Public Board Meeting

Thu 28 September 2023, 09:30 - 14:30

Woodland House, Nant Fawr Room 2 & 3

Agenda

09:30 - 09:32
2 min

1. Welcome & Introductions

Charles Janczewski

09:32 - 09:34
2 min

2. Apologies for Absence

Charles Janczewski

09:34 - 09:36
2 min

3. Declarations of Interest

Charles Janczewski

09:36 - 09:38
2 min

4. Minutes of the Board Meeting held on 27 July 2023

Charles Janczewski

4. Public Board Minutes 27.07.2023.pdf (21 pages)

09:38 - 09:40
2 min

5. Action Log – 27 July 2023

Charles Janczewski

5. Public Board Action Log.pdf (3 pages)

09:40 - 12:40
180 min

6. Items for Review and Assurance

6.1. Patient/Staff Story – Vinnie’s Story

Fiona Kinghorn

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

Charles Janczewski

6.2 Chair's Report to Public Board - Sept 2023.pdf (8 pages)

6.3. Chief Executive Report

Suzanne Rankin

6.3 CEO Report to Board - September.pdf (4 pages)

6.4. Board Assurance Framework

Matt Phillips

6.4 Cover Report Board Assurance Framework - Sep 2023.pdf (3 pages)

6.4a Board Assurance Framework.pdf (73 pages)

6.5. Chairs' reports from Committees of the Board:

i) Audit & Assurance Committee: 05.09.23 (verbal)

ii) Finance & Performance Committee: 23.08.23 (report) & 20.09.23 (verbal)

iii) Quality, Safety & Experience Committee: 30.08.23 (report) & 26.09.23 (verbal)

iv) People & Culture Committee: 12.09.23 (verbal)

v) Mental Health Legislation & Mental Capacity Act Committee: 01.08.23 (report)

6.6. Integrated Performance Report:

Fiona Kinghorn / Paul Bostock / Rachel Gidman / Jason Roberts / Catherine Roberts

Public Health

Operational Performance

People & Culture

Quality, Safety & Experience

Finance

6.6 C&V IPR Corporate Header September 2023.pdf (5 pages)
6.6a C&V Integrated Performance Report September 2023.pdf (30 pages)

6.7. Break for Refreshments (10 minutes)

6.8. Reinforced Autoclave Aerated Concrete (RAAC) – Structures and Condition within Cardiff and Vale University Health Board Estate

Catherine Phillips

6.8 RAAC Board Report.pdf (7 pages)

6.9. Vaccination and Tackling Inequities in Uptake

Fiona Kinghorn

Presentation

6.9 Vaccination and inequities slides.pdf (12 pages)

6.10. Neonatal Care / Letby

Jason Roberts

6.10 Neonatal Report.pdf (8 pages)

6.11. Strategic Planning Update

Abigail Harris

6.11 Strategic Planning Update Sept 23.pdf (6 pages)

6.12. Integrated Annual Plan Quarter 1 Report

Abigail Harris

6.12 Integrated Annual Plan 20232024 Quarter 1 Report.pdf (3 pages)
6.12a Integrated Annual Plan 20232024 Quarter 1 Report.pdf (14 pages)

6.13. Shaping our Future Wellbeing - Refreshed Strategy

Abigail Harris

The English & Welsh Version of the Refreshed Strategy can be located in the Supporting Documents Folder.

- 6.13 Strategy Refresh - Board Paper.pdf (2 pages)

12:40 - 14:05
85 min

7. Items for Approval / Ratification

7.1. Operational Winter Plan

Paul Bostock

- 7.1 Winter Plan Cover Paper - Board.pdf (4 pages)
- 7.1a Winter Plan - Board 28th September 2023.pdf (19 pages)

7.2. Tissue and Organ Donation Annual Report

Richard Skone

- 7.2 Tissue and Organ Donation Cover Report.pdf (3 pages)
- 7.2a Tissue Donation - March 2023 committee report.pdf (4 pages)
- 7.2b Tissue and Organ Donation Detailed Report.pdf (36 pages)

7.3. Equity, Equality, Experience and Patient Safety Framework

Fiona Kinghorn

- 7.3 Equity Equality Experience & Patient Safety Framework.pdf (3 pages)
- 7.3a Equity Equality Experience and Patient Safety Framework.pdf (11 pages)

7.4. Interventional Radiology Business Report

Paul Bostock

- 7.4 Interventional Radiology Business Report ns.pdf (3 pages)
- 7.4a NWSSP Procurement Report IR Replacment Project.pdf (5 pages)

7.5. Ombudsman Annual Letter 2022/23

Jason Roberts

The Welsh Version of the letter can be located in the Supporting Documents Folder.

- 7.5 Psow Ombudsman Annual Letter for Board.pdf (5 pages)
- 7.5a CAVUHB- ENG - 22-23 Annual Letter (2).pdf (8 pages)

7.6. Armed Forces Covenant

Suzanne Rankin

- 7.6 Armed Forces Covenant 24 Aug 23.pdf (3 pages)
- 7.6a Armed Forces Covenant Business Covenant.pdf (4 pages)

7.7. Naming of “CD1” – Cardiff Edge Business Park

Abigail Harris

- 7.7 GPW Cardiff Edge CD1 Building Name Report Board Sept 2023 v.2.pdf (3 pages)

7.8. Break for Lunch (30 minutes)

14:05 - 14:05
0 min

8. Items for Noting and Information

8.1. Corporate Risk Register

Matt Phillips

- 8.1 Corporate Risk Register Update.pdf (5 pages)
- 8.1a Appendix A - Corporate Risk Register September 2023 - Board Summary.pdf (3 pages)
- 8.1b Appendix B - Assurance Map September 2023.pdf (2 pages)

8.2. Declare as surplus – Park View Site

Catherine Phillips

8.3. Chair's Reports from Advisory Groups and Joint Committees:

i. EASC Chair's Report - 18.07.23

ii. Local Partnership Forum - 10.08.23

- 8.3.1 Chair's EASC Summary from 18 July 2023.pdf (9 pages)
- 8.3.2 LPF Summary from 10 August 2023.pdf (3 pages)

8.4. Model Standing Orders for The Emergency Ambulance Services Committee (EASC)

Matt Phillips

- 8.4 Model SOs for the EASC.pdf (56 pages)

8.5. Committee / Governance Group Minutes:

Matt Phillips

i. Local Partnership Forum Minutes - 08.06.23

ii. Quality, Safety & Experience Minutes - 18.07.23

iii. Digital & Health Intelligence Minutes - 30.05.23

iv. Finance & Performance Minutes - 19.07.23

v. People & Culture Minutes - 11.07.23

vi. Audit & Assurance Minutes - 04.07.23

vii. Mental Health Legislation & Mental Capacity Act Minutes - 02.05.23

- 8.5.1 LPF minutes 8 June 2023.pdf (9 pages)
- 8.5.2 QSE Minutes 18.07.23.pdf (13 pages)
- 8.5.3 DHIC Minutes 30.05.23.pdf (11 pages)
- 8.5.4 Finance & Performance Minutes 19.07.23.pdf (10 pages)
- 8.5.5 People & Culture Minutes 11.07.23.pdf (10 pages)
- 8.5.6 Audit Minutes 04.07.23.pdf (9 pages)
- 8.5.7 MHLMCA Minutes 02.05.23.pdf (12 pages)

14:05 - 14:05
0 min

9. Agenda for Private Board Meeting:

i. *Approval of Private Board minutes*
ii. *South Wales Fire and Rescue Service Prosecution Update (Confidential Discussion)*
iii. *Approval of Private Committee minutes:*

14:05 - 14:05
0 min

10. Any Other Business

Charles Janczewski

14:05 - 14:05
0 min

11. Review of the meeting

Charles Janczewski

14:05 - 14:05
0 min

12. Date and time of next meeting:

Charles Janczewski

Thursday 30 November – CF61 Community Space, Station Road – CF61 1ST

14:05 - 14:05
0 min

13. Declaration:

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Unconfirmed Draft Minutes of the Public Board Meeting
Held On 27 July 2023
The All Nations Centre, Cardiff
9.30am

Chair:		
Charles Janczewski	CJ	University Health Board Chair
Present:		
Paul Bostock	PB	Chief Operating Officer
Marie Davies	MD	Deputy Director of Strategy & Planning
David Edwards	DE	Independent Member – ICT
Susan Elsmore	SE	Independent Member – Local Authority
Rachel Gidman	RG	Executive Director of People & Culture
Akmal Hanuk	AH	Independent Member – Local Community
Keith Harding	KH	Independent Member – University
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
Sara Moseley	SM	Independent Member – Third Sector
Ceri Phillips	CP	University Health Board Vice Chair
Catherine Phillips	CP	Executive Director of Finance
James Quance	JQ	Interim Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Nurse Director
David Thomas	DT	Director of Digital & Health Information
Rhian Thomas	RT	Independent Member – Capital & Estates
John Union	JU	Independent Member – Finance
In attendance:		
Joanne Brandon	JB	Director of Communications, Arts, Health Charity and Engagement
Angela Hughes	AH	Assistant Director of Patient Experience
Mark Jones	MJ	Financial Audit Manager – Audit Wales
Purva Shrivastava	PS	Operational Peer
Ian Virgil	IV	Head of Internal Audit
Robert Warren	RW	Head of Health & Safety – *Joined at 3.15pm*
Observers:		
Rebecca Aylward	RA	Deputy Director of Nursing
Joanne Brandon	JB	Director of Communications
Urvisha Perez	UP	Audit Lead – Audit Wales
Aaron Fowler	AF	Head of Risk & Regulation
Sarah Mohamed	SM	Corporate Governance Officer
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies:		
Sam Austin	SA	Deputy Chief Executive – Llamau
Lance Carver	LC	Director of Social Services
Abigail Harris	AH	Executive Director of Strategic Planning

Item No	Agenda Item	Action
UHB 23/07/001	**Welcome & Introductions** The University Health Board Chair (UHB Chair) welcomed all to the Board meeting in English and in Welsh.	
UHB 23/07/002	**Apologies for Absence** Apologies for absences were noted.	
UHB 23/07/003	**Declarations of Interest** No Declarations of Interest were noted	
UHB 23/07/004	**Minutes of the Meeting Held on 25 May 2023** The minutes from the Board meeting held on 25 May 2023 were received. Two grammatical changes were noted. **The Board resolved that:** a) The minutes from the Board meeting held on 25 May 2023 were approved as a true and accurate record of the meeting pending the grammatical changes.	
UHB 23/07/005	**Action Log** The Action Log was received. The Executive Director of People & Culture (EDPC) advised the Board that the Action UHB 23/01/011 around the Retire and Return could be marked as completed as the policy was out for consultation and would be reviewed as per process. **The Board resolved that:** a) The Action Log was reviewed and noted.	
UHB 23/07/006	**Patient/Staff Story – Purva Shrivastava** The Patient/Staff Story was received. Purva Shrivastava, the Operational Peer (OP) shared a presentation to the Board entitled “Lived Experience” and spoke of their journey and experience around working with the Recovery & Wellbeing College. They outlined the difficulties seen within mental health topics in coming from a South Asian background and noted that it took 6 months to accept their mental health issues and to then ask for help and treatment. The OP outlined the importance of adopting a “Lived Experience” approach as it could provide a number of positive outcomes which included: • A comprehensive understanding which involved lived experience individuals in discussions which led to a deeper understanding of complex issues.	

