staff wellbeing and initiatives to help staff and asked if adding those initiatives to the Strategy would be a good thing to do. She added that areas such as what the Health Board could be doing for its staff should be included, such as providing hot meals for staff on 12 hours shifts for those who could not afford a meal.	**JB/NS**

	It was noted that Betsi Cadwaladr Health Board had a “wellbeing Wednesday” with a subsidised lunch but noted that the overall cost could add pressure to various teams so further conversations would be required before committing. The Independent Member – Trade Union offered his support in the drafting of the Strategy and offered his support in the ongoing discussions around staff wellbeing and subsidised lunch initiatives. He asked if discussions had been held around period poverty as staff had often raised the issue of the cost of sanitary products. The DC responded that discussions had been held around period poverty and that discussions would continue offline. The Head of Corporate Governance suggested carrying out some form of consultation with the public, staff and other forums before the final draft Strategy was taken to the Charitable Funds for recommendation to the Board of Trustees for approval. **The Committee resolved that:** a) The progress on the review of the Charity Strategy Review was noted.	
CFC22/12/010	**Health Meadow Secured Funding Proposal** The Health Meadow Secured Funding Proposal was received. The DC thanked the DDF for his team’s help on the financial side of the proposal. It was noted that “Our Health Meadow” (OHM) was a “committee” in its own right and had been running for a number of years. The Committee was advised that the paper set out the proposal regarding a continued funding requirement and the request for a financial underwriting to develop phase 2 (called the “Nature Haven”). It was noted that phase 2 funding would be essential to deliver the project and that a decision on funding was time dependent because the ENRAW match funding of £600,000, was secured by Down 2 Earth (D2E) in phase one and had stipulated that had to be utilised by June 2023. It was noted that after June 2023, the costs of the project were subject to increase and would need to be secured from an alternative funding source. The Committee was advised that securing financial commitment for the project would also reduce future development/build costs, would capitalise on the ENRAW monies currently provided, build on the established working relationships within the organisation and would place the project in a strong position to seek alternative funding streams. It was noted that the costs, as outlined within the paper, were just under £2m (£1,986,864). The DC advised the Committee that there were potential risks associated with not funding phase 2 of the project, which included: a) Loss of social value, intervention, prevention and sustainable healthcare and the impact of the burden of health provision from healthcare services. b) Loss of potential grants funding - from organisations which scrutinised the Health Charity’s funding reserves and subsequently declined applications c) Loss of the established partnership with D2E – It was noted that they were currently exploring options to partner with other Health Boards due to the current insecurity of continued project funding. d) Reputational damage to the Health Charity and the Health Board. It was noted that in respect of the potential funds available from the sale of Rookwood Hospital, the Charity had liaised with Geldards Solicitors and had received advice regarding the sale of Rookwood.	

	The DC advised the Committee than another area being considered was to set up OHM as its own charity. Often the Charity had bids rejected due to the reserves being "too healthy" and were being asked to justify why money was being requested when it appeared the charity's own funds could cover various amounts. She concluded that the potential risk of not supporting the proposal would be that the project was discontinued and that the Health Board would no longer be able to support the social value projects and wellbeing benefits to staff and patients. It was noted that creating social value was at the heart of the OHM project and that it had been created to make a positive difference to patients, staff, volunteers, the local community and the planet, as well as contributing to the long-term well-being and resilience of society, bolstering communities outside of the Health Board's direct services. The EDF advised the Committee that the Health Board was on the cusp of phase 2 and so detailed discussions were required so that all of the hard work achieved during phase one, which included the relationship with D2E, was not lost. She added that the recommendations made during the meeting would be taken back to D2E in an open and transparent way to ensure the project could move forward proactively. The DDF advised the Committee that to date, there had been no professional scrutiny of the costs and so the build costs (circa £2.1milllion) still needed to be verified. The CEO noted that the Health Board could not commit to phase 2 until clarity was provided on the costs and also where the underwriting of the £2.1 was coming from. She added that the Health Board was already operating in a deficit position and so clarity would be required regarding the mechanism for underwriting. The EDF responded that underwriting the costs was what was required to move onto phase 2 of the proposal. However, the Health Board was not in a position to realise the additional funds to pay for it outside of what was outlined by the DC as well as the cost uncertainty highlighted by the DDF. She added that fundamentally it needed to be underwritten and that the first place that was being suggested for it be underwritten from was the charitable funds. The problem was that would be the general fund and that the general fund was already in some level of distress that could not be tolerated and so adding another £2m into that did not feel like the right thing to do. The Executive Director of Therapies and Health Sciences (EDTHS) advised the Committee that it could not spend what had not been realised and that good governance would be required. She added that it was a really worthy cause and she was certain there would be great understanding from D2E and other stakeholders should the Charity require a pause from investing further funds. The IMLC noted that it was a difficult position in relation to governance and asked if there was clarity in terms of timings and risks because clearly the Committee was not in a position to make any decisions at the meeting. The DCG responded that the Committee needed to be clear on what was going to be recommended to the Board of Trustees (the Trustees) and advised that each recommendation should be discussed individually to provide clarity. She added that as mentioned, some of the costs identified within the paper were not "set in stone" and that the financial underwriting risk required a solution as well as the sale of Rookwood Hospital and so all of the risks would need to be received by the Trustees. The EDF advised the Committee that the reputational risks around the relationship with D2E needed to be added as a recommendation because it was a difficult position for the Health Board because it wanted to support D2E on their project.	

	She added that she had been looking after Charitable Funds in her role as Director of Finance for over 15 years and had never had to report a negative general fund which provided context of the position the Health Board and Charity found itself in. The Committee was advised that the first 2 recommendations should be rejected at the meeting based on the discussions held. The CEO asked what the timeline would be to get to the £2.1m, taking into account all of the areas raised by the DC around alternative funding and what the deadline was for a decision to D2E around phase 2 of the project. The DC responded that the deadline for the D2E decision was January 2023. The CEO added that this meant an additional pressure to get the recommendations agreed or discussed and then recommended to the Trustees. The EDF responded that that the Health Board had informally spoken to D2E and that they understood the difficult position held by the Health Board. She added that a plan would be required to enable the enactment of phase 2 of the project as well as all of the risks. It was noted that Trustee approval would be required not move onto phase 2 of the proposal by January 2023. The EDF added that a proposal to fundraise a significant portion of the money before going ahead with phase 2 of the project. The CC concluded that it had been a very important and robust discussion and confirmed that the Committee had noted the recommendations outlined within the paper but would be unable to approve any actions required to move forward on the phase 2 of the OHM project. **The Committee resolved that :** e) the financial underwriting of £1,788,259 for the mobilisation and construction phase (Phase 2) of the Nature Haven at Our Health Meadow could not be supported via the Charity's funds; f) The work of Down to Earth as an exemplar Wellbeing of Future Generation Act project was commended and it was noted that conversations with Down to Earth on smaller scale opportunities and projects would continue; and g) the work of the Our Health Meadow Committee in delivery of phase One of the OHM project was commended.	
CFC22/12/011	**Disposal of Rookwood Hospital (verbal)** The Disposal of Rookwood Hospital verbal update was received. The EDTHS advised the Committee that she was not in a position to provide a written report due to a number of factors. She added that her role as the Senior Responsible Officer (SRO) was to maximise the income for the Charity from the sale of Rookwood. It was noted that there were terms around the conditions of the sale of Rookwood and that the Health Board had taken legal advice regarding a potential variation to the covenant against the site, and that the Health Board was not in a position to ask for that covenant to be varied. The Committee was advised that the Health Board needed to consider whether it could maximise more income for the Charity by selling the entire Rookwood site rather than just a part of it. The EDTHS added that the site hosted the Artificial Limb Appliance Centre (ALAC) and the Assistive Technology Centre and so discussions had been held with the Specialised	

	Services Clinical Board about relocation of those services. It was noted that all of the options around that needed to be considered. She concluded that the Director of Capital, Estates and Facilities and the EDF were in discussion with the Health Board's agents regarding the sale of the site, and with regards to the relocation of existing services, and so she would await the outcomes of those conversations before she brought a paper to the Committee. The EDF added that there were 2 sites, one of which was charitable (Rookwood Hospital) and the other was Health Board owned (Whitchurch Hospital) and she had asked a specialist advisor to do a piece of work. She added that a report had been drafted by that advisor which would be shared with the Trustees at their next meeting. **The Committee resolved that:** a) The Disposal of Rookwood Hospital verbal update was noted.	
CFC22/12/012	**Over £25k bids for approval** The Over £25k bids for approval information was received. The DC advised the Committee that the bid had been received from the Directorate Manager of the Cardiac Services and that it asked for £70k of the money that they had been gifted through a legacy to be spent on the refurbishment of the Cardiac catheterisation theatre changing facilities at the University Hospital of Wales (UHW). She added that a paper had been written by them and received by the Committee which outlined the reasons for the request. It was noted that the money had been gifted to that service and was not coming out of the general reserves but that it was one of their restricted funds, hence why the Committee was receiving the information for approval due to being over the £25k limit. The CC asked for clarity that it was their own funds they were spending and that the Committee was receiving the information because it fell outside of the £25k limit. The DC confirmed that the approval was for the service to spend their own money. **The Committee resolved that:** a) The indicative planned expenditure of £70,000 from Cardiac Services Endowment Fund 9541 was approved.	
CFC22/12/013	**Policies: - Fundraising Policy** The Fundraising Policy was received. The DC advised the Committee that the draft revised policy was published for consultation via Sharepoint (staff facing) and copies were sent to the Chairs of the SRG, Local Partnership Forum and Cardiff Health Council for wider consultation. **The Committee resolved that:** a) The revised Fundraising Policy was reviewed and recommended to the Board of Trustees for approval.	
CFC22/12/014	**Health Charity Fundraising Report** The Health Charity Fundraising Report was received. The DC advised the Committee that she would take the report as read and would note some of the key appeals outlined in the report:	

	• The Prop Appeal – It was noted that after a gap of two years, the Health Charity welcomed nearly 200 guests to Mercure Holland House for the Prop Appeal Ball. The event was well attended and that total amount raised was £11,875 minus the expenditures for venue hire, food, and entertainment, which left a profit of £3,118. The DC added that the profit was slightly disappointing as pre-Covid, profit had been around £17k. • Breast Centre – It was noted that fundraising from events had currently raised around £26,000. • Legacy donations received since 1st April 2022: £217,581.07 **The Committee resolved that:** a) The Fundraising Report was reviewed b) The progress and activities of the Health Charity as advised was noted.	
CFC22/12/015	**Reporting Feedback on Successful CFC bids** The DC advised the Committee that she would take the report as read. She noted that there were 3 areas that the Charity had provided funding for: • Staff Recognition Awards • Keeping Me Well Website • Welsh Transplant Games **The Committee resolved that:** a) The Committee accepted and noted the report as assurance of the appropriate use of the allocated charitable funds.	
CFC22/12/016	**Breast Centre Appeal** The Breast Centre Appeal was received. The DC advised the Committee that they had received the Breast Centre's annual report for assurance. She added that the report outlined the work that had been undertaken and noted that it was one of the oldest and long-standing appeals. The Committee was advised that Irene Hicks Nicholls, had been a fundraiser for the Breast Centre Appeal since 2014 and that in August 2022, Irene and her team of fundraisers and supporters reached a fundraising total of £200,000. The DC noted that a letter of thanks had been written to Irene. The CC asked if the Committee had expressed their thanks to Irene. The DC confirmed that a letter had been written from the Charitable Funds Committee. **The Committee resolved that:** a) The report was noted.	
CFC22/12/017	**Events Planner 2023 Update** The Events Planner 2022 Update was received. The DC advised the Committee that it had been agreed that the Events Planner would be received at each Committee.	

	She asked Members for support and commented that their presence at events would be greatly appreciated. **The Committee resolved that:** a) The Health Charity Events Planner 2023 was noted.	
CFC22/12/018	**Staff Benefits Group Report** The Staff Benefits Report was received. The DC advised the Committee that the amount of work undertaken to get the benefits out to staff was huge. She added that the Health Charity team had worked with the Executive Director of People & Culture's (EDPC) team to provide information to staff with regards to accessing savings/discounts and financial support. The IMTU noted that he had been part of the group for a number of years and that over the past 18 months he had seen it grow and thanked the DC and her team for the amount of benefits provided to staff. The CC added that it would be good to try and get data on the amount of savings provided by schemes such as the Blue Light card and to encourage people to use it. The Committee resolved that: a) The Staff Benefits Group Report for the period September – November 2022 was noted.	
CFC22/12/019	**Staff Lottery Bids Panel Report** The Staff Lottery Bids Panel Report was received. The DC advised the Committee that the report was noting and that the Staff Lottery had continued to go from strength to strength. She added that the Mega Draw of £22,000 had occurred in November 2022 and that it would continue to be built upon for future draws. The Committee was advised that the Lottery funds provided support to patients, staff and visitors and was extremely efficient in terms of its turnaround of fast-track bids of up to £250 for funding, which benefited services across the Health Board. The Independent Member – Local Council (IMLC) asked why charitable funds had been used for Staff Lottery Bid BP731 - Optimal Birth Training. The DC responded that it was probably due to the fact that the training was not part of the Health Board's core services but noted that she would clarify that detail and let the IMLC know. The EDF advised the Committee that period poverty was an area that should be considered by the Health Charity and noted that it would be difficult to withdraw once it was put in place. The IMTU added that somebody would need to put in a bid for that so that the Charity could look at it and response accordingly. **The Committee resolved that:** a) The content of the Staff Lottery Bids Panel Report was noted.	JB
CFC22/12/020	**Any Other Business**	

	The DCG advised the Committee that the current Chair of the Staff Lottery Panel would be retiring in June 2023 and that he had suggested that the IMTU could be the replacement. The IMTU noted his thanks for the recommendation and that he would be delighted to pick it up.	
CFC22/12/021	**Review of the meeting**: The EDF advised the Committee that a large number of difficult topics had been covered and that they have been covered well which should be commended.	
	Date and Time of Next Meeting Tuesday 21 March 2023, 9:00am	

Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 31 January 2023 – 10am
Via MS Teams

Chair:		
Sara Moseley	SM	Committee Vice Chair
Present		
Mike Jones	MJ	Independent Member – Trade Union
John Union	JU	Independent Member - Finance
In Attendance:		
Daniel Crossland	DC	Director of Operations - Mental Health
James Quance	JQ	Interim Director of Corporate Governance
Jason Roberts	JR	Executive Nurse Director
David Seward	DS	Mental Health Act Manager
Observers		
Morgan Bellamy	MB	Deputy Mental Health Act Manager
Marcia Donovan	MD	Head of Corporate Governance
Bianca Lepore	BL	Deputy Mental Health Act Manager
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Akmal Hanuk	AH	Independent Member - Community
Ceri Phillips	CP	UHB Vice Chair and Committee Chair

Item No	Agenda Item	Action
MHLMCA 23/01/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everybody to the meeting. She advised the Committee that the meeting was not quorate and so any items for approval would need to be approved at the Board meeting being held on March 30th 2023 and would be outlined in the Chair's Report.	
MHLMCA 23/01/002	**Apologies for Absence** Apologies for Absence were noted	
MHLMCA 23/01/003	**Declarations of Interest** No Declarations of Interest were noted.	
MHLMCA 23/01/004	**Minutes of the Meeting held on 25 October 2022** The Minutes of the Meeting held on 25 October 2022 were received. **The Committee Resolved that:** a) The minutes of the meeting held on 25 October 2022 were agreed as a true and accurate record.	

MHLMCA 23/01/005	**Action Log from the meeting held on 25 October 2022** The Action Log was received and discussed. **The Committee Resolved that:** a) The Action Log was noted.	
MHLMCA 23/01/006	**Chair's Action taken since last meeting** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHLMCA 23/01/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
MHLMCA 23/01/008	**Mental Capacity Act Monitoring Report and DoLS monitoring** The Mental Capacity Act Monitoring Report and DoLS monitoring was received. The Executive Director of Nursing (END) advised the Committee that he would take the paper as read. He added that the paper had been split into three areas which included: • IMCA referrals by type • Mental Capacity Training • DoLS assessments It was noted that key points would be identified for each. The END advised the Committee that Independent Mental Capacity Advocacy (IMCA) referrals had increased. He added that was no clear reason for that. However, it was likely that it was due to an increased awareness of the types of decisions that required IMCA referral , both as a result of MCA training and the informal training provided to clinicians by the Advocacy Service when visiting ward areas. It was noted that the new MCA and Consent Lead had begun in post in November 2022 and was in the process of linking in with each Clinical Board to explore how the Mental Health Clinical Board could make the training more accessible for staff and increase attendance through the provision of bespoke sessions. The Committee was advised that the LPS Project Lead had recently provided an MCA update for the medical workforce within the Mental Health Clinical Board and arrangements were in place to support Junior Doctors training.	

	The Committee received assurance that compliance levels had increased since November 2022 and that Mental Capacity and Best Interests training (Edge Training) continued to be well received by staff. As a result, four further sessions were being arranged to take place between May and June 2023. The END noted that the lowest group of trained professionals was in Medical and Dental services and so there would be more focus on those areas moving forward. It was noted that five Health Board staff had recently completed the Level 7 MSc module 'Assessing Decision Making Capacity' and that the Mental Health Clinical Board was awaiting the return of evaluation forms from staff who had undertaken the course. The END advised the Committee that five more staff were due to begin the module in February 2023 and that the Health Board was securing additional places for next year with the remaining LPS funding. It was noted that an increase in DoLS applications had been observed and an upward trend continued, which could be linked to the work carried out within the Medicine Clinical Board, as well as awareness raising initiatives. The Committee was made aware that 66% of applications were within time and 34% had breached, which was expected due to the significant increase in applications. It was noted that the average percentage breach for the year to date was 27%. It was recognised as a national problem and one of the main reasons for the development of the new safeguards under the LPS. The CVC asked how the backlog identified would be addressed. The END responded that once a backlog was created, the team could work through that, although the backlog identified would compound further backlogs. He added that overall, the reporting position outlined within the paper was much more positive in comparison to previous reports received by the Committee. The CVC agreed and noted the Committee's thanks to the Mental Health Team and all of the Clinical Boards who were engaged with them. **The Committee resolved that**: a) The contents of the report and the current compliance and actions with Mental Capacity Act and Deprivation of Liberty indicators were noted.	
MHLMCA 23/01/009	**Liberty Protection Safeguards Monitoring Report** The Liberty Protection Safeguards (LPS) Monitoring Report was received.	

	The END advised the Committee that he would take the report as read and that there was not much to add. He noted that the same update was brought month on month for the Committee and that the Health Board was still waiting for Welsh Government (WG) to implement the LPS. It was noted that the constant delays proved difficult for the Mental Health teams because when trying to establish the new teams in readiness to move to LPS, all of the older systems needed to be observed. The END assured the Committee that the delays did not mean that patients were worse off because the 2 systems were running side by side. He added that the focus for the Organisation was a robust foundation of mental capacity assessment, whilst waiting for an implementation date. He noted that the Health Board continued to implement Mental Capacity Assessment training and development which was outlined in the previous paper. It was noted that the new training lead had been looking at a digital solution for training and reporting and that they would undertake a formal training strategy whilst waiting for WG support on training packages. The END concluded that despite best efforts to identify an appropriate use of the IMCA funding available to the Health Board from WG, there did not appear to be any way that money could be effectively utilised within the financial year and so the money would be returned. He added that the current IMCA contract appeared to meet current demand and as it had already been extended once, it was likely that there was little room for further expansion within the Procurement Regulations. It was noted that assurance had been provided by WG that it would not have any negative impact upon future funding allocation and WG were aware that the IMCA contract was due for renewal in April 2024. The CVC asked if work could be continued on the current DoLS arrangement in the meantime. The END responded that it could and noted that the risk was minimal. **The Committee resolved that:** a) The contents of the report and the progress to the implementation of Liberty Protection Safeguards was noted.	
MHLMCA 23/01/010	**Mental Health Act Monitoring Exception Report** The Mental Health Act Monitoring Exception Report was received.	

	The Mental Health Act Manager (MHAM) advised the Committee that there had been 1 fundamentally defective Section 2 application for the quarter. He added that on 08/12/2022 a Patient was detained under Section 3 at the University Hospital of Wales (UHW). Papers had been left on the ward as that Patient was meant to be transferring to University Hospital Llandough (UHL) or Hafan Y Coed that day, although the transfer did not take place until 23/12/2022. It was noted that the papers were not passed to an authorised person. Therefore, they were never formally accepted on behalf of the hospital managers and the Patient was detained without authority for 34 days. Hence the fundamentally defective Section 2 application. The MHAM assured the Committee that he had spoken to the Local Authority (LA) about the issue, he had spoken to shift coordinators and a checklist had been created for Approved Mental Health Professionals (AMPs). He added that the Mental Health Team had to tell the Patient that they were not detained and were told that they could seek legal advice should they wish. The CVC noted that learnings had been identified from the issue and asked if there were any legal consequences arising from the defective application. The MHAM responded that from past situations, the fact remained that the Patient still would have been detained and that because of that fact, any monetary legal consequence would be minimal for the Health Board because as stated, the Patient was always going be detained. He added that the issue was more reputational. The MHAM advised the Committee that during the quarter, one Section 5(2) had lapsed where by the Patient was detained at UHW after taking an overdose and had wanted to leave. He added that the on-call doctor assessed that there would be a risk to the Patient if they were to leave and completed a Section 5(2) form. Shortly after, the Patient ran away from Staff and left the hospital site. It was noted that the Police were alerted, but had been unable to locate the Patient before the 72-hour expiry limit. Hence the lapse in Section 5(2). The MHAM advised the Committee that the Patient was located eventually and returned to the hospital under Section 2. The Committee was advised that during the quarter there were two invalid uses of the MHA: • A Patient was in MEAU in UHL where a doctor completed a report under Section 5(2). The report was completed in order to give the Patient an IM injection due to their aggression. However, it was an	

	invalid use of Section 5(2) as the Part 4 (consent to treatment) provisions did not apply to that Section, which meant that the Patient could not be treated without capacity and consent. The MHAM assured that the Committee that the doctor and MEAU were advised that it was an invalid use of Section 5(2) and that the Patient was not currently held under the MHA and a formal MHA assessment should be arranged if appropriate. • A Patient was recalled from their community treatment order to hospital and assessed by their responsible Clinician on the 01/12/2022. The Patient along with their responsible clinician agreed to remain in hospital informally whilst still being subject to their community treatment order. On the 04/12/2022, the Patient decided they wanted to leave hospital to go back home. However, the doctor on the ward felt they would be at risk if they were to leave and completed a report under Section 5(2). It was noted that it was an invalid use of that Section as it could not be used to hold a Patient who was subject to a community treatment order. The MHAM advised the Committee that if the doctor had wanted to stop the Patient from leaving hospital, they should have completed a recall form which would have given the Clinical team up to 72 hours to assess and decide whether to revoke the community treatment order. The CVC asked if the Mental Health Team was aware of any training gaps. The MHAM responded that there was a gap and that pre-Covid, he had started to put some training together but when the pandemic occurred, it had put a stop to that. He added that it was his intention to restart that training as soon as possible. The CVC asked to log that as an action and for an update to be provided on where training had got to on general wards at the meeting in August 2023. The MHAM advised the Committee that during the quarter reporting period (October – December 2022) the number of Section 136 referrals had decreased, of which 73.9% were not admitted to hospital. He added that the number received had been an appropriate use of Section 136, and within the appropriate parameters. It was noted that the number of those individuals under 18 years old assessed under Section 136 had remained the same (ie 8) from the previous quarter. There were 3 repeat presentations for one Patient. The CVC noted that if a young person was repeatedly being detained, perhaps access to more specialist services was required for those individuals.	**DC**

	The MHAM responded that repeat admissions were well known to CAMHS and that discussions were ongoing around ways to report and record repeat presentations on the Patient Management System, PARIS. He added that there was a digital lead working on that. The Director of Operations - Mental Health (DOMH) advised the Committee that there were a few ongoing areas regarding Section 136 which would have a wider impact on usage, which included: • The "111, press 2" service which had started and that an advice line was being considered for the service for Police colleagues. • Two Patient sanctuaries were progressing through the commissioning process. • Local data meetings were being held with Police teams to make sure data was tied together and that the Health Board and LA were measuring the same things. The MHAM advised the Committee that the Senior Operations Manager for the Mental Health Tribunal (MHT) had confirmed that face to face hearings would start again from 1st March 2023. He added that since the paper was compiled, the finer details of how that would work and whether the Patient would be given a choice had been received. It was noted that the Patient would not be given a choice. It was noted that the main issue with the MHT was observer requests and noted that through the pandemic, nobody had been approved to observe hearings. The MHAM asked if there was anything the Committee could do to support doctors and nurses in their observer requests because he had raised it with the President of the tribunal and had been met with barriers. The Independent Member – Trade Union (IMTU) asked if other Health Boards had received the same barriers. The MHAM responded that every Health Board had been met with the barriers and it was an all Wales issue. The CVC noted that having a future workforce being able to work in a way that sat within the legal framework required observation of the MHT. She added that the Committee would provide support to the MHAM in their ongoing conversations with the MHT. The DOMH noted that it had previously been raised by the Executive Nurse Director (END) for the Health Board in 2021 and asked if it could be escalated to the Executive Medical Director and the END. The CVC asked if the MHT sat under WG. The DOMH responded that it did.	

	The CVC added that the issues raised appeared to be pretty administrative and so the appropriate area of WG should be made aware. The MHAM advised the Committee that the MHA office continued to run awareness sessions. That included a monthly MHA training day which was available to all staff within the Health Board, a monthly Consent to Treatment workshop and a quarterly Rights workshop. He added that the MHA office had also recently started attending the wards again to conduct audits. It was noted that it was to ensure compliance with the MHA and best practices were being maintained. The CVC concluded that taking the information from the report, given the pressures being seen on the service, the team had performed very well and offered the Committee's thanks. **The Committee resolved that:** a) The approach taken by the Mental Health Clinical Board to ensure compliance with the appropriate Mental Health legislation as set out in the report, was noted.	
MHLMCA 23/01/011	**HIW MHA Inspection Reports** The Health Inspectorate Wales (HIW) MHA Inspection Reports update was received. The DDOMH advised the Committee that he would take the report as read and that it provided a summary of the HIW inspection of the Beech, Willow and Cedar Wards at Hafan Y Coed Hospital, Llandough between 14th and 16th February 2022. It was noted that the HIW inspection covered a range of areas of interest to the Committee: • Quality of patient experience • Delivery of safe and effective care which included: • Record keeping • Mental Health Act Monitoring • Monitoring of the Mental Health (Wales) Measure 2010 • Quality of management and leadership It was noted that the summary reports included Action Plans, and Immediate Action Plans. No Immediate Actions required and so the Action Plan was shared with HIW. The DOMH advised the Committee that there were some recommendations for improvements required which included:	

	• The range of information available for patients on the wards • Structural damage needed repairing. It was noted that in relation to the MHA 1984 the report found: • Improvements in Mental Health Act monitoring, • Detentions were compliant with both the Act and the Code of Practice for Wales • Detentions were reviewed by MHRT and at Hospital Manager Hearings, where required. • Section 17 leave forms were up to date and well recorded. The DOMH advised the Committee of some of the recommendations and actions being undertaken, which included: • Consistent ward information required across wards. It was noted that training via the I&I team would be provided to improve the information on wards available to make sure it was helpful, current, accessible and consistent. • Ward information displayed must be bilingual. It was noted that the Mental Health team would link the work to the Welsh Language Officer to ensure it was compliant with law and best practice. • Consider introducing Getting to know you boards on each ward. It was noted that a review of that was currently underway and would link to the I&I work. • Rectify structural damage to flooring and walls. It was noted that this issue related to the underfloor heating leaking into the walls of Cedar ward and the Emergency Assessment Suite. It was noted that the issue had been raised with the Capital, Estates and Facilities department who had escalated the issue to Laing O'Rourke during the handover period of the new build, but that it remained unresolved. • Consider how to ease patient concerns regarding electronic bedroom observation screens. It was noted that the issue would be addressed within patient information and admission packs. • Availability of laundry facilities. It was noted that washing machines had been purchased. • Ensure all patients were able to have a choice at each mealtime. It was noted that currently the menus were agreed with Dietetics and at present Facilities were running a limited menu but from April 2023 patients would be receiving Health Board internally provided meals once again. • Ensure wards are sufficiently staffed with appropriate skill mix to support therapeutic engagement and prevent staff fatigue. It was noted that as the Nurse Staffing Act for Mental Health had been indefinitely paused, the nursing establishments remained an issue for	

	resolution. The DOMH added that the People and Culture Plan and the work of the Mental Health Clinical Board to support staff retention, recruitment and wellbeing was ongoing with a number of initiatives within the Safety and Stabilisation Programme Plan. The DOMH concluded that a subsequence inspection 11 months later had been undertaken and that findings would be reported back to the Committee once the formal report was received. **The Committee Resolved that:** a) The content of the HIW Mental Health Inspection were noted.	**DC**
MHLMCA 23/01/012	**Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.** The Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was received. The DDOMH advised the Committee that the report was separated into 4 parts and he would take the report as read. **Part 1A – target: 28-day referral to assessment compliance target of 80% (Adult)** It was noted that the service was at full clinical recruitment and sickness absence remained low which had allowed for ongoing high levels of assessment activity. Quarter 3 with 2870 referrals (adults only) had continued the trend of lower numbers than predicted. PMHSS assessed 1332 people (adults) in quarter 3 which was very similar numbers to quarter 2. **Part 1A – target: 28-day referral to assessment compliance target of 80% (Children & Young People)** It was noted that challenges and areas of concern continued to be seen in the CAMHS service. However compliance against the Part 1A MHM target had been met since August 2022 as a result of a waiting list initiative supported by agency staff which was being undertaken in the service. The Committee was advised that since April 2021, the volume of referrals had increased and had remained significantly higher than pre-Covid levels and that the average wait for assessment was currently 28 days. In order to combat challenges, the Committee was advised that: - • Active sickness monitoring and wellbeing support would be provided to the team • Additional capacity through the use of agency staff would continue to deliver the waiting list initiative.	

- A full launch of the assessment team model would occur in April 2023 when all staff were in post

Part 1B – 28-day assessment to intervention compliance target of 80% (Adult)

The Committee was advised that Primary Mental Health Support Services continued to be compliant with the Part 1B performance target.

Part 1B – 28-day assessment to intervention compliance target of 80% (Children & Young People)

The Committee was advised that the service continued to face challenges with Part 1B compliance and that the waiting list initiative had focused on both internal and external waiting lists. Due to the volume of assessments currently being undertaken within the service, a previous focus on the external waiting list only and vacancy within the team, there had unfortunately been limited improvement in performance.

The DOMH assured the Committee that actions to improve compliance against the target included:

- Active sickness monitoring and wellbeing support provided to the team
- Regular monitoring of caseloads to ensure that young people were discharged when appropriate
- Regular triage of the internal waiting list and waiting list validation
- Additional capacity through the use of agency staff to continue delivering the waiting list initiative.
- Regular monitoring of job planning requirements to ensure that capacity met demand
- Development of a clear and standardised service offer for children and young people
- Recruitment to vacant posts

Part 2 – Care and Treatment Planning (CTP) - Over 18.

The Committee was advised that compliance remained steady in the Adult service, with a slight decline in MHSOP performance (which was possibly due to the calculation methods referred to at the previous Committee meeting).

It was noted that a concurrent quality audit had been restarted on a quarterly basis using the Delivery Unit audit tool.

Part 2 – Care and Treatment Planning (Children & Young People)

	It was noted that in quarter 3, compliance against the Part 2 target had seen significant improvement and the target was achieved in December 2022. The DOMH advised the Committee that the service still faced challenges in relation to achievement, including poor engagement from patients in the CTP process and a high number of new patients requiring one. He added that the team was working hard to ensure that the process could be completed in a meaningful manner through a range of options, including face to face, telephone and video conferencing where appropriate and in a supportive multi-agency approach. **Part 3 - Right to request an assessment by self –referral.** The Committee were advised of 4 breaches since the last reporting period. The DOMH noted that those breaches represented 12.5% of the total number during the 3-month period, compared to 33% in the last quarter. **Part 4 – Advocacy – standard to have access to an IMHA within 5 working days** The Committee was advised that the service was 100% compliant with no further actions required. **The Committee Resolved that:** a) The contents of the report were noted.	
MHLMCA 23/01/013	**Part 1 Scheme Report Verbal Update** The Part 1 Scheme Report Verbal Update was received. The DOMH advised the Committee that a meeting had been held within the Mental Health team regarding the Part 1 scheme. He added that the Part 1 scheme was defined by Local Health Boards as to what constituted Part 1 services. It was noted that the Delivery Unit (DU) was advised of what those services consisted of. The DOMH advised the Committee that Mental Health Services had changed significantly since the inception of care and treatment plans in 2005 and so a collaborative piece of work was ongoing with Clinicians to note the future of the service. He added that another piece of work was ongoing to establish the principles to make sure that Patients were no worse off because of the decisions made by Clinicians and that it would be ratified by the Committee when completed. The CVC asked if the Part 1 services were something that could be seen by GPs when they were seeing patients in their surgery.	

	The DOMH responded that there were a number of challenges around it because some Part 1 services could only be referred into through health provision. He added that some of that would change with the implementation of the "111, press 2" service but noted that it would not referred to by GPs. The CVC advised the DOMH that previously, the Committee had received Patient stories and asked if the new care providers would provide those insights in the future. The DOMH responded that he would liaise with the care providers for that information. **The Committee Resolved that:** a) The Part 1 Scheme Update was noted.	
MHLMCA 23/01/014	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The IDCG advised the Committee that there was one risk on the CRR for the Mental Health Clinical Board. He added that the risk had been downgraded to a score of 15 but noted that the risk always had the capacity to increase and so it would need to be monitored closely. The Committee was assured that the Risk and Regulation team would continue to work with the Mental Health Clinical Board to further integrate the Health Board's Risk Management policies and procedures to ensure that those entries detailed on the Register provided an accurate indication of the risks that the Health Board was dealing with operationally. **The Committee Resolved that:** a) The Corporate Risk Register risk entries linked to the Mental Health Legislation and Mental Capacity Act Committee and the Risk Management development work which was now progressing with Clinical Board, was noted.	
MHLMCA 23/01/015	**Sub-Committee Meeting Minutes:** The Committee received copies of the Sub-Committees' meeting minutes: • Mental Health Act Hospital Managers Power of Discharge Sub Committee	

	The MHAM advised the Committee that care and treatment plans (CTPs) were still a concern for the Mental Health Act Hospital Managers Power of Discharge Sub Committee, as well as the appointment of nearest relatives. He added that it was noted that some of the CTPs were not outcome focused and needed more information in them. • Mental Health Legislation and Governance Group (MHLGG) **The Committee Resolved that:** a) The Sub-Committee Meeting Minute were noted.	
MHLMCA 23/01/016	**Committee Annual Report 2022/23** The Committee Annual Report 2022/23 was received. The CVC asked what happened to the Committee's Annual Report. The IDCG responded that it was combined and put into the main annual report of the Organisation which was published at the end of the year. **The Committee Resolved that:** a) The draft Annual Report 2022/23 of the Mental Health Legislation & Mental Capacity Act Committee was reviewed. b) The Annual Report was recommended to the Board for approval.	
MHLMCA 23/01/017	**Committee Terms of Reference and Work Plan – 2023/24** The Committee Terms of Reference and Work Plan – 2023/24 was received. The IDCG advised the Committee that the covering report had noted no changes had been made to the Terms of Reference. However there had been some minor changes which were outlined within the Terms of Reference. He added that clarification on the number of Committee members was required and also, in terms of attendees the ToR would include the Chief Executive and the Executive Medical Director (EMD). **The Committee Resolved that:** a) The Terms of Reference and work plan 2023/24 for the MHLMCAC were reviewed b) The Terms of Reference and work plan 2023/24 for the MHLMCAC were ratified c) The changes were recommended to the Board for approval on 30th March 2023.	

MHLMCA 23/01/018	**Policies** No policies **The Committee Resolved that:**	
MHLMCA 23/01/019	**Any Other Business** No further business was raised.	
	To note the date, time and venue of the next meeting: 2 May 2023 at 10am Via MS Teams	

Unconfirmed Minutes of the Quality, Safety & Experience Committee
Held on 07.03.2023 at 09.00am
Via MS Teams

Chair:		
Ceri Phillips	CP	Vice Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
In Attendance		
Mike Bond	MB	Managing Director – Acute Services
Paul Bostock	PB	Chief Operating Officer
Guy Blackshaw	GB	Clinical Board Director – Specialist
Marcia Donovan	MD	Head of Corporate Governance
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Fiona Kinghorn	FK	Executive Director of Public Health
Sarah Lloyd	SL	Interim Director of Operations – Specialist
Bryony Roberts	BR	Senior Nurse – Major Trauma
Jason Roberts	JR	Executive Nurse Director
Melissa Rossiter	MR	Clinical Director (Major Trauma)
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Richard Skone	RS	Deputy Medical Director (joined at 11.15am)
James Quance	JQ	Interim Director of Corporate Governance
Catherine Wood	CW	Director of Operations - Children & Women
Observing		
Rebecca Aylward	RA	Deputy Executive Nurse Director
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Paul Bostock	PB	Chief Operating Officer
Susan Elsmore	SE	Independent Member – Local Authorities / Chair of the Committee
Meriel Jenney	MJ	Executive Medical Director

QSE 23/03/001	**Welcome & Introductions** The Committee Vice Chair (CVC) welcomed everyone to the meeting in English & Welsh.	**Action**
QSE 23/03/002	**Apologies for Absence** Apologies for absence were noted. The Executive Medical Director (EMD) advised the Committee that she would need to leave the meeting early to attend another meeting. The Chief Operating Officer (COO) advised the Committee that he would need to leave at 10am to attend the Trauma Network Group.	
QSE 23/03/003	**Declarations of Interest** No declarations were noted.	
QSE 23/03/004	**Minutes of the Committee meeting held on 10 January 2023** The minutes of the Committee meeting held on 10 January 2023 were received. The Executive Director of Public Health (EDPH) advised the Committee that minute QSE 23/01/005 should have stated that the data was collated by the substance misuse APB commissioning team.	

	The Committee resolved that: a) The minutes of the meeting held on 10 January 2023 were approved as a true and accurate record of the meeting pending the one amendment noted.	
QSE 23/03/005	**Action Log following the Meeting held on 10 January 2023** The Action Log following the Meeting held on 10 January 2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 10 January 2023 was noted.	
QSE 23/03/006	**Chair's Actions** No Chairs Actions were raised.	
QSE 23/03/007	**Specialist Clinical Board Assurance Report (including a Patient Story).** The Specialist Clinical Board Assurance Report was received. The Clinical Board Director – Specialist (CBDS) highlighted the following areas in the report:- • The Patient at Risk Team (PaRT) team. The CBDS advised the Committee that it was the first anniversary of the PaRT team being set up. He added that during that first year of the service impressive results had been seen and that the team would get called those who had a national early warning score of greater than three. The CBDS advised the Committee that it had been agreed last week to extend the PaRT team in order to provide a more robust service. He concluded that the case for expanding the PaRT service to 24/7 cover was being progressed. The Executive Director of Public Health (EDPH) advised the Committee that it was clear that the PaRT team had provided an extensive amount of support right across the three sites (i.e. University Hospital Wales (UHW), University Hospital Llandough (UHL) and Hafan Y Coed (HYC)) and asked if outcomes could be observed, even if direct correlation with The Risk-Adjusted Mortality Index (RAMI) could not be shown. The EDPH also asked if there was any training element. The CBDS responded that the team had dedicated time within their schedule for education and to try and educate other staff on the wards. He added that even though the PaRT service had been up and running for a year, the team was still trying to get the message out as to what exactly the PaRT team did. The Committee was advised that in relation to outcome data, there were figures which related to the proportion of patients who went to Critical Care and the proportion of those who improved and stayed on the wards. The CBDS concluded that the data could be looked at in more depth to provide better outcome data. • National Organ Retrieval Service (NORS) The Committee was advised that the Health Board did not transplant livers, but that it did transplant kidneys and pancreas. The CBDS noted that the Health Board was the only standalone NORS team in the UK and that it had started to use a pioneering technique, normothermic Regional Perfusion (NRP), to allow the retrieval of organs from donors after circulatory death, increasing the pool of accepted organs.	

	He added that Cardiff was one of only 3 centres in the UK able to deliver that option and the only non-liver centre in the UK able to retrieve livers. The CBDS concluded that it allowed people on the waiting list an opportunity (that had not previously been available to them) to receive an organ. • Major Trauma Centre (MTC) The Committee was advised that the (MTC) was still in its infancy stages and that it went live in September 2020. It was noted that the Major Trauma Directorate management team (DMT) was led by the Clinical Director for Major Trauma and sat within, and was accountable to, the Specialist Services Clinical Board. The CBDS added that Major Trauma care did not sit in one single Directorate, but was delivered in a coordinated way which involved multiple different specialities and organisations across the network. He added that, as anticipated, the MTC treated a significant proportion of silver trauma (43% of all cases in Q3) and that the majority of patients were transferred straight home from the MTC rather than repatriated to their home Health Board. It was noted that that the intensive rehabilitation model had been a success. The CBDS advised the Committee that in March 2022 the South Wales Trauma Network had its first peer review. He added that the review identified 6 serious concerns and that an action plan had been developed to address the issues raised. It was noted that a number of the issues were within the control of the organisation and had been addressed and closed, whilst others required investment from commissioners to resolve. The CBDS concluded that the Clinical Board was working with WHSSC to seek additional investment and to mitigate the risks. The CVC asked where the Clinical Board was in relation to working with WHSSC to get additional investment. The Interim Director of Operations – Specialist (IDOS) responded that in April 2022, the Clinical Board submitted a bid to WHSSC to address a number of concerns that had been highlighted as part of the action plan. She added that they had not been successful in securing any funding from WHSSC during the prioritisation process and that WHSSC did not have sufficient revenue to be able to allocate any funding to the Clinical Board for this year. She noted that it presented a problem to the Clinical Board and the organisation as a whole because it meant that there would be a whole year without any allocation from WHSSC to support the service. The IDOS advised the Committee that what had been agreed at the most recent delivery assurance group was that Welsh Government (WG) was going to do a Gateway 5 review on the service in quarter two of the year. She added that all of the outcomes would hopefully be seen from that review and that it meant there would be some weight to some of the areas needed to develop the service and that the bidding process would start again with WHSSC. The CVC noted that it would be useful for the Committee to be kept up to date with ongoing conversations with WHSSC. • Infection Prevention and Control	**JR/SL**

	The CBDS advised the Committee that during 2021/2022 the Clinical Board had seen an increase in MSSA cases, particularly within the renal population. He added that the Directorate reviewed both incidences of infections between centres within South East Wales and the Renal Registry data across the UK which had showed that whilst the Clinical Board's data was very similar to other populations, it highlighted some variances in practice. It was noted that the review resulted in a standardisation of practice for dialysis line care both prior to insertion and also through each dialysis session, and an enhanced training package for staff. • National Reported Incidents (NRIs) The CBDS advised the Committee that overall, the Clinical Board had seen a decrease in the number of National Reported Incidents that it had occurred between the twelve-month periods, despite seeing an increase in the number of incidents reported overall. That was a positive indicator within the safety agenda. The CVC thanked the CBDS, the IDOS and their teams for all of the hard work being undertaken in the Specialist Services Clinical Board. The Senior Nurse – Major Trauma presented the Committee with a Patient Story. The Patient Story outlined a Polytrauma Patient. It was noted that the patient had come off his quad bike at force and that the quad bike had landed on him. The patient's journey was presented which included: • The Incident – Quad Bike incident in a rural location. • Pre-Hospital – The Emergency Medical Retrieval and Transfer Service Cymru (EMRTS) arrived at the scene • Emergency Department – Pre-alert by EMRTS. The trauma team awaited arrived. • Theatre – Surgery to fix significant injury • Critical Care – a 2 day stay in ITU • Polytrauma Unit • Major Trauma Centre • Specialist Rehabilitation • Repatriation to patient's local Health Board. • Follow on care The Executive Nurse Director advised the Committee that the patient story provided was an example of where a system came together in the NHS. The IDOS advised the Committee that as part of the South Wales Trauma Network, the story would be shared wider across Wales which was important about how to garner support from WHSSC longer term. She added that the story demonstrated the acute phase, but also touched across the wide range of services provided across the Organisation. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted. b) The content of the report and the assurance given by the Specialist Clinical Board was noted.	
QSE 23/03/008	**Looked After Children – Assessment Backlogs** The Looked After Children – Assessment Backlogs were received. The Committee received an updated position regarding assessments for Looked after Children (LAC).	

	The Director of Operations - Children & Women's Clinical Board (DOCW) noted that performance against Statutory Regulations stipulated that a child being accommodated by the Local Authority should have a holistic health assessment within 28 days. She added that meeting the Regulations was difficult, due to insufficient capacity for both medical and nursing assessments, which had further deteriorated due to the retirement of a Consultant within the team. It was noted that there had been a consistent increase in children in care in Cardiff and the Vale of Glamorgan, with 1,638 children currently on the LAC database in February 2023. The increase in LAC numbers had impacted significantly on the number of Initial & review Health Assessments required each year. The Committee was advised of the actions that had been undertaken or started. That included: • Alternative staffing models were being explored to consider options to address the backlog, meet current demand and also to manage caseload in line with recommendations. • Additional nurses had been appointed and would commence employment in March 2023. It was anticipated that would deliver a total of 1,130 assessments, and reduce the backlog assessments for children over the age of 10. • There was a medium-term plan to recruit an additional 2.4 wte Band 6 nurses to assess all children over 5, and a longer-term plan to deal with expected growth and safe caseload numbers. • Other modernisation and change of delivery models would continue to be explored with the service to ensure efficiency and best use of resources, with a further expansion in nursing resource to support assessments for children over 5. The DOCW asked the Committee for permission to return in a few months with another paper that demonstrated the actions being taken. The EDPH noted that discussions had been held in the Children & Women's Clinical Board performance review to note the proactive approach to dealing with the challenges raised and welcomed the paper being received to outline actions. The END noted that the increased number of LAC and that the Clinical Board had identified the risks and was working through those in order to mitigate the same. The Independent Member – Community (IMC) asked if there was a collaboration with other areas such as Social Services, other community settings and Third Sector services. The DOCW responded that the growth in LAC identified related to children who were in the adoption or foster process or residential care and that from that specific side, it was difficult to work in partnership because it was a clinical need set out in statute. She added that in terms of the wraparound care offered to the children that was where the partnership working could be beneficial. The Independent Member – University (IMU) asked if there was anything that could done to get more finance from WG. The EDPH responded that it was complex because LAC and vulnerable children were just one example of a disadvantage in the population and noted that when allocation of funding was received by WG, there was a method used by them right across Wales and that all Local Authorities (LA) were seeing an increase in LAC. The CVC asked what would happen now that the actions had been initiated to respond to the trajectory of growth in LAC because it appeared that the trajectory would continue upwards. The DOCW responded that at the current point in time, the actions initiated had helped the Clinical Board to maintain a position but not to manage the demand at the increasing rate. She added it would take time to test the actions being undertaken, and then further information could be provided to the Committee at a later date.	**JR/CW**

	The QSE Committee resolved that: a) The content of the paper and the actions taken to mitigate the risks associated child health assessments were noted.	
QSE 23/03/009	**Quality Indicators Report to include: C-Diff Update.** The Quality Indicators Report was received. The END advised the Committee that the report was presented during a climate that had experienced some of the most difficult challenges with regards to capacity and the workforce in Health Care. He added that the report initially talked about the implementation of the Quality Framework. He added that the Duties of Quality and Candour had a start date of 1st April 2023 and noted that the teams were well trained to implement both of those new Duties. The END provided the Committee with updates on a number of areas which included: • Incident reporting – It was noted that reporting remained consistently high within the Organisation, with pressure damage providing the largest number of incidents reported. The END advised the Committee that pressure damage was being monitored and measured carefully and that he was pleased to say that the number of incidents, specifically related to staffing issues, had reduced. • Nationally Reportable Incidents (NRIs) – It was noted that the position was improving and that had reflected the focus and hard work of the Clinical Boards and Patient Safety Teams. It was noted that there had been a reduction of overdue NRIs by 41% since September 2022. • Infection Control - Hospital Infections – The END advised the Committee that the grouped total C'diff, Ecoli, MRSA and MSSA infections, was showing no in-year improvement against the baseline but noted that Ecoli, MRSA and MSSA were demonstrating an in-year improvement, whereas C'diff in-year had increased, compared to baseline of December 18th. • MRSA – The END advised the Committee that the Health Board had achieved 135 days free since the last hospital acquired MRSA. The END added that C'diff rates were observed to be high across the UK after the first and subsequent waves of Covid and that all cases were now subject to investigation to understand the cause of the infection and would be monitored through the C'diff oversight group. He concluded that there had been a small investment in the IP&C team in the past 2 years, which had enabled increased audit and review of infections and had supported a bespoke approach to supporting wards and Primary Care reviews. • Performance – The END advised the Committee that it had been a very challenging period and noted that the Chief Operating Officer (COO) had continued to outline the significant amount of work going on operationally to improve the position of the Health Board. • Patient Concerns – The END advised the Committee that during December 2022 and January 2023, it had been pleasing to note that, despite the current demand on the service, the Health Board had achieved a slight improvement in an overall 30 working day response time for all concerns. He added that the Patient Experience team had closed 80% of concerns in December within 30 working days and 77% in January. • Civica 'Once for Wales' Platform – The END advised the Committee that the Civica platform went live on Friday 28th October 2022 and that the Patient Experience team was currently surveying up to 600 patients daily via SMS.	

He added that at the time of reporting the Patient Experience team had contacted circa 36,227 people for feedback via text messaging with a return rate of 18%.

- Stroke – The Managing Director – Acute Services (MDAS) advised the Committee that the Stroke pathway was time critical with key decisions that improved both mortality and outcome in relation to Quality of Life.

He added that there has been significant public awareness raising of the symptoms of a stroke and it's time critical nature. Ongoing work to improve the service had included:

- Increased out of hours CNS support for "Code Stroke".
- Dedicated specialist middle grade to support Emergency Unit for Stroke.
- Focused training for acute medics on Stroke assessment, thrombolysis and thrombectomy.
- Ring-fencing additional Stroke beds and deploying pull model "Think thrombolysis, Think Thrombectomy".
- Thrombectomy next steps – work to strengthen neuroradiologist workforce.

- Ambulance Handovers – The Committee was advised that there has been a sustained improvement in Ambulance patient handovers, although it was noted that, unfortunately, due to a number of events 2 ambulances had waited overnight the previous Saturday.

The IMU asked, in relation to the operating hours of the Patient Experience team, if a 3-hour period of manning phones from 10am until 1pm was sufficient to get a real picture of complaints, and asked if the 3-hour limit was due to financial constraints.

The Assistant Director of Patient Experience (ADPE) responded that the 3-hour phone manning operation was just the Patient Experience inquiry line and noted that the team their early resolution phone lines which were manned from 7am until 6pm.

She added that the Patient Experience line was for those matters that could be resolved on the Ward and that the reason for it being 3 hours was due to no additional resource.

The IMU asked if there was any potential for other agencies to help the Health Board to get more enriched data.

The Assistant Director of Quality and Patient Safety (ADQPS) advised the Committee on mortality data.

She noted that the November 2022 Quality Safety and Experience Committee had agreed a three-tier model for reporting and monitoring mortality data across the Health Board. Data was received by the Committee which included:

- Age-standardised mortality rates in 2022 were significantly lower than most other years since 2001 in Wales and England, although it remained above the rate observed in 2019.

- Alzheimer's and dementia remained the leading cause of death in Wales in December 2022, with a rate higher than the five-year average.

- Cancer mortality rates per 100,000 population had demonstrated a reducing trend in population rates in Wales and in Cardiff and Vale UHB area.

- Still birth rates in the UK fell to 3.9 per 1000 births in 2019 and 2020 with increased rates associated with ethnicity in several populations, in particular, Bangladeshi, Pakistani, Black African and Black Caribbean. Provisional figures from the Office of National Statistics suggested that still birth rates increased in 2021 to 4.2 per 1000 births, with a particular increase noted in the second half of 2021. National rates for 2022 were not yet reported.

- Still birth rates in Cardiff and Vale UHB increased from 4.39 in 2021 to 5.74 in 2022. The presence of a Foetal Medicine Unit, meant that the Health Board could provide specialist diagnosis and treatment of complications which could arise in unborn babies.

The END advised the Committee that it was important to note the explanation on still birth rates because the Health Board had received some criticism that the still birth rate had been higher than the national average.

	He added that assurance could be provided that every still birth was robustly investigated by the formal NRI process. **The QSE Committee resolved that:** a) The content and the developing process to monitor Quality Indicators was noted.	
QSE 23/03/010	**HIW Activity Overview** The HIW Activity Overview was received. The END advised the Committee that Heath Inspectorate Wales (HIW) had undertaken three unannounced visits, namely: - • Maternity Services • Hafan Y Coed - HIW undertook an unannounced inspection in Hafan Y Coed from the 9th to the 11th of January 2023. An immediate action plan was submitted in response to the recommendations and an update would be provided following the publication of the report. • IRMER Inspection - An Ionising Radiation Medical Exposure Regulations (IRMER) compliance inspection was undertaken in the Nuclear Medicine Department at UHL on the 11th and 12th of October 2022. Overall, the feedback was positive, and no immediate concerns were identified. An action plan was submitted and accepted in response to the recommendations and the final report was published on 12th January 2023. He added that the Committee would receive full reports with regards to each visit once the formal HIW reports had been published. **The QSE Committee resolved that:** a) The assurance provided by the response to HIW inspections and progress against existing improvement plans were noted.	**JR**
QSE 23/03/011	**Community Health Council Reports** The Community Health Council Reports were received. The END advised the Committee that a number of Community Health Council (CHC) Announced Scrutiny Visits had occurred. The Committee received a list of CHC Q2, Q3 &Q4 final reports in the following areas: • Alcohol Treatment Centre • Spinal Rehabilitation Unit UHL • Ward West 1 UHL • Transport to Health Services The main issues highlighted in those reports included: • Infrastructure • Estates • Patient Experience. The CVC thanked the CHC for the reports and noted that it was a good initiative for the Committee to receive them. **The QSE Committee resolved that:** a) The contents of the report and the CHC feedback and recommendations were noted.	
QSE 23/03/012	**Maternity Services – Verbal Update** The verbal Maternity Services Update was received.	

	The END advised the Committee that Health Inspectorate Wales (HIW) had undertaken an unannounced visit in November 2022 and that the Health Board had submitted its improvement plan, which would be received by the Committee as soon as the HIW report had been published. He added that following the Ockenden review, a resource gap analysis had been undertaken and the same was due to be submitted to the Health Board's Investment Group for consideration. It was noted that a MatNeo programme had been established in order to share best practice across Wales. The END advised the Committee that they would be updated on progress as the MatNeo programme matured. The Independent Member – Trade Union (IMTU) asked about staff morale in the Maternity Service. The END responded that work there had been continuous and that he had heard that staff were feeling much better about outcomes. He added that the Committee should not forget that HIW had visited after a prolonged staff sickness period as well as a gap in staff vacancy. It was noted that in September 2022, the Maternity Service had overfilled its vacancies which had closed the gap. The END concluded that the teams continued to review and monitor staff evaluations and staff wellbeing. **The QSE Committee resolved that:** a) The Maternity Services Update was noted.	
QSE 23/03/013	**Quality, Safety and Experience Framework - Effectiveness review – Verbal** The Quality, Safety and Experience Framework - Effectiveness review was received. The ADQPS presented to the Committee. She advised the Committee that in September 2021, the Quality, Safety and Experience Framework was published which set out a 5-year ambition to improve quality and safety across the organisation. It was noted that traditionally, the focus of quality and safety had been on what had gone wrong and what patients were telling the Health Board about why they were unhappy. The ADQPS advised the Committee that where there was no doubt that the learning from those incidents or information sources was vitally important. There was a significant body of evidence that demonstrated that the health system was moving to a more contemporary approach to include more psychological safety and staff engagement, as well as focusing on human factors and development of a whole systems approach to quality and safety. She added that it would support the Health Board in meeting its statutory requirements in relation to the Duty of Quality and the Duty of Candour. It was noted that one of the areas the team had wanted to focus on was around leadership and prioritisation and noted that the Health Board would be looking to support the organisational and compassionate leadership programme and to embed quality and safety as part of that. The Committee was advised that the Health Board was also looking at developing multidisciplinary roles and role profiles across the organisation, which focused on those people who were involved in quality and patient safety, whether a medical role, allied health care professional or nursing role. The ADQPS noted that in relation to patient safety learning improvement, the Health Board would be developing an organisational learning committee and the role of that committee would be to have Health Board wide engagement.	