	• Improved Policies and Programs and the ability to design policies with the needs and experiences of those they intended to help in mind. • Empowerment of marginalised Communities which empowered by giving those communities a voice in decisions that affected them. The OP explained what the Recovery & Wellbeing college was and outlined the services and areas within the college that she had used for support which included: • Peer led support • Mental Health and Wellbeing Educational Service • Co-produced personal recovery • Lived Experiences She concluded the Recovery College had transformed them, had instilled hope, support, and a renewed purpose in navigating their mental health challenges. The Independent Member – Community (IMC) thanked the OP for sharing their story and noted that as part of the South Asian community himself, he understood the complexities around mental health and person acceptance and noted how important it was to highlight. The Executive Director of Public Health (EDPH) added that it was important to take time to engage with different groups and noted that a framework would be received by the Board at a future meeting and that the OP's experience and learning would help to form part of the framework. The Vice Chair of the Health Board (UHB Vice Chair) invited Board members to attend an open forum in September 2023 that would highlight the work being undertaken at the Recovery College. The Chief Executive Officer (CEO) concluded that the OP had provided an interesting perspective of the Recovery College from a personal view through to an operational one and thanked the OP for attending the Board and sharing their story. **The Board resolved that:** a) The Patient Story was noted.	
UHB 23/07/007	**Chair's Report and Chair's Action taken since last meeting** The Chair's Report and Chair's Action taken since the last meeting were received. The UHB Chair started by noting that it was the final meeting for the Interim Director of Corporate Governance (IDCG) as they would be leaving the Organisation in August. He thanked the IDCG for their hard work and support since starting in January 2023. The UHB Chair advised the Board that there were 2 areas to highlight from his report which included: • Recognition of our Capital Estates and Facilities Colleagues. It was noted that the Security Services Team had won the Estates and Facilities Team of the Year Award at the Welsh Institute of Healthcare Engineering & Estates	

	Management (IHEEM) awards in June 2023 and the UHB Chair added that the team touched every area of the Organisation and were crucial to the operation of the Health Board. • Fixing the Common Seal/Chair's Action and other signed documents. **The Board resolved that:** a) The report was noted. b) The Chair's Actions undertaken were approved c) The application of the Health Board Seal and completion of the Agreements detailed within the report were approved	
UHB 23/07/008	**Chief Executive Report** The Chief Executive Report was received. The CEO advised the Board that she would take the report as read and identified some key elements from the report which included: • The NHS at 75 years of age – It was noted that the driving force behind the success of the NHS across the UK, and closer to home within Cardiff and the Vale of Glamorgan, had been the commitment, dedication and excellence displayed by colleagues and friends over the last 75 years and recognising the successes and achievements of the NHS and colleagues at that historic milestone would be important. The CEO added that whilst the operating model continued to be a work in progress, there was a continued need to bring the overarching strategies to life and that during the period of celebration for NHS75, it was an opportune time to consider the Health Boards People and Culture Strategy and to celebrate the successes of colleagues to support the aim of having a workforce that felt valued, developed and supported, whilst maintaining their health and wellbeing at work. • RCN Wales Nurse of the Year 2023 – The CEO advised the Board that Tara Rees, a Lead Nurse Practitioner for the Hepatology Service within the Health Board had been named as the RCN Wales Nurse of the Year for 2023. • NHS Wales University Eye Care Centre – It was noted that the Cardiff Based team had won an award for their innovative work at the HSJ Digital Awards 2023 in Manchester in the Digital Literacy, Education and Upskilling category for their fantastic collaborative work in helping reduce sight loss. The CEO added that it was one of the most sought-after UK wide awards. Climb Leadership Programme – The CEO advised the Board that the Health Board's Dragon's Heart Institute shared the success of the Climb Leadership Programme's recent Summit Event, which took place on June 19th. The event celebrated the graduates of the second cohort of Climb as well as the 75th anniversary of the NHS. The CEO added that the event brought together leaders from diverse fields to exchange invaluable insights and explore the future of leadership in health and social care.	

	She added that the Climb Leadership Programme provided access to researchers, professors and leaders at the forefront of change which would support ongoing improvement and innovation within the Health Board's leadership teams for the future. The IMLA requested that Tara Rees be invited to the People & Culture Committee to discuss the work she had undertaken which had resulted in her being named RCN Nurse of the Year 2023. The Independent Member – Third Sector (IMTS) noted that the CEO report fitted in well with the rebranding of the Health Board's strategy and reinforced the development of the Health Board's position and branding being about the people in the Organisation. **The Board resolved that:** a) The strategic overview and key Executive activity to provide assurance described in the report was noted.	**RG**
UHB 23/07/009	**Board Assurance Framework** The Board Assurance Framework (BAF) was received. The Director of Corporate Governance (DCG) advised the Board that he would take the report as read. He added that the Board had received an extensive review at its meeting in May 2023 and that since that meeting, there had been once change in the score which included: • Risk 7. Planned Care had increased from a score of 8 to 12, in recognition of the challenge associated with delivering on the Ministerial priority in this area. The UHB Chair noted that he was content that the Board had drawn out the planned care risk. The Independent Member – Capital & Estates (IMCE) asked for further clarity around the risk on Maternity Care which outlined that the Health Board were currently unable to demonstrate compliance against a number of recommendations against the various external reviews and reports provided and the shortfall in midwives. The Executive Nurse Director responded that Midwifery had always been a bit of a passport into Health Care and that lack of midwives was not a trend. He added that in relation to experience and skill-mix within Midwifery, there was nobody in the Health Board with "midwife" in their title would could not deliver a baby. **The Board resolved that:** a) The 15 risks to the delivery of Strategic Objectives detailed on the BAF for July 2023 were reviewed and noted.	
UHB 23/07/010	**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: • **Charitable Funds Committee –** The Independent Member – Finance (IMF) noted that it was the first meeting held with him as the Chair of the Charitable Funds Committee and noted that the amount of work going on with the Health Charity and charitable funds was great. • **Finance & Performance Committee –** The Independent Member – Legal (IML) and Chair of the Committee advised the Board that at the meeting held the week prior to the Board meeting, the Committee had looked at the operational deficit situation and that ideas, savings and how that converted into actual real savings on the ground were discussed. He added that the Committee would keep a close eye on it. • **Quality, Safety & Experience Committee –** The UHB Vice Chair and Chair of the Committee advised the Board that a meeting was not held in June 2023 due to industrial action taking place and noted that the July meeting was a very full agenda. He added that having monthly meetings enabled the Committee to dig deeper into issues and that the trajectory of the Committee was providing evidence as to what was going wrong within the Health Board and signs of improvement. • **People & Culture Committee –** The IMTS and Chair of the Committee advised the Board that it had been the Committee's second meeting and that time had been spent on the Terms of Reference and Work Plan which were due to be received and approved by the Board at the meeting. She added that the Committee needed to make sure that it was focused on Clinical Directorates as well as the corporate team. **The Board resolved that:** a) The Committee Chairs' Reports were noted.	
UHB 23/07/011	**Integrated Performance Report:** The Integrated Performance Report was received. The Chair noted that the covering report was concise and noted that its new format which had been reviewed at the Board Development session held in June 2023 was being presented at the meeting and that all of the information could be seen within the document. **Public Health:** The Executive Director of Public Health (EDPH) advised the Committee that a lot of work was ongoing around vaccinations which included: • Spring Booster - surveillance data showed that the Cardiff and Vale uptake was below the 75% target, but was the same as the Welsh average with circa 9,300 opt outs locally, and it was noted that according to operational data, Cardiff and the Vale uptake was 88% excluding the opt outs.	

	• Childhood vaccination – It was noted that the Health Board was not where it wanted to be and so a paper would be taken the Quality, Safety & Experience Committee to provide further assurance. The EPDC concluded that the Board would receive a paper on Vaccination and Tackling Inequities in Uptake at the September Board meeting. **Operational Performance** The Chief Operating Officer (COO) advised the Committee that the Report was still a work in progress and would be updated with firmer trajectories in future iterations. Urgent care: • It was noted that internal ward moves had been finalised and the assessment unit and the speciality hub in the Emergency Unit (EU) had been closed. • It was noted that the Health Board were likely to see a spike in 12 hour waits for the next few weeks due to patients being "off the clock" in an area deemed not suitable. • It was noted that teams were expecting the overall 4-hour performance to worsen slightly due to the way in which patient's activity would be coded and counted. • It was noted that Welsh Government were very supportive of the approach being taken and that they wanted to use the Health Board as an exemplar on how same day emergency code was being counted and coded. Mental Health: • It was noted that there had been a spike in demands and that there were also issues in being able to cover the assessments. • The COO expressed confidence that the position would be recovered once quarter 4 was reached. • It was noted that a summit had been set up to take place in early September 2023 and would be attended by several Clinical Boards, Executives and the UHB vice Chair to understand what was driving the demands, the capacity and what could be reasonably done to manage the problem. Cancer: • It was noted that the Health Board was back on track and the 62-day position had improved. Planned care: • It was noted that the Health Board had received a letter from WG which confirmed £6m of funding but noted that there were clear conditions on what the money should be spent on. The CEO provided a reflection on the Mental Health demand and noted the risk associated with that demand. She added that the teams were doing their best to manage difficult circumstances with the support of the Executives.	**FK**

People & Culture

The Executive Director of People & Culture (EDPC) advised the Board that the data presented was concise and noted that more control was being observed around the temporary workforce.

She added that the trend of proportion of the pay bill spend on variable pay (bank staff, overtime etc.) was falling.

Quality and Safety:

The END advised the Board that he would take the paper as read and noted 5 key points which included:

- Concerns – 30-day performance had increased to 80% and maintained at that level.
- Duty of Candour - 3785 incidents have been reported by staff across the Health Board which reflected an open culture where staff felt comfortable to be able to speak up. The END provided assurance the Duty of Candour was being embedded into the Health Board system every day.
- Incident reporting - Pressure damage continued to be the highest incident reported which was being closely observed.
- Nationally Reportable Incidents (NRIs) observed an improving position which reflected the focus and hard work of the Clinical Board and Patient Safety Teams. The END advised the Board that the quality section of the Executive reviews in September 2023 would aim to close off any long standing NRIs to bring an approved position into the autumn.
- Infection Control – There had been significant improvement observed in C. difficile transmission.