	The ADPE advised the Committee that World Patient Safety Day 2023 would be observed on September 17th 2023 under the theme of "Engaging Patients for Patient Safety". She added that the really important part was that patients and families had an important role in elevating the voice of patients. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Framework - Effectiveness review was noted.	
QSE 23/03/014	**Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response** The Review of Quality Governance Arrangements - Audit Wales Report and Health Board Management Response was received. The Interim Director of Corporate Governance (IDCG) reminded the Committee that it had asked for regular updates regarding progress made with the implementation of the recommendations of the report, as recorded in the Committee Action Log. He added that the implementation of recommendations continued to be monitored by the Risk and Regulation Team and a number of the recommendations were recognised as longer-term and formed part of the Health Board's preparations for the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act. The Committee was advised that six recommendations had been made by Audit Wales, which formed part of the wider quality improvement programme in place within the Health Board, with specific actions shown against each recommendation. It was noted that all recommendations were in progress and formed part of the Health Board's preparations for the implementation of the Quality and Engagement Act. **The QSE Committee resolved that:** a) the progress made with the implementation of the recommendations of the Audit Wales report was noted.	
QSE 23/03/015	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The IDCG advised the Committee that a number of risks linked to Patient Safety were included on the Board Assurance Framework (BAF) which included: • Maternity (score of 20) • Critical Care (score of 20) • Cancer (score of 15) • Stroke (score of 15) • Planned Care (score of 12). He added that those were in addition to the risks already logged on the BAF: • Patient Safety (score of 20) • Urgent and Emergency Care (score of 15) The CVC noted that the format in which the report was received was very helpful and gave the Committee an indication of where it was and where it was going. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety, Quality and Experience were reviewed and the Committee was able to provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety.	
QSE 23/03/016	**Corporate Risk Register**	

	The Corporate Risk Register (CRR) was received. The IDCG advised the Committee that a robust process continued whereby the Risk and Regulation Team continued to work with Clinical and Corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. He added that the risks linked to the Quality, Safety and Experience Committee were received by the Committee for further scrutiny and to provide assurance to the Committee that relevant risks were being appropriately recorded, managed and escalated. **The QSE Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Quality, Safety and Experience Committee and the Risk Management development work which was progressing with Clinical Boards and Corporate Directorates, were noted.	
QSE 23/03/017	**Committee Work Plan 2023/24** The Committee Work Plan was received. The IDCG advised the Committee that the Committee Work Plan had been prepared by his predecessor and that no further changes had been made from it. He added that the work plan identified key areas of work, but noted that it did not prevent other items from being added as and when required. The CVC added that the QSE Committee was moving to monthly meetings from April 2023 and so flexibility on the work plan would need to be observed. **The QSE Committee resolved that:** a) The Quality, Safety and Experience Committee Work Plan 2023/24 was reviewed. b) The Committee Work Plan for 2023/24 was ratified c) The Work plan was recommended to the Board on 30th March 2023 for approval.	
QSE 23/03/018	**Policies for ratification including:** The Deteriorating Patient Policy was received. The END assured the Committee that the policy had been through the resuscitation forums and that good governance had been observed. **The QSE Committee resolved that:** a) The Deteriorating Patient Policy was approved.	
QSE 23/03/019	**Minutes from Clinical Board QSE Sub Committees:** **Exceptional Items to be raised by Assistant Director Patient Safety & Quality:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/03/020	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/03/021	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) Royal College of Physicians Summary Report: Inpatient Suicides – Verbal (Confidential Discussion)*	

QSE 23/03/022	**Any Other Business** The CVC asked for thanks to be placed on record to Susan Elsmore as Chair of the QSE Committee who would be stepping down in April 2023.	
QSE 23/03/023	**Review of the meeting.**	
	Date & Time of Next Meeting: Tuesday, 11 April 2023 via Teams	

Unconfirmed Minutes of the Quality, Safety & Experience Committee

Held on 11.04.2023

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Mike Jones	MJ	Independent Member – Trade Union
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance		
Paul Bostock	PB	Chief Operating Officer
Sandeep Hemmadi	SH	Interim Clinical Board Director for Children & Women
Angela Hughes	AH	Assistant Director of Patient Experience
Charles Janczewski	CJ	University Health Board Chair
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Andy Jones	AJ	Director of Nursing and Midwifery, Children & Women's Clinical Board
Fiona Kinghorn	FK	Executive Director of Public Health
Anna Mogie	AM	Deputy Director of Nursing - PCIC
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
James Quance	JQ	Interim Director of Corporate Governance
Catherine Wood	CW	Director of Operations - Children & Women
Clare Wade	CW	Director of Nursing for Surgical Clinical Board
Observing		
Stephen Allen	SA	Regional Director - Llais
Rebecca Aylward	RA	Deputy Executive Nurse Director
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Marcia Donovan	MD	Head of Corporate Governance
Meriel Jenney	MJ	Executive Medical Director
Richard Skone	RS	Deputy Medical Director

QSE 23/04/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh and noted that it was the first meeting being performed under the new monthly format.	**Action**
QSE 23/04/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/04/003	**Declarations of Interest** The Independent Member – University (IMU) advised the Committee that he was the Clinical Expert in relation to the Jasmine Report which was being discussed later on in the agenda. The CC noted that the IMU would not be required to leave the meeting and that he could respond to any discussion points raised.	
QSE 23/04/004	**Minutes of the Committee meeting held on 7 March 2023** The minutes of the Committee meeting held on 7 March 2023 were received. **The Committee resolved that:**	

	a) The minutes of the meeting held on 7 March 2023 were approved as a true and accurate record of the meeting.	
QSE 23/04/005	**Action Log following the Meeting held on 7 March 2023** The Action Log following the Meeting held on 7 March 2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 7 March 2023 was noted.	
QSE 23/04/006	**Chair's Actions** No Chairs Actions were raised.	
QSE 23/04/007	**Children & Women's Clinical Board Assurance Report** The Children & Women's Clinical Board Assurance Report was received. The Interim Clinical Board Director for Children & Women (ICBDCW) advised the Board that significant and innovative work was being delivered by the Children & Women's Clinical Board (the Clinical Board). He added that Children had been disproportionately impacted by the Covid 19 pandemic, and the Clinical Board had seen significant growth in demand for the service since 2019, with that demand continuing to outstrip capacity. It was noted that the Health Inspectorate Wales (HIW) had undertaken 2 unannounced visits of Maternity services but that they had been impressed with the Clinical Board for the work undertaken following the initial inspection in November 2022. The Director of Operations for Children & Women (DOCW) presented the Committee with the work undertaken to support Women, Children and Families over the past 12 months and noted that the scope of the Clinical Board's services was large. The Clinical Board team was very cognisant that whilst the Maternity services were high profile, the breadth of services provided by the Clinical Board to young people and their families in the community did not always get the same attention as the more well-known services. She added that one of the lesser known, but high impact, services was one that had been reported to the Committee in March 2023 in relation to Looked After Children (LAC). It was noted that the Committee had received information at the March meeting regarding the demand and capacity perspective of LAC as well as the actions being taken, and that the latest report received for the current meeting was the LAC service from a patient's perspective. A patient story would be shared to highlight that. The Director of Nursing and Midwifery, Children & Women's Clinical Board (DNCW) read out the reflections of a Grandmother of a Looked After Child, aged 15 who had been in foster care since the age of 3. The story highlighted the struggles the child had been through and noted that arrangements were made for an independent review officer, a social worker, and a LAC nurse to intervene and contact the child. The Grandmother noted that the LAC nurse had been brilliant with the Grandchild and that the struggles in their life started to improve and that they were now happy, smiling and working towards their GCSEs in 2023. She concluded that the LAC nurse had made a positive impact on the 15-year-old which had created a real turning point and had made a great difference in their life. The DNCW noted that the story indicated the value of the LAC service and noted the importance of the work undertaken by that team as well as all of the additional and unseen work that the LAC nurses provided.	

The Committee was advised of another service which the Clinical Board wanted to highlight - the continence service.

The DNCW noted that over the past 12 months, the team had been able to halve the number of young people waiting for continence input due to a combination of a number of actions. Notably the service was moving to a much more nurse led service, using Band 4 assistants, using additional training and referral criteria and other interventions.

He added that the work was continuing and was a really good example of a service that only a year or so ago had been struggling under significant restraints.

The DOCW noted that the examples provided were very strong examples of where the service had impacted on, not just the physical health of children and young people, but the holistic care of that child, enabling them to go to school, giving them a quality of life and confidence that would hopefully go with them as they moved into adulthood.

She added that a key part of that was working together with all of the Clinical Board's partners, such as Local Authority (LA) and Third Sector colleagues.

It was noted that partnership working linked into some of the great work undertaken in Child and Adolescent Mental Health Services (CAMHS) which had recently been relaunched and showcased the different facets of the emotional health and wellbeing that the Clinical Board had to offer.

The DOCW advised the Committee that in relation to the eating disorders in Children's services, the team had extended the scope and reach of the team. Assessments for the team were completed in pairs as per the Maudsley model which was recognised as the gold standard model of care for that group of children in the UK.

She added that the eating disorder service had also set up a Multi-Family Group Therapy which was very well received and provided a holistic model of care that allowed children and families to access support.

The DNCW advised the Board that following the Ockenden report publication in 2022, the service had undertaken a gap analysis of the Maternity service against the recommendations of the report.

He added that the Maternity service and Clinical Board were very grateful for the support received by the Board in supporting the resources required and the investment of £2.7m.

The CC conveyed the thanks of the Committee and asked for that to be fed back to the relevant teams.

The Independent Member – Community (IMC) asked if there were any specific programmes of work or assurance that could be given in terms of developing more nurses, like the one identified in the Patient Story.

The DOCW responded that work was being undertaken to recruit "community connectors" who would provide wrap around support for young people and their families and noted that in terms of LAC nurses, the Clinical Board was actively recruiting more into the team.

The Independent Member – Capital & Estates (IMCE) noted that she had been encouraged to see the co-working between the Children and Women's Clinical Board and the Mental Health Clinical Board and in particular the 16-25-year olds transition period.

She asked how that was progressing.

The DOCW responded that it had progressed very well. The Health Board had received funding from Welsh Government which would usually be split between Adult Mental Health services and CAMHS. The Clinical Board had looked at services with a completely different lens across the 2 clinical boards and asked "what was the right thing to do for that young person" and it was decided that the Clinical Board would move away from historic boundaries of how the service could be delivered and pool resources to create a seamless waiting list entry for that child which would follow them right through the pathway.

The Executive Director of Therapies and Health Sciences (EDTHS) invited the DNCW to draw attention to non-hospital services, such as the work undertaken by the Designated Education Clinical Lead Officer (DECLO).

	The DNCW responded that the DECLO was a very busy role and that they had undertaken a lot of great work. He added that the only issue the Clinical Board could raise was that the role was shared between 2 Health Boards and so work would need to be undertaken to revisit the amount of resource each Health Board would receive from the DECLO. The Chair of the University Health Board (UHB Chair) thanked the team on behalf of the Board and noted that the Board had been pleased to see the way in which the Clinical Board had responded to the recommendations made by the HIW in relation to Maternity services which had helped the Health Board to avoid any escalation process with HIW. He added that in relation to the report received, it did not note what was being done for long waiters and asked what was being done with regards to those patients. The DOCW responded that it was being looked at with 2 lenses: • Support whilst they waited for the service • How the wait could be addressed She added that over the past few months, the Clinical Board had looked at the waiting lists and re-evaluated how the services could run those lists. It was noted that the biggest challenge for the Clinical Board was the volume of the waiting list and the struggle to recruit and retain staff. The UHB Chair thanked the DOCW for the response and asked that the QSE Committee revisit the issues identified in 6 months' time to provide more assurance. **The QSE Committee resolved that:** a) The progress made by the Clinical Board to date was noted. b) The content of the report and the assurance given by the C&W Clinical Board was noted.	**JR**
QSE 23/04/008	**Quality Indicators including: Peri-Natal Mortality** The Quality Indicators including: Peri-Natal Mortality were received. The DNCW advised the Committee that the Health Board had established a system for the critical review of still births. He added that when a stillbirth occurred a monthly MDT review discussion took place very quickly after the incidents. It was noted that the information provided to the Committee showed the count of still births tracked per 1000 and that there had been a downward trajectory in stillbirths between 2016 and 2018. The DNCW advised the Committee that since 2020 the trajectory had increased from 16 stillbirths to 30 in 2022. He added that there was isolation in the data from the Covid-19 pandemic and noted a national increase since the lifting of lockdowns which was mirrored in the data presented by the Health Board. It was noted that the stillbirths were robustly reviewed. All incidents had the MDT rapid review undertaken and all incidents reports had gone on to have a full MDT review. It was noted that the Health Board had benchmarked stillbirth rates against other organisations of a similar size to the Health Board and noted that the average rate was 3.3 per 1000. The DNCW added that the provisional Office for National Statistics (ONS) data suggested there would be a national rise but noted that the statistics were yet to be confirmed and released. The Committee were presented with the Perinatal Mortality Review Tool which identified the areas that the review undertook which included:	

- Patients perspective of care
- Social circumstances
- Antenatal care
- Screening for gestational diabetes and fetal anomalies
- Growth screening
- Management of fetal movements
- Development of significant obstetric complications
- Intrapartum care
- Fetal Monitoring

It was noted that the Health Board utilised the tool for the robust and standarisation review of all deaths of babies up until 28 days post birth to provide answers to the bereaved families and to support local and national learning.

The DNCW advised the Committee that the review panel comprised of an obstetrician consultant, DNA theologist, senior midwives, the bereavement team, risk managers and, importantly, lay members (to ensure compliance with the Ockenden recommendations in terms of that lay member representation).

He added that in terms of outcomes, the grades identified were:

- A – The review group concluded that there were no issues in care identified up to the point that the baby was confirmed as having died

- B – The review group identified care Issues that they considered would have made no difference to the outcome of the baby

- C – The review group identified care issues that they considered may have made a difference to the outcome of the baby

- D – The review group identified care issues which they considered were likely to have made a difference to the outcome of the baby

The majority of the Health Board's cases in 2021/22 were category A or B which would have not changed the outcome.

It was noted that the Health Board had 3 category C, 2 of which were delays in Women attending the outpatient assessment unit with reduced fetal movement, and the other a failure to prescribe aspirin at the 16-week check.

It was noted that the Health Board had also two category D cases. Both were complex patients in complex social care circumstances and substance misuse and that there was a human error in mis-plotting the first growth scan of one of those patients.

The DNCW added that had it been plotted correctly, it would have shown a small for gestational age baby, but that the outcome would have unlikely been any different.

He added that since the category D incident, the Clinical Board had introduced electronic growth plotting into the system which reduced any risk of human error and was shown to be much safer.

He concluded that learning was shared through risk and governance meetings and quality, safety and experience meetings both at Directorate level and at Clinical Board level and that communication briefings had been developed to share the learning and were distributed across a number of different mediums.

The Executive Director of Public Health (EDPH) advised the Committee that conversations were being held separately on the planned equality, equity, safety, experience framework and the stillbirth data on ethnicity did not appear to have been analysed by socio economic status.

She asked if there was something that the Health Board could be doing in that arena.

The DNCW responded that it was recognised that those from ethnic minority backgrounds were at greater risk of stillbirth and it was also known that there was a communication barrier. It was important to strive to ensure that those groups received effective communication and were made aware of the risk factors that they had as well as the need for them to access services early.

	He added that work was being undertaken with regards to those individuals who were seeking asylum and who were coming into the area geographically, to see how the system could provide information to them in a timely manner because of their risk profiles. The EDPH noted that it could be an area that could be explored for the framework. The CC asked how concerned the Committee should be given that the trajectory was continuing upward. The DNCW responded that there was a danger in looking at just 2 months of data because no stillbirths had been observed in March 2023 and noted that a sufficient time frame would be required to look at data because the current percentages were small. **The QSE Committee resolved that:** a) The Quality Indicators including: Peri-Natal Mortality were noted.	
QSE 23/04/009	**Pressure Damage Collaborative Work Plan** The Pressure Damage Collaborative Work Plan was received. The Director of Nursing for Surgical Clinical Board (DNS) advised the Committee that the report had been delayed since January 2023. She added that the report provided the Committee with information about what the Pressure Damage Collaborative (the Collaborative) was and its aims. It was noted that when the Committee had received the Pressure Damage Collaborative Work Plan in Summer 2022, one of the goals of the Collaborative was to reduce the incidents of healthcare acquired pressure damage within the Health Board by 25% by July 2022. The DNS advised the Committee that the most recent data available to the Collaborative showed that the current figure for February 2023 for “Health Acquired Pressure Damage” was 2.55 cases of pressure damage per 1000 bed days which indicated that the initial goal of a 25% reduction had been exceeded as it was now 27%. The Independent Member – University (IMU) noted that it was pleasing to see the data, but asked if there was a risk of complacency because the Collaborative had driven down incidents but it had been quoted in a number of places that all pressure ulcers were potentially preventable. He added if the ambition to drive down further than 25% had been lost. The DNS responded that the Collaborative would never get complacent and noted the data being captured was for all pressure damage across the Health Board. She added that the data could be considered for that as well and that it was important to recognise that the team should be looking at all pressure damage. It was noted that one of the complexities was that as the Health Board increased its regional service and was bringing more patients into the system, a much higher incidents of pressure damage was being reported and there was a risk for reporting multiple times if the referring Health Boards were also reporting those incidents. The DNS added that she would gladly take on the advice of the IMU as to how to report on the data in a different way. The Deputy Director of Nursing – PCIC (DDNP) added that in terms of the Community element of pressure damage a lot more could be done with patients, such as providing them with the right equipment. She added that all pressure damage was scrutinised and was supported by the District Nurses in exactly the same way as other areas. The same root cause analysis was undertaken, although the findings of such analyses did, on times, highlight themes that were outside of the Health Board’s control.	

	The UHB Chair asked whether length of stay in acute settings was factored in for any allowance to the exceptional circumstances and also if there was an ability to learn from others who may have made more progress with pressure damage. The DNS responded that patients who were waiting for periods of time before they could get into the Health Board with regards to ambulance waits was something that could be linked to incident reporting data once the data and business intelligence was completed. She added that the team would then be able to track patients who had waited for longer and that the next six months would give the Collaborative rich data that could be interrogated. It was noted that a pressure damage update report would be received by the Committee again in 6 months' time. The END noted that he could provide further assurance that the Collaborative would not get complacent and that they would continue to drive pressure damage down in the Health Board. He added that in relation to benchmarking, there was nowhere in Wales that had been perceived to have done better than the Health Board, but that data would be looked at for similar sized organisations in NHS England and reported back to the Collaborative. **The QSE Committee resolved that:** a) The contents of this report and the actions being taken forward to address areas for improvement were noted.	**JR**
QSE 23/04/010	**Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine & the Flynn Report** The Quality of Care Assurance in Commissioned Services in response to the Operation Jasmine & the Flynn Report was received. The DDNP advised the Board that Operation Jasmine was a major and wide-ranging investigation into the deaths of 63 individuals living in residential and nursing care homes in South East Wales and had been carried out by Gwent Police between 2005 and 2013. She added that a review of Operation Jasmine and the events associated with it was announced by the First Minister of Wales and that the review was led by Dr Margaret Flynn and involved consultation and workshops with key stakeholders across Wales, including involvement from the Health Board. It was noted that that since the recommendations from Operation Jasmine and the Flynn Report, much had changed in how Local Authorities, Health Boards and the regulators operated and dealt with monitoring and identifying care concerns with residential and domiciliary care providers. Social care legislation had also been introduced to address the issues. The DDNP advised the Committee of the partnership assurance mechanisms which had been put in place. Those included Key Performance Indicators (KPIs) which were monitored weekly and could provide an early indication of risks to patient safety in care homes and included: • Pressure Ulcers – Stage 3 and above pressure damage was reportable to Care Inspectorate Wales (CIW) by care homes under the revised RISCA guidance on notifications • Regulation 60 notifications of incidents (CIW) • Safeguarding referrals • Contract monitoring visits • Formal Advocacy services • CIW Inspection reports – non-compliance notices She added that the Health Board had commissioned, wholly or jointly with Local Authorities, from a range of independent sector care providers which included: • The Funded Nursing Care Contribution (FNC) to all individuals who were placed in nursing homes in the Cardiff and Vale geographical area • Entirely funded nursing and residential/supported housing placements for individuals assessed as eligible for Continuing NHS Health Care (CHC)	

	• Cardiff and Vale residents placed with residential providers under CHC outside of the Cardiff and Vale geographical area • Domiciliary Care Packages for individuals assessed as eligible for CHC or joint funding arrangements. It was noted that the majority of individuals placed and funded in the above areas were done so under the auspices of Primary, Community and Intermediate Care Clinical Board. The Committee was advised that there had been a joint contract and service specification for residential nursing care across the Health Board and both Local Authorities since 2005. However, this was out of date and did not reflect legislative changes and responsibilities. The DDNP added that partner agencies undertook a significant piece of work during 2019/20 to review and update that and a joint Regional Common Contract for residential care was agreed and implemented across all agencies in 2021. She added that the terms of the contract were clear and detailed with a focus on individuals' and services outcomes, and assessment and monitoring against fundamental health and social care standards, and that such requirements had been built into the new contracts from the Flynn report. The END advised the Committee that the reports had been received by the UHB Chair via Welsh Government (WG) and the Health Board had responded on the UHB Chair's behalf to WG and that WG had the assurance from the Health Board's response. The IMU asked if the Health Board knew, as a result of post the COVID situation, what percentage of delayed transfers of care was due to patients with pressure damage. The DDNP responded that she was sure that the information was available if it was contributing to someone's delayed discharge, but noted that pressure damage was not usually a 'contributory factor' because both District Nurses in the community and in Nursing homes had the ability to manage all but the very most complex of discharges the Health Board undertook. **The QSE Committee resolved that:** a) The recommendations of the Flynn Report and the current UHB and partnership arrangements in place to support quality assurance of care for commissioned placements in residential care homes in Cardiff and Vale were noted.	
QSE 23/04/011	**Board Assurance Report – Patient Safety** The Board Assurance Report – Patient Safety was received. The Interim Director of Corporate Governance (IDCG) advised the Committee that he would take the paper as read and noted that it was the version that had been received by the Board the week prior to the Committee meeting. He added that the Committee received to consider those risks that were allocated to the Committee and provide ongoing assurance to the Board. The UHB Chair highlighted that the Committee was being asked to look at 7 areas of risk on the report and noted that seven areas of risk seemed to be disproportionate to the time the Committee had available to consider them in any depth. He asked if the Chair would prefer to rotate those risks so that the Committee would look at a couple of the risks at each Committee meeting and then move on next time to another couple of risks considering the Committee was now meeting monthly. The Chair agreed with that approach. **The QSE Committee resolved that:** a) The risks in relation to Patient Safety, Quality and Experience were reviewed and the Committee would provide further assurance to the Board when the Board Assurance Framework was reviewed in its entirety, were noted.	

QSE 23/04/012	**National Collaborative Commissioning Unit Quality Assurance and Improvement Service Annual Position Statement 2021-2022** The National Collaborative Commissioning Unit Quality Assurance and Improvement Service Annual Position Statement 2021-2022 was received. The Assistant Director of Patient Experience (ADPE) advised the Committee that the report came to the Committee for assurance from the National Collaborative Commissioning Unit. She added that the report provided the Committee with an overview of the three National Collaborative Frameworks which were overseen by the National Collaborative Commissioning Unit and included: • National Collaborative Framework Adult Mental Health and Adult Learning Disability Hospital Services ('Adult Hospital Framework') • National Collaborative Framework for Child Adolescent Mental Health Service (CAMHS) Low Secure & Acute Non-NHS Wales Hospital Services ('CAMHS Hospital Framework'). • National Collaborative Framework for Adults (18+ years) in Mental Health and Learning Disabilities care homes & care homes with nursing for NHS and Local Authorities in Wales ('Care Home Framework') It was noted that the report was received nationally and so there was very little Cardiff and Vale data to reflect upon, but the ADPE advised the Committee that the Health Board specific data from the report was as follows: • Medium secure hospitals • Low secure hospitals • Controlled egress hospitals • Uncontrolled egress hospitals The CC noted that it would have been good to see the outcomes in the report and asked for those to be discussed when future iterations of the report came to the Committee. **The QSE Committee resolved that:** a) The activity for the three National Collaborative Frameworks throughout 2021/22 was noted.	
QSE 23/04/013	**Minutes from Clinical Board QSE Sub Committees:** The Minutes from Clinical Board QSE Sub Committees were received. **The Committee resolved that:** a) The Minutes from the Clinical Board QSE Sub-Committees were noted.	
QSE 23/04/014	**Committee Self-Effectiveness Survey** The Committee Self-Effectiveness Survey was received. The IDCG advised the Committee that 8 survey responses had been received in regards to the Committee and that the one area to highlight was regarding questions 8 and 9 which related to Committee meeting packages and the organisation and time afforded to Committee business. He added that work was being undertaken to improve those areas highlighted, including the move to a monthly meeting. **The Committee resolved that:** a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Quality, Safety and Experience Committee were noted.	
QSE 23/04/015	**Items to bring to the attention of the Board / Committee:** No items were raised.	

QSE 23/04/016	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) Relocation of Pentyrch Surgery*	
QSE 23/04/017	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 6th June 2023 at 2pm via MS Teams.	

Confirmed Minutes of the Health & Safety Committee
Held On 17th January 2023 at 09:00 am
Via MS Teams

Chair:		
Mike Jones	MJ	Independent Member – Trade Union / Committee Chair
Present:		
Michael Imperato	MI	Independent Member – Legal
Akmal Hanuk	AH	Independent Member – Local Community
In attendance:		
Janice Aspinall	JA	Safety Representative RCN
Rachel Gidman	RG	Executive Director of People & Culture
Fiona Kinghorn	FK	Executive Director of Public Health
Robert Warren	RW	Head of Health and Safety
Jonathan Strachan-Taylor	JS	Safety Representative GMB
Rachel Sykes	RS	Assistant Head of Health & Safety
Nigel Fryer	NF	Barrister
Nicola Foreman	NF	Director of Corporate Governance
Geoff Walsh	GW	Director of Capital Estates and Facilities
Catherine Phillips	CP	Executive Director of Finance
Observers:		
Sarah Gray	SG	Health & Safety Representative
Marcia Donovan	MD	Head of Corporate Governance
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Ceri Phillips	CP	UHB Vice Chair
Rachael Daniel	RD	Assistant Head of Health and Safety

Item No	Agenda Item	Action
HS 17/01/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
HS 17/01/002	**Apologies for Absence** Apologies for absence were noted.	
HS 17/01/003	**Declarations of Interest** No Declarations of Interest were noted.	
HS 17/01/004	**Minutes of the Meeting Held on 18 October 2022**	

	The Minutes of the Committee Meeting held on 18 October 2022 were received. **The Health & Safety Committee resolved that:** a) The minutes of the meeting held on 18 October 2022 were approved as a true and accurate record.	
HS 17/01/005	**Action Log – Following Meeting Held on 18 October 2022** The Action Log was received. **The Health & Safety Committee resolved that:** a) The Action Log was noted.	
HS 17/01006	**Chair's Action taken since last meeting** No Chair's Actions were noted.	
	Items for Review and Assurance	
HS 17/01007	**Corporate Manslaughter Update** The Barrister presented the Corporate Manslaughter Update and highlighted the following: • The following laws might apply:- - The Health and Safety Act 1974. - Corporate Manslaughter as set out in Section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007 • Health and Safety legislation had a reverse burden. That meant the onus was on the organisation to prove that their working practices were reasonable and practical in the circumstances of the case. • In Corporate Manslaughter the burden fell to the Prosecution to prove the criminal standard. • The offence of Corporate Manslaughter was set out in Section 1 of the *Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA): -* "*An organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised that;*	

	(a) causes a person's death, and *(b) amounts to a gross breach of a relevant duty of care owed by the organisation to the deceased".* "*An organisation is guilty of an offence under this section only if the way in which its activities are managed or organised by its senior management is a substantial element in the breach*". • The Act only applied to 'organisations' as defined by the Act, but the definition was broad and included public bodies. Crown Immunity was expressly removed in Section 11. • The 'harm resulting in death' would typically be the physical injury that proved to be fatal. • For the offence to apply, the organisation concerned must have owed a 'relevant duty of care' to the deceased. The Act did not create or define duties of care, rather it simply listed certain existing duties of care which were now to be regarded as "relevant". • In order to be prosecuted for manslaughter there needed to be a gross failure in the management of the organisation. The Independent Member – Legal (IML) queried what measures should the organisation take to reduce its risk. The Barrister replied that the organisation should have a good health and safety culture system in place. That should be reviewed on a regular basis. For Corporate Manslaughter to apply there would need to be a total failure from senior management. The Barrister added that the organisation would need to identify risks, produce appropriate policies and communicate those policies to staff via training. The organisation would also need to make sure the training was reviewed on a regular basis. The Independent Member for Local Community (IMLC) queried where the responsibility lay with the Health and Safety Committee. The Barrister responded that each department would need to look at its risks. It was the Committee's	

	responsibility, on behalf of the Board, to make sure that the organisation's working practices were reasonable and practical in the circumstances. a) The Corporate Manslaughter Update was noted.	
HS 17/01/008	**Health & Safety Overview (Verbal)** The Head of Health & Safety (HHS) presented the Health and Safety (H&S) Overview and highlighted the following: <u>Lone worker</u> • A new contract had been signed. • Peoplesafe had reneged the contract. There were ongoing discussions with them via Procurement. • He added that there were ongoing arrangements in place and hence the issue did not currently raise a risk. <u>Staff update</u> • Two new Fire Safety Advisors were now in post. • A new trainer was starting that month. • An Assistant Health and Safety Advisor for manual handling was also starting that month. • There were a few vacant positions that needed to be filled. <u>UHB classroom training compliance</u> • There had been positive increases in the classroom training compliance rates. <u>Health and Safety Culture Plan Update</u> • The HHS would bring, to the next meeting, a tracking document to allow the Committee to understand what actions had been completed. <u>Serious incident review</u> • There had been an incident in December 2022. • A waste yard operative had sustained head and shoulder injuries from a 770-litre bin that had fallen from a stericycle lorry whilst being offloaded. The operative had fallen to his knees and collapsed unconscious. • It was reported under RIDDOR.	RW

	• Improvements had been made to delivery lorries and procedures. • The Health Board had implemented an exclusion zone around delivery activities. • The staff member was now back in work. The CC queried whether staff on the yard needed to wear personal protective equipment. The HHS responded that was something he would need to look at with the Waste team. The Executive Director of Finance (EDF) stated that the exclusion zone sounded like a good idea to reduce footfall. She queried what activities were going on in that yard. The Health Board needed to protect staff and put appropriate processes in place to significantly reduce the risk. She added that a more pro-active piece of work about the activities going on in that yard should be undertaken. For example, a Standard Operating Procedure could be drawn up setting out what was reasonable behaviour and what was not. The Director of Capital Estates and Facilities (DCEF) stated that the injured employee was trying to help. Due to the pressures on the yard and the size of it, the yard was becoming overcrowded with bins. **The Health & Safety Committee resolved that:** a) The Health and Safety Overview was noted.	GW
HS 17/01/009	**Fire Safety Update** The Committee were advised on the following: • The Health and Safety team had struggled to attract a pool of credible candidates for the Senior Fire Safety Advisor position. • The HHS had re-evaluated the position and it would now become the Assistant Head of Fire Safety Management at a higher band. • The new role would assume responsibilities for Fire that currently sat with the HHS. • Two new Fire Safety Advisors had started yesterday. • A Fire Safety Advisor had retired after his part-time three-month contract had ended in January.	

	• The HHS had secured the services of a previously retired Senior Fire Safety Advisor for 2 days a week for 3 months. <u>Unwanted fire signals</u> • There had been a total of 308 unwanted fire signals, of which 246 had been attended by South Wales Fire Rescue Service (SWFRS). • Some of those events were avoidable and were attributed to staff behaviours. The Executive Director of Public Health (EDPH) queried what behaviours existed around those incidents and was there a common set of themes. The HHS responded that kettles and toasters in offices had set off the fire alarms. The Independent Member – Legal (IML) queried how the Health and Safety team could raise better awareness with staff and whether people would pay attention to that. The HHS responded that communication was key. Policies had been placed on ESR for focused groups. The EDPC stated that kitchens had been upgraded. The Health and Safety Culture Plan needed to reinforce accountability of staff. **The Health & Safety Committee resolved that:** a) The on-going efforts to meet the requirements of enforcement action and C&V UHB's statutory and mandatory fire safety obligations were considered.	
HS 17/01/010	**Enforcement Agencies Report** The HHS presented the Enforcement Agencies Report and highlighted the following: <u>T2 Animal Laboratories</u> • There was a request from the Health and Safety Executive (HSE) to take a voluntary statement from the Head of Estates and Facilities in a meeting on 5th January 2023.	

	• It was not deemed appropriate during the meeting as the inspector was still gathering information. • A request was given to afford time to respond to the questions agreed. • The HHS signed a voluntary statement for information previously sent in February 2022. • The next meeting was planned for February 2023. The DCEF advised the Committee that the funding for the Capital programme would be reduced next year. The EDC asked where the Health Board was on fire dampeners and what risks were being held from a fire safety point of view. That could also be shared with the Fire Service. The DCEF responded that he would bring back a list of the wards that had been completed so far. **The Health & Safety Committee resolved that:** a) The contents of the report were noted.	GW
HS 17/01/011	**Waste Management Compliance Report** The DCEF presented the Waste Management Compliance Report and highlighted the following: • The current Health Board wide Waste Department continued to process higher volumes of waste than would normally be expected, with the continued disposal of additional Personal Protective Equipment (PPE) and the impact of the Healthcare Environment Standards (HES). • The move to de-clutter areas to ensure wards and clinical areas could be cleaned more effectively to comply with the HES was resulting in a significant increase in larger items of equipment for disposal. • Chairs, tables, office furniture and racking which were no longer required or damaged and considered an Infection Control risk, were being scrapped, adding to the overall waste increase. The EDPH advised that should be added to the decarbonisation agenda. **The Health & Safety Committee resolved that:**	

	a) The content of the report recognising the increased waste being managed and the increased costs associated with the increased demand and fuel costs, was noted. b) The proposal for discussions with the Clinical Board Directors of Nursing to ensure that waste was separated appropriately at Ward/department level and that the correct procedures for waste disposal was adhered to when disposing of waste within areas, and that Staff should also be advised of the cost implications of non-compliance, was supported. c) The appointment of 'Green Champions' from the Clinical Boards/Directorates to raise the awareness of waste and its impact on the environment, with aim of reducing waste, increasing re-cycling and ensuring safe and appropriate disposal, was supported. d) The RIDDOR reportable incident and the ongoing investigation by the Corporate H&S team was noted.	
HS 17/01/012	**Ventilation Annual Report 2022** The DCEF presented the Ventilation Annual Report 2022 and highlighted the following: • An audit was completed in May 2022, the outcome of which was 4 recommendations for consideration/action. • Capital Estates and Facilities (CEF) had produced an action plan which indicated the management response/action and current status. • CEF had also re-established the Ventilation Safety Group to oversee all aspects of ventilation across the Health Board estate. • In addition to Clinical Board representation, Infection, Prevention and Control (IP&C) was a key member to the group. IP&C worked closely with Estates and Capital colleagues to manage ventilation systems. **The Health & Safety Committee resolved that:** a) The content of the report and the progress made in response of the recommendations was noted. b) The re-establishment of the Ventilation Safety Group was noted.	

	c) Critical air plant as identified in the WHTM have annual independent verification checks undertaken to ensure compliance was noted.	
HS 17/01/013	**Medical Gas Pipeline Systems (MGPS) AE Report 2021** The DCEF presented the Medical Gas Pipeline Systems Report 2021 and highlighted the following: • The independent Authorising Engineer (AE) had undertaken an annual audit of the Medical Gas Pipeline Systems across the Health Board in 2021. • 13 recommendations were identified. • Capital, Estates & Facilities Service Board had developed an action plan (Appendix 1) which provided the management response/actions, together with the current progress against each recommendation. • CEF had experienced difficulty in recruiting trade staff over recent years which had impacted upon his department's ability to train suitably competent AP's. • The Health Board had also benefited from the appointment of a senior member of the Estates team to the role of coordinating AP. • The Pharmacy department had a key role in the management of the medical gas services including oversight of medical gas procurement and the testing of new or altered pipework systems. • The Health Board had re-established its Medical Gas Committee to oversee all aspect of the installation and purchase of medical gas across organisation. **The Health & Safety Committee resolved that:** a) The content of the report and the progress made against each of the recommendations resulting from the audit was noted. b) The re-establishment of the Medical Gas Committee to oversee the safe management of the Medical Gas systems, was noted.	

HS 17/01/014	**Triennial Inspection Annual Report – low Voltage Installation 2022** The DCEF presented the Triennial Inspection Annual Report and highlighted the following: • Following the annual audit undertaken by the AE in February 2022, there were 5 recommendations for areas of improvement. • CEF had reviewed the findings of the report and produced an action plan (appendix 1), which identified the management response and current status of the recommendations. • To review progress with the recommendations and to ensure that risks were appropriately monitored, an Electrical safety group had been established which would report to the CEF Health & Safety Group. • As part of the process to ensure that the Electrical infrastructure across the sites operated effectively in the event of a mains failure, the Health Board was in the process of planning a 'Black Start' at University Hospital Wales (UHW) in June 2022. • That exercise had not been undertaken on the UHW site for many years and, to comply with the HTM, it should be undertaken annually. • A project team, chaired by the DCEF had been established with a number of sub groups leading in specific areas to ensure that risk on the actual day of the test was minimised. • The project team had presented the proposals to the Operational Planning Group with further meetings planned **The Health & Safety Committee resolved that:** a) The content of the report and the progress made in addressing the recommendations of the audit were noted. b) The establishment of an UHB electrical safety group was noted. c) The risk associated with the age and obsolescence of the infrastructure was noted.	
	Items for Approval/Ratification	
HS 17/01/015	**Policies for ratification: -**	

	i. Sharps Management Policy and Procedure (UHB 269) **The Health & Safety Committee resolved that:** a) The Sharps Management Policy and Procedure (UHB 269) were approved.	
HS 17/01/016	**Committee Annual Work Plan 2023/24 and Terms of Reference** The Director of Corporate Governance (DCG) advised that, subject to Board approval, the Health and Safety Committee would become a Sub Committee of the new People and Culture Committee from the new financial year. The EDPH commented that it should be made clear why the Health and Safety Committee was going to become a Sub Committee as it might seem that it had been demoted. The DCG responded that the main reason was to keep all the "people" issues together. It was also proposed that (i) the EDPC would lead both Committees and (ii) the IMs appointed to the Health and Safety Committee would also remain on the new People and Culture Committee. The EDPC advised that as the People and Culture Committee matured, it would be good to see how it would affect Quality and Safety and to add that in. **The Health & Safety Committee resolved that:** a) The changes to the Terms of Reference 2023-24 and associated Health and Safety Sub Committee Work Plan 2023-24 for the Health and Safety Sub Committee, were ratified. b) The Health and Safety Committee would become a Sub Committee of the Board reporting into the People and Culture Committee, was recommended to the Board for approval.	
HS 17/01/017	**Health and Safety Committee Annual Report** The DCG presented the Health and Safety Committee Annual Report and stated that it was in draft.	

	The final version would be taken to Board and would need to include discussions and attendance from the meeting held that day. It would then feed into the Annual Report. **The Health & Safety Committee resolved that:** a) The draft Annual Report 2022/23 of the Health and Safety Committee was approved. b) The Annual Report was recommended to the Board for approval.	
	Items for Noting and Information	
HS 17/01/018	**Sub Committee Minutes:** **The Health & Safety Committee resolved that:** a) The Operational Health and Safety Group – 06/09/22 minutes were noted.	
HS 17/01/019	**Fire Prosecution Update (Verbal)** • The HHS advised the Committee that the Health Board was in court last week. The HHS, EDPC and CEO had attended. • The Health Board had entered a “not guilty” plea on 4 accounts. • The trial date was set for the 9th of October 2023. It was a 2-week trial. • The next step was for the prosecution to provide full disclosure by 24th February 2023. • The legal team would look at that and say what the next steps were. **The Health & Safety Committee resolved that:** a) The Fire Prosecution Update was noted.	
HS 17/01/020	**Any Oher Business** The CC thanked the DCG for all her support on behalf of the Committee and wished her all the best in her new role. **The Health & Safety Committee resolved that:** a) Any Other Business was noted.	

HS 17/01/021	**Items to bring to the attention of the Board/Committee** It was noted that the fire prosecution update would be discussed at the upcoming Board Development session. Both the Barrister and Solicitor in the case had been invited. **The Health & Safety Committee resolved that:** a) Items to bring to the attention of the Board/Committee were discussed and noted.	
	Review of the meeting	
	Date and time of next meeting 18th April 2023 at 09:00am MS Teams	

MINUTES OF CARDIFF AND VALE STAKEHOLDER REFERENCE GROUP MEETING HELD ON TUESDAY 24 JANUARY 2023 CONDUCTED VIA MICROSOFT TEAMS

Present:

Sam Austin	Llamau (Chair)
Rhys Burton	South Wales Police
Janice Charles	Vale of Glamorgan Local Authority
Richard Cox	One Voice Wales
Shayne Hembrow	Wales and West Housing Association
Duncan Innes	Cardiff Third Sector Council
Paula Martyn	Independent Care Sector
Siva Sivapalan	Third Sector, Older Persons
Lauren Spillane	Care Collective
Chris Willis	WAST

In Attendance:

Marie Davies	Deputy Director of Strategy & Planning, UHB
	Programme Support Officer, UHB
Abigail Harris	Director of Strategy & Planning, UHB
Angela Hughes	Assistant Director of Patient Experience, UHB
James Quance	Interim Director of Corporate Governance
Suzanne Rankin	Chief Executive, UHB
Calum Shaw	Sustainability Improvement Manager, UHB
Caitlin Thomas	NHS Wales Graduate Trainee

Apologies:

Frank Beamish	Volunteer
Jason Evans	South Wales Fire and Rescue
Zoe King	Diverse Cymru
Lani Tucker	Glamorgan Voluntary Services

SRG 23/01 WELCOME AND INTRODUCTIONS

The Chair wished members of the Group happy New Year and welcomed Richard Cox and Chris Willis to the Group.

The Chair explained that Nikki Foreman would be leaving the UHB at the end of the month and wished to formally record her thanks for Nikki Foreman's huge contribution to SRG meetings. James Quance the Interim Director of Corporate Governance was then introduced and welcomed to the Group

SRG 23/02 APOLOGIES FOR ABSENCE

Although not members of the SRG apologies had been received from the Community Health Council.

SRG 23/03 DECLARATIONS OF INTEREST

There were no declarations of interest.

SRG 23/04 REFLECTIONS OF THE UHB'S CHIEF EXECUTIVE

The Chair welcomed back Suzanne Rankin.

Suzanne Rankin explained that her initial positive impressions of the UHB had been proved correct and indeed they had deepened. She now had a much greater understanding of the very complex underlying challenges and now felt far more emotionally connected to the Health Board and its population.

Suzanne Rankin then briefly outlined what she perceived to be the UHB's strengths, weaknesses, opportunities and threats

Strengths

- Its people are indisputably the Health Board's biggest strength. They are warm, compassionate, capable, resilient, ambitious yet humble.

Weaknesses

- The appalling state of much of its infrastructure. Many of its estate facilities are no longer fit for purpose and there is a large maintenance backlog. The digital infrastructure is extremely poor which means that the UHB's data is not comparable to that of English teaching hospitals.

Opportunities

- The desire of staff to learn.
- The population it services including the capital city
- Good communications links
- Partnerships with Local Authorities, the third sector, higher education institutions, social enterprise etc.
- Cardiff Edge at Coryton, which provides facilities to support Life Sciences and will be the new home for Genomics Partnership Wales.

Threats

- High staff sickness and turnover rates due to the unrelenting pressures facing the NHS.

- The pressures created by the worst flu season for many years, the ongoing prevalence of COVID and Strep A. One example of the additional pressures being faced is that on a normal day the Paediatric Emergency Unit at UHW would expect to see 50-60 patients per day but at the height of Strep A this figure was in excess of 200.
- The industrial action being taken by different sectors of the NHS. The UHB understands that the cost of living crisis is affecting its staff and has done as much as possible to support them.
- The difficult financial environment. At the beginning of the year the UHB had a balanced budget but it was now predicting a circa £27m deficit by the end of the financial year. Nevertheless, it is one of the better performing Health Boards in Wales.
- The deepening of health inequalities and outcomes.

Suzanne Rankin explained that the UHB will focus on delivering best value healthcare and there will be an emphasis on strategic interventions to prevent people requiring healthcare e.g. public health initiatives. There have been a number of significant recent improvements in the care that the UHB delivers. Ambulance handover times have improved greatly with many patients being handed over within an hour. Cancer performance has improved and post-COVID planned care recovery is well underway with no planned admissions being cancelled over the Christmas/New Year period. The UHB's Mental Health Service is doing some extraordinary outreach work and signposting citizens to other potential services e.g. those provided by the third sector

Chris Willis thanked the UHB for the work it had undertaken which had resulted in the improvement to ambulance handover times. The industrial action is extremely difficult to plan for and manage. It was worth noting that the volume of ambulance calls dropped dramatically during the days on which there was industrial action.

The SRG enquired whether there were lessons to be learned from the industrial action and whether there was anything that the UHB could do to prevent further action. Suzanne Rankin explained that the UHB recognises the right of staff to strike. It was always possible to learn lessons but the UHB is unable to influence pay scales and the cost of the pay demands are unaffordable to Welsh Government.

The SRG thanked Suzanne Rankin for attending. It was agreed that Suzanne Rankin would return to the SRG later in the year.

SRG 23/05 MINUTES AND MATTERS ARISING FROM STAKEHOLDER REFERENCE GROUP MEETING HELD ON 29 NOVEMBER 2023

The SRG **RECEIVED** and **APPROVED** the minutes of the SRG meeting held on 29 November 2022.

SRG 23/06 FEEDBACK FROM BOARD

It was noted that the UHB Board had not met since the SRG's previous meeting.

SRG 23/07 DECARBONISATION PLAN

The SRG received a presentation from Calum Shaw on the development of the UHB's Decarbonisation Plan which will be published in March 2023.

The context in which the Decarbonisation Plan would be developed was explained. Welsh Government has set a target of a net zero carbon Wales by 2050 and a net zero carbon public sector by 2030. The UHB through the NHS Wales Shared Services Partnership Decarbonisation Strategic Delivery Plan, also has emission reduction targets of 16% by 2025 and 34% by 2030. The UHB's 2021/22 emissions profile was outlined and the challenges faced by the UHB if it was to meet this target were explained. Although calculation of supply chain emissions is immature, it is estimated that 81% of the UHB's emissions can be attributed to its supply chain which has a single use business model. It is worth noting that even a 50% reduction in electricity use would save just 2% of carbon emissions. A lot of different initiatives undertaken by many people will therefore be required to make significant progress with reducing carbon emissions.

The SRG was then asked some specific questions

- Do you have any advice or suggestions around the Decarbonisation Plan process?
- Do you have any comments/thoughts on the approach?
- Has anyone had any experience of decarbonisation behaviour change with their organisation? What worked well/not so well?
- Any other comments?

Abigail Harris explained that the UHB was not developing its Decarbonisation Plan in isolation as both Cardiff and Vale of Glamorgan Public Services Boards have carbon reduction in their respective draft Wellbeing Plans. The UHB Strategy and Delivery Committee had discussed how decarbonisation could be embedded in the organisation and there was extremely good clinical

leadership with one of the UHB's Associate Medical Directors championing decarbonisation.

The SRG then made a number of observations and suggestions.

- It will not be possible to achieve the desired reduction in emissions unless individuals relate to decarbonisation in their everyday lives
- Can pharmaceutical regulations be revisited to reduce waste? Abigail Harris agreed that pharmaceutical waste needed to be addressed and informed the SRG that the UHB had its own pharmaceutical production unit that produced generic drugs.
- Drugs should only be prescribed if they will benefit patients rather than patients obtaining automatic repeat prescriptions.
- Further work needs to be undertaken on the way staff and patients travel to the UHB's sites and more sustainable means of transport must be encouraged. Calum Shaw agreed and confirmed that the Action Plan would address how the UHB can improve public transport links and encourage active travel.

SRG 23/08 STRATEGY REFRESH

Marie Davies thanked the SRG for the role it had played in the development of the Strategy Refresh Engagement pack before talking the Group through the pack.

The Strategy refresh timeline will be as follows:
January to mid-March – The UHB will undertake the initial staff and key stakeholder engagement.
March to April – The feedback from engagement will be reviewed and a draft Strategy will be produced.
May to June – Formal engagement on the refreshed strategy
Autumn 2023 – Launch of refreshed strategy which will be a very high level document of 5-10 pages in length. It was worth noting that the UHB Chair is keen for the launch to be brought forward to late summer if possible.

Marie Davies informed the SRG that Duncan Innes and his colleagues in Cardiff Third Sector Council would help with rolling-out the engagement to the third sector networks and harder to reach groups. The Community Health Council would also run a number of public engagement sessions. Members of the SRG were encouraged to complete the online survey themselves and were asked to take the engagement pack out to their own organisations and networks. The engagement pack could be downloaded from the Shaping Our Future Wellbeing website, where there was also a link to the online survey. A link to the website would be sent to members.

Action: All

SRG 23/09 ANY OTHER BUSINESS

Future Provision of Cochlear Implant and Bone Conduction Hearing Implant Device Services for Children and Adults in South East Wales, South West Wales, South Powys

Marie Davies informed the SRG that Welsh Health Specialised Services Committee had launched engagement on the Future Provision of Cochlear Implant and Bone Conduction Hearing Implant Device Services for Children and Adults in South East Wales, South West Wales, South Powys and encouraged the SRG to participate in the engagement a link to which would be issued with the notes of the meeting

Action: All

SRG 23/10 NEXT MEETING OF SRG

9.30am -12pm, Thursday 23 March 2023.

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 14 MARCH 2023 AT 09:30HOURS VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner (CASC) (in part)
Nicola Prygodzicz	Chief Executive, Aneurin Bevan ABUHB
Suzanne Rankin	Chief Executive, Cardiff and Vale CVUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
Carol Shillabeer	Chief Executive, Powys PTHB
Associate Members:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)

In Attendance:	
Nick Wood	Deputy CEO NHS Wales, Welsh Government
David Coyle	Integrated Community Health Director, Betsi Cadwaladr BCUHB
Deb Lewis	(in part) Interim Chief Operating Officer, Swansea Bay SBUHB
Kerry Broadhead	Assistant Director of Strategy, Swansea Bay SBUHB
Shaun Ayres	Deputy Director of Operational Planning and Commissioning Hywel Dda UHB
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Stuart Davies	Director of Finance EASC
Matthew Edwards	Head of Commissioning & Performance EASC Team, National Collaborative Commissioning Unit (NCCU)
Lee Leyshon	Communications and Engagement Lead Interim for EASC
Sian Ashford	Head of EASC Team
Phill Taylor	Head of Commissioning & Performance EASC Team, National Collaborative Commissioning Unit (NCCU)
Gwenan Roberts	Committee Secretary

In Attendance:	
Ricky Thomas	Head of Informatics EASC
Colette Rees	Head of Planning and Programme Design and Delivery National Collaborative Commissioning Unit

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 23/021	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual 'Teams Live' meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee and gave an overview of the arrangements for the meeting. Sian Harrop-Griffiths was thanked for her regular attendance and contributions over the last few years and all wished her a happy retirement.	Chair
EASC 23/022	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Steve Moore, Andrew Carruthers, Mark Hackett, Sian Harrop-Griffiths, Gill Harris, Nick Lyons and Ross Whitehead	Chair
EASC 23/023	**DECLARATIONS OF INTERESTS** There were none. Members were reminded that the annual request to complete the forms would be sent out shortly and the Chair asked that they be completed and returned as soon as possible.	Chair
EASC 23/024	**MINUTES OF THE MEETING HELD ON 6 DECEMBER 2022** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 17 January 2023. Members **RESOLVED** to: • **APPROVE** the minutes of the meeting held 17 January 2023.	Chair
EASC 23/025	**ACTION LOG** Members **RECEIVED** the action log and **NOTED**: **EASC 23/012** • **Manchester Inquiry Recommendations** Jason Killens explained that work had commenced to respond to the comprehensive report and a report would be provided as the findings for implementation emerged via the EASC Management Group in the first instance. Saunders,Nathan 24/05/2023 15:05:05	Chair Added to EASCMG forward look

	EASC 22/123 • **Additionality diagram** Linked to the additional staff recruited and information presented at the November meeting. A further update would be provided. **EASC 22/81** • **Roster Reviews** Members noted that the roster reviews had been completed and a table showing the breakdown of numbers and the investment level would be shared via the Committee Secretary. • **Changes to WAST working practices** Members noted that this was currently on hold in view of negotiations in relation to Industrial Action. **EASC 22/10** • **Key Reports and Updates** It was reported that these discussions were continuing with Digital Health and Care Wales (DHCW) which also linked with information in the Chief Ambulance Services Commissioner's report. **EASC 21/26** • **Committee Effectiveness** It was noted that this work as ongoing and arrangements would be made to meet with the Citizen Voice Body - Llais. Members **RESOLVED** to: **NOTE** the Action Log.	WAST WAST Chair
EASC 23/026	**MATTERS ARISING** There were no matters arising from the minutes.	Chair
EASC 23/027	**CHAIR'S REPORT** The Chair's report including the Chair's Objectives was received. Members noted the ongoing National Commissioning Review by Welsh Government (a review of the functions) and Members would have an opportunity to meet with Steve Combe who was leading the work. A discussion took place in relation to the Vice Chair and it was suggested and agreed that Suzanne Rankin undertake the role for the next two years. Members **RESOLVED** to: • **NOTE** the information within the report • **NOTE** the Chair's objectives set by the Minister • **APPROVE** the appointment of Suzanne Rankin as Vice Chair of the Committee.	Chair

Part 2. ITEMS FOR DISCUSSION AND APPROVAL		ACTION
EASC 23/028	**PERFORMANCE REPORT** The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan. Noted that: • Core demand had reduced • There was a continued increase in hear and treat • There was an increase in 'units of hours produced' (UHP) • Red performance in January 2023 was 48.9% • Amber performance an improving position from December • Over 24,000 hours lost to handover delays in January • Work to change the presentation of performance information to assist health board teams to understand system performance which includes the weekly dashboard shared by the EASC Team • The new performance report was presented for the first time (and had been presented and supported for use at the recent EASC Management Group meeting) • Information on post production lost hours and the discussion whether this showed the impact of industrial action • There was a lack of consistency in the performance and the need for clarity in regard to the direction for the service • Although trends had been improving this had not impacted on the overall red performance • Information would be presented in a new way in the report to assist the correlation and impact of different factors on the performance of the service • There was a need to continue to utilise the work with WAST and health boards to work together to deliver the agreed plans to improve performance • Cardiff and Vale undertook learning in a systematic way to eliminate 4 hour delays and it was suggested that using the same methodology could be helpful to learn lessons across the system and improve performance • Variation was being monitored across the system with health boards trying to identify areas for improvement • The 111 Service could have an impact on local service utilisation and could be included • It was difficult at times of high system pressure to have the time to consider why and take learning opportunities • There was a positive impact of the roster review and the improvement in sickness absence rates • Is should be possible to articulate what a bad week looks like to deep dive to have a better understanding of the variation in performance either by a mechanism such as root cause analysis or reviewing patient pathways where people came to harm or very long delays	

	• There would be a need to articulate and agree a methodology for use across the system • Should be able to utilise the data linking information (and add key trigger points) and could be helpful to hold a short workshop (added to Action Log) and link to the Six Goals for Urgent and Emergency Care Programme to avoid cutting across work already in train. Members **RESOLVED** to: • **NOTE** the content of the report. • **NOTE** the Ambulance Services Indicators • **NOTE** the continued work on ambulance handover improvements • **APPROVE** the new Performance Report format for ongoing use • **NOTE** the content of the EASC Action Plan	CASC
EASC 23/029	**LOCAL INTEGRATED COMMISSIONING ACTION PLANS (ICAP) UPDATE** The Local Integrated Commissioning Actions Plan Update report was received. Noted that: • Progress had been made against the development of Integrated Commissioning Action Plans (ICAPs) aligned to the Emergency Ambulance Services Collaborative Commissioning Framework Agreement • The EASC Team had been worked collaboratively with health boards and WAST in the development of the ICAPs • Each health board had submitted ICAPs which had been reviewed by the EASC Team • Going forward meetings would be held with health boards and WAST to review performance data relating to ambulance handover delays and data aligned to the delivery of actions set out in the health board's ICAP, also to consider any operational or strategic matters arising. Performance data would be monitored via the weekly performance dashboard that would be circulated to all health boards and WAST • The actions and outputs of the ICAP process will provide direction and content for the development of each organisation's IMTPs and linking to the Six Goals work • Good relationships were being developed and working together providing new opportunities • Although some progress being made, there was a lot of work to do to address the variation and performance across the system • Going forward would be reported with the commissioning intentions	

	Members **RESOLVED** to: • **NOTE** the progress made via the ICAPs. • **NOTE** that future ICAP updates will be included within the EASC Commissioning Intentions update. • **NOTE** the risks highlighted and links with the Six Goals for Urgent and Emergency Care Programme.	
EASC 23/030	**QUALITY AND SAFETY REPORT** The Quality and Safety Report was received. In presenting the report, Sian Ashford highlighted key areas of progress. Noted that: • Report provided Members with an update on the quality and safety matters for commissioned services currently being supported by the EASC Team • Responding to the Healthcare Inspectorate Wales (Welsh Ambulance Services NHS Trust) Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover. Following feedback from HIW a further update was provided on a number of specific areas with HIW recently accepting the progress made to date. During 2023, the EASC Team would be required to develop a final output response for HIW on the recommendations. Input from Health Boards and WAST would be essential in the development of this response. A further workshop was planned to complete the response to the recommendations • Established and coordinated a task and finish group to review the Appendix B process, to make recommendations for improvement and to monitor the impact. Now embedded across the system important to share learning. Task and Finish Group Members have asked to continue the work and an update Terms of Reference was provided to Members with the request to approve • Work would also now be undertaken to include key quality and safety matters relating to Non-Emergency Patient Transport Services and the Emergency Medical Retrieval and Transfer Service within a new EASC Quality & Safety Report with the intention to develop the report to include more metrics and performance measures to sit alongside the existing Performance Report and to enhance the Committee's knowledge in terms of quality, outcomes and harm. • The EASC team would continue to work with WAST and HB colleagues to understand the level of harm within the system and to develop additional processes for the committee to assure itself that it is discharging its statutory responsibilities for the planning and securing of emergency ambulances Saunders,Nathan 24/05/2023 15:05:05	

	• Ongoing work to develop a dashboard linked to Datix and the Welsh Risk Pool involved and an update would be provided at a future meeting (Action Log) • It was important to receive quality and safety information at EASC as well as the performance data and it was suggested a thematic data driven report would be helpful across the system (to be included in new Quality and Safety Report) Members **RESOLVED** to: • **NOTE** the content of the report and the progress made by both Task and Finish Groups • **APPROVE** the Terms of Reference for the continuation of the Joint Investigation Group to create an opportunity to feedback and evaluate the new process • **NOTE** the impact of deteriorating performance and the resulting challenges in commissioning the provision of safe, effective and timely emergency ambulance services. • **NOTE** the potential impact of industrial action on patient harm within the system • **NOTE** the development of a new Quality and Safety report for future submission.	EASCT EASCT
EASC 23/031	**EASC INTEGRATED MEDIUM TERM PLAN (IMTP) 2023 to 2026** The EASC IMTP 2023 to 2026 was received. Stephen Harrhy provided an update on the progress to date and raise specific issues on key areas. Noted that: • The IMTP had been discussed at the recent EASC Management Group and various peer groups • Comments received have been included in the final draft presented • Page 15 provided the summary of the commitments in relation to performance improvement • There was consistency between the EASC IMTP and the WAST IMTP and there were no particular risks to draw attention to • The individual health board ICAP information was also reflected and there was no different between the assumptions in the EASC IMTP than in health boards in relation to delivery • It would be key to deliver the performance improvement outcomes • The finance appendix had been discussed by the Directors of Finance peer group and had been included in health board plans	

	• There was a gap at present and there were difficult choices to be made in relation to the additional 100 wte staff recruited and the assumption that the support for this would be provided from a central source. Ongoing discussions were taking place with Welsh Government officials. • Assumptions had been made that hear and treat services would improve and how these may link to alternative pathways in health boards in line with ICAPs • Alignment between EASC IMTP assumptions and the assumptions of the 111 service (working with Richard Bowen) including the contribution to WAST overhead costs • Cost reduction expectation for WAST would be in line with health board assumptions in terms of this • There was a gap in the WAST finances which was identified and referred to the 100wte additional staff and the remaining gap would be expected to be met through efficiencies • The expectations on performance improvement (page 15) and the deliverability was discussed with the understanding that there were dependencies and would be contingent on each other • Including the reduction of conveyances would also be part of the ongoing work although it was not explicitly included on page 15, this was included in the Ambulance Service Indicators • Other areas could be included in relation to wider work within the system such as the emerging policy on further faster • IMTPs would need to be submitted to Welsh Government by end of March 2023 and agreed that Chair's action could take place for any further minor amendments and additions. Members **RESOLVED** to: • **NOTE** the update provided. • **APPROVE** Chair's action for minor amendments and additions prior to submission to Welsh Government.	
EASC 23/032	**UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW** The update report was received. Lee Leyshon presented the report and gave an overview of work to date Noted that: • Core bilingual engagement materials had been developed following work with health boards and the Community Health Councils across Wales • Websites in Welsh and English had been prepared • Substantial amounts of information had been provided to respond to misinformation particularly in social media	

	• Efforts made to ensure the process is undertaken correctly and diligently • Original timescales set aside to ensure robust and transparent process • External supplier sought to support analysis of questionnaire to complement the activities of the EASC Team • Augmenting information for meaningful dialogue • Underpinning by methodological approach in briefing, engaging and sharing • Working with venues across mid and north Wales for face to face activities and large meeting room opportunities • Building trust and confidence in the approach • Team receiving positive helpful responses • Carefully meeting the Gunning principles for engagement and the legal requirements for health boards Members thanked Lee and the team for the process to date and supported the approach being taken to build confidence and trust in the approach, working with health board engagement, communication and service change leads. The Chair explained that Chair's action had not been taken since the last meeting and as the meeting was arranged that the Joint Committee should take the decision to commence the formal engagement process for at least 8 weeks mindful that all engagement materials had now been prepared. Members **RESOLVED** to: • **NOTE** the dedicated engagement and communication expertise • **NOTE** that the EASC Team continued to work with health board engagement, communication and service change leads to commence the engagement process • **NOTE** the testing, development and publishing of content and engagement materials in preparation for the engagement process • **NOTE** the activities and pre-engagement work undertaken since the previous meeting including the engagement timetable of sessions currently being arranged • **NOTE** the pending proposal for external supplier support to undertake data collation, analysis and reporting to include a representative sample • **APPROVE** the commencement of the formal engagement process, straight away following the EASC meeting on 14 March 2023 (Action Log).	CASC
EASC 23/033	**WELSH AMBULANCE SERVICES NHS TRUST REPORTS** The reports of the Welsh Ambulance Services NHS Trust (WAST) were received.	