The EMD advised the Board that mortality data would be brought back to the Board as performance against mortality reviews was a new measure from WG which could mature for the Integrated Performance Report.

She added that in relation to maternity data, multiple reports were being received by the Health Board and so a matrix was being developed which would be reported to WG and then to the Board when appropriate.

JR/MJ

Finance:

The Executive Director of Finance (EDF) advised the Board that the report highlighted the month 2 data and that the Finance and Performance Committee had received the month 3 data the week prior to the Board at its meeting.

She added that there had been significant escalation of finance meetings to finalise the Health Boards savings plan over the coming weeks.

The Board resolved that:

a) The contents of the report were noted.

UHB 23/07/012	**CIVICA Patient Feedback Update** The CIVICA Patient Feedback Update was received. The Assistant Director of Patient Experience (ADPE) presented the Board with the CIVICA Patient Feedback where it was noted that: • The CIVICA Once for Wales Feedback System was rolled out in October 2022. • The CIVICA Once for Wales Feedback System, was a new patient feedback system that allowed the Patient Experience Team to engage with the local community, to understand how the services the Health Board provides were working. • Patients would be sent a text message link to leave feedback on the services they had received. • The system allowed the Patient Experience Team to listen, learn and act upon what the public were telling them, on how to make improvements and provide a better experience. It was noted that accessibility had been looked at when creating the CIVICA Patient Feedback mechanism and that there were the options: • British Sign Language • "Recite Me" for those with visual impairment • Mobile friendly pages • Themes and posters designed for children and young people. • Surveys in various languages including English and Welsh. The Board were presented with some of the data which outlined how many text messages had been sent out as well as the number of responses received. The IMCE asked how CIVICA would reach the communities that were defined as "hard to reach". The ADPE responded that CIVICA had built good ways to communicate with those communities and noted that part of the strategy was about being clear and going out into those communities. The Chair asked if it was the intention to use CIVICA to inform the QSE Committee. The END responded that it was and noted it would form part of the reports received by the QSE Committee. **The Board resolved that:** a) The CIVICA Patient Feedback Update was noted.	
UHB 23/07/013	**Strategic Planning Update** The Strategic Planning Update was received. The Deputy Director of Strategy & Planning (DDSP) advised the Board that she would take the paper as read and noted that there were some areas to highlight which included 4 strategic programmes that were in progression.	

	She added that the strategic planning team held the ring on a number of key planning arenas including: • Updating of the Health Board's overarching strategy and strategic plans • The annual planning process leading to the production of the IMTP • Regional planning and partnership planning which included both the RPB Area Plan and the two PSB Wellbeing Plans. It was noted that the Area Plan had been finalised and endorsed by statutory partners which linked with the programme to continue to develop services in the community in a relation to emergency and unplanned response. The DDSP noted that the outline business case for the Ely Wellbeing Hub had been approved and work had commenced on the full business case and noted that discussions regarding the Penarth Wellbeing Hub were ongoing with Council colleagues and the local community. It was noted that a successful regional orthopaedics summit had taken place on 30th June 2023 which was very well attended by colleagues from all clinical and non-clinical disciplines across the region and that the summit provided the opportunity to give an overview of the purpose of regional working, enable clinical leads to outline the current clinical models, including what worked well and the obstacles they faced. The Chair noted that the annual plan cycle had been reviewed and asked if WG had provided any updated. The DDSP responded that no formal decisions had been made and noted that more discussion around strengthening the financial in year delivery would be required. The Chair noted that a slot would be held at the Board Development to discuss. **The Board resolved that:** a) The progress being made across the strategic planning portfolio was noted. b) The approach to Board engagement in the development of the 2024 – 2025 Annual Plan was supported. c) The development of a strengthened partnership approach for the future delivery of specialised services was supported.	
UHB 23/07/014	**Digital Transformation Progress Report** The Digital Transformation Progress Report was received. The Director of Digital & Health Intelligence (DDHI) reminded the Board that the Digital Strategy had been approved in 2020 and that the road map and detail within the plan continued to change but that the general vision still stood. The Board were presented with the progress made by way of a presentation which included: • A sample of initiatives that were underway including the national Radiology Informatics System Procurement (RISP) programme, the national Welsh critical care system, the national Ophthalmology and Genomics at the Cardiff Edge site. • Capacity for projects and large local initiatives	

	• Learning taken from discussions around the Digital Transformation Progress including the fact that it would be critical to have resources, leadership and capacity to support digital transformation and investment would be required to better support the transformation programme. • Journey to digital maturity – It was noted that there were over 100 programmes and projects in train at any one time as the Health Board responded to operational needs and that the digital SoC would build upon the Digital Strategy ambition to be a learning health and care system and work towards becoming a SMART healthcare system to facilitate delivery of redesigned and reimagined clinical pathways, models of care and, in time, new hospital buildings. The IMCE asked how the Health Board determined how much was required for digital spend. The DDHI responded that it was a historic figure and noted that the Health Board factored in what was coming through in terms of national programmes. He added that some investment cases were being devised which would feed into the overall plan. The Independent Member – Legal (IML) asked how much of the programme would be driven by WG because when talking about areas such as electronic patient records, that would be an All Wales item. The DDHI responded that WG expected Digital Health Care Wales (DHCW) to devise some of the systems and that they would not deliver an electronic patient record but noted that the key element was to develop a system that would talk to each other across Wales and deliver a national data resource. The Independent Member – ICT (IMICT) advised he Board that the amount of legacy concerned them and noted that there had been a historic underinvestment in digital. He added that the DDHI must be supported in getting the relevant investment because at present it represented a risk to the Health Board and noted that he had met with other Independent Members who had observed that the Health Board were aligned, if not ahead of other Health Boards in Wales but noted that it was behind NHS England Health Boards. The DDHI concluded that in terms of business cases, the ICT teams were getting better at articulating what the impact would be on digital if not funded and noted that in terms of investment cases, there was a need to be very clear on the impact of not funding programmes. **The Board resolved that:** a) The digital transformation plans as outlined were noted.	
UHB 23/07/015	**Shaping our Future Wellbeing - Refreshed Strategy** The Shaping our Future Wellbeing - Refreshed Strategy was received. The DDPS advised the Board that the time had arrived where a draft document was ready for Board approval.	

	She added that there had been an increased engagement period ending in June 2023 and that over 1100 responses had been received which included 297 surveys supported by staff of the Health Board, the wider community and harder to reach groups. It was noted that overall, the broad response rate had been good and in response to the draft document, feedback had been very positive. The DDPS advised the Board that there had been a lot of qualitative feedback which was reflected in the final draft version presented to them. She added that there were some typing errors which needed to be addressed and some measures needed strengthening within the document and noted that some formatting changes had been undertaken to ensure that areas could be easily read. The CEO advised the Board that she was happy with the document and noted that although not perfect, it set out the Health Boards strategy well noting that perfect was hard to achieve. She added that the changes noted by the DDPS around some of the narrative being turned in measures was to ensure that each strategic objective articulated 1 or 2 measures. The UHB Chair thanked the DDPS for their hard work on the revised strategy and thanked the steering group for driving it forward. He added that it was important for the Board to support and approve the document as it was the Health Board's strategy going forward. The UHB Chair concluded that the Health Board's refreshed strategy would be launched at the Annual General Meeting in September 2023. **The Board resolved that:** a) The strategy document agreeing the strategic objectives as the Health Board's wellbeing objectives, as required under the Wellbeing of Future Generations Act was approved, pending amendments noted.	
UHB 23/07/016	**Capital Plan 2023 – 24** The Capital Plan 2023 – 24 was received. The EDF advised the Board that the plan was separate to the Health Board's Annual Plan being approved later in the meeting and that in the future she would like to see it amalgamated into the Health Board's Annual Plan. She added that the purpose of the report was to provide the Board with details of the Health Board's Capital programme for the financial year 2023/24 and provided an explanation of how the schemes within the programme were prioritised against the limited available budget. It was noted that within one of the tables received in the report, a red line was identified which shows where the money had run out and that 3 items beyond that	

	red line had not “made the cut” but were still being explored with alternative streams of funding. The EDF added that those 3 schemes were a priority and deemed necessary but had no funding at present. The COO added that he had supported the EDF in collating the data and noted that a robust process had been undertaken and thanked the EDF and their team for all of the support provided. He added that the ideal scenario was to remove the red line, but noted that planning for further funding was being undertaken. The CEO added that engagement around that with the Senior Leadership Board had been an important element in the process and that proactive communications would be required to set out the approach and challenges. The IMTS advised the Board that it was always difficult to provide a list of priorities when funding stopped and agreed that the messaging needed to be open and transparent and asked that an overall approach be provided to Independent Members so that they were all on the same page during their patient safety visits. The IMF noted that WG were undertaking a review of all business cases submitted across Wales, to determine the prioritisation of schemes to progress and asked if the Health Board needed to ask for updates around the process. The CEO responded that clarity was required and that the Health Board would be meeting with WG in August 2023 because submitting business cases and getting little feedback was not helpful. The DDSP added that it was difficult because WG had asked the Health Board to prioritise the business cases which was a complex ask and noted that an example would be the Cardiff Royal Infirmary Business Case which was proposed as a phased investment but WG had asked for one whole business case. The UHB Chair noted that as a Board, they would need to be clear what the priorities were. The IMC noted that on Patient Safety Walks, he was often asked about the waste disposal business case and asked if there was any way the process could be accelerated. The EDF responded that the Health Board did not wait for WG funding because there was some money in the discretionary programme and noted that in relation to waste disposal there were some options for the Health Board, particularly around decarbonisation because that could bring external funding into play. **The Board resolved that:** a) The content of the paper and in particular the extremely limited unallocated discretionary capital funding available was noted. b) The schedule of priority schemes identified which would require £2.457m of funding against the unallocated budget of £1.998m was noted.	**JB**