These included:
- Provider Report
- WAST Integrated Medium Term Plan (Presentation)

WAST Provider Report
Members received the Provider Update.

Noted that:
- The update on the red performance target of 8,9 and 10mins
- Amber response now less than 60mins
- Sickness absence trend tracking in line with expectation
- Consistency of performance good in some areas but weak in others

Members raised:
- Opportunities to learn from last winter and need to think ahead for improvements in the last few months of the year
- Important to have preparedness and plans for next winter now
- Seasonal planning and the links to further and faster work already started.

WAST Integrated Medium Term Plan (Presentation)
The presentation gave an overview of the issues to be considered in line with discussions earlier in the meeting to include meeting performance targets, taking the learning and sharing from the local Integrated Commissioning Action Plan meetings; taking forward the WAST Board commitment to invert the triangle and meeting the requirements of the Commissioning Intentions and Quality and Delivery Framework.

Noted that:
- WAST giving greater emphasis to listening to the public and to staff in particular to their experiences of the service received and as work
- Maintaining their long-term strategy and keeping in mind
- Priorities identified including for the 111 Service and more to do
- a pilot for an amber category patient night sitting service was planned to oversee a specific group of patients using remote and on scene resources – this could include overnight reviews which would include working with St John Cymru
- plan to review Amber calls over the next year
- Same Day Emergency Care (SDEC) – WAST would be looking at referral criteria which would give a huge opportunity to work more closely with health boards in relation to access and improving performance in local areas
- Working with an independent consultancy to improve the way WAST operate and potentially more formal engagement processes

	• Plan to try small tests of change with flow centre work, use of advanced paramedic practitioners in the clinical control centres utilising information from the ICAP work for example for mental health patients, falls patients and those on a respiratory pathway • Ongoing work for the Non-Emergency Patient Transfer Service • Accountable Officer letter sent in relation to the financial gap if no recurrent funding forthcoming for the 100wte; a savings programme had been identified for £6m to reach balance • Specific risks had been identified and included in the plan Members asked about the plans for reducing conveyances and the expectations for the hear and treat service as well as the need to improve the service for those in the red category calls. The Cymru High Acuity Response Unit was also discussed with an expectation that the service would be available across Wales. Stephen Harrhy welcomed the information identified within the resource envelope and opportunities for choices to be made, this would provide strategic and local opportunities and would need to link with the ICAP commitments. Members suggested it might be helpful to further develop the ICAP process so all local areas are clear of their commitments and targets. ICAPs have health board actions, health board and WAST actions and WAST actions identified to ensure responsibility is clear within the system. This work also would link to the Six Goals for Urgent and Emergency Care Programme. The Chair summarised and agreed to provide a letter of support from EASC to WAST for inclusion in their IMTP submission to Welsh Government. Members **RESOLVED** to: • **NOTE** the update provided • **APPROVE** the provision of a letter in support of the IMTP.	
EASC 23/034	**CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT** The Chief Ambulance Services Commissioner's Update Report was received. Noted that: • The link at EASC to the Six Goals for Urgent and Emergency Care Programme (particularly Goal 4) and the specific priorities identified for the Joint Committee Saunders.Nathan 24/05/2023 15:05:05	

	• Funding for the **Night Sitting Service** had been provided by the Six Goal programme for 12 weeks to implement and evaluate the impact (Action Log) • Would be important to link to the work of the Regional Partnership Boards as a whole system issue • The **Transfer, Discharge and Repatriation** Service – specialist Adult Critical Care Transfer Service had been specifically requested to be expanded by Betsi Cadwaladr, Swansea Bay and Hywel Dda health boards although this had not yet been completed. • A letter had been received from the Deputy Chief Medical Officer, Dr Chris Jones requesting that The Chief Ambulance Services Commissioner specifically review the transfer, discharge and repatriation services. This work had just commenced and the product would need to be a clear defined and specific framework which addressed national and local needs. Members felt it would be helpful to discuss on a wider scale for all services (not just ACCTS) and agreed that the Managing Director of the Welsh Health Specialised Services Committee, Dr Sian Lewis should also be involved (Action Log). Members **RESOLVED** to: • **NOTE** the information within the report.	CASC CASC
EASC 23/035	**EASC COMMISSIONING UPDATE** The EASC Commissioning Update Report was received. This included: • Commissioning Framework • Integrated Medium Term Plan • Commissioning Intentions Noted that: • Progress had been made against the key elements of the collaborative commissioning approach Members **RESOLVED** to: • **NOTE** the collaborative commissioning approach • **NOTE** the progress made in terms of developing the EMS Commissioning Framework, including the development of the local Integrated Commissioning Action Plans and the agreed approach • **NOTE** the Quarter 3 update against the EASC Commissioning Intentions and the key priorities from the EASC IMTP 2022-25 • **NOTE** the Commissioning Intentions for 2023-24 included within the EASC IMTP.	

EASC 23/036	**EASC FINANCIAL PERFORMANCE REPORT MONTH 11 2022/23** The EASC Financial Performance Report at month 11 in 2022/23 was received. Stuart Davies presented the report and gave an overview of the current position. Noted that: • There was a current £400,000 underspend • Further ongoing work to finalise the year end position • A dispute had been ongoing in relation to £186,000 non recurrent funding not paid by one member of EASC; and due to the way EASC is funded the dispute had to be passed on to WAST and the NHS Finance Team at Welsh Government to resolve. Members were concerned about the dispute and confirmed their understanding that as a collaborative function this was not in line with the Standing Orders in the way decisions are made at EASC. The decision making process is clear at EASC, a decision making Committee where a 2/3 rule applies. This matter would be raised with Steve Combe undertaking the review of National Commissioning Functions. Members would be kept informed of the progress with this matter. Work was being undertaken in relation to WHSSC and EASC Standing Financial Instructions to finalise the information for wider circulation to health boards. Members **RESOLVED** to: • **NOTE** the current financial position, the forecast year-end position and the ongoing dispute.	
EASC 23/037	**EASC SUB-GROUPS CONFIRMED MINUTES** The confirmed minutes from the following EASC sub-groups were received: • EASC Management Group – 20 October 2022 • Non-Emergency Patient Transport Services (NEPTS) Delivery Assurance Group – 1 December 2022 Members **RESOLVED** to: • **APPROVE** the confirmed minutes.	
EASC 23/038	**EASC GOVERNANCE** The report on EASC Governance was received. Gwenan Roberts presented the report and highlighted key areas.	

	Noted that: • The Risk Register had been reviewed and updated by the EASC Team during January 2023. • Five red risks in total, three scoring the highest level at 25. Additional information had been included and related to the ongoing system pressures and the impact on patients and the increasing risk of harm. Further work on the Quality and Safety Report would allow Members to be better informed of the appropriateness of the current risk scores and Members agreed to maintain the status quo. • The EASC Assurance Framework has been updated in line with the changes above approved at the last meeting for the Risk Register • The EASC Standing Orders were presented for approval. No changes had been made (no material differences). Memorandum of Understanding and Hosting Agreement to be reviewed in March 2024. • A letter was received on 22 November 2022 from the Welsh Language Commissioner (WLC) which indicated that a member of the public had concerns regarding documentation on the EASC website and related to the EMRTS Service Development Proposal. The member of the public had visited the website on 11 November 2022 and had been unable to find a Welsh language version of the EMRTS Service Development Proposal on the website. This occurred due to annual leave of a member of the EASC Team with responsibility for the website. Further arrangements had been made to avoid this happening again. The EASC website had been reviewed to ensure compliance with the Welsh Language standards including ensuring that Welsh was not treated less favourably than English and also that the Welsh website is of the same standard as the English website in terms of content. • A further update would be provided as the investigation continued. • The key organisational contacts, Members were asked to ensure that they were content with their representatives for the sub groups. • The summary of the most recent host body Audit and Risk Committee summary was provided for assurance. Members **RESOLVED** to: • **APPROVE** the updated risk register • **APPROVE** the updated EASC Assurance Framework • **APPROVE** the EASC Standing Orders • **NOTE** the investigation by the Welsh Language Commissioner. • **NOTE** the information within the EASC Key Organisational Contacts • **NOTE** the Audit and Risk Committee summary	

EASC 23/039	**FORWARD LOOK AND ANNUAL BUSINESS PLAN** The Forward Look and Annual Business Plan was received. The Chair asked Members to forward any suggestions for future 'Focus on' sessions. Members **RESOLVED** to: **APPROVE**	
Part 3. OTHER MATTERS		**ACTION**
EASC 23/040	**ANY OTHER BUSINESS** There was no other business raised. The Chair closed the meeting by thanking Members for their contribution to the discussions.	
DATE AND TIME OF NEXT MEETING		
EASC 23/041	The next scheduled meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 16 May 2023 virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……
Christopher Turner (Chair)

Date ……

Saunders.Nathan 24/05/2023 15:05:05

Report Title:	Draft Annual Report			Agenda Item no.	8.1
Meeting:	Board	Public	x	Meeting Date:	25 May 2023
		Private			
Status *(please tick one only)*:	Assurance		Approval		Information x
Lead Executive:	Director of Corporate Governance				
Report Author (Title):	Head of Corporate Governance				

Main Report
Background and current situation:

Background

Board Members will be aware that the Health Board is required to publish, as a single document, a three part Annual Report and Accounts which includes:-

a. The **Performance Report** comprising of:

- An Overview
- A Performance and Delivery analysis.

b. The **Accountability Report** – to demonstrate how the Health Board has met key accountability requirements to the Welsh Government, and includes:

- The **Corporate Governance Report** – this explains the composition and organisation of the Health Board's governance structures and how they support the achievement of the Health Board's objectives.

- The **Remuneration and Staff Report** – this contains information about the renumeration of senior management, fair pay ratios, sickness absence rates etc.

- **The Senedd Cyrmu/Welsh Parliament Accountability and Audit Report** – this contains a range of disclosures relating to the regularity of expenditure, fees and charges, compliance with the cost allocation and charging requirements set out in HM Treasury guidance, material remote contingent liabilities, long term expenditure trends and the audit certificate and report.

c. The **Financial Statements** – this includes Audited Annual Accounts 2022-23.

For 2022-23: -

- There will be no requirement to prepare a separate Annual Quality Statement, or to prepare a separate Annual Putting Things Right report. Information on dealing with concerns should be contained in the Performance Report, unless a separate report has already been developed.

The structure adopted is the one described in the FReM. NHS bodies may omit headings or sections where they consider that these are not relevant, but all of the content outlined in the Manual for Accounts should be included.

The purpose of this report is to present the draft Performance Report, Accountability Report and Remuneration Report 2022-2023 for noting and discussion.

Current position

The draft Annual Report provides useful information to our public and staff, holds us accountable for what we do and both celebrates our achievements and acknowledges our challenges and what we intend to do about them. The draft Performance Report, Accountability Report and Remuneration Report 2022-2023 were last considered by the Audit Committee at its Workshop session on 11 May 2023. The updated document is presented at **Appendix 1** for information.

The timetable for developing the Annual Report in readiness for submission to Welsh Government as a single unified document by 31 July 2023 is outlined in Table 1 below. The Board is asked to note that at the time of writing this report, a date for the AGM has not yet been confirmed.

Table 1 – Proposed Timetable for Creating the Annual Report 2022-2023

Date	Task
28 April	Draft report to Management Executive
4 May	Internal Audit to receive draft Annual Governance Statement.
5 May	Draft Accounts to be submitted to HSSG Finance and Audit Wales
11 May	Audit Committee Workshop – endorse the draft Performance Report, Accountability Report and Remuneration Report
11 May	Circulate draft Annual Report to Board members for comment.
12 May	Draft Performance Report Overview, Accountability Report (including the Governance Statement), and the draft Renumeration Report to be submitted to HSSG Finance and Audit Wales
15 June	Comments back from Welsh Government to be incorporated for approval of the final draft Annual Report by Audit Committee.
15 June	Comments back from Board members to be incorporated in draft Annual Report.
15 June	Send the document to the Medical Illustration Team for graphic design work
25 July	**Special Audit Committee meeting** – recommend Board approval of the final Annual Report and Accounts
27 July	**Board meeting** – to approve the final Annual Report and Accounts
31 July	Final Annual Report and Accounts to be submitted to Welsh Government HSSG Finance and Audit Wales
31 July	Send the final Annual Report to Cardiff Council's Welsh Translation Unit
4 August	WG to issue Debtor and Creditor Matrix Income and Expenditure Matrix
August (date TBC)	Send Welsh version of Annual Report to Medical Illustration Team to design Welsh version
September	Publish Annual General Meeting papers (including the fully illustrated bilingual version of (i) the Annual Report and (ii) an abridged version of the Annual Report.

(date TBC 10 days before AGM)	
September (*date TBC*)	Present bilingual Annual Report 2022-2023 to the AGM
September (*same date as AGM*)	Publish the full Annual Report 2022-2023 plus the abridged version of the Annual Report on website, email to key stakeholders etc

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

The Draft Accounts were submitted to the Welsh Government Finance team and Audit Wales on 5 May 2023 and any feedback received will be incorporated into the final document.

The Draft Performance Report, Accountability Report (including the Annual Governance Statement), and Draft Remuneration Report were submitted to the Welsh Government Finance team and Audit Wales on the 12 May 2023 in accordance with the required timescale. Any feedback received from the Welsh Government Finance team and Audit Wales will be incorporated into the final document.

The final Annual Report and Accounts 2022-2023 will be submitted to the Audit and Assurance Committee on 25 July 2023, and to the Board on 27 July 2023 for final approval.

Recommendation:

The Board is requested to:

a) **NOTE** the minimum reporting requirements outlined in Chapter 3 of the Financial Reporting Manual (FReM) guidance for collating an Annual Report for 2022-2023; and

b) **NOTE** the draft Performance Report, Accountability Report and Remuneration Report and provide any comments in relation to the same to the Corporate Governance team by 15 June 2023.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

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

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No

Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)

Safety: No

Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Financial: No

Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Workforce: No

Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Legal: No

Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)

Reputational: No

Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)

Socio Economic: No

The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail.

Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES
(If this has been addressed in the main body of the report, please confirm)

Equality and Health: Yes/No

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.
Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)
(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: No

Has consideration been given to the delivery of proposals in accordance with NHS Wales Decarbonisation Plans. If so, please confirm the detail of issues considered and plans made.
(If this has been addressed in the main body of the report, please confirm)

Approval/Scrutiny Route:

Committee/Group/Exec	Date:
Audit and Assurance Committee Workshop	11 May 2023

Report Title:	HIA Draft Opinion & Annual Report 22-23			Agenda Item no.	8.2	
Meeting:	Board	Public	X	Meeting Date:	25/05/23	
		Private				
Status *(please tick one only)*:	Assurance	X	Approval		Information	X
Lead Executive:	Director of Corporate Governance					
Report Author (Title):	Head of Internal Audit					

Main Report

Background and current situation:

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

This is achieved through delivery of an audit plan that has been focused on key strategic and operational risk areas and known improvement opportunities. The 2022/23 plan was formally approved by the Audit and Assurance Committee at its April 2022 meeting.

The draft Annual Report sets out the draft HIA Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

The report also details the outcome of audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for the Health Board.

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

The draft HIA Opinion for 22/23 is that 'The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively'.

From the individual audits completed at the time of producing the draft Annual Report, the following final / draft ratings have been provided:

- 6 Substantial Assurance
- 24 Reasonable Assurance
- 3 Limited Assurance
- 2 advisory or non-opinion.

The Report also includes details of the 11 audits that have been removed or deferred from the plan during 2022/23, as reported to the Audit & Assurance Committee. These audits and the reason for their removal / deferment have been considered when compiling the draft HIA Opinion.

The draft Annual Report includes a number of highlighted areas where reference is made to reports that were in draft and audits that were work in progress (WiP) at the time of writing. These will be updated to reflect the position when the final HIA Opinion and Annual Report are produced and submitted to the Audit & Assurance Committee and Board in July 2023.

The HIA Opinion will need to be reflected within the Health Board's Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to the 3 Limited Assurance opinions issued during the year and the significance of the recommendations made.

Recommendation:

The Board are requested to:

- **Consider and note** the Draft Head of Internal Audit Opinion and Annual Report for 2022/23.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	x	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	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	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		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

Prevention		Long term	x	Integration	x	Collaboration	x	Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: Yes/~~No~~

The Annual Report provides the Board with a level of assurance around the management of a series of risks covered within the specific audit assignments delivered as part of the Internal Audit Plan. The report also provides information regarding the areas requiring improvement and assigned assurance ratings.

Safety: Yes/No

Financial: Yes/No

Workforce: Yes/No

Legal: Yes/No

Reputational: Yes/No

Socio Economic: Yes/No

Equality and Health: Yes/No

Decarbonisation: Yes/No

Approval/Scrutiny Route:

Committee/Group/Exec	Date:
Audit & Assurance Committee	11 May 2023

Head of Internal Audit Opinion & Annual Report 2022/2023

April 2023

Cardiff & Vale University Health Board

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Appendix A Conformance with Internal Audit Standards
Appendix B Audit Assurance Ratings

Report status:	Draft
Draft report issued:	27 April 2023
Final report issued:	
Author:	Ian Virgill, Head of Internal Audit
Executive Clearance:	Director of Corporate Governance
Audit Committee:	May 2022

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Cardiff and Vale University Health Board's (The 'Health Board') Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2022-23

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2022/23 is that:

Reasonable assurance		The Board can take **Reasonable Assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

1.3 Delivery of the Audit Plan

Our internal audit plan is agile and responsive to ensure that key developing risks to Cardiff & Vale are covered. As a result of this approach, and with the support of officers and independent members across the Health Board, the plan has been delivered substantially in accordance with the agreed schedule and changes required during the year, as approved by the Audit and Assurance Committee (the 'Committee'). In addition, regular audit progress reports have been submitted to the Committee. Although changes have been made to the plan during the year, we can confirm that we have undertaken sufficient audit work during the year to be able to give an

overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

The Internal Audit Plan for the 2022/23 year was initially presented to the Committee in April 2022. Changes to the plan have been made during the course of the year and these changes have been reported to the Committee as part of our regular progress reporting.

There are, as in previous years, audits undertaken at NWSSP, DHCW, WHSSC and EASC that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy (CIPFA) (in March 2023), and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards for 2022/23. We are able to state that our service 'fully conforms to the IIA's professional standards and to PSIAS.'

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have given Limited Assurance, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

In addition, we also undertook a number of advisory and non-opinion reviews to support our overall opinion. A summary of the audits undertaken in the year and the results are summarised in table 1 below.

Table 1 – Summary of Audits 2022/23

Substantial Assurance	Reasonable Assurance
• IMTP 2022-25: Development Process • Follow-up: 5 Steps to Safer Surgery • Medical & Dental Staff Bank • Financial Reporting and Savings Targets • Clinical Audit Follow-up • Commissioning – IPFR Process	• Monitoring and Reporting of Staff Sickness Absence (From 21/22 plan) • Capital Systems Management (From 21/22 plan) • Follow-up: Ultrasound Governance • Stock Management – Neuromodulation Service (Specialist Services CB) • Staff Wellbeing – Culture & Values • Implementation of National IT Systems (WNCR) • Digital Strategy • Medical Equipment & Devices • University Hospital Llandough – Endoscopy Expansion • Core Financial Systems (Treasury Management) • Management of Locum Junior Doctors (Women & Children's CB) • Endoscopy Insourcing (Medicine CB) • Access to In-Hours GMS Service Standards (PCIC Clinical Board) • New IT Service Desk Tool • Development of Genomics Partnership Wales • University Hospital Llandough – Engineering Infrastructure • Nurse Staffing Levels Act • Charitable Funds • Follow-up: Nurse Bank (Temporary Staffing Department) • Community Patient Appliances (Specialist Services CB) • Data Warehouse • Risk Management • Inclusion & Equality • UHW-Hybrid and Major Trauma Theatres (Draft)
Limited Assurance	**Advisory & Non-Opinion**
• Medical Records Tracking (CD&T CB) • Cyber Security • Management of Health Board Policies	• Assurance Mapping • Estates Assurance – Decarbonisation

No Assurance	Assurance yet to be determined
N/A	• Planned Care Transformation Delivery (Recovery of Services) (WiP) • Medical Staff Additional Sessions (Planning) • Consultant Job Plans (Surgery CB) (WiP) • Shaping Our Future Wellbeing – Future Hospitals Programme (WiP)

Please note that our overall opinion has also taken into account both the number and significance of any audits that have been deferred during the course of the year (see section 5.7) and also other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Health Board's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known

improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Health Board. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board takes into account but is not intended to provide a comprehensive view.

The Board, through the Audit and Assurance Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Cardiff and Vale University Health Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be taken into account by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

The overall opinion by the Head of Internal Audit on governance, risk management and control results from the risk-based audit programme and contributes to the picture of assurance available to the Board in reviewing effectiveness and supporting our drive for continuous improvement.

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the course of the 2022/23 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight assurance domains that were used to frame the audit plan at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit and Assurance Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance	 - + Yellow	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any

Limited Assurance opinions issued during the year and the significance of the recommendations made (of which there were three audits in 2022/23).

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2022/23 and reported to the Audit and Assurance Committee has been aggregated at Section 5.

The evidence base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit and Assurance Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).
- The results of any audit work related to the Health & Care Standards including, if appropriate, the evidence available by which the Board has arrived at its declaration in respect of the self-assessment for the Governance, Leadership and Accountability module.
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Health Board.

In reaching this opinion we have identified that the majority of reviews during the year concluded positively with robust control arrangements operating in some areas.

From the opinions issued during the year, six were allocated Substantial Assurance, twenty three were allocated Reasonable Assurance and three were allocated Limited Assurance. No reports were allocated a 'no assurance' opinion. In addition, two advisory or non-opinion reports were also issued.

At the time of producing the draft Annual Report, five audits are still work in progress with the assurance rating yet to be confirmed. It is anticipated

that the majority of the work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit and Assurance Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the 8 areas of the Health Board's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken five reviews in this area.

Assurance Mapping – This was an advisory review. The Health Board's Assurance Strategy 2021-24 aligns to recommended best practice and the Assurance Map Template captures appropriate assurance and risk information. There is a defined governance structure underpinning the Assurance Strategy and an action plan is in place for its implementation. However, more medium-term actions are required to assist in embedding and implementing the Assurance Strategy within the Health Board.

Nurse staffing Levels Act – The Health Board is complying with the requirements of the Act. However, it needs to ensure that all staffing level templates are signed off and budgeted establishments reflect the recorded levels. The Nurse staffing levels were also not consistently displayed on all wards. We issued a **reasonable** assurance opinion.

Risk Management - The Health Board is continuing its journey to strengthen and improve the maturity of the risk management system in place. However, further training is required to ensure that all Directorates and Departments are complying with the procedures for identifying, recording, reviewing and escalating/de-escalating risks. We issued a **reasonable** assurance opinion.

Management of Health Board Policies The Health Board has developed a Plan to get the system in place for the management of policies and procedures up to date and operating effectively. However, significant work is still required to fully implement the plan and at the time of audit most policies and procedures were overdue for review. We have issued a **limited** assurance opinion.

A review of the draft Annual Governance Statement highlighted that it was generally consistent with our knowledge of the UHB through the audit work performed in the Internal Audit plan and a review of other organisational documents. *– Still to be confirmed by review of the draft AGS submitted to the May AC.*

The planned work on the Application of the Local Choices Framework was removed from the plan as it was unclear what the potential scope or benefit would be in the current environment.

Strategic Planning, Performance Management & Reporting

We have undertaken two reviews in this area.

IMTP 2022-25: Development Process - The Health Board has good governance arrangements in place to oversee the development of the Integrated Medium-Term Plan, although we did make a recommendation to enhance the accessibility and transparency of the arrangements. We issued a **substantial** assurance opinion.

Commissioning IPFR Process The Health Board processes IPFR applications in line with the requirements of the All-Wales IPFR Policy. Applications are subject to appropriate review and decision at the IPFR panel and effective monitoring of approved IPFR is undertaken to ensure their continued relevance and benefit to the patient. We issued a **substantial** assurance opinion.

The planned audits of Regional Planning Arrangements and Strategic Programmes / Recovery & Redesign Governance Arrangements were removed from the 22/23 Plan, due to operational pressures on the Health Board.

The planned advisory audit of Performance reporting was removed from the plan. An assurance audit has been included in the plan for 2023/24.

Financial Governance and Management

We have undertaken three reviews in this area.

Core Financial Systems (Treasury Management) – The Treasury Management function has in place adequate systems and controls for managing all cash transactions relating to the funding of revenue and capital operations of the Health Board. We did recommend strengthening the Treasury Management Financial Control Procedure and operational arrangements and controls over the online banking system. We have issued a **reasonable** assurance opinion.

Financial Reporting and Savings Targets - The Health Board has effective processes in place for monitoring and reporting the financial position and delivery of savings. We have issued a **substantial** assurance opinion.

Charitable Funds – Effective procedures are operating to ensure that Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance. We did highlight that the governance arrangements for the Fundraising Team and individual fundraising events require review and enhancement. We have issued a **reasonable** assurance opinion

The audits of the payment systems provided by NWSSP, which we undertake each year to provide assurance to the Health Board all concluded with positive assurance. The four primary care contractor payment systems were given either Reasonable or Substantial Assurance, with the audits of Payroll and Accounts Payable both receiving Reasonable Assurance.

Quality & Safety

We have undertaken three reviews in this area.

Follow-up: Five Steps to Safer Surgery – Significant progress has been made with addressing the recommendations from the previous Limited assurance audit, with all agreed management actions completed. We issued a **substantial** assurance opinion.

Medical Equipment & Devices – The Health Board has an up-to-date policy and procedure in place, with effective processes for the purchase and maintenance of Medical Equipment and Devices. We highlighted a number of areas for improvement around; Increasing awareness of the policy and procedure, the accuracy of information on the medical equipment database and the availability of evidence to support training. We issued a **reasonable** assurance opinion.

Follow-up: Clinical Audit – Significant progress has been made with addressing the recommendations from the previous Limited assurance audit, with only one low priority action remaining to be completed. We issued a **substantial** assurance opinion.

The planned advisory work on the Q&SE Governance arrangements was deferred to the 23/24 plan to allow coverage of developments around the Duties of Quality and Candour.

The planned work on the Reporting of Covid Deaths was removed due to the implementation of the Medical Examiner role and the evolving Covid position.

Information Governance & Security

We have undertaken five reviews in this area.

Implementation of National IT Systems (WNCR) - National systems are included within the digital roadmap for the Health Board and communications and synchronisation of workplans with DHCW is improving. However, there was no overall programme for uptake of national systems within the Health Board. There was no project plan for the roll out of the

Welsh Nursing Care Record across the Health Board and there had been no baselining work to demonstrate its benefits. - We issued a **reasonable** assurance opinion.

Digital Strategy – The Health Board has an appropriate Digital Strategy in place that matches the needs and objectives of the organisation and the transformation agenda. We identified that there was a process in place for defining the roadmap for delivery of the Strategy, but it required further detail around key activities and milestones. Clear governance arrangements are in place for overseeing the development and delivery of the Digital Strategy, but we highlighted that there was a funding gap. We issued a **reasonable** assurance opinion.

New IT Service Desk Tool - The new Ivanti Management System has been successfully implemented, and this has addressed many of the issues identified through the 21/22 Limited Assurance IT Service Management report. However, areas for further improvement were identified covering; the development of procedural guidance for the monitoring and closing down of calls, the effective prioritisation of calls, the development of system access controls and the development of service Level Agreements and Key Performance Indicators. We issued a **reasonable** assurance opinion.

Cyber Security - Although cyber security issues are being monitored and reported through the CAV Cyber Security Group, there is still no cyber improvement plan in place, and the position is not being regularly reported to the DHIC. In addition, whilst there are processes in place to ensure the Health Board's data is backed up, testing of the back-ups is not presently being routinely undertaken for all systems. We issued a **Limited** assurance opinion. The scope of the audit included a follow-up of the 21/22 Limited Assurance audit on the Network & Information Systems (NIS) Directive.

Data Warehouse – The data warehouse has been in place for many years and provides a large amount of useful information. There are good processes in place to define user needs, and develop appropriate information products, with a data quality process in place. We noted security weaknesses with the database, and a lack of documentation regarding feeds in and report products out. Going forward there is an intent to improve the use of data, however there is no formalised plan for this. The Digital directorate have started working towards more advanced analytics, however there is a lack of staff resource and skills. We issued a **reasonable** assurance opinion.

Operational Service and Functional Management

We have undertaken nine reviews in this area.

Follow-up: Ultrasound Governance (CD&T CB) – Good progress has been made in addressing the recommendations from the 21/22 limited assurance report. There was just one medium priority action to still to be completed. We issued a **Reasonable** assurance opinion.

Stock Management – Neuromodulation Service (Specialist Services CB) – The review was requested by management to build on improvements they had instigated to strengthen the stock management arrangements within the Neurosciences Directorate. We made a number of recommendations, the most notable of which related to actions to address missing stock. The implementation of the recommendations from the review will strengthen the control environment, which should mitigate the risk of future financial losses due to missing stock. We issued a **reasonable** assurance opinion

Management of Locum Junior Doctors (Women & Children's CB) - Locum Junior Doctors are being sourced via internal staff or through the Medical and Dental Managed Locum Bank and are supported by appropriate justification. Locum shits are subject to approval but not always before the shift is worked. Standard payment rates are in place and any deviation from them is approved. We issued a **Reasonable** assurance opinion.

Endoscopy Insourcing (Medicine CB) - There is an SLA in place between the Health Board and the service provider that details the contractual arrangements for the insourcing contract. However, we identified a number of issues relating to; Consideration of the weekly points targets for the contract, strengthening of key documentation held, the development of KPIs for the contract and the accuracy of payments made to the provider. We issued a **Reasonable** assurance opinion.

Medical Records Tracking (CD&T CB) – The matters raised which require management attention included the out-of-date Records Management Policy (UHB 142) and Procedure (UHB 326). The documents referred to governance fora no longer in operation. The Health Records department had no direct link into the Executive Medical Director, the executive sponsor of the Policy and Procedure. The author of the documents also sat outside of the Health Records department. Further high priority recommendations related to the security and storage of acute records, and the ability to track records from the patient management system to their physical location. The majority of issues associated with the tracking of records was a result of those held in a clinical setting or outside of Health Records. We issued a **Limited** assurance opinion.

Access to In-Hours GMS Service Standards (PCIC Clinical Board) – The Health Board monitors compliance against the Access Standards on a quarterly basis and proactively works with practices to address areas of non-compliance. An Access Forum has been established but reporting lines did not reflect Welsh Government guidance. The operation of the Forum could also be strengthened by reviewing the terms of reference. We issued a **Reasonable** assurance opinion.

Community Patient Appliances (Specialist Services CB) - Our audit testing was predominantly informed by reviewing data within the BEST patient management system and from system reports, which highlighted the following anomalies; absence of documentation held within the system,

the timeliness of moving open repairs to complete and the better utilisation of management reporting. The stock management arrangements also appeared ad-hoc at the time of our review and the 'Request for Repair' Procedure has been 'draft' since 2019 and requires finalisation. Whilst the service has a 'Declaration of the Terms and Conditions of Loan of Equipment', there were instances where these were not signed and dated by service users in receipt of equipment. We issued a **Reasonable** assurance opinion.

Planned Care Transformation Delivery (Recovery of Services) *[WiP]*

Consultant Job Plans (Surgery CB) *[WiP]*

The planned audit of the Administration Services within the Mental Health CB was removed due to delays in receiving information to commence the audit which impacted on the availability of Internal Audit resources.

Workforce Management

We have undertaken six reviews in this area.

Monitoring and Reporting of Staff Sickness Absence – As part of the audit we suggested that reporting on sickness absence within the Clinical Boards and Corporate Departments look beyond the high-level sickness rates, to provides greater analysis of sickness absence. In response to the pandemic the role of the HR Advisors has moved away from traditional relationships focused within the Clinical Boards, to locating to specialist teams such as the Managing Attendance at Work Team. We identified the opportunity to clarify the People and Culture Operating Model with regards to roles and responsibilities for sickness absence. We issued a **reasonable** assurance opinion

Staff Wellbeing – Culture & Values –The Health Board has clear plans in place of how it intends to support staff wellbeing, principally driven by the People and Culture Plan 2022 – 2025. The Plan was moving into the delivery phase and our recommendations focused on the mechanisms and means of evaluation to support the implementation of the ambitious aspirations. We also made further recommendations around references within the Board Assurance Framework, and the need to verify source material signposted on the new SharePoint site. We issued a **reasonable** assurance opinion

Medical & Dental Staff Bank - A framework agreement is in place for the Medical and Dental Managed Bank Service. We found that robust processes were operating to ensure appropriate employment checks are completed and terms & conditions are issued for all bank staff. Bank shifts are verified and authorised prior to payment and regular performance reporting and monitoring is undertaken. We issued a **Substantial** assurance opinion.

Follow-up: Nurse Bank (Temporary Staffing Department) - Management have made good progress in implementing the management actions detailed in the previous Limited assurance report. Of the eight

recommendations made, five have been closed including one high priority. Two of the recommendations have been moved to low priority as actions had been undertaken within these areas. One of the high recommendations has moved down to medium and still requires a review to be undertaken of the use of agencies. We issued a **Reasonable** assurance opinion.

Inclusion & Equality Team – The Health Board has the basis of effective governance arrangements in place relating to inclusion & equality. However, the Terms of Reference, membership and remit of the Equality Strategy & Welsh Language Standards Group need to be reviewed to ensure appropriate oversight of all current and future requirements. A review is also required of the responsibilities of the Inclusion and Equality team and the structures in place within the Health Board to support them in delivery. An effective process and structure need to be implemented to enable the development and delivery of required action plans to ensure that the Health Board complies with all current and future inclusion and equality requirements. We issued a **Reasonable** assurance opinion.

Medical Staff Additional Sessions *[Planning]*

The planned audit of the Implementation of the People & Culture Plan was deferred to 23/24 as the majority of the implementation plan was reviewed as part of the Staff Wellbeing audit.

Capital & Estates Management

We have undertaken six reviews / outputs in this area.

Capital Systems Management - The action plan developed was endorsed by the required officers and appropriate action was being taken. However, whilst a process for change management was defined, this was not consistently applied across teams or in accordance with the defined delegated limits. Monitoring and reporting arrangements also require review to ensure their consistent application across all capital schemes. Key matters requiring management attention included; Application of the change management (Project Issues Form) process at all capital schemes, review of the scheme of delegation applied to capital schemes, review of the content, and consistency of use, of the highlight reports prepared for capital schemes and completeness of reporting to the appropriate forums. We issued a **reasonable** assurance opinion.

Decarbonisation – This was an advisory review which affirmed common themes to provide an overview of the overarching position across NHS Wales. Our report concluded that, whilst some progress has been observed, this has been restricted by the availability of financial and staff resource. Our recommendations aimed to aid management in driving forward the strategies, whilst also highlighting some of the competing pressures/ risks.

Development of Genomics Partnership Wales - With six months of the construction programme remaining, a forecast overspend of £639k

(4.17%) was being reported. Additional funding of £239k had been approved by the Capital Management Group to partially offset this (from discretionary capital) and further funding support was being sought from Welsh Government at the time of reporting. The full extent of the time impact of the project changes remained ongoing at the time of reporting. Acknowledging the financial pressures at the project, an appropriate financial reporting regime was seen to be operating with all key parties made aware of the ongoing challenges. We issued a **reasonable** assurance opinion.

University Hospital Llandough – Endoscopy Expansion - Contractual arrangements for the project were appropriately approved; however, they deviated from the requirements determined within the approved Business Justification Case (BJC); with no amended procurement strategy approved. Despite this issue, with the agreed arrangements, a robust project governance structure was in place with continual liaison and effective reporting to the relevant forums. At the date of fieldwork (8 weeks into the construction programme) the Project Manager was reporting a delay of seven weeks. There was a risk that this could be further extended and needed to be monitored and managed appropriately. We issued a **reasonable** assurance opinion.

University Hospital Llandough – Engineering Infrastructure - At the date of the audit fieldwork (September/ October 2022) the Project Manager was reporting a delay to the project's completion of approximately nine weeks. There was a risk that timescales could be further extended due to open Early Warning Notices (EWN) and Project Managers Instructions (PMIs). Robust cost and project management arrangements controls were in place. Contractual arrangements were appropriately approved. We issued a **reasonable** assurance opinion.

UHW-Hybrid and Major Trauma Theatres [Draft] - The Full Business case for this scheme was submitted to Welsh Government in December 2022, with an estimated cost of £40.6m and an anticipated delivery date of 24th March 2025. At this early stage of the construction phase, the project remained within key time, cost and quality parameters. However, the project did not have a dedicated Project Board with oversight provided by a wider Programme Board. The review identified gaps in assurance arising from this arrangement. The Health Board also continues to have issues in the timely and appropriate execution of contractual documentation.

Shaping Our Future Wellbeing – Future Hospitals Programme *[WiP].*

Advice and support were also provided to the Health Board through the year in relation to the future development of integrated audit plans.

The planned audit of Capital Systems was deferred to the 23/24 as the 21/22 audit was only completed and finalised in this year.

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports for which we were able to give only Limited Assurance. In addition, where appropriate, we also consider progress made on high priority findings in reports where we were still able to give Reasonable Assurance. We also undertake some testing on the accuracy and effectiveness of the audit recommendation tracker.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

It is the role of Audit Committees to consider and agree the adequacy of management responses and the dates for implementation, and any subsequent request for revised dates, proposed by Management.

We have considered the impact of both our follow-up work and where there have been delays to the implementation of recommendations, on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

From the specific follow up audits undertaken in 2022/23, it was identified that progress had been made by management in implementing recommendations from the following previous Limited Assurance audits, with improved assurance ratings, as identified:

- Follow-up: Five Steps to Safer Surgery – Substantial Assurance;
- Follow-up: Clinical Audit – Substantial Assurance;
- Follow-up: Ultrasound Governance (CD&T) – Reasonable Assurance; and
- Follow-up: Nurse Bank (Temp Staffing Dept) - Reasonable Assurance

The audit of the New IT Service Desk Tool provided assurance that many of the issues identified through the 21/22 Limited Assurance IT Service Management report had been addressed.

The Cyber Security audit also included a follow-up of the 21/22 Limited Assurance audit on the Network & Information Systems (NIS) Directive. Whilst this identified that some progress had been made, further work is still required.

The planned Follow-up of the ChemoCare IT System Limited assurance audit has been deferred to the 2022/23 plan due to delays in implementation of the new system.

The Health Board has continued to develop its recommendation tracking process during 2022/23. The Corporate Governance team continue to review all outstanding recommendations with management and the outcomes have been reported to each meeting of the Audit & Assurance Committee.

We have worked with the Corporate Governance team through the year to review and provide feedback on the tracker prior to its submission to each meeting of the Committee. We have also undertaken work towards the end of the year to validate the stated position for a sample of recommendations within the tracker. *We were able to confirm the recorded position for the majority of the sampled recommendations and therefore provide the Audit Committee with additional assurance around the accuracy of the tracker.* - *This work is on-going so will need to confirm this wording as it is completed.*

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on previous year's programme makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Health Board, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

The majority of audit reviews will relate to the systems and processes in operation during 2022/23 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Health Board's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2022/23.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales. In addition, at least once every five years, we are required to have an External Quality Assessment. This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023. The CIPFA concluded that NWSSP's Audit & Assurance Services conforms with all 64 fundamental principles and 'it is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it fully conforms to the IIA's professional standards and to PSIAS.'

The NWSSP Audit and Assurance Services can assure the Audit and Assurance Committee that it has conducted its audit at the Health Board in conformance with the Public Sector Internal Audit Standards for 2022/23.

Our conformance statement for 2022/23 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023; and
- the results of the work completed by Audit Wales.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2022/23 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any member of NWSSP's Audit & Assurance Service who undertook work on the Cardiff & Vale audit programme for 2022/23.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE HEALTH BOARD

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership;
- Digital Health & Care Wales;
- Welsh Health Specialised Services Committee; and
- Emergency Ambulance Services Committee.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership (NWSSP), a hosted body of Velindre University NHS Trust, a number of audits were undertaken which are relevant to the Health Board. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Health Board, derived the following opinion ratings:

Audit	Opinion	Comments
Accounts Payable	Reasonable	To evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP P2P service.
Payroll	Reasonable	To evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.
Primary Care Services – Medical (GMS), Pharmaceutical (GPS), Dental (GDS), and Ophthalmic (GOS) Services	Reasonable Substantial Substantial Substantial	To evaluate and determine the adequacy of controls in place to administer timely and accurate payments to primary care contractors.
Other audits: Recruitment Services	Reasonable	To assess the adequacy and effectiveness of systems and controls for the management of Recruitment Services
Procurement	(WiP)	

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is *(to be determined)* Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, a number of audits were undertaken which are relevant to the Health Board. These audits derived the following opinion ratings:

Audit	Opinion	Comments
Switching Services	Reasonable	
Embedding the Stakeholder Engagement Plan	Reasonable	
Centre of Excellence	(WiP)	
Technical Resilience	Substantial	
Cyber Security	(WiP)	

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is *(to be determined)* Assurance.

Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC)

The work at both the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) is undertaken as part of the Cwm Taf Morgannwg internal audit plan. These audits are listed below and derived the following opinion ratings:

Audit	Opinion	Comments
WHSSC – Quality Unit	Substantial	
WHSSC – Neurosciences and long-term conditions	Substantial	
EASC – Ambulance handover improvement arrangements	Substantial	

While these audits do not form part of the annual plan for the Health Board, they are listed here for completeness as they do impact on the organisation's activities. The Head of Internal Audit has considered if any issues raised in the audits could impact on the content of our annual report and concluded that there are no matters of this nature.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual

Report, and the WHSSC and EASC audits are summarised in the Cwm Taf Morgannwg University Health Board Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit and Assurance Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit and Assurance Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2023/24 operational audit plan.

The audit plan approved by the Committee in April 2022 contained 41 planned reviews. Changes have been made to the plan through the year with 11 audits deferred/cancelled and 7 audits added. All these changes have been reported to and approved by the Audit Committee. In addition, 2 reviews from the 2021/22 plan were delivered during 2022/23. As a result, we have delivered a total of 39 reviews.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Health Board. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit and Assurance Committee.

4.2 Service Performance Indicators

In order to monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed. The key performance indicators are summarised as follows:

Indicator Reported to Audit and Assurance Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	April 2022	By 30 June	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2022/23	G	90% (35/39)	100%	v>20%	10%<v<20%	v<10%
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	93%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management	R	61%	80%	v>20%	10%<v<20%	v<10%

response to draft report [15 working days]						
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20 %	v<10%

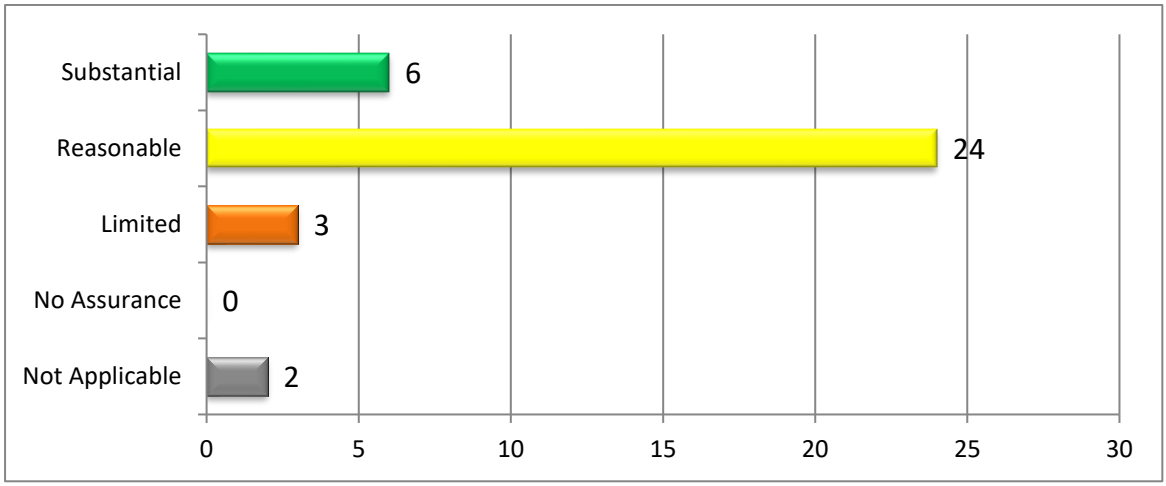
5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 39 *(table currently showing 35 and will need to be updated following completion of work in progress)* audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2 Summary of audit ratings



* Need to add in outcomes for the 4 audits that are still to be completed.

Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP and DHCW.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

In addition to the above, there were several audits which did not proceed following preliminary planning and agreement with management. In some cases, the impact of service pressures on the Health Board was the reason for the deferral or cancellation and in other cases, it was recognised that there was action required to address issues and/or risks already known to management and an audit review at that time would not add additional value. These audits are documented in section 5.7.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas, the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
IMTP 2022-25: Development Process	To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the 'Integrated Medium Term Plan 2022 - 2025 Development Process'.
Follow-up: 5 Steps to Safer Surgery	To provide the Health Board with assurance regarding the implementation of the agreed management actions from the 21/22 'Five Steps to Safer Surgery' Audit, which reported 'Limited' assurance.
Medical & Dental Staff Bank	To review the effectiveness of the processes and controls operating within the Health Board's new Medical and Dental Staff Bank managed by Medacs Healthcare.
Financial Reporting and Savings Targets	To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Financial Reporting and Savings Targets'.
Clinical Audit Follow-up	To provide the Health Board with assurance regarding the implementation of the agreed management actions from the 21/22 'Clinical Audit' Audit, which reported 'Limited' assurance.
Commissioning – IPFR Process	To establish and review the systems and processes in place to assess, make decisions on, and monitor spend related to Individual Patient Funding Requests (IPFRs).

5.3 Reasonable Assurance (Yellow)

In the following review areas, the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Monitoring and Reporting of Staff Sickness Absence (21/22)	To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to Monitoring and Reporting of Staff Sickness Absence.
Capital Systems Management (21/22)	Post reporting of potential breaches, at capital schemes, to Standing Financial Instructions and Standing Order requirements, recommendations and an action plan were agreed to be implemented to mitigate the risk of the same reoccurring. The audit was undertaken to provide assurance on the application of the plan; and to identify any enhancements to existing operational procedures / working practices.
Follow-up: Ultrasound Governance	To provide the Health Board with assurance regarding the implementation of the agreed management actions from the 21/22 Ultrasound Governance review that reported 'Limited' assurance.
Stock Management – Neuromodulation Service (Specialist Services CB)	To evaluate and determine the adequacy of the systems and controls in place within the Neurosciences Directorate in relation to neuromodulation equipment stock management.
Staff Wellbeing – Culture & Values	To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Staff Wellbeing – Culture and Values'.
Implementation of National IT Systems (WNCR)	To evaluate and determine the adequacy of the systems and controls in place within the Health

Review Title	Objective
	Board for the implementation and use of national IT systems.
Digital Strategy	To ensure that the refreshed Digital Strategy meets the needs of the UHB and there is a roadmap for delivery.
Medical Equipment & Devices	To review the arrangements in place for recording, monitoring and replacing medical equipment and devices.
University Hospital Llandough – Endoscopy Expansion	To review the delivery and management arrangements for the University Hospital Llandough (UHL) Endoscopy Expansion Project, and the performance, against its key delivery objectives i.e., time, cost, and quality.
Core Financial Systems (Treasury Management)	To evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to 'Core Financial Systems – Treasury Management'.
Management of Locum Junior Doctors (Women & Children's CB)	To review the system for agreeing and booking locum junior doctors, including appropriate use of the Envoy system before offer of increased rates and cross checking of shifts against claims.
Endoscopy Insourcing (Medicine CB)	To review the governance and operational arrangements in place to manage the Endoscopy Insourcing Contract.
Access to In-Hours GMS Service Standards (PCIC Clinical Board)	To review the processes and procedures in place for assessing GP practices achievement against the 'Access to In-Hours GMS Service Standards'
New IT Service Desk Tool	To review the set-up and implementation of the new system, and to assess the extent to which the new system has been able to drive improvements.
Development of Genomics Partnership Wales	To review the delivery and management arrangements in place to progress the Genomics Partnership Wales project, and the performance, against its key delivery objectives i.e., time, cost, and quality.

Review Title	Objective
University Hospital Llandough – Engineering Infrastructure	To review the delivery and management arrangements for the University Hospital Llandough (UHL) Engineering Infrastructure Project, and the performance, against its key delivery objectives i.e., time, cost, and quality.
Nurse Staffing Levels Act	To review of the processes in place to ensure compliance with the requirements of the Act, with a focus on paediatric arrangements, which is a new part of the Act.
Charitable Funds	To review the processes in place within the Health Board to ensure that Charitable Funds are appropriately managed and administered in accordance with relevant legislation and Charity Commission guidance.
Follow-up: Nurse Bank (Temporary Staffing Department)	To provide the Health Board with assurance regarding the implementation of the agreed management actions from the 21/22 'Nurse Bank (Temporary Staffing Department)' review that reported 'Limited' assurance.
Community Patient Appliances (Specialist Services CB)	To review the systems in place to monitor and manage the risks of posture and mobility equipment that needs to be repaired or replaced. Including how cases are managed when there are delays to equipment ordering / delivery because of supply chain issues.
Data Warehouse	To review the effectiveness of the data warehouse and ensure that it continues to be fit for purpose.
Risk Management	To determine and evaluate the ongoing development and implementation of the Risk Management and Board Risk Assurance Framework Strategy and associated Risk Management Procedures.
Inclusion & Equality	To review the structure of the Inclusion and Equality Team and the plans in place to take key actions forward relating to areas such as the Welsh Government's Anti-Racist Wales Action Plan.
UHW - Hybrid and Major Trauma Theatres	To evaluate the progression and delivery of the project against the key business case objectives

Review Title	Objective
	and to assess the adequacy of the systems and controls in place to support the successful delivery of the project.

5.4 Limited Assurance (Amber)

In the following review areas, the Board can take only **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with moderate impact on residual risk exposure until resolved.

Review Title	Objective
Medical Records Tracking (CD&T CB)	To review the effectiveness of the mechanisms for tracking medical records both inside and outside of the Health Records department.
Cyber Security	To ensure that the organisation is working to improve its cyber security position, reporting is in place that accurately reflects the current cyber security status and data is adequately backed up.
Management of Health Board Policies	To review the arrangements in place for the creation, management and review of Health Board policies and procedures.

5.5 No Assurance (Red)

No reviews were assigned a 'no assurance' opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Assurance Mapping	To support the development of assurance mapping within the Health Board.
Estates Assurance – Decarbonisation	To affirm common decarbonisation themes, to provide an overview of the overarching position across NHS Wales

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Reason for Deferral
Implementation of People & Culture Plan	The majority of the implementation plan was reviewed as part of the Staff Wellbeing audit.
Reporting of Covid Deaths	The implementation of the Medical Examiner role and the different Covid position.
Application of Local Choices Framework	Unclear on the potential scope or benefit given current position / lack of comparability to other organisations.
Regional Planning Arrangements	Focus would have been on identifying lessons to take forward into future regional planning so not a key risk area in the current year.
Administration Services (Mental Health CB)	Delays in receiving information to commence the audit which impacted on the availability of Internal Audit resources.

Review Title	Reason for Deferral
Strategic Programmes / Recovery & Redesign Governance Arrangements	The governance arrangements will be reviewed as part of the separate audit of Planned Care Transformation Delivery (Recovery of Services)
Capital Systems	The 21/22 audit was only recently finalised, so there was little benefit in reviewing again in 22/23.
Network & Information Systems (NIS) Directive Follow-up	Follow-up of management actions covered as part of the Cyber Security audit.
QS&E Governance (Deferred from 21/22 plan)	Advisory review moved to Q1 23/24 to allow coverage of developments around the Duty of Quality.
ChemoCare IT System Follow-up	Deferred to 23/24 plan due to delay with implementation of new system.
Performance Reporting (WiP)	Advisory review removed from the plan and replaced with an assurance review in the 2023/24 plan

5.8 Work in Progress

At the time of producing the draft Annual Report, the following audits were still work in progress and the assurance ratings had not been determined. It is anticipated that the majority of this work will be sufficiently progressed so that the ratings can be established before production of the final Annual Report.

Review Title	Objective
Planned Care Transformation Delivery (Recovery of Services) (WiP)	To review the systems and controls in place to deliver the transformation of planned care during 2022/23.
Medical Staff Additional Sessions (Planning)	Review of the new policy and procedure being developed in relation to additional sessions worked by medical staff.
Consultant Job Plans (Surgery CB) (WiP)	Review of Consultant Job Planning arrangements, to include focus on service lines with elective and emergency splits.

Review Title	Objective
Shaping Our Future Wellbeing – Future Hospitals Programme (WiP)	Advisory review to provide proactive advice, identify good practice and relevant systems weaknesses for management consideration and, where appropriate, provide direction to existing guidance.

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Health Board to support delivery of the Internal Audit assignments undertaken within the 2022/23 plan.

Ian Virgill
Head of Internal Audit
Audit and Assurance Services
NHS Wales Shared Services Partnership
April 2023

Appendix A

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2018.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of

	specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.
2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.

2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B - Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Report Title:	Corporate Risk Register				Agenda Item no.	8.3	
Meeting:	Board Meeting		Public	x	Meeting Date:	25.05.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Head of Risk and Regulation						

Main Report
Background and current situation:

The Corporate Risk Register ("the Register") has been developed to provide the Board with an overview of the key operational risks from the Clinical Boards and Corporate Directorates.

The Register includes those extreme risks which are rated 20 (out of 25) and above but, it may also include risks of a lower score when required to inform the Board of specific risks with the potential to affect the achievement of UHB strategic objectives.

The Board has oversight of the Health Board's Strategic Risks via the Board Assurance Framework and its extreme Operational Risks via the Register.

The Register Summary is attached at Appendix A. The Board are asked to note that the Register Summary lists risks in order of highest to lowest risk scores, whilst retaining reference numbers from the detailed Register to enable cross referencing between the two documents. The detail of each risk listed is also discussed and reviewed at the appropriate Committee of the Board.

The Health Board's Risk Management and Board Assurance Framework Strategy and the Health Board's Risk Management procedures have been reviewed by Internal Audit and received a reasonable assurance rating at the May Committee meeting of the Audit and Assurance Committee.

Executive Director Opinion and 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 and Board Assurance Framework Strategy and associated procedures.

The Team's predominant focus of support to Clinical Boards/Corporate Directorates has been to provide advice and guidance to risk leads/risk owners in their assessment and management of complex risks, and the refinement of their internal risk management processes. In addition, the Team continue to support requests from senior risk managers to deliver risk assessment and risk management training to their teams and newly appointed risk managers. The Board should note that Clinical Board risks are also monitored and scrutinised at Bi-Monthly Clinical Board Review Meetings.

Operating within the three 'Lines of Defence', the team have continued to provide risk register 'check and challenge' feedback reports to Clinical Boards/Corporate Directorates detailing recommendations for the improvement of their risk registers and, where relevant, the rationale for not placing candidate risks onto the Register. The team have maintained the assurance of this process by adopting a 'whole team' peer review approach prior to providing feedback to risk leads.