	c) The draft capital programme which identified a slight shortfall of £0.024m being funded by slippage from other projects, income from Business Case expenditure or contingency was approved. d) It was approved that the CMG would manage and allocate the capital contingency in line with the Health Boards SFI's	
UHB 23/07/017	**Business Cases:** The BMT/Haematology/Cardiff Cancer Research Hub Strategic Outline Case and Thrombectomy Business Case were received. **1. BMT/Haematology/Cardiff Cancer Research Hub Strategic Outline Case.** The Deputy Director of Strategy & Planning (DDSP) advised the Board that she would take the paper as read and noted that it was the third attempt at getting an integrated solution that met the needs of patients. She added that the paper outlined all of the drivers in detail and described the importance of the BMT/Haematology/Cardiff Cancer Research Hub. The DDSP concluded that the case needed to be progressed due to the risk the Health Board held with the patients for the service and noted that the case came with a significant financial challenge which had been scrutinised by the Finance & Performance Committee and the Senior Leadership Board. The IML confirmed that the case had been received by the Finance and Performance Committee and that detailed discussions had been held and that the case had been recommended to the Board from the Committee for approval. The EMD advised the Board that BMT had been at the top of the risk register for a number of years and so the case would go towards mitigating the risk. The UHB Chair asked if the Board were content to approve the case and noted that the paper received included a number of abbreviations and asked for future reports to alert members as to what the abbreviations meant by including the longer terminology first. **2. Thrombectomy Business Case** The COO advised the Board that a constructive conversation had taken place at the Finance & Performance Committee around the Thrombectomy Business Case and that the case had been received by the Investment Group and WHSSC. He added that WHSSC had supported the case. The IMCE asked that the case meant for the operations held at the North Bristol NHS Trust. The COO responded that by doing the business case in collaboration with WHSSC, the North Bristol NHS Trust had been supportive of the case because the Health Board were already working alongside them. **The Board resolved that:** a) The submission of the Haematology/BMT Strategic Outline Case to Welsh Government for capital funding support was approved	

	b) The Thrombectomy Strategy FBC with specific approval to support Phase 1 and 2 of the Business Case, and a commitment to further develop Phase 3 and 4 and the ambition to become the regional centre for Thrombectomy for South Wales was approved.	
UHB 23/07/018	**Genomics Investment Business Plan** The Genomics Investment Business Plan was received. The EDTHS advised the Board that the Genomics Investment Business Plan had been received by the Finance & Performance Committee and had been seen by other Committees of the Board. She added that the plan was largely funded by the Welsh Health Specialised Services Committee (WHSSC) and that it was important for the Board to note that WHSSC had a 2023/24 operating budget of circa £24.2m and employed 314 whole time equivalents (WTEs). She added that the All Wales Medical Genomics Service (AWMGS) would also receive additional uplifts to existing WG strategic investment through the Genomics Partnership Wales (GPW) programme during the 2023/24 financial year as well as new investments for specific strategic outputs. **The Board resolved that:** a) The All Wales Medical Genomics Service 2023-2024 Investment Business Plan, whilst recognising that the fast pace of change in the field which the service required to respond to, which could see additional demand from WHSSC with associated funding being allocated during the year was supported.	
UHB 23/07/019	**Commissioning Intentions 2024 – 27** The Commissioning Intentions 2024 – 27 were received. The DDSP advised the Board that the intentions were updated and received by the Board annually and that it provided the first footing for the preparation of the 3-year plan. She added that it would have been the end of the process and so the commissioning team had done a full refresh which is the reason for additional papers received by the Board. **The Board resolved that:** a) The proposed Commissioning Intentions for 2024/27 as part of the commissioning cycle and to inform the development of the IMTP were approved.	
	WHSSC Consultation on BCHIs and Cochlear Implants The WHSSC Consultation on BCHIs and Cochlear Implants was received. The DDSP advised the Board that the purpose of the report was to outline the targeted engagement process undertaken regarding Cochlear and Bone Conduction	

	Hearing Implant (BCHI) services for people in South East Wales, South West Wales and South Powys, to present the findings from that process; and to establish the necessary next steps. She added that it was a WHSSC commissioned service and they had led the engagement phase. The EDF asked if it could be confirmed that it would be a fully funded transfer. The DDSP responded that it would be. The COO noted that some of the Clinical Teams had asked if the Health Board were being asked to re-tender the service. The DDSP responded that the Health Board would be accepting a fully funded service. **The Board resolved that:** a) The report was noted. b) The outcome of the engagement process was received. c) The process that had been enabled both in respect of the temporary urgent service change for Cochlear services and the requirements against the guidance for changes to NHS services in Wales was noted. d) The feedback received from patients, staff and stakeholders with respect to the commissioning intent was noted and considered. e) The next steps, specifically the undertaking of a designated provider process; followed by a period of formal consultation were supported and approved. f) The process that had been enabled to seek patient and stakeholder views in line with the requirements against the guidance for changes to NHS services in Wales was noted g) The WHSSC Joint Committee meeting on 16 May 2023 agreed the preferred commissioning model of a single implantable device hub for both children and adults with an outreach support model and was noted.	
UHB 23/07/020	**Annual Report and Annual Accounts 2022-2023** The Annual Report and Annual Accounts 2022-2023 were received. The EDF advised the Board that the Audit & Assurance Committee had met that week to consider the papers being received by the Board. She added that the Health Board had relied on the Head of Internal Audit (HIA) opinion which had provided the Health Board with reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively which was the 2nd highest rating achievable. It was noted that from the individual audits completed at the time of producing the Annual Report, the following ratings had been provided: • 6 Substantial Assurance • 25 Reasonable Assurance • 3 Limited Assurance. • 2 advisory or non-opinion	

It was also noted that the Audit and Assurance Committee had recommended for the Board to agree and endorse:

- Annual Report and Accounts for 2022-23
- The response to the audit enquiries of those charged with governance and management
- Letter of Representation
- Head of Internal Audit Opinion
- Audit Wales ISA 260 Report

The EDF advised the Board that there was a qualified audit opinion on regulatory which was because the Health Board had failed to break even “in year” and cumulatively because the 3 year Integrated Medium Term Plan was not met.

She added that the Health Board had met the public payment and noted that there was an unqualified opinion on the financial accounts.

It was noted that any items of error had been accepted and adjusted and presented in the draft being received by the Board.

The DCG advised the Board that the draft versions in relation to Health Board performance and accountability had been well articulated and well circulated.

The IMF advised the Board that a workshop had been held by the Audit & Assurance Committee in May 2023 where the draft documents were looked at in detail and then all amendments made in preparation for the special meeting held that week.

a) Audit Wales ISA 260 Report for 2022-23

The Financial Audit Manager – Audit Wales (FAMAW) advised the Board that they were being asked to note all of the areas identified within the report before approval of the Performance Report, Accountability Report and Financial Statements.

He added that the Auditor General was due to certify the accounts the following day and that they would then be laid by the Senedd but noted that the accounts would remain open until that point of certification.

The FAMAW concluded that the report was shorter than previous years which reflected well on the content of the documents.

The Head of Internal Audit (HIA) presented the Head of Internal Audit Opinion and Annual Report for 2022-23 and highlighted the following:

- The HIA Opinion for 2022/23 was that ‘The Board could take reasonable assurance that arrangements to secure governance, risk management and internal control, within those areas under review, were suitably designed and applied effectively’.
- It was a positive Opinion overall and consistent with the draft report.

The Board resolved that:

a) The reported financial performance contained within the Annual Report and Accounts and that the UHB had:
   - Not met its statutory financial duties in respect of revenue expenditure.

	- Met its statutory financial duties in respect of capital expenditure was noted. b) The response to the audit enquiries of those charged with governance and management was agreed and endorsed. c) The Head of Internal Audit Opinion and Annual Report for 2022/23 was agreed and endorsed. d) The Audit Wales ISA 260 Report for 2022/23 which included the letter of representation was agreed and endorsed. e) The Annual Report and Accounts for 2022/23 were approved.	
UHB 23/07/022	**Long Term Agreements 2023-24** The Long-Term Agreements 2023-24 were received. The EDF advised the Board that the Long-Term Agreements was the contracting arrangement with other Health Board for the work that Cardiff and Vale did on their behalf. She added that a number of material baseline adjustments were anticipated during the financial year associated with WG Allocation adjustments which were expected to be cost neutral and largely associated with WHSSC and EASC commissioning arrangements, and directed funding. It was noted that due to the change around WHSSC commissioning arrangements the recommendation would need to be updated to exclude the WHSSC arrangement. The EDF concluded that it was important to note that the Board were not happy with the WHSSC arrangements. **The Board resolved that:** a) The current Long-Term Agreements and their indicative baseline values for 2023/24 were noted. b) Delegated Board authority for the LTAs to be agreed and signed by the Chief Executive was approved noting that WHSSC and EASC Commissioning arrangements were not subject to a signed LTA document. c) Delegated Board authority for in-year LTA baseline changes and variation / settlement invoices to be agreed as set out in the Executive Director Opinion was approved d) LTA financial performance as both provider and commissioner feature as part of reports into Finance Committee monthly was noted.	
UHB 23/07/024	**Funded Nursing Care Uplift** The Funded Nursing Care Uplift was received. The END advised the Board that in seeking approval for the Interim 2023/24 FNC uplift, it was important to note that it was a sensitive issue, with Providers raising concerns with the Minister and WG policy officials that the uplift had not been in place at 1 April as required. He added that there were reputational risks and risks of relationship and legal challenge if the rate was not issued as a matter of urgency.	

	The Board resolved that: a) The 2023/24 Interim FNC Rate be uplifted by 5%. The cost is estimated at £0.540m was approved. b) It was approved that the uplift be issued urgently in order to provide compliance with the policy expectations. c) The impacts of the 2022/23 two additional non-consolidated announced NHS Pay Awards on the 2022/23 FNC rate to be further considered by Health Board finance and professional leads and resolved as soon as possible was approved.	
UHB 23/07/025	**Continuing Healthcare Inflationary Uplift** The Continuing Healthcare Inflationary Uplift was received. The END advised the Board that he Health Board maintained commissioning responsibility for patients placed in care homes who met the key Continuing Healthcare criteria that the primary reason for placement in the care home setting was a health need. He added that the Health Board was required by WG to make an adequate uplift to care providers and that there was a risk to sustainability of care providers and availability of care packages if fees paid were not reflective of business costs, with consequent impact on services available to the population of Cardiff and Vale and the ability to maintain flow out of hospital. It was noted that the additional uplift of £4.411m was required to be funded by Welsh Government. **The Board resolved that:** a) The 2023/24 annual uplift that should be offered to care homes was approved, recognising that 10% was within the provision in the current financial plan of £7.259m. b) The fact that joint packages of care would increase at a greater rate than this in line with Local Authority increases already offered was noted c) The risk that providers may not accept the new rate was noted.	
UHB 23/07/026	**Committee / Governance Group Minutes:** The Committee / Governance Group Minutes were received. **The Board resolved that:** a) The Committee / Governance Group Minutes were noted	
UHB 23/07/027	**WHSSC Governance and Accountability Framework** The WHSSC Governance and Accountability Framework was received. The DCG advised the Board that he would take the paper as read and noted that changes were summarised within the covering report. **The Board resolved that:**	

	a) The report was noted. b) The proposed changes to the Standing Orders (SOs) and include as schedule 4.1 within the respective HB SO's were approved. c) The proposed changes of the Memorandum of Agreement (MoA) and Hosting Agreement in place with CTMUHB, and include as schedule 4.1 within the respective HB SO's were approved. d) The proposed changes to the financial scheme of delegation and financial authorisation matrix updating the Standing Financial Instructions (SFIs) were approved.	
UHB 23/07/028	**Committee Terms of Reference and Annual Work Plan 2023/24 for: -** a) Finance and Performance Committee b) People and Culture Committee c) Quality, Safety & Experience Committee The Committee Terms of Reference and Annual Work Plans were received. The DCG advised the Board that the Terms of Reference and Work Plans had been discussed at the relevant Committees. **The Board resolved that:** a) The Terms of Reference and Work Plans for the following Committees of the Board for 2023-24: - Finance & Performance Committee - People & Culture Committee Were approved b) The recommended amendments to the Quality, Safety and Experience Committee Terms of Reference were approved.	
UHB 23/07/029	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The DCG advised the Board that the report was for noting. **The Board resolved that:**	
UHB 23/07/030	**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.	
UHB 23/07/031	**Health and Safety (H&S) Annual Report** The H&S Annual Report was received. The Head of Health & Safety (HHS) advised the Board that the Medicine Clinical Board had not held any H&S meetings and noted that he would be looking at that	

	and would update the H&S sub-Committee and People & Culture Committee where appropriate. The COO added that there was now a stable leadership team in place within the Medicine Clinical Board and so H&S meeting should start back up again. The HHS noted that the H&S Culture Plan was an important piece of work that would embed fundamental H&S processes into place. **The Board resolved that:** a) The H&S Annual Report was noted.	
UHB 23/07/032	**Any Other Business** No other business was received.	
	Agenda for Private Board Meeting: ***i.*** *Approval of Private Board minutes* ***ii.*** *LINC Update (Confidential Discussion)* ***iii.*** *Covid-19 Inquiry Update (Confidential Discussion)* ***iv.*** *Financial Position (Confidential Discussion)* ***v.*** *Approval of Private Committee minutes* ***vi.*** *WHSSC Joint Committee Private Briefing – 16 May 2023*	
	Date & time of next Meeting: Thursday 28th September – Future Inn Cardiff.	

ACTION LOG

Following Public Board Meeting

27 July 2023

(Updated for the meeting 28 September 2023)

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
UHB 23/05/018	**Strategic Planning Update**	The EDSP would provide further details on potential shared delivery model option for Tertiary services.	**27.07.2023**	Abigail Harris	**COMPLETED** *Updated on 27 July 2023 via the Strategic Planning Update – agenda item 6.9*
UHB 23/05/015	**Integrated Performance Report: Finance**	It was agreed that the savings made to date would be profiled and illustrated by way of a graph and would be brought back to Board	**27.07.2023**	Catherine Phillips	**COMPLETED** *Updated on 27 July 2023 via agenda item 6.6*
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	**COMPLETED** *Updated on 27 July 2023 via agenda item 6.7*
UHB 23/01/011	**Integrated Performance Report**	To undertake a review of the Retire and Return Policy	**27.07.2023**	Rachel Gidman/Paul Bostock	**COMPLETED** **Updated on 27 July 2023** *Verbal update provided from Rachel Gidman*
Actions in Progress					
UHB 23/05/015	**Integrated Performance Report: QSE**	Mortality data assurance to be provided following a deep dive at a QSE Committee meeting	**28.09.2023**	Meriel Jenney	**Update on 28 September 2023** *Agenda item 6.6*
UHB 23/05/014	**Chairs' reports from Committees of the Board – Senior**	The EDPC to provide assurance to the Board on WAGESTREAM decisions	**28.09.2023**	Rachel Gidman / Jason Roberts	**Update on 28 September 2023** *Agenda item 6.6*

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
	Leadership Board (SLB)				
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 on 28 September 2023** *Agenda item 6.6*
UHB 23/01/018	**Board Champions**	Report to be provided at the end of each year to detail the work undertaken by Board Champions.	**30.11.2023**	Rachel Gidman/James Quance	**Update on 30 November 2023**
Actions referred TO Committees of the Board/Board Development					
UHB 23/03/013	**S&D Chair's Report**	The Gender Pay Gap is to be considered at the new People and Culture Committee	**27.07.2023**	Rachel Gidman	**COMPLETED** *People and Culture Committee* updated on 11 July 2023
UHB 23/05/028	**Fire Safety Policy**	The UHB Chair asked the Health and Safety Sub-Committee to review how the Policy could be circulated to staff.	**27.07.2023**	Rachel Gidman / Joanne Brandon	**COMPLETED** **Updated on 27 July 2023** *Verbal update from Rachel Gidman / Jo Brandon*
UHB 23/07/008	**CEO Report**	Tara Rees to be invited to a People & Culture Committee meeting	**12.09.2023**	Rachel Gidman / Jason Roberts	**COMPLETED on 12.09.2023** *Tara attended the People & Culture Committee on 12.09.2023*
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.	**27.07.2023**	Jason Roberts/Angela Hughes	**COMPLETED** *QSE Committee updated on 18 July 2023*
UHB 23/05/016	**6 Goals Improvement Programme**	Board Development session to be held on the 6 Goals Improvement Programme	**29.02.2024**	Paul Bostock/James Quance	**Update on 29 February 2024** *Going to Board Development February 29th 2024*

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
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	**COMPLETED** **Board updated on 27 July 2023** *Agenda item 6.10*

Report Title:	**Chair's Report to Board**				Agenda Item no.	6.2	
Meeting:	**Board**		Public	x	Meeting Date:	28th September 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:							

I would like to take the opportunity to recognise and acknowledge, the amazing work of the wonderful staff that we have in Cardiff and the Vale UHB. We have faced, and continue to deal with, significant challenges within the services we provide to our communities in primary care, secondary care and mental health settings. I continue to be humbled and inspired by the truly remarkable care and compassion that you all provide when looking after our patients both in direct contact and supporting roles. On behalf of the Board and myself, I would like to express my sincere gratitude to you all for your unstinting commitment, dedication and determination to provide the best possible care to our patients in all areas of our work.

Recognition of our Allied Health Professional and Therapies Teams

As the Health Board navigates its way through a difficult period in the prevailing financial circumstances, it is important to celebrate the fantastic work that continues to be undertaken by our colleagues and teams across all areas of the Health Board. On this occasion I would like to highlight the work undertaken by our Allied Health Professional (AHP) and Therapies teams who are leading the way in a number of exciting areas.

Therapies colleagues have been working closely to expand the application of the CAV Rehabilitation Model supported by a series of Rehabilitation Roadshows. This provides a shared language and tiered approach for planning and delivery of rehabilitation services, maximising use of resources and supporting self-management.

Keeping Me Well
Cardiff and Vale University Health Board

The 'Keeping Me Well' website (https://keepingmewell.com/) which is informed by the Therapies Co-Production group, continues to grow with almost 5000 new visitors a month. This programme of work is developed alongside those with lived experience to support the co-production of the Shaping our Clinical Services Programme and supports individuals and patients whether they are preparing for treatment, recovering from treatment, managing a long-term condition or looking to live a healthier and more active lifestyle.

As well as delivering positive patient outcomes, the programmes of work within the Keeping Me Well service have also delivered significant social return on investment (SROI). The "Prepare Well Orthopaedics Programme", which is a weekly session over six weeks to help people look after their joints and prepare their bodies and minds before surgery, has demonstrated a SROI of £2.86 for every £1.00 spent. The "Escape Pain Programme", a rehabilitation programme for people with chronic joint pain, has also delivered an impressive SROI of £6.51 for every £1.00 spent.

Notable achievements have also been made against waiting times by our AHP and Therapies colleagues. Podiatry Services have won the Making It Better award for changing to a mixed template of virtual and face to face interventions allowing time to focus on preventative work as well as reducing the waiting list in Children's Podiatry.

Physiotherapy services have addressed a post pandemic backlog of 2878 patients through targeted efficiency interventions, co-produced clinical pathways and service redesign to include digital models and group consultations. Since October 2022, adults and children with musculoskeletal problems have continued to access physiotherapy within the 14-week target despite rising referral rates.

A further 12 months of funding has also been secured by Physiotherapy to continue a successful Bevan Exemplar project that provides physiotherapy led Paediatric Orthopaedic clinics based in the community and GP practices. This project has reduced the waiting list position by 59 weeks with 94% of service users feeling that they had seen the 'right person' and reported being happy with the service they received.

Within Occupational Therapy Children's Services, transformative work has been undertaken based on the CAV Rehabilitation Model, which seeks to widen the scope of the service and improve access. As a result of this work they have reduced the number of children waiting over 14 weeks from 274 (July 2022) to 52 (July 2023) despite a significant increase in referrals.

In line with the Strategic Programme for Primary Care the AHP Collaborative has been established to support a multidisciplinary response to population need at cluster level. Over 4,500 requests from primary care for radiological images linked to knee, lumbar spine and shoulder MSK conditions are made each year in Cardiff and the Vale of Glamorgan. The development of a co-produced Health Pathway between primary care, radiology, surgery and physiotherapy for knee, lumbar spine and shoulder MSK conditions has led to a significant reduction in imaging requests for these conditions resulting in predicted recurrent annual savings in the region of £375k.

Our colleagues within the Diabetes, Nutrition and Dietetic service have been instrumental in the development of the All-Wales Diabetes Prevention Programme in partnership with Public Health Wales. This programme has been established in 4 clusters within Cardiff and the Vale of Glamorgan with a further two to be introduced. Over 1700 people with 'pre-diabetes' have received the brief intervention through 95 different languages to support them in reversing their pre-diabetes.

Podiatry services have also been delivering diabetic foot services within the community which has seen a reduction in amputations and increased healing rates as identified by NDFA (National Diabetic Footcare Audit) data. This is a result of care closer to home with the introduction of Vascular and Trauma and Orthopaedic services within community clinics alongside Podiatry first contact practitioners and the successful upskilling of the Podiatry workforce.

On behalf of the Board I would like to extend my gratitude to our AHP and Therapies colleagues for the sterling work that they have delivered, and continue to deliver on behalf of the Health Board, for our patients and population.

Board Development Session

On the 31st August 2023 the Board undertook a Board Development Session to devote time to group development and discussion of the following topics:

- **Integrated Plan Approach and Setting Prioritisation Principles:**

  The Board undertook a session facilitated by the Strategic planning team to review the Health Board Planning Approach for 2024/2025, Interim Planning Assumptions for 2024/2025 and to agree Plan Development Principles. The Board were supportive of the following planning principles for the development of the Health Board's planning approach and agreed that plans should:

  - Address significant safety risks within the system;
  - Demonstrate Value Based Health Care
  - Deliver Strategic Intent; and
  - Deliver the national mandate and Ministerial Priorities.