May 2023 Update

Assurance Strategy Update:

Following the March 2023 Board Meeting the Team have also worked with Clinical Board Triumvirates and Corporate Directorates to develop a Corporate Risk Register Assurance Map that will identify what Assurance can be taken in relation to those risks included within the Register. The Assurance Map will also be used as a tool to identify where there may be gaps in assurance that should be further investigated internally and also by Audit colleagues. A copy of the Assurance Map is attached as Appendix B.

Please note that the yellow markers within the First and Second lines of Defence indicate that evidence of assurance has been provided in the listed areas. At this stage, we are not in a position to validate the robustness of the assurance provided but this is something that will be worked towards. Within the Third line of Defence assurance provided is rated Red, Amber or Green (as per the key provided) as our internal and external Auditors provide external ratings within their reports. The overall Assurance rating within the key is arrived at on the basis of the following criteria from the Health Board Assurance Strategy:

Assurance Key	
Assurance on one line of defence, limited or no third line of defence, assurance over 3 years old.	Low
Assurance across two lines of defence, positive assurance on third line of defence, assurance within last three years.	Medium
Assurance across all three lines of defence, positive assurance on the third line of defence, assurance within last three years.	High

The Internal Audit Plan for the Health Board is linked to and informed by the Corporate Risk Register and Board Assurance Framework. Whilst the Internal Audit Plan for 2023/24 has been finalised it is hoped that the Assurance Map will act as a more precise took to inform the development of the 2024/25 Audit Plan and ad hoc internal reviews of our services.

The attached Assurance Map highlights that there are 9 risks rated amber where we are able to report that that there is reasonable assurance that risks are being adequately mitigated and 21 risks (rated red) where there is limited assurance. Where a limited assurance finding has been arrived at this can be due to a number of factors which include:

1) The absence of external review of our services within the Third Line of Defence (see risks CRR9, 11, 12, 14, 15, 16, 17, 18, 26);
2) Where limited assurance external reviews have been shared (CRR 6, 7 10, 19, 22, 23, 25, 27, 28 and 29) and
3) Where there is no evidence of assurance within the first and second lines of defence.

Where there are references to external review within the third line of defence, assurance can be taken, even where such reviews have led to a limited finding, due to the ongoing scrutiny in such areas by the Health Board Audit and Assurance and Quality, Safety and Experience Committees which receive regular updates on the Health Board's compliance with Audit recommendations.

Whilst there are a high number of areas where limited assurance is listed it should be noted that there is evidence of significant assurances that risks are being mitigated at an operational level and within the second line of defence, however the Assurance Map does provide an indication that further oversight can and should be undertaken in relation to a number of the risks listed, including those referenced above, where there is no external review in place.

<u>Corporate Risk Register Update:</u>

There are currently 29 Extreme Risks recorded on the Register. 27 risks were carried forward from the March Board meeting, with Risks CRR21 and CRR26 added for the current meeting. All 27 risks carried forward remain unchanged following the March 2023 Board Meeting and all 29 Risks will continue to be recorded on the Register beyond the May 2023 Board meeting.

The Board are asked to note that some of the risks within the Corporate Risk Register are amalgamations of separate risks:

- Risks CRR1 and CRR4 on the Corporate Risk Register are amalgamations of risks within the Capital Estates and Facilities Risk Register; and
- Risk CRR24 is an amalgamation of Estates and Infrastructure risks originating within Critical Care settings.

The amalgamation allows for ease of incorporation onto the Corporate Risk Register and does not detract from the description, impact, score or management of the original entries.

Candidate risks were accepted from Capital Estates, Digital Health and Facilities and Finance Corporate Directorates and the Medicine, Children and Women, CD&T, PCIC and Specialist Services Clinical Boards. The Strategic Planning and Health and Safety Corporate Directorates reported no Extreme Risks.

A return was not received from the Surgery Clinical Board, albeit no risks scoring 20/25 or higher were reported by the clinical Board at the May executive Clinical Board review meeting. A return was received from the Mental Health Clinical Board with no reported risks added to the Register on this occasion. The Head of Risk and Regulation is meeting with the Surgery and Mental Health Clinical Board Triumvirate and Directorate Managers to provide additional support and guidance in relation to their risk management processes during May so that, where appropriate, relevant risks are accurately reported within the Register.

The present position is therefore as follows:

March 2023	May 2023
• 27 Risks rated 20 (Extreme Risk), 8 of which are new entries. It should be noted that Risk 6, in relation to Nursing Workforce, has been de-escalated to a 20 having previously recorded a score of 25. • 3 risks to be removed from the Corporate Risk Register.	• 29 Risks rated 20 (Extreme Risk), 2 of which are new entries.

<u>Trend Analysis</u>.

Staff shortages, particularly within the Nursing Workforce, and Capital and Estates issues, remain a dominant feature of a number of risks. Operational level mitigations appear to be reducing the impact of these risk types on patient safety but they are adversely impacting on Urgent and Planned care capacity.

Each risk on the Register can be linked to the Strategic Risks detailed upon the BAF and are grouped as follows:

Board Assurance Framework Risk	Corporate Risk Register Entry
Patient Safety	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26.

Capital Assets	1, 2, 3, 4, 10, 20, 21, 24, 25, 26, 29
Workforce	4, 6, 9, 12, 17, 18, 19, 22
Financial Sustainability	5, 27, 28
Staff Wellbeing	4, 6, 9, 22
Critical Care	22, 23, 24
Planned Care	11, 12
Cancer	11, 12
Maternity	13, 16, 19
Urgent and Emergency Care	6, 7, 8
Digital Strategy and Road Map	29
Delivery of IMTP 22-25	27, 28

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The Risk and Regulation Team's 'check and challenge' of Clinical Board/Corporate Directorate candidate risks.
- 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.
- Increasing routine dialogue on risk issues between Clinical Board/Corporate Directorate Risk Leads and the Team.
- The Reasonable Assurance rating provided by Internal Audit for the Health Board's Risk Management processes.

Recommendation:

The Board are requested to:

Note the Corporate Risk Register and the work in this area which is now progressing.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

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	x

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention	x	Long term		Integration		Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
The management and maintenance of the Health Board's Corporate Risk Register contributes to the Health Board's Risk Management processed and procedures.
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Quality Safety and Experience Committee	06.06.2023
Finance and Performance Committee	21.06.2023

Saunders.Nathan
24/05/2023 15:05:05

CORPORATE RISK REGISTER SUMMARY MAY 2023

Risk Ref	Risk (for more detail see individual risk entries)	Clinical Board / Corporate Directorate	Link to BAF	Initial Risk Score	Risk Score January 23	Risk Score March 23	Risk Score May 23	Target Risk Score
CRR1	Risk of patient harm due to obsolete Oxygen and Nitrous Oxide medical gas Plant and Equipment at various UHB sites	Estates	Patient Safety Capital Assets	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR2	Risk of patient harm due to interruption of oxygen supply to the whole of UHW resulting from a corroded oxygen pipeline.	Estates	Patient Safety Capital Assets	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR3	Risk of loss of heating throughout UHL due to serious corrosion of Main Boiler F&E Tanks	Estates	Capital Assets Patient Safety	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR4	Risk to staff safety and regulatory compliance due to non-compliance with HTMs for ventilation - multiple locations UHW	Estates	Workforce, Capital Assets Staff Wellbeing, Patient Safety	5x4=20	5x4=20	5x4=20	5x4=20	5x1=5
CRR5	Risk to estimated expenditure in financial plans due to significant increases in energy tarrifs	Estates	Financial Sustainability	4x5=20	4x5=20	4x5=20	4x5=20	4x4=16
CRR6	Risk of staff and patient harm due to difficulties recruiting sufficient numbers of nursing staff.	Medicine	Workforce, Staff Wellbeing Patient Safety Urgent and Emergency Care	5x5=25	5x5=25	5x4=20	5x4=20	5x3=15
CRR7	Risk of patient harm due to delays to patient treatment and flow following a speciality referral from the Emergency Unit	Medicine	Patient Safety Urgent and Emergency Care	5x5=25	5x4=20	5x4=20	5x4=20	5x3=15
CRR8	Risk of patient harm and breaches of Welsh Government waiting time guidance due to delays admitting patients from WAST	Medicine	Patient Safety Urgent and Emergency Care	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR9	Risk of delay in the assessment of patients leading to clinical risk and poor patient experience due to an inability to provide medical cover across the Medicine Clinical Board.	Medicine	Patient Safety Workforce, Staff Wellbeing	5x5=25	5x4=20	5x4=20		5x2=10
CRR10	Risk of overcrowding in the Emergency and Acute Medicine footprint resulting in an ability to meet key quality standards impacting on patient experience, quality of care and discharge.	Medicine	Patient Safety Capital Assets	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR11	Risk of patient harm due to the progression of conditions from benign to malignant disease due to increased waiting times for surveilance and planned recall endoscopy procedures.	Medicine	Patient Safety Cancer Planed Care	5x5=25		5x4=20	5x4=20	5x2=10
CRR12	Risk of patient harm due to workforce and capacity constraints across Gastroenterology & Endoscopy	Medicine	Patient Safety Cancer Planed Care Workforce	5x5=25		5x4=20	5x4=20	5x2=10
CRR13	Risk of harm to mothers and babies due to delayed lift replacement works and inadequate repairs within the Maternity Services lifts	Children and Women	Patient Safety Maternity Capital Assets	5x5=25		5x4=20	5x4=20	5x1=5
CRR14	There is a risk of harm and poor patient experience as a result of lack of available provision for emergency gynaecology care.	Children and Women	Patient Safety	4x5=20		4x5=20	4x5=20	4x2=8
CRR15	Risk of harm to Children and young people due to increased demand for CAHMS services	Children and Women	Patient Safety	5x5=25		5x4=20	5x4=20	5x2=10
CRR16	Risk of patient harm and experience and reputational damage due to non-compliance against Ockenden Report recommendations	Children and Women	Patient Saferty Maternity	4x5=20		4x5=20	4x5=20	4x2=8

CRR17	Risk of patient harm within Child and Adolescent Learning Disability Services due to staff vacancies.	Children and Women	Patient Safety Workforce	4x5=20		4x5=20	4x5=20	4x2=8
CRR18	Risk of failure to comply with regulatory requirements and patient harm due to delays in assessment within Children Looked After Services.	Children and Women	Patient Safety Workforce	4x4=16		4x5=20	4x5=20	4x2=8
CRR19	Risk of patient harm and poor patient experience due to staffing difficulties and shortages within maternity services.	Children and Women	Maternity Workforce	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR20	There is a risk to the delivery of modern, safe and sustainable healthcare due to suboptimal estate across the Clinical Board	CD&T	Patient Safety Capital Assets	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR21	There is a risk to the delivery of modern, safe and sustainable healthcare due ageing equipment across the clinical board	CD&T	Patient Safety Capital Assets	5x5=25			5x4=20	5x2=10
CRR22	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 Critical Care Staff Wellbeing Workforce	5x5=25	5x4=20	5x4=20	5x4=20	5x2=10
CRR23	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient bed capacity.	Specialist Services	Patient Safety Critical Care	5x4=20	5x4=20	5x4=20	5x4=20	5x2=10
CRR24	Risk that patients will not receive care in a suitable environment due to a number of shortcomings in Critical Care facilities.	Specialist Services	Patient Safety Critical Care Capital Assets	4x5=20	4x5=20	4x5=20	4x5=20	4x2=8
CRR25	Risks to harm to haematology patientx (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.	Specialist Services	Patient Safety Capital Asstes	5x5=25	5x4=20	5x4=20	5x4=20	5x1=5
CRR26	Risk of patient harm due to reduced access to Epilepsy Telemetry Services	Specialist Services	Patient Safety Capital Assets	5x5=25			5x4=20	5x1=5
CRR27	Risk failure to achieve revenue statutory duty breakeven duty and achieve an approved three year IMTP	Finance	Financial Sustainability Delivery of IMTP 22-25	5x4=20	5x4=20	5x4=20	5x4=20	5x2=10
CRR28	Risk of failure to achieve an approved Three Year IMTP due to a planned defecit of £88.4 million	Finance	Financial Sustainability Delivery of IMTP 22-25	5x4=20	5x4=20	5x4=20	5x4=20	5x2=10
CRR29	Risk of service interuption and potential patient harm due to cyber security threats	Digital Health	Capital Assets Digital Strategy and Road Map	5x5=25	5x4=20	5x4=20	5x4=20	5x3=15

Corporate Directorate/Clinical Board	CRR Reference as at 10.05.23	Corporate Risks as at 10.05.2023	Current Risk Score as of 10.05.23:	First Line of Defence Management Controls: Operational Processes and Management Reviews	First Line of Defence: Management informantion and data	First Line of Defence: Other - Self assessment	Second Line of Defence Oversight functions, e.g. Compliance and quality sub-groups and risk management: Compliance / Quality	Second Line of Defence: Health and Safety / Estates	Second Line of Defence: Risk Management	Third Line of Defence Internal Audit, External Audit and other regulators and independent assurance providers.: Regulatory Body	Third Line of Defence: Internal Audit/NWSSP Estates	Third Line of Defence: External Audit (Audit Wales)	Reviewed Assurance Level
CEF	CRR1	Risk of patient harm do to obsolete Medical Gas and air delivery equipment and plant.	5x4=20	x	x		x	x	x	x	x		
CEF	CRR2	Risk of patient harm due to corrosion of Main 02 pipeline in UHW which may impact equipment failure leading to loss of service and interruption of oxygen supply.	5x4=20	x	x	x	x	x	x	x	x		
CEF	CRR3	Risk of loss of heating throughout UHL due to main boiler F&E tanks which are badly corroded.	5x4=20	x	x	x	x	x	x		x		
CEF	CRR4	Risk of safety to staff due to ventilation verification of critical systems identified across UHW site which does not comply with HTMs for ventilation.	4x5=20	x	x	x	x	x	x	x			
CEF	CRR5	Risk of overspend in financial plans due to unstable energy markets resulting in significant tariff increases.	4x5=20	x	x		x	x	x		x		
Med	CRR6	There is a risk of physical and emotional harm to patients and staff due to the number of nursing vacanies across the Clinical Board.	5x4=20	x	x	x	x	x	x	x	x		
Med	CRR7	There is a risk of patient harm due to delays in patient treatment and flow following a speciality referral from the Emergency Unit.	5x4=20	x	x	x	x		x	x			
Med	CRR8	There is a risk to patients which may cause potential harm by not meeting Welsh Government targets, due to delays admitting patients from WAST resulting in delays for patient assessment and treatment.	5x4=20	x	x	x	x		x	x			
Med	CRR9	There is a risk of patient and staff harm due to an inability to safely provide medical cover across the Medicine Clinical Board, resulting in the delay of assessment for patients.	5x4=20	x	x		x		x				
Med	CRR10	There is a risk of patient harm due to overcrowding within the Emergency and Acute Medicine footprint resulting in the inability to provide and maintain key quality standards, impacting on patient experience, quality of care and discharge.	5x4=20	x	x	x	x	x	x	x			
Med	CRR11	There is a risk of patient harm due to the progression of conditions from benign to malignant disease due to increased waiting times for surveilance and planned recall endoscopy procedures.	5x4=20	x	x	x	x		x				
Med	CRR12	Risk of patient harm due to workforce and capacity constraints across Gastroenterology & Endoscopy.	5x4=20	x	x		x	x	x				
C&W	CRR13	Risk of harm to mothers and babies due to delayed lift replacement works and inadequate repairs within the Maternity Services lifts.	5x4=20	x	x		x	x	x	x	x		
C&W	CRR14	There is a risk of harm and poor patient experience as a result of lack of available provision for emergency gynaecology care resulting in delays.	4x5=20	x	x	x	x	x	x				
C&W	CRR15	There is a risk of harm to children & young people due to a lack of appropriate clinical settings because of increased demand for services.	5x4=20	x	x	x	x	x	x				

C&W	CRR16	There are risks clinically, experientially and reputationally associated as a result of the current non-compliance against the Ockenden Report recommendations across Maternity and Neonatal Services	4x5=20	x	x		x		x				
C&W	CRR17	Due to vacancies within Child and Adolescent Learning Disability Services there is a risk of physical harm to child and staff.	4x5=20	x	x	x	x		x				
C&W	CRR18	Due to staffing levels and service capacity within Children Looked After Services. There is a risk of harm due to failure to comply with regulatory requirements.	4x5=20	x		x	x		x				
C&W	CRR19	There is the risk of poor patient experience / outcomes in maternity due to staffing levels within Maternity services	5x4=20	x	x	x	x		x	x			
CD&T	CRR20	There is a risk to the delivery of modern, safe and sustainable healthcare due to suboptimal estate across the CD&T Clinical Board.	5x4=20	x	x	x	x	x	x	x		x	
CD&T	CRR21	There is a risk to the delivery of modern, safe and sustainable healthcare due ageing equipment across CD&T Clinical Board.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR22	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.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR23	Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient bed capacity.	4x5=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR24	Risk that patients will not receive care in a suitable environment due to a number of shortcomings in Critical Care facilities.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR25	Risks to harm to haematology patients (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR26	Risk of patient harm due to reduced access to Epilepsy Telemetry Services	5x4=20	x	x	x	x		x				
Fin	CRR27	Risk failure to achieve revenue statutory duty breakeven duty and achieve an approved three year IMTP	5x4=20	x	x	x	x		x		x	x	
Fin	CRR28	Risk of failure to achieve an approved Three Year IMTP due to a planned defecit of £88.4 million	5x4=20	x	x	x	x		x		x	x	
Dig H	CRR29	Due to national and international Cyber Security threatre, there is a risk that the Health Board's IT infrastructure could be compromised.	5x4=20	x	x	x	x		x	x	x		

Assurance Key	
Assurance on one line of defence, limited or no third line of defence, assurance over 3 years old.	Low
Assurance across two lines of defence, positive assurance on third line of defence, assurance within last three years.	Medium
Assurance across all three lines of defence, positive assurance on the third line of defence, assurance within last three years.	High

Third Line of Defence - External Audit Rating Key	
Limited	Low
Reasonable	Medium
Substantial	High

CRR 1	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm due to obsolete Oxygen and Nitrous Oxide medical gas Plant and Equipment at various UHB sites	All existing plant is maintained in line with manufacturers recommendations. Manifolds quarterly and Medical air plant six monthly.	All inspections have passed their relevant checks. Continually monitored through maintenance reports.	No reports received of unsatisfactory performance.	Assurance & compliance meetings are held monthly at which escalated risks can be discussed. Six monthly reviews of risk assessments carried out by Assurance & Compliance team.	Continually monitored through maintenance reports. Replacement of the manifold has been instructed. Date of works to be confirmed. The Medical Air Plants at UHW has been included in the EFAB replacement schemes for 2023/2024. This has been endorsed by NWSSP and we await final approval from WG for replacement of both plants at UHW.	Last risk register workshop for CEF was held on 5th October 2022. Risk Description reviewed January 2023 by Risk Manage Team.	No Regulatory Body reports as system still meeting requirements. NWSSP have recommended replacement of the Medical air plant due to none conformity to HTM.	Review undertaken by NWSSP Authorising Engineer - NWSSP have recommended replacement of the Medical air plant due to non conformity to HTM - NWSSP Authorising Engineer (Medical Gas Pipe Line Systems) Annual Report Estates Review Follow-up report	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR2	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm due to interruption of oxygen supply to the whole of UHW resulting from a corroded oxygen pipeline.	Weekly visual monitoring of pipeline carried out.	Continually monitored through maintenance reports.	Surveys are ongoing to determine isolation & back up requirements.	Assurance & compliance meetings are held monthly at which escalated risks can be discussed. Six monthly reviews of risk assessments carried out by Assurance & Compliance team.	Continually monitored through maintenance reports. Replacement of the O2 pipeline has been identified in backlog maintenance. Surveys are ongoing to determine isolation & back up requirements. Replacement has been included in the EFAB replacement schemes for 2023/2024. This has been endorsed by NWSSP and we await final approval from WG.	Last risk register workshop for CEF was held on 5th October 2022. Risk reviewed by Risk and Regulation team in January 2023	None as system still meeting requirements. NWSSP Authorising Engineer (Medical Gas Pipe Line Systems) Annual Report	Review undertaken by NWSSP Authorising Engineer - Replacement has been included in the EFAB replacement schemes for 2023/2024. This has been endorsed by NWSSP and we await final approval from WG. - Authorising Engineer (Medical Gas Pipe Line Systems) Annual Report Estates Review follow-up report	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR3	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit/NWSSP Estates	External Audit
Risk of loss of heating throughout UHL due to serious corrosion of Main Boiler F&E Tanks	Weekly visual monitoring of the tank is carried out.	Continually monitored through maintenance reports	Replacement of the F&E Tanks has been included in the EFAB replacement schemes for 2023/2024.	Assurance & compliance meetings are held monthly at which escalated risks can be discussed. Six monthly reviews of risk assessments carried out by Assurance & Compliance team.	Continually monitored through maintenance reports	Last risk register workshop for CEF was held on 5th October 2022. Risk reviewed by Risk and Regulation team in January 2023	None as system still meeting requirements.	Replacement of the F&E Tanks has been included in the EFAB replacement schemes for 2023/2024. This has been endorsed by NWSSP and we await final approval from WG for replacement of F&E Tanks.	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR4	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk to staff safety and regulatory compliance due to non-compliance with HTMs for ventilation - multiple locations UHW	All existing plant is maintained in line with manufacturers recommendations. AHU are services every quarter. However some areas do not have HTM compliant system in place. Other areas have non compliant systems above ceiling which can not be accessed for regular maintenance due to location above ceiling.	Continually monitored through maintenance reports	Issues have been raised with NWSSP. Major cost and disruption implication to upgrade. Some issues being dealt with under Acute Master Planning Programme.	Assurance & compliance meetings are held monthly which escalated risks can be discussed. Six monthly reviews of risk assessments carried out by Assurance & Compliance team.	Continually monitored through maintenance reports		NWSSP Authorising Engineer (Ventilation) Annual Report	Authorising Engineer (Ventilation) Annual Report - Ventilation AE	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR5	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit/NWSSP Estates	External Audit
Risk to estimated expenditure in financial plans due to significant increases in energy tariffs	Energy usage is constantly monitored against usage & cost.	Electronic data measuring of meters is in place.		Energy costs are reported at CMG monthly.	Meetings with suppliers, HB's within Wales via NWSSP are regularly held to ensure continuity of service	Risk Description reviewed May 2023 by Risk Management Team.		Weekly meetings are held with NWSSP and other HB in Wales to monitor the buying of energy. This assess markets and react collectively to purchase energy credits in advance. These meetings have their frequency increase or decrease to demands / changes in markets.	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR6	**First Line of Defence** Management Controls			**Second Line of Defence** Oversight functions, e.g. Compliance and quality sub-groups and risk management			**Third Line of Defence** Internal Audit, External Audit and other regulators and independent assurance providers.		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
There is a risk of physical and emotional harm to patients and staff due to the number of nursing vacanies across the Clinical Board. Secondary to this is the risk of failure to comply with regulatory staffing requirements (Nurse Staffing Levels (Wales) Act 2016).	2 hourly safety huddles, Acute and Emergency Medicine Professional Standards. Escalation to MCB and UHB OPAT. FCP and onboarding well embedded	2 hourly huddle reports, E datix, Tendable patient experience audit feedback. Tendable key tier 1 audits	Senior/Lead Nurse walkarounds and Tendable audits	Directorate and Clinical QSE meetings monthly. Patient Story for Clinical Board QSE every 3 months.	Health & Safety can respond from an E Datix submission and escalate as required highlighting poor patient experience, quality of care and discharge.	Reviewed by risk management team in May 2023.	HIW UHW Emergency Unit and Assessment Unit June 2022 - Significant recommendations made.	Nurse Bank review - Limited Assurance albeit not specifically linked to the MCB.	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR7	**First Line of Defence** Management Controls			**Second Line of Defence** Oversight functions, e.g. Compliance and quality sub-groups and risk management			**Third Line of Defence** Internal Audit, External Audit and other regulators and independent assurance providers.		
	Operational Processes and Management Reviews	Management Information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
There is a risk of patient harm due to delays in patient treatment and flow following a speciality referral from the Emergency Unit.	2 hourly safety huddles, Acute and Emergency Medicine Professional Standards. Escalation to MCB and UHB OPAT for any speciality review delays. Specific patient pathways that are time specific, eg, Stroke.	EU workstation, Acute & Emergency Unit 2 hourly Huddle Reports. Patient Access/UHB capacity reports. BIS to inform 4 and 12 hour performance and referral times	Acute and Emergency Medicine Professional Standards	4 and 12 hour performance and referral times shared at Clinical Board QSE meetings bi monthly.		*Reviewed by risk management team in May 2023.*	HIW Emergency / Assessment Unit Report - Significant recommendations made.		
	Please include the detail of any operational processes or checks that are in place which show the effectivess of	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk -*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g -*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection,*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other*

CRR8	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm and breaches of Welsh Government waiting time guidance due to delays admitting patients from WAST	Triage of all patients held on an ambulance and clear escalation process in place for a deteriorating patient. Protection of resus buffer wherever possible. Standard Operational Policy in place to support Immediate Release requests. Joint partnership with OPAT and the use of FCP and onboarding when ambulances are held for 3 hours. Transformational work undertaken and the implementation of initiatives to support flow eg, RATZ, Virtual Ward, and Speciality Hub. 2	BIS used to provide data on waiting times. Use of WAST Launchpad in the Emergency Unit and OPAT to monitor performance. E Datix submitted for long waits and acuity of patients in the department	Performance is tracked, and discussed at Directorate Performance Reviews monthly. Joint meetings with the Clinical Board and WAST colleagues to monitor performance.	Directorate Performance Reviews and Quality and Safety meetings. Discussed at Clinical Board Quality and Safety Meetings bi monthly.		Review by risk management team in May 2023	HIW WAST Local Review 2021 and updated October 2021 - Welsh Ambulance Services NHS Trust Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover		
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR9	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of delay in the assessment of patients leading to clinical risk and poor patient experience due to an inability to provide medical cover across the Medicine Clinical Board.	Medical staffing reviewed daily at OPAT meetings with ongoing planning to ensure safe staffing. Ongoing work with Medi Team and Locums to support the Emergency Unit footprint. Ongoing recruitment into F3 posts.	Datix reports to highlight staffing shortfalls. Dashboard available for Clinical Board where specific areas can be reviewed. Discussed at Directorate Performance Reviews		Directorate Performance meetings are held every two weeks where staffing and vacancies are discussed. Also discussed every two weeks with each Directorate Clinical Board General Manager and Director of Operations every two weeks. Clinical Board Vacancy Panel meetings are held every two weeks. Staffing is a standard agenda item at Clinical Board QSE meetings.	Health & Safety can respond from an E Datix submission and escalate as required if staffing has impacted on patients or staff.	Risk Management management review in May 2023.			
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR10	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of overcrowding in the Emergency and Acute Medicine footprint resulting in an ability to meet key quality standards impacting on patient experience, quality of care and discharge.	2 hourly safety huddles, Acute and Emergency Medicine Professional Standards. Escalation to MCB and UHB OPAT. FCP and onboarding well embedded	2 hourly huddle reports, E datix, Tendable patient experience audit feedback. Tendable key tier 1 audits	Senior/Lead Nurse walkarounds and Tendable audits	. Directorate and Clinical QSE meetings monthly. Patient Story for Clinical Board QSE every 3 months.	Health & Safety can respond from an E Datix submission and escalate as required highlighting poor patient experience, quality of care and discharge.	Risk Management Review - May 2023	HIW UHW Emergency Unit and Assessment Unit June 2022		
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Regular reviews of bed availability or patient flow.	*Are there any data systems or streams that highlight the effeciveness of controls in place - e.g. Datix Reports to show a decline in entries following implementation of controls*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds, Patient Feedback.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, Audit Wales*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR11	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of serious patient harm due to increased waiting times for surveillance and planned recall endoscopy procedures.	*Clinical validation of surveillance waiting list completed until the end of 2021.* *Corporate risk stratification cube available in BIS to pull through surveillance patients based upon individual risk vs chronological waiting times.* *NEP also provided documentation for risk stratification*	*NEP surveillance spreadsheet validation completed*		*Clinical Board QSE Meetings and DMT Reviews*		Risk Management Review May 2023			
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Regular reviews of bed availability or patient flow.	*Are there any data systems or streams that highlight the effeciveness of controls in place - e.g. Datix Reports to show a decline in entries following implementation of controls.*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds, Patient Feedback.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk .*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR12	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm and experience alongside a detrimental impact on staff due to workforce and capacity constraints within Gastroenterology and endoscopy.	*Referral vetting and USC prioritisation Validation of waiting lists undertaken, both clerical and clinical*	*Rosterpro and Consultant Workplans*		*Regular review of endoscopy position with MCB/exec team*	*Endoscopy expansion and build underway and scheduled for completion in October 23 Day case activity for admission avoidance*	*Risk Management Review*			
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Regular reviews of bed availability or patient flow.	*Are there any data systems or streams that highlight the effeciveness of controls in place - e.g. Datix Reports to show a decline in entries following implementation of controls.*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds, Patient Feedback.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, Audit Wales*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR13	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Due to delayed lift replacement within Maternity Services. There is a risk for potential harm to mothers and babies.	Regular review and assessments undertaken and any issues escalated directly to Estates Team for support/resolution. Interim plans implemented where required to manage/mitigate risks of any lift failure	Datix Reporting & Monitoring	Escalation to Clinical Board/Capital Estates	Monthly Review of Risks Directorate Q&S Meetings (monthly) Clinical Board Q&S Meetings (monthly) Regular walkabout with Estates (monthly)	Lifts are part of the UHB Lift Refurbishment Programme. Regular updates provided on progress and management when lifts are out of action	Monthly Review of Risks by Directorate 3-6 monthly review of Risks by Clinical Board	HIW Maternity Report and CHC Maternity Report and survey	Estates Review Follow-up Report	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Regular reviews of bed availability or patient flow.	*Are there any data systems or streams that highlight the effeciveness of controls in place - e.g. Datix Reports to show a decline in entries following implementation of controls.*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds, Patient Feedback.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk .*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, Audit Wales*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR14	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
There is a risk of harm and poor patient experience as a result of lack of available provision for emergency gynaecology care resulting in delays.	Daily Staff Huddles Sickness Reviews Planning Meetings for staffing review for each shift Weekend Planning Meetings Wkly Seniors Meeting- review of next 10days of staffing	Datix Reporting & Monitoring Staff Rosters Sickness Rates ESR	Escalation to Clinical Board	Monthly Review of Risks Directorate Q&S Meetings (monthly) Clinical Board Q&S Meetings (monthly) 1:1 meetings with Head of Midwifery & Director of Nursing (weekly) Wkly Seniors Meeting- review of next 10days of staffing	Estates review of ward space undertaken.	Monthly Review of Risks by Directorate 3-6 monthly review of Risks by Clinical Board	HIW Unannounced Visit (Full report awaited)	N/A	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR15	**First Line of Defence** Management Controls			**Second Line of Defence** Oversight functions, e.g. Compliance and quality sub-groups and risk management			**Third Line of Defence** Internal Audit, External Audit and other regulators and independent assurance providers.		
	Operational Processes and Management Reviews	Management Information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of harm to children and young people due to increased demand for CAMHS services.	Daily Staff Huddles (3x times per day) Sickness Reviews x2 weekly meeting with Local Authority Partners	Datix Reporting & Monitoring Staff Rosters Sickness Rates ESR	Escalation to Director of Nursing / Executive Director of Nursing for enhanced overtime where necessary	Monthly Review of Risks Directorate Q&S Meetings (monthly) Clinical Board Q&S Meetings (monthly) 1:1 meetings with Lead Nurse & Director of Nursing (weekly)	Involvement from H&S Team and V&A team (Carl Ball) for training support CAMHS	Monthly Review of Risks by Directorate 3-6 monthly review of Risks by Clinical Board	Not currently	Not currently	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk -*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g -*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection,*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other*