- **Financial Position**

  In response to the financial challenges faced by Health Boards in 2023/24, the Welsh Government and NHS Executive have set out plans to strengthen system controls and provide a consistent financial framework across Wales. This will be a systematic approach that will involve all Health Boards with the

aim of providing additional system support, applying additional scrutiny and to provide capacity in areas that effect all Health Boards.

Updates in response to the challenges posed by the prevailing financial circumstances will continue to be shared at Board and Committees in the coming months.

- **Neonatal Services and Speaking Up Safely**

Following the outcome of the Lucy Letby trial and the tragic circumstances of that case, the Board took time to reflect on the case and I would like to share the Board's thoughts and sympathies with all the families affected, who have suffered unimaginable pain and anguish.

The Board sought, and received, assurance that Neonatal Services in Cardiff & Vale were as safe as they could possibly be at present and that all possible learning from the Letby Case would be captured. It was also agreed that this would be discussed at the next meeting of the Board held in public.

In light of the findings of the Letby case, the Board has commissioned a review of its internal procedures that enable colleagues to speak up safely. The Board will also undertake a self-assessment of its Speaking Up Safely framework which will be finalised by the end of October 2023. An update on this work will be shared at the November 2023 Board meeting.

- **UHB Strategy**

Following a review of the refreshed Health Board Strategy, Shaping our Future Wellbeing to 2035, at our July Board meeting a number of minor updates were made to the strategy document. The updated strategy was shared with the Board for support and will be launched formally at the Health Board Annual General Meeting on the 21st September 2023.

- **Integrated Performance Report**

The Board took the time to review and discuss the Health Board's Integrated Performance Report which provided a summary of the Health Board's performance:

- Against Public Health goals, including Smoking Cessation and Vaccination targets;
- Operationally, including against Ambulatory wait times, referral to treatment targets and compliance with Cancer Pathway targets.
- Quality and Safety issues were highlighted and discussed
- Within People and Culture, including turnover and sickness rates; and
- Financially at Month 4 of the financial year.

- **Televised Documentary Access**

The Health Board has been approached by a Television Company for permission to access our sites to produce a documentary series. The over-arching aim of the documentary will be to connect health with the audience, and the community the Health Board serves. Discussions remain ongoing in relation to this project and a further update will be shared following the outcome of those discussions.

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
1036	Lease	Lease of Units 1, 3 and 5 Cardiff Medicentre, Heath Park between (1)

		Cardiff University and (2) Cardiff and Vale University Health Board.
1037	Licence to Alter	Licence to Alter in relation to a Lease of Units 1 and 2 Treforest Industrial Estate between: (1) Treforest Trustee (Jersey) Limited as Trustee of the Treforest Unit Trust and Treforest Nominee (Jersey) Limited (2) Welland Property Trustee I Limited and Welland Property Trustee II Limited (as Trustees of the Welland Property Unit Trust) and (3) Cardiff and Vale University Health Board

Following the update shared at the July 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
12.07.2023	NEC 3 Short Form Contract	A contract for Asbestos Remediation at the Health Board Dental Clinic between (1) Cardiff and Vale University Health Board and (2) Severn Insulation Company Ltd
13.07.2023	NEC 3 Short Form Contract	A contract for UHW Dental Hospital Electrical Works between (1) Cardiff and Vale University Health Board and (2) Lorne Stewart PLC
14.07.2023	Contract and Amendment Agreement	A Contract and Amendment Agreement for the Supply of Stem Cell and Immunotherapy Services between - (1) NHS Blood and Transplant and (2) Cardiff and Vale University Health Board
19.07.2023	Victims and Vulnerability Grant Agreement	A grant agreement between (1) Police and Crime Commissioner for South Wales and (2) Ynys Staff Cardiff and Vale University Health Board
20.07.2023	Amendment Agreement	An amendment agreement for additional funding from the Wales Cancer Research Centre between (1) Cardiff University and (2) Cardiff University Health Board
27.07.2023	Tenancy at Will	Tenancy at Will of Concourse Unit 12 between (1) Cardiff and Vale University Health Board and (2) Nicolas Charles Cole trading as the Post Office
04.08.2023	Tenancy at Will	Tenancy at Will of Concourse Units 1 and 2 between (1) Cardiff and Vale University Health Board and (2) WH Smith Hospitals Limited

04.08.2023	Licence to Occupy	Licence to Occupy the Podiatry Room at Llanrumney Health Centre between (1) Cardiff and Vale University Health Board and (2) City Hospice Cardiff and Vale
10.08.2023	Licence to Occupy	Licence to Occupy land at Riverside Health Centre, Canton Court, Cardiff between (1) Cardiff and Vale University Health Board and (2) Grow Cradiff
18.08.2023	Licence to Occupy	Temporary Licence to Occupy land at Rookwood Hospital between (1) Cardiff and Vale University Health Board and (2) BBC Studios Productions Limited
18.08.2023	Tenancy at Will	Tenancy at Will of Concourse Units 4 and 5 between (1) Cardiff and Vale University Health Board and (2) Boots UK Limited
21.08.2023	Grant Agreement	Welsh Government Grant Agreement relating to the Feasibility of developing personalised treatment pathways for relief of plantar heel pain using a sequential multiple assignment randomised trial (SMART) study design between (1) Welsh Government and (2) Cardiff and Vale University Health Board
30.08.2023	Memorandum of Understanding	Care Inspectorate Wales data sharing Memorandum of Understanding between (1) Care Inspectorate Wales (2) Welsh Local Authorities and (3) Welsh Local Health Boards (Including Cardiff and Vale University Health Board)
04.09.2023	NEC 3 Construction Contract	A contract for the UHW Oxygen Pipeline Replacement between (1) Cardiff and Vale University Health Board and (2) M&M Medical Ltd

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	
13.07.23	UHW Dental Hospital Electrical Works Contract	Approval to enter into a contract for electrical works at the Health Board Dental Hospital, at a value of £915,362.40 inc VAT	20.07.23	Ceri Phillips 18.07.2023	Mike Jones 17.07.2023	

04.08.23	Lease of Units 1, 3 and 5 Cardiff Medicentre, Heath Park	Approval to apply the Health Board Seal and enter into a two year lease of Units 1, 3 and 5 Cardiff Medicentre, Heath Park.	10.08.23	Ceri Phillips 04.08.23	Mike Jones 04.08.23	
09.08.23	Licence to Alter in relation to a Lease of Units 1 and 2 Treforest Industrial Estate	Approval to Apply UHB Seal and enter Licence.	10.08.23	John Union 09.08.23	Ceri Phillips 10.08.23	
10.08.23	Uplift in Genomics Construction Contract Value	Approval of an increase in cost totaling: £1,136,203.93 incl VAT	16.08.23	Mike Jones 15.08.23	Ceri Phillips 15.08.23	
18.08.23	Whitchurch Dental Service Practice Contract	Approval of Dental Services Contract at a value of up to £831,000.00.	23.08.23	David Edwards 22.08.23	Keith Harding 22.08.23	
18.08.23	Opthalmology Consumables	Approval of a four-year contract totaling £4,462,779.37 (including VAT)	24.08.23	John Union 21.08.23	Akmal Hanuk 23.08.23	
18.08.23	Provision of Radiopharmaceutic als and Krypton Gas Generators	Approval of a four-year contract totaling £2,510,848.93 (including VAT)	26.08.23	Ceri Phillips 25.08.23	John Union 24.08.23	
18.08.23	Electronic Prescribing and Medicines Administration	Approval to enter into a contract with a value of £2,730,000.00 incl VAT	25.08.23	Ceri Phillips 25.08.23	Mike Jones 25.08.23	
04.09.23	Approval of UHB Strategy	Approval of UHB Strategy prior to the September 2023 Board meeting, following sign off at the August 2023 Board Development Meeting	08.09.23	Ceri Phillips 04.09.23	John Union 06.9.23	
04.09.23	Provision of support for the Chair to Sign the Armed forces Covenant for 2023	Provision of support for the Chair to Sign the Armed forces Covenant for 2023 following approval at the Senior Leadership Board	06.09.23	Mike Jones 04.09.2023	Rhian Thomas 05.09.23	

		meeting of the 24.08.2023				

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:	28th September 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:

Following months of extensive colleague, stakeholder, patient and public engagement the Health Board has approved its refreshed strategy, Shaping our Future Wellbeing to 2035 ("the Strategy"), *Living Well, Caring Well, Working Together*.

Since development of the Health Board's first Shaping Our Future Wellbeing strategy in 2013 much has changed. We have responded to and learnt from the Pandemic alongside the increasingly visible impacts of climate change, health inequalities have deepened and the once future opportunity that novel treatments and interventions presented are rapidly becoming reality. We commit to taking the actions necessary to respond to these challenges as well as to adapt quickly and take new opportunities to improve the wellbeing of generations to come. We finalised the strategy as we celebrated the 75th anniversary of the NHS and formally launched the document at our Annual General Meeting on the 21st September 2023.

Born in Wales, the NHS has saved and transformed hundreds of thousands of lives, prioritising those in greatest need. To ensure it continues to have such positive impact we will work together to focus more on prevention and innovation and continuously learn and improve what we do as we invest in our infrastructure and people.

This commitment is now enshrined in the Vision and Strategic Objectives..

Vision

Working together we will help improve lives so that by 2035 people are healthier and unfair differences in outcomes are reduced. The care we provide for people who need our services and those delivering services will be outstanding, with outcomes and experience that compare with the highest performing peer organisations.

Strategic Objectives

- Putting people first
- Providing outstanding quality
- Delivering in the right places
- Acting for the future.

Developing and approving strategy is clearly the work of the Board and I am pleased that we now have the refreshed Strategy to guide the organisations operational delivery and activities. This report serves to give assurance that the next steps in terms of strategy deployment, planning, activation and implementation are

underway and to confirm that the Executive Team and I will now move to ensure the intent of the Board is fulfilled.

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

At our May 2023 Board Meeting I articulated that the Strategy would 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.

In order for the Strategy to be effective we first need to take steps to deploy it, by which I mean using methods of communication and engagement, products and materials alongside discussions to begin to familiarise colleagues with the content of the Strategy so that they can begin to plan their part in delivery. This deployment activity will evolve into implementation in order to convert the Strategy into the coordinated actions needed to deliver in an aligned and efficient manner.

One of the key strategy deployment mechanisms is the process of generating the Integrated Annual Plan (the "IAP"). We are currently moving into the planning timetable for the FY 24.25 IAP which presents a great opportunity to familiarise colleagues with the Strategy and to ensure that emerging planning priorities are strategically aligned and aimed firmly on delivery of the vision we have set out.