CRR16	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm and experience and reputational damage due to non-compliance against Ockenden Report recommendations	Regular meetings between Directorates, Clinical Board and Executive Team to review all controls and assurances	Datix Reporting & Monitoring Business case submitted outlining RAG rated position against recommendations approved and implementation phase commenced	Escalation to Clinical Board/Executive Team	Monthly Review of Risks Directorate Q&S Meetings (monthly) Clinical Board Q&S Meetings (monthly)	N/A	Monthly Review of Risks by Directorate 3-6 monthly review of Risks by Clinical Board	HIW Unannounced Visit (Full report awaited)		
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR17	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm within Child and Adolescent Learning Disability Services due to staff vacancies.	Currently new referrals are not able to be managed. All inquiries are triaged at weekly meetings to assess risk and communicate across	Child case notes audited via Paris. Minutes and Action Logs from weekly meetings audited and sent to JH on a regular basis	Senior manager review escalation to general manager and QSPE.	Monthly Directorate and CB QSPE meetings.	N/A	Monthly Review of Risks by Directorate 3-6 monthly review of Risks by Clinical Board			
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR18	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of failure to comply with regulatory requirements and patient harm due to delays in assessment within Children Looked After Services.	Daily staffing reviews and updates.		Senior manager review escalation to general manager and QSPE.	Monthly Directorate and CB QSPE meetings.		Monthly Review of Risks by Directorate 3-6 monthly review of Risks by Clinical Board			
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR19	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm and poor patient experience due to staffing difficulties and shortages within maternity services.	Daily Staff Huddles Sickness Reviews Planning Meetings for staffing review for each shift Weekend Planning Meetings Wkly Seniors Meeting-review of next 10days of staffing	Datix Reporting & Monitoring Staff Rosters Sickness Rates ESR	Escalation to Director of Nursing / Executive Director of Nursing for enhanced overtime where necessary	Monthly Review of Risks Directorate Q&S Meetings (monthly) Clinical Board Q&S Meetings (monthly) 1:1 meetings with Head of Midwifery & Director of Nursing (weekly) Wkly Seniors Meeting-review of next 10days of staffing		Monthly Review of Risks by Directorate 3-6 monthly review of Risks by Clinical Board	HIW Unannounced Visit (Full report awaited)	Nurse Bank Report	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR20	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
There is a risk to the delivery of modern, safe and sustainable healthcare due to suboptimal estate across the Clinical Board	Regular walkarounds of high risk estate, e.g morturay and Radiopharmacy. Escalating immeditae works to CEF colleagues. Working with national programmes on regional solutions regarding radiopharmacy (TrAMS)	Incidents monitored through regulatory compliance and QSE meetings	Regular audit underatken as part of regulatory compliance meetings, including environmental monitoring.	Monthly regulatory compliance meetings for regulated areas. QSE meetings for directorates to escalate risks. Monthly clinical board reviews with execs to escalate risks when required	CEF and mortuary working up outline business case for submission to WG to seek additional capital funds.	Risk Management Review May 2023	**MHRA** inspected radiopharmacy Dec 2019: findings included major deficiencies in facility not meeting current design and maintenance expectations in that the Grade B clean room is directly linked to unclassified hot lab support room. The Grade C/B change room is		The external inspections review all of the quality management systems ensuring that we continue to evidence the sustaining of other quality factors through the regulatory compliance dashboard, providing some mitigation to the
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR21	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
There is a risk to the delivery of modern, safe and sustainable healthcare due to ageing equipment across the Clinical Board	Regular walkarounds of high risk estate, e.g morturay and Radiopharmacy. Escalating immeditae works to CEF colleagues. Working with national programmes on regional solutions	Incidents monitored through regulatory compliance and QSE meetings	Regular audit underatken as part of regulatory compliance meetings, including environmental monitoring.	Monthly regulatory compliance meetings for regulated areas. QSE meetings for directorates to escalate risks. Monthly clinical board reviews with execs to escalate risks when required	CEF and mortuary working up outline business case for submission to WG to seek additional capital funds.	Risk Management Review May 2023	**MHRA** inspected radiopharmacy Dec 2019: findings included major deficiencies in facility not meeting current design and maintenance expectations in that the Grade B clean room is directly		The external inspections review all of the quality management systems ensuring that we continue to evidence the sustaining of other quality factors through the regulatory
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR22	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk to patient safety causing serious incidents due to patients not being admitted Critical Care Department in a timely manner due to insufficient nursing workforce.	*ITU Phased 'Doubling up' of nursing staff where 1 nurse cares for 2 patients instead of 1* *Use of overtime, bank, agancy & locum staff to fill gaps in rotas* *Staff redeployment to areas with greatest need* *Delayed ITU transfers to CT/MRI etc to balance clinical requirements* *Daily prioritisation of clinical caseload based on those with highest need.* *Flexible AHP workforce between critical care and long-term ventilation service.* *Weekly multi-professional meetings to discuss patient goals and needs* *Regular senior AHP meetings to discuss service provision*	*Management tracking of staff changes to ensure prompt recruitment to minimise gaps* *Vacancy tracking and recruitment data from Trac* *Patient acuity data* *Safe staffing compliance data per shift* *Regular daily huddles and coordination with Senior Management Team as risk level increases.* *Weekend planning process* *Tendable audit data* *Datix incident data* *Nationally Reportable Incident investigations* *Mortality Review Process*	*BIS Dashboard data* *Quarterly Intensive Care National Audit & Research Centre (ICNARC) Audits* *Values based appraisal process* *Exit questionnaires* *Staff sickness absence data*	*Monthly Directorate DMT and Q&S Meeting. Issue regularly escalated to Clinical Board QSE and via Directorate and Clinical Board Performance Reviews* *Multiple Q&S initiatives to improve the working environment reduce turnover including Health & Safety Initiatives, policy and equipment updates* *Focus on staff wellbeing led by the ITU Clinical Psychology Service* *Team meetings provide educational and general support systems for staff as well as creating a feedback loop*	*No clear plan for increase in ITU AHP workforce in line with national guidelines and existing workforce vulnerable to further deterioration e.g., maternity leave, long term sickness, relocation of LTV services Director of Finance and Clinical Board exploring commissioning arrangements to agree strategy for increased ITU funding in line with required capacity. Engagement with key stakeholders in the production of the Critical Care escalation policy.*	*An increase in AHP workforce within critical care will reduce the associated risks however there is currently no clear plan for this to occur. Previous attempts to increase funding and hence staffing to recommended standards (GPICS v2.1) have not been successful.* *Risk Management Review May 2023*	*Non-compliance with GPICS V2.1 Guidelines advocated by Intensive Care Society and Faculty of Intensive Care Medicine* *Interaction with Welsh Critical Care Network*	*None known*	*Excess patient deaths associated with the Standardised Mortality Ratio in Critical Care (provided by ICNARC) being above the national mean.* *FICM External Audit of Compliance with GPICS V2.1 Guidelines* *Ongoing potential for Healthcare Inspectorate Wales Audit/Inspections*
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR23	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk to patient safety causing serious incidents due to patients not being admitted to Critical Care Department in a timely manner due to insufficient bed capacity.	*Temporary surge capacity in use within C3 Link to provide 10 additional beds.* *Prioritisatipn of patients with highest IP&C risk/need for isolation.* *Risk of capacity loss due to plumbing leaks and blockages minimised by prompt fault reporting.* *Plumbing infrastructure on site known to be unfit for purpose. Escalation of unresolved issues to clinical board.* *PACU designated as decant location for significant infrastructure failures.* *Local Operational Policies, SOP's and operational guidelines to be followed.* *Maintanance of clutter-free clinical environment* *Precise stock management and decanting processes*	*Regular daily patient flow huddles and coordination with Patient Access Team. Escalation to, and involvement of, Senior Management Team as risk escalates.* *Prompt repatriation and warding of patients deemed suitable for discharge.* *Tendable audit data including monitoring comliance with operational, clinical, IP&C, environmental and waste management policies as well as the general condition of facility environment* *Datix incident data* *Nationally Reportable Incident investigations* *Mortality Review Process*	*BIS Dashboard data* *Housekeeping C4C score data* *IP&C Specialist Nurse Audit* *Targeted environmental microbial screening as required* *Quarterly Intensive Care National Audit & Research Centre (ICNARC) Audits*	*Monthly Directorate DMT and Q&S Meeting.* *Issue regularly escalated to Clinical Board QSE and via Directorate and Clinical Board Performance Reviews* *There is a requirement for a bespoke 10 bed LTV facility but no funding and location is available.* *Approach made to Critical Care Network to seek an alternate provider of LTV services but none available*	*Director of Finance and Clinical Board exploring commissioning arrangements to agree strategy for increased funding in line with required capacity.* *Engagement with key stakeholders in the production of the Critical Care escalation policy.* *Acute Hospital Service relocation and renovation scheme commenced.* *Architectural drawings for refurbiushment being developed. The design will include pendant replacement.* *Space constraints mean that full WHBN04-02 compliance is unlikely without a full rebuild* *Plumbing potentially replaceable with a refurbishment provided work required in other departments/floors can take place.*	*Risk escalated to Clinical Board, Estates amnnd Capital Planning Team who are in the design process for refurbishment and expansion of Critical Care.* *It is unclear whether C3 Link (or another surge location) will continue to be available and not all aspects of the escalation policy have been signed off by the relevant stakeholders* *Risk Management Review May 2023*	*Non-compliance with GPICS V2.1 Guidelines advocated by Intensive Care Society and Faculty of Intensive Care Medicine* *Non-compliance with WHBN04-02* *Interaction with Welsh Critical Care Network*	*None known*	*Excess patient deaths associated with the Standardised Mortality Ratio in Critical Care (provided by ICNARC) being above the national mean.* *FICM External Audit of Compliance with GPICS V2.1 Guidelines* *Ongoing potential for Healthcare Inspectorate Wales Audit/Inspections*
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR24	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk that patients will not receive care in a suitable environment due to a number of shortcomings in critical care facilities.	*Local Operational Policies, SOP's and operational guidelines to be followed.* *Facility Cleaning and Task Schedules.* *Prompt reporting of facility maintenance requests and escalation of persisting problems.* *Maintanance of clutter-free clinical environment* *Precise stock management and decanting processes*	*HCAI monitored monthly and RCA completed for monitored organisms.* *Tendable audit data including monitoring comliance with operational, clinical, IP&C, environmental and waste management policies as well as the general condition of facility environment* *Datix incident data* *Nationally Reportable Incident investigations* *Mortality Review Process*	*BIS Dashboard data* *Housekeeping C4C score data* *IP&C Specialist Nurse Audit* *Targeted environmental microbial screening as required* *Quarterly Intensive Care National Audit & Research Centre (ICNARC) Audits*	*Monthly Directorate DMT and Q&S Meeting.* *Issue regularly escalated to Clinical Board QSE and via Directorate and Clinical Board Performance Reviews*	*Acute Hospital Service relocation and renovation scheme has commenced and the Capital Planning team are in the process of developing architectural drawings for a reconfigured space. Refurbishment design work includes pendant replacement.* *Due to space constraints, full WHBN04-02 compliance is unlikely to be possible, but it is possible to reduce this risk further.* *A full rebuild would be required to reduce this to zero*	*Risk escalated to Clinical Board, Estates amnnd Capital Planning Team who are in the design process for refurbishment and expansion of Critical Care.* *Risk Management Review May 2023*	*Non-compliance with GPICS V2.1 Guidelines advocated by Intensive Care Society and Faculty of Intensive Care Medicine* *Non-compliance with WHBN04-02* *Interaction with Welsh Critical Care Network*	*None known*	*Excess patient deaths associated with the Standardised Mortality Ratio in Critical Care (provided by ICNARC) being above the national mean.* *FICM External Audit of Compliance with GPICS V2.1 Guidelines* *Ongoing potential for Healthcare Inspectorate Wales Audit/Inspections*
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR25	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risks to harm to haematology patients (including bone marrow transplant) due to cross infection hazards created by an inadequate clinical environment.									
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR26	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of patient harm due to reduced access to Epilepsy Telemetry Services.									
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR27	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Financial Reporting and Savings Target Report								Financial Reporting and Savings Target Report	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR28	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data.	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of failure to achieve an approved 3 year IMTP due to a planned deficit of £88.4 million								Financial Reporting and Savings Target Report	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

CRR29	First Line of Defence			Second Line of Defence			Third Line of Defence		
	Operational Processes and Management Reviews	Management information and data	Other - Self assessment	Compliance / Quality	Health and Safety / Estates	Risk Management	Regulatory Body	Internal Audit	External Audit
Risk of service interruption and potential patient harm due to cyber security threats.								Network and Information Systems Report	
	Please include the detail of any operational processes or checks that are in place which show the effectivess of controls in place - e.g Staff huddles	*Are there any data systems or data streams that highlight the effeciveness of controls in place - e.g. Datix Staffing reports*	*Are there any local assessments or audits undertaking to monitor the effectiveness of controls in place to manage this risk - e.g. Tendable Reviews, Senior Manager/Lead Nurse Walk Arounds.*	*Are the regulary Q&S or Compliance Meetings that take place to review the effectivess of controls to mitigate this risk - e.g - Monthly Clinical Board Reviews or Escalations to Corporate Nursing.*	*Have H&S or Estates provided any support or assurance regarding controls in relation to this risk - Unlikely for this specific Risk.*	*When was this risk last reviewed by the Risk Management Team - To be populated by Risk Colleagues.*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. HIW Inspection, feedback on Nurse Staffing Levels.*	*Have Internal Audit Undertaken a Review in Relation to the issues identified by this risk? If so what was the Audit Report Title and Outcome?*	*Have we received any feedback from an external regulator in relation to this issue? What was the feedback? - E.g. CHC or other external review?*

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	23 March 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Recruitment Update

The Recruitment Modernisation Plan is positively impacting performance, with the time to hire for new recruits effectively being halved at the initial sites where the changes have been fully implemented. Actions have included the training of over 1800 Recruitment Managers across NHS Wales in the last twelve months and the provision of regular and dedicated communications. One area still in need of improvement is to receive more comprehensive forecast information from Health Boards, Trusts, and Special Health Authorities, in terms of recruitment plans for the medium and longer term.

The Committee **NOTED** the update.

Chair's Report

The Chair updated the Committee on attendance at recent meetings, both within NWSSP and externally. The Chair also confirmed the dates of further Committee development sessions, on the 9th of June and the 10th of November.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The number of fleet electric vehicles has increased but the UK Government trial of electric HGVs is stalled.
- Consultation with staff has started regarding the move from Companies House to Cathays Park.
- Brecon House accommodation in Mamhilad continues to have structural issues

with the concrete roof structure which means that we will need to look for alternative accommodation to store the primary care records.
- Welsh Government have confirmed that the required capital is not available to support the OBCs for the Laundry Service, and we are therefore working on an alternative "do minimum" plan which will allow us to refurbish three of the existing sites but within a substantially reduced capital envelope.
- There is an ongoing conversation with colleagues in Welsh Government around PPE storage, stock management, ordering, delivery, and the links to supplies to Primary Care and Social Care.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Duty of Quality

The Committee discussed and **APPROVED** a paper setting out the proposed approach that NWSSP will adopt to take forward compliance with the Duty of Quality. This includes the role of the Partnership Committee to provide oversight and the twofold role NWSSP will have in providing evidence under Duty of Quality.

Chair's Action – Telephony and Contact Centre

This relates to a joint procurement led by DHCW to award a new contract for telephony and contact centre systems that just missed the deadline for the January Committee. Approval had been given under Chair's Action on behalf of both the Committee and the Velindre Trust Board.

The Committee **RATIFIED** the contract award.

Energy Procurement

Eifion Williams attended to present this item. Following the withdrawal of British Gas from the commercial energy market, alternative options had been presented to Directors of Finance and a decision taken to establish a revised procurement arrangement with Crown Commercial Service (CCS), due to their substantial presence in the energy market across the public sector. The new arrangements will come into force in October of this year, NHS Wales would participate in fixed price energy baskets to cover the first 18 months of the contract removing financial uncertainty. Existing forward purchases with British Gas will be sold back to the supplier generating a surplus for NHS Wales. The Directors of Finance also suggested a change in governance arrangements and consequently the Energy Price Risk Management Group will be replaced by the Welsh Energy Group and the Welsh Energy Operating Group, with the former being a sub-committee to the Partnership Committee.

The Committee **APPROVED** the transfer to CCS, the fixed purchase price of energy, the sale back of existing forward purchase to British Gas, and the establishment of the Welsh Energy Group and the Welsh Energy Operating Group.

Items for Noting

Chair's Appraisal

The Chair's appraisal was conducted earlier in the month and included feedback by Committee members. A summary of the appraisal was provided to Committee members.

The Committee **NOTED** the paper.

Overpayment Policy

The Committee Members discussed the Overpayments update report presented by the Director of Finance. It was agreed that further work was needed to develop an all-Wales Overpayment policy as well as to review the end-to-end processes and streamline procedures which would make it easier for managers to submit termination documentation. It was agreed that further updates would be provided to the Committee members once the various Task and Finish Groups and Service Improvement Team had looked into the issues in more detail.

The Committee **NOTED** the paper.

Finance, Performance, People, Programme and Governance Updates

Finance –The position at M11 forecasts a break-even position with £2m re-distributed to Health Boards. The Welsh Risk Pool forecast outturn position remains as forecast in the IMTP, and all allocated capital funding should be utilised by the end of March.

People & OD Update – Sickness absence rates remain very low, and there has been an increase in Statutory and Mandatory Training compliance to 91%. PADR completion is almost at green. The only area of concern is staff turnover, which is higher than expected, and a review is being undertaken to investigate the reasons for this.

Performance – The in-month (January) performance was generally good with 32 out of 37 KPIs achieving target. The one red-rated indicator was Payroll call-handling, but steady improvements are now being noted in this area.

IMTP Q3 Progress Report - 78% of required actions are either complete or on-track, with those actions that are off track are assessed during the quarterly review process within NWSSP.

Project Management Office Update – The Case Management System and the Laundry Transformation Projects remain red-rated and are also included as red risks on the Corporate Risk Register. All other projects are on track.

Corporate Risk Register – There remain seven red-rated risks covering areas such as energy costs and provision, industrial action, insufficient staff resource, the Legal and Risk and Laundry project risks, and an issue with the roof of Brecon

House that may require the lease to be terminated. The Committee **NOTED** the above Reports.
Papers for Information
The following items were provided for information only: • Audit Committee Assurance Report; • Finance Monitoring Returns (Months 10 and 11).
AOB
N/a
Matters requiring Board/Committee level consideration and/or approval
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.
Matters referred to other Committees
N/A

Date of next meeting	18 May 2023

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 14 MARCH 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 14 March 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at:
2022/2023 Meeting Papers - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on 10 January 2023, 17 January 2023, and 13 February 2023 were **approved** as a true and accurate record of the meeting, subject to one minor amendment.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. Governance System and Process – WHSSC & HB Shared Pathway Saving Target
Members received a presentation on the outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target, which had been requested following the Joint Committee approving the Integrated Commissioning Plan (ICP) 2023-2024 on 13 February 2023.

Members noted that WHSSC had applied a programme management approach to establishing a mechanism to monitor savings and efficiencies and had developed a Project Initiation Document (PID) outlining that a Programme Board be established comprising of representatives from each Health Board (HB). The PID had been shared with the Management Group in readiness for detailed discussion on the 23 March 2023.

Members noted that updates on progress would be provided as a standing item on the agenda for future Joint Committee meetings.

Members **noted** the presentation.

4. Chair's Report

Members received the Chair's Report and **noted**:

- The Chair's Action taken on 2 February 2023 to approve urgent patient expenditure for Advanced Medicinal Therapeutic Products (AMTPs) through the Blueteq High Cost Drugs (HCD) software programme,
- The request to extend the interim Chair of the Individual Patient Funding Request (IPFR) Panel from 31 March 2023 to 30 September 2023,
- That the Minister for Health & Social Services had approved a review of the national commissioning functions, linked to the commitment within a "Healthier Wales" on a set of actions to strengthen and streamline the NHS landscape in Wales. Members noted that the joint workshop between EASC and WHSSC planned for 14 March 2023 to enable a facilitated discussion on the review had been postponed as the independent facilitator had been taken ill; and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Ratified** the Chairs action taken on 2 February 2023 to approve expenditure for Advanced Medicinal Therapeutic Products (AMTPs) through the Blueteq High Cost Drugs (HCD) software programme; and (3) **Approved** the recommendation to extend the tenure of the interim Chair of the Individual Patient Funding Request Panel (IPFR) to 30 September 2023 to ensure business continuity.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **Plastic Surgery Outreach Clinics in BCUHB: Update on Quality Concerns** - During the plastic surgery workshop held with the Management Group on 22 September 2022 to consider the future commissioning model for plastic surgery, significant quality concerns were raised by the clinical leads from St Helen's & Knowsley NHS Trust (SHKNT). Since then further concerns were raised during an SLA meeting in February 2023, WHSSC has discussed the issues with colleagues in Welsh Government (WG), and it was agreed that, given the issues did not lie directly within the WHSSC commissioning responsibility, WG will lead on the escalation process but in liaison with WHSSC. In addition, a Harm Review has been commissioned by BCUHB and the Terms of Reference (ToR) are in the process of being signed off through internal HB processes,
- **Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement Process Update -** the formal engagement ran between 4 January 2023 and 14 February 2023. The consultation feedback is now being analysed and will be presented to members at the Joint Committee meeting on 16 May 2023; and

- **Spinal Operational Delivery Network (ODN)** - The implementation of the Spinal Operational Delivery Network (ODN) has been delayed due to unforeseen circumstances. A more detailed update will be presented to the Joint Committee meeting on 16 May 2023.

Members **noted** the report.

6. Delivering Thrombectomy Capacity in South Wales
Members received a report outlining WHSSC's position on the commissioning of Mechanical Thrombectomy for the population of Wales.

Members (1) **Noted** the report, (2) **Noted** the WHSSC Position Statement on the Commissioning of Mechanical Thrombectomy, (3) **Noted** the associated risks with the current delivery model for Welsh stroke patients requiring access to tertiary Thrombectomy centres; and (4) **Noted** the NHS Wales Health Collaborative (NWHC) proposal to strengthen and improve regional clinical stroke pathways in Wales to support the Mechanical Thrombectomy pathway to ensure that patients receive this time-critical procedure in a timely manner.

7. Eating Disorder In-Patient Provision for Adults
Members received a report outlining the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements.

Members (1) **Noted** the information presented within the report to progress tendering and procurement options with the independent sector in line with service need for Welsh patients requiring specialist eating disorder services, (2) **Noted** the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements; and (3) **Received assurance** that there are robust processes in place to ensure delivery of eating disorder services for adults.

In addition, it was agreed to bring the tender specification back to a future meeting to provide assurance to the JC regarding the quality requirements of the new service.

8. Neonatal Transport ODN – Additional Funding Release
Members received a report advising that the Management Group approved the release of £125k for the establishment of the Neonatal Transport Operational Delivery Network (ODN) for Swansea Bay UHB as the host provider in December 2022, and which sought approval from the Joint Committee for an additional £54k of funding to bridge the shortfall from the original funding request from SBUHB and to allow the implementation of the ODN to proceed.

Members (1) **Noted** the report; and (2) **Approved** the release of an additional £54k funding for the Neonatal Transport ODN to allow the implementation of the Operational Delivery Network (ODN) to proceed.

9. Neonatal Cot Configuration Project

Members received a report outlining the outcomes of the Neonatal Cot Configuration project, the proposed preferred option as recommended by the Project Board and seeking approval for the required long-term next steps.

Members discussed the need for broader discussion linked to interdependencies with maternity services and other core paediatric services, in developing the next steps. The challenges associated with meeting the British Association of Perinatal Medicine (BAPM) standards and the historic work previously undertaken through the South Wales plan were also discussed.

Members (1) **Noted** the background within the report, (2) **Noted** the outcomes of the Neonatal Cot Configuration Project, (3) **Noted** the financial assessment, (4) **Noted** the preferred option of the Project Board, (5) **Approved** the recommended preferred option and the release of funding in line with the provision within the 2022/25 Integrated Commissioning Plan (ICP) as an interim measure; and (6) **Did not Approve** the recommendation of the Management Group for a phase 2 programme of works to be undertaken, but agreed that the NHS Wales Directors of Planning Group consider the approach to reviewing the neonatal service model, aligning with Health Boards' strategic plans, regional work, and key service interdependencies. The output of the discussion to be brought back to the Joint Committee in May.

10. IPFR Engagement Update – ToR and All Wales Policy

Members received a report presenting the outcomes from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request (IPFR) Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy.

Members (1) **Noted** the report, (2) **Noted** the feedback received from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request (IPFR) Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy, (3) **Approved** the proposed changes to the WHSSC IPFR Panel ToR, (4) **Noted** that the additional feedback on the specific and limited review of the All Wales IPFR Policy is being reviewed and an update will be presented to the Joint Committee on 16 May 2023; and (**5) Noted** that when the limited review of the policy was completed and approved by the Joint Committee, the updated All Wales IPFR Policy (including the WHSSC ToR) will go to each Health Board (HB) for final approval.

11. WHSSC Governance & Accountability Framework – SOs and SFIs

Members received a report providing an update on the WHSSC Governance and Accountability Framework.

Members (1) **Noted** the report, (2) **Approved** the proposed changes to the Standing Orders (SOs), prior to being issued to the seven HBs for approval and inclusion as schedule 4.1 within their respective HB SOs, **(3) Approved** the proposed changes of the Memorandum of Agreement (MoA) and Hosting Agreement in place with CTMUHB, prior to being issued to the seven HBs for approval and inclusion as schedule 4.1 within their respective HB SOs; and (4) **Approved** the proposed changes to the financial scheme of delegation and financial authorisation matrix updating the Standing Financial Instructions (SFIs).

12. Performance & Activity Report Month 9 2022-2023

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period, and outlining signs of recovery in specialised services activity. The activity decreases were shown in the context of the potential risk regarding patient harms and of the loss of value from nationally agreed financial block contract arrangements

Members **noted** the report.

13. Financial Performance Report – Month 10 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 10 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 10 for WHSSC is a year-end outturn forecast under spend of (£14.353m). Members noted that the under spend predominantly relates to releasable reserves of (£18m) arising from 2021-2022 as a result of WHSSC assisting Health Boards manage resources over financial years on a planned basis, as HBs could not absorb underspends above their own forecasts and to ensure the most effective use of system resources.

Members **noted** the current financial position and forecast year-end position.

14. Neonatal Delivery Assurance Group (DAG) Update

Members received a report providing a summary of South Wales Neonatal Transport Delivery Assurance Group (DAG) Report for July-November 2022.

Members (1) **Noted** the information in the report; and (2) **Received assurance** that the Neonatal Transport service delivery and outcomes were being scrutinised by the Delivery Assurance Group (DAG).

15. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

16. Other reports

Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC),
- Quality & Patient Safety Committee (QPSC; and
- Welsh Kidney Network (WKN).