With regards to the current IAP a Quarter 1 Report and update will be shared at this September Board Meeting by our Strategic Planning team. We have iterated the approach to reporting progress of the IAP but acknowledge there is still more to do to demonstrate the impact of actions and inputs reported alongside trajectories. Executive colleagues are working on a further iteration which will aim to present a fully integrated and triangulated report of the IAP delivery, Ministerial Priorities and the financial position alongside a measure of impact and trajectory progress.

I have previously referred to the development of an Operating Model for the organisation. This work has not progressed significantly over the summer months whilst the Strategy itself has been finalised and approved but as we move forward, I will re-energize this work and engage Independent Members and Executive colleagues in that development work.

As Board members will be aware there is an existing suite of strategic delivery programmes and supporting plans which now need to be reflected upon and where necessary adjusted or reframed to align to the refreshed Strategy. Almost without exception the "Shaping our Future….", suite of programmes remains absolutely relevant in terms of intent and content and in most cases require only minor adjustment to meet future needs. This work is currently underway and shall be reported to Board in due course.

The nature of our Strategic Programmes broadly falls into two categories. Cross cutting, enabling programmes that focus on issues such as digitisation, the support of our people and the creation of an enabling organisational culture and areas of work focused on improving operational delivery and service/care model re-design such as the Shaping our Clinical Services Programme. These programmes and those emerging will need to be aligned to the new strategic objective portfolios. At our October 2023 Board Development session, the Board will reflect

on the Health Board's existing and emerging Strategic Programmes, the output from which will be shared at a future Board Meeting.

We have set ourselves key milestones in 2027 and 2035 to measure success against our Strategic Objectives and to track progress towards achieving the Vision to improve the lives of the communities we serve so that by 2035 people are healthier and unfair differences in health outcomes are reduced. Work to track, present and provide assurance on key milestone progress will be undertaken and shared with the Board.

In advance of and in between the midpoint (2027) and conclusion (2035) of the Strategy the HB will continue to develop rolling three-year Integrated Medium Term Plans ("IMTP") that describe how we will align our resources to deliver the Strategy and achieve our milestones whilst remaining responsive to emerging priorities, opportunities and risks. The three-year IMTPs will provide a planning horizon within which the Integrated Annual Plans will sit. Thus, the planning and delivery hierarchy will form a framework of annual plans (detailed and specific, short planning horizon), three-year plans (more strategic and over-arching, medium term planning horizon) and the Strategy and strategic programmes (high level strategic intent, long planning horizon to 2035) all of which will be linked by and orientated around the Strategic Objectives.

There is much to do to both deliver and provide assurance on the delivery of the Strategy, but the work set out above will, with the support and engagement of Board and HB colleagues, provide a comprehensive approach that seeks to assure optimal execution of the Strategy and its Vision.

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:

Report Title:	Board Assurance Framework 23-24 – September 2023				Agenda Item no.	6.4	
Meeting:	Board		Public	x	Meeting Date:	28 September 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. It comprises:

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. 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)

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

This is the last time that the current strategic objectives will appear in the BAF following the launch of the new Strategy to 2035.

The new BAF will be presented at Board in November, with a refresh of Risk Appetite carried out at Board Development in October.

The key changes to the risks on the BAF from the Board Meeting in July 2023 are track changed for clarity. Key assessment changes:

Risk 9 Workforce has reduced the net risk score.
Risk 11 Wellbeing has increased the net risk score.
Risk 15 Digital has increased the target risk score.

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 September 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

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 Jul 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:** 06.07.23	Quality, Safety and Experience **Last Reviewed:** 18.07.2307.03.23
2. Maternity	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:** 06.07.2304.09.2023	Quality, Safety and Experience **Last Reviewed:** 18.07.2307.03.23

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 7am-7pm/7 days a week to 24/7 by the end of Q3.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** ~~06.07.23~~01.09.23	Quality, Safety and Experience **Last Reviewed:** 18.07.23~~07.03.23~~
4. Cancer	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. Despite improvements seen through Q1 23/24, it is not expected that the UHB will reach the WG target of 75%. The weekly cancer delivery group has now implemented a standardised and revised demand and capacity approach across all tumour	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** ~~06.07.23~~04.9.23	Quality, Safety and Experience **Last Reviewed:** 18.07.23~~07.03.23~~

							sites. The likely improvement timescale to reach the standard is now the end of Q2.		
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. The next stroke summit to review performance and finalise the proposed changes to the clinical model ~~is on~~took place on 30th July. The NHS Executive is supporting in the review and updating of the improvement plan following its assessment of the pathways in the UHB and across Wales. Meetings commenced 29.08.23.	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** ~~06.07.23~~04.9.23	Quality, Safety and Experience **Last Reviewed:** 18.07.23~~07.03.23~~
6. Urgent and Emergency Care	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	Executive Nurse Director/ Executive Medical	Quality, Safety and Experience Committee

							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. 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. Urgent and Emergency performance has continued to improve compared to last year. Q2 has more challenged then expected, largely due to increased length of stay for adult inpatients.	Director/ Chief Operating Officer **Last Reviewed:** ~~06.07.23~~04.09.23	**Last reviewed:** 18.07.23~~14.03.23~~

7. Planned Care	Cautious		**16**	**12**		**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. 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. The NHS executive have outlined revised ministerial standards which include no patient waiting for 3 years for an outpatient appointment and working towards 97% of patients receiving treatment in less than 104 weeks by September and 99% of patients by the end of the financial year. Each Clinical Board will be signing off revised trajectories and delivery plans by the 30th June 2023. Each Clinical Board have revised plans for the 23/24 financial year to meet the revised standards above. Welsh Government have responded positively to the plans for the regional funding for planned care and as a result there will be non-recurrent funding	Executive Nurse Director/ Executive Medical Director/ Chief Operating Officer **Last Reviewed:** ~~06.07.23~~04.09.23	Quality, Safety and Experience **Last Reviewed:** 18.07.23~~07.03.23~~

							to the clinical boards to deliver plans as well as recurrent funding for a protected surgical zone at UHL as well as a community diagnostic hub. These are designed for sustainable increases to capacity and controls for demand respectively		
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:** ~~26.06.23~~ 22.08.23	Quality, Safety and Experience Committee **Last Reviewed:** 18.07.23~~14.03.23~~
9.	Workforce	Open	4, 6, 11, 16	**25**	~~16~~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:** 12.09.23~~07.07.23~~	People & Culture Committee **Last Reviewed:** 11.07.23
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	Executive Director of People and Culture **Last Reviewed:**	People & Culture Committee **Last Reviewed:** 11.07.23

							change in our health system for our staff and the population of Cardiff and the Vale.	07.07.23	
11. Staff Wellbeing	Open	4, 6, 11, 16,	**20**	2015		**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:** 12.09.2307.07.23	People & Culture Committee **Last Reviewed:** 11.07.23
12. Capital Assets	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:** 23.08.2023 11.07.23	Finance & Performance Committee **Last Reviewed:** 23.08.2023 4.01.23
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	Executive Director of Strategic Planning **Last Reviewed:** 23.08.2311.07.23	Finance & Performance Committee **Last Reviewed:** 23.08.2023 4.01.23

							leading a healthy life is the same wherever they live and whoever they are.		
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:** 23.08.2311.07.23	Finance & Performance Committee **Last Reviewed:** 23.08.2023 15.02.23
15. Digital Strategy and Road Map	Cautious	23	**25**	**20**		2015	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.	Director of Digital Health Intelligence **Last Reviewed:** 11.07.2312.09.23	Digital Health Intelligence Committee **Last Reviewed:** 14.02.23

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 were reported to Management Executive, Strategy and Delivery Committee and the Board (1) (3) • CAHMS position was 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 JulMay 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. The final report for CaV indicates a midwifery shortfall of 11wte.		
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 38 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 ~~Jul~~May 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 for patients not admitted to critical care • Ringfenced PACU to protect high-risk 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] • Plans in development to roll out 24/7 PART team • 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 need not fully understood across the organisation.		

Actions	Lead	By when	Update since ~~Jul~~May 2023
1. Secure funding and develop implementation plan for further three ICU beds	PB	30/04/23	Complete Board approved in April 2023 Recruitment has commenced, beds planned to open on phased basis in 2023/24. On track for first bed to open Sept 2023
2. Implementation of 24/7 PART team	PB	31/10/23	Plan developed. Board approved in April 23 Recruitment commenced, offers have been made to prospective candidates, on track to implement model by October 2023.
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	Approval from CMG/SLB to proceed with the Strategic Outline Case for Critical Care expansion and refurbishment. Approval from CMG/SLB to proceed with the Strategic Outline Case for Critical Care expansion and refurbishment. Aim to submit to WG in Q4 23/24. ~~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~~ a. Design completed for C3S, further work required on design for C3N. The design will include additional cubicles to meet IP&C demand. ~~Funding from discretionary capital approved to commence work on the SOC~~ (medium term plan to bridge to UHW2).

				b. Engaged with the Programme Director for UHW2 on future demand for CC to inform planning. c. LTiV/complex care now established on C3L. No current planning to create a bespoke facility in UHL
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 202~~2/23~~ 3/24Operational 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 • Weekly cancer delivery group in place with directors of operations owning accountability for improvements in delivery • 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 Finance & Performance 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 will require Q2 in order to recover the current cancer performance standard after stalled progress at the end of Q1. This was largely an impact of increased waiting times for Endoscopy where there is now a clear plan of improvement		
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 ~~Jul~~May 2023
1. Continue to develop and iterate the demand/capacity work	MT	30.6.23	Complete. D&C reviewed weekly in cancer oversight meeting~~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	Partially complete. Individual pathways reviewed based on D&C analysis. ~~Support from the WCN to undertake a number of deep dives: – urology, breast, lower GI and gynaecology 4 areas of focus~~ ~~Action to be completed by 30.07.2023~~
~~3. Establish a weekly PTL meeting with General Managers/Directorate Managers~~	~~JC~~	~~30.01.23~~	~~Complete~~
~~4.~~3. Finalise the Cancer Strategy and develop a workplan	RL/BW	30.06.23	Complete and published. Cancer services developing a workplan. ~~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.~~4. Development of recruitment and retention strategies		RG	31.03.23	See separate BAF risk on workforce
5. Delivery of cancer improvement plan – SCP and backlog – via revised governance structures		MT	Ongoing	New
6.				
7. Individual patient reviews of all longest waiting patients with Directors of Ops		MT	30.09.23	New
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. • Protection of stroke beds • Roll out of ROSIER tool at triage		
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 JulMay 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	Ongoing - Pilot continuing temporarily with CNS team supporting 12 hour shifts 7 days per week. Case being made for current pilot to be made permanent with a view to 24/7 CNS cover in the future. Proposal to be tabled at 5th Stroke Summit on

			25.9.23~~Pilot in place and clinical workforce model to be presented at 3rd stroke summit on the 23/5/23, and reviewed at 4th summit on the 30/7/23.~~
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	6 Front door sessions continue despite no longer continuing with locum SHO cover at SRC based on balance of risk. 4 vacant stroke sessions now covered in split ITU post from 1.8.23 on 12 month contract. Future clinical model for delivery 24/7 consistent stroke care to be presented at 5th stroke summit on the 25/9/23. Will require significant investment. An enhanced shared front door model with Neurology will be explored at the stroke summit on the 25/9/23. Previous submissions did not meet service requirements so revised model with wider window to be presented. ~~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.~~ ~~A shared front door model with Neurology will be explored at the stroke summit on the 30.7.23.~~
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	NT/DP/NW/SB	31/03/2023	Completed - Ringfencing of all C4 stroke beds now in place and embedded. SOP

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.			agreed.~~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. **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.		NT/TH	31/05/2023	Completed - New process of escalating urgent diagnostics in place which is responsive to requests in a timely manner. Hot slots no longer required. ~~Ongoing discussions with radiology to create slots~~ ~~Use of the CD&T escalation email to prioritise Stroke 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. Work continues on the clinical model with the next summit planned for 30/07/23.~~
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) The need for respiratory capacity 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.4,000 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 delivered improvements • 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 Finance & Performance 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~~N/A		

Actions	Lead	By when	Update since ~~Jul~~May 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.~~ ~~76% 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.~~ Focus continues on UPCC, programme being delivered via Six Goals programme, coverage not yet at 100%,
~~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. Complete~~
~~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.~~Completed

~~4. Introducing frail assessment service in emergency and assessment area UHW~~	~~PB~~	~~30/11/22~~	~~Complete - Frail service went live.~~Complete
~~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.~~Complete
~~6.~~2. 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~~Complete
~~7.~~3. Develop acute admission protocols	MJ	05/06/23	~~Acute referral policy has been launched.~~Complete
~~8.~~4. 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.~~5. 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.~~Complete
~~10.~~6. 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~~. The first phase of the UHW reorganisation has been completed – closure of speciality hub, provision of assessment wards on A1, ward moves to facilitate. Work has now turned to getting the models embedded and performing.
~~11.~~7. Development of recruitment and retention strategies	RG	31/03/23	See separate BAF risk on workforce
~~12.~~8. Review trauma pathways across UHW and UHL and agree make-up of both ambulatory, same day urgent and emergency and inpatient services and footprint	PB	30/8/23	~~Develop plan that right-sizes trauma and drives efficient, safe care~~Ongoing. Revised aim to complete by 30.09.2023
~~13.~~9. Develop business case for "safer home" multi-disciplinary team that caters immediately for people in crisis to support locally and timely rather than admit into hospital	PB	30/8/23	~~Developing plan with partner organisations whilst reviewing current services and analysing workforce gaps~~Business case for Safer at home in development with a revised target date of 31st October.
10. Delivery of redesigned Emergency Department – CDU, Paeds CDU, e-triage	PB		

11. Development and approval of the 2023 / 24 Winter Plan		PB	30/09/2023	New
12. Review of Board round processes as part of bed pressure and length of stay programme		PB	30/09/23	New
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~~2023/24 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, additional waiting list initiative clinics • 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~~Planned Care Delivery ~~Group~~ Board in place bi-weekly~~monthly~~; suite of metrics reviewed at every meeting [1] • Monthly meeting with the ~~Delivery Unit~~NHS Executive 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 Finance & Performance Committee [1] • Planned Care reported as part of the Board Integrated Performance report [1]		
Impact Score: 3	Likelihood Score: 4	Net Risk Score:	**12 (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 • Delivery of Ssolutions 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		

Commented [AW(aVU-Ho1]: Matt Temby to comment

Actions	Lead	By when	Update since ~~Jul~~ ~~May~~ 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.~~ Complete. Revisions have been made against the new ministerial targets.
~~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~~Complete~~.~~
~~3. Continue to progress plans to maximise activity and monitor via the Planned Care Performance group~~	~~JC~~	~~Weekly~~	~~Complete - Meetings in place~~Complete
~~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~~Complete
~~5.~~2. Development of recruitment and retention strategies	RG	31.03.23	See separate BAF risk on workforce
~~6.~~3. Revise trajectories and delivery plans	MT/AH	30/6/23	Complete. ~~All clinical boards will create delivery plans and trajectories to meet the revised ministerial standards~~

4. Implemented High Volume Low Complexity (HVLC) lists in UHW to reduce long waiting patients		RT	01.10.23	
5. Implement mobile diagnostic solution in UHL (in advance of community diagnostic hub)		SL	01.11.23	
6. Develop plan for UHL HVLC lists – to be delivered in 2024/25 (Q1)		RT	01.11.23	
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 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).

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	• 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 • 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 ~~• 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 people who are 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 • The total annual cost associated with inequality in hospital service utilisation to the NHS in Wales is estimated to be £322 million, equivalent to 8.7% of the total hospital service expenses, driven largely by higher service use among people living in the more deprived areas compared to those living in the least deprived areas (PowerPoint Presentation (nhs.wales) • 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 People & Culture 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~~ has been strengthened in 2023/24 by the development of a strategic framework for tackling ~~inequalities~~ equity, equality, experience and patient safety • 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	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 ~~Jul~~May 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 is being reviewed on an All Wales basis with the view of creating a Once for Wales approach. C&VUHB will contribute to the development and ~~implemetation~~implementation. ~~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. The first year of Amplifying Prevention has strengthened collective action being taken by partner agencies to address inequalities, particularly in

		April 2024 June 2023 Sep 2023 and every 6 months	relation to communication with people who live in C&V and staff. The second year will additionally include a focus on targeted work with communities and settings known to experience inequity. 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. An equity, equality, experience and patient safety strategic framework went to the SLB in June 2023, and ~~will also go~~ to the Board Development session in June 2023 ~~for discussion~~ . and has been shared with the Local Partnership Forum. The Framework will go to Board in Sept 23 for formal adoption, then updates will be made to Board on implementation every 6 months.
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	High level Amplifying prevention indicators developed. More granular indicators and evaluation to be developed in year. The national Gap analysis of health equity data collection was well responded to by C&VUHB teams, and the local

			January 2024	survey results are to be discussed at the next C&VUHB Value Based Healthcare and Data Improvement Groups. The insight from these discussions will help lead to the development of 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. There are improvements that need to be made in the routine collection of protected characteristics in order to support the introduction of new indicators, this will need to be addressed by each Clinical Board.
Impact Score: 4	**Likelihood Score: 3**	**Target Risk Score:**		**12 (High)**

9. Workforce – Executive Director of People and Culture (Rachel Gidman)

We pride ourselves on being a great place to train, work and live; with inclusion, wellbeing and development at the heart of everything we do. We know that in order to meet our population's health and care needs effectively we are completely dependent on our people.

Our people have continued to respond to the challenges despite the impact the workforce crisis is having on Health and Social Care. Recent engagement surveys have told us that our people are leaving the sector and/or their profession due to stress, burnout, poor working conditions and lack of development opportunities. This has made recruitment and retention extremely challenging, resulting in staff shortages that have impacted negatively on the wellbeing of our people.

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 unprecedented events of the last three years have 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. • 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~~improved slightly ~~month on month~~, from 13.66% to 12.8152%. • Sickness Absence rates remain high; although the rates appear to be falling to more 'normal' levels. The monthly sickness rate for ~~May~~July 2023 was 6.125.57% and ~~April~~ August2023 was 5.897%, after an all-time high of 8.56% for December 2023. • Significant operational pressures across the whole system s~~ince March 2020~~over the last three years has impacted negatively on the health and wellbeing of our staff. • The development of our existing workforce has reduced as a direct result of t~~he 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. The Industrial Action that commenced in December 2022 has not helped the national reputation of the NHS as an employer.
Impact	• Negative impact on our people and our teams, as a result we are experiencing: - Higher levels of sickness absence and lack of management capacity to support staff appropriately; - Higher levels of turnover; - Low morale and poor staff engagement; - Increased reliance on temporary workforce e.g. bank, agency, locums, etc; - 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.

	• We are starting to see improvements in the above areas; we need to sustain this improvement going forward • Negative impact on quality of care provided to the population. • Inability to meet on-going demands, operational pressures and needs of our workforce		
Impact Score: 5	Likelihood Score: 5	**Gross Risk Score:**	**25 (Extreme)**
Current Controls	• The People and Culture Committee was established 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 ~~(over 400 additional staff)~~ and RN's on the bank which will support the reduction of agency usage and improve quality. 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. • Starter Survey implemented for all newly appointed novice nurses to identify their experience of working at C&V UHB during their first 3-6 months of employment. • The People Services Team are ~~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. • Centrally 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. • Health & Wellbeing strategy monitored through the strategic Health & Wellbeing Group. • Monthly ~~Executive Performance~~Clinical Board Reviews with a focus on improving our workforce position are now well established.		

	• Monthly Nursing Productivity Group to review nursing workforce metrics and develop appropriate plans to improve performance. • 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. • 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. • The implementation of Band 4 Assistant Practitioner roles has also enabled a further RN recruitment pipeline for international nurses who can undertake an OSCE to progress to an RN role within potentially 3-6 months.			
Current Assurances	• Robust monitoring of People and Culture Plan KPI's at the People and Culture Committee and Board. (1) • ~~Regular~~Monthly monitoring and~~of~~ forecasting of~~ed~~ RN, ODP and HCSW 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) • Workforce Sustainability Group, aligned to Sustainability Programme Board			
Impact Score: 45	Likelihood Score: 4	**Net Risk Score:**		~~1620~~ **(Extreme)**
Gap in Controls	Workforce supply affected by National Shortages.			
Gap in Assurances				
Actions		**Lead**	**By when**	**Update since May 2023**
Impact Score: 5	Likelihood Score:2	**Target Risk Score:**		**10 High)**

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. • Existing inequalities exacerbated		
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 but is increasing across the UHB Capacity to respond to requests for cultural and transformation work Effective measures of culture / engagement		

Actions	Lead	By when	Update since ~~Jul~~May 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~~ November 2023 September 2023 – March 2024 ~~May Sept 2023~~ ~~June Sept 2023~~November 2023 September 2023 – December 2023 ~~Jan-March 2023~~ July – November 2023	Acceler8 Senior Leadership Programme Cohort 2 ended in May 2023. Evaluation is ~~to take place June 2023~~currently postponed while we await outcomes of internal audit review re Leadership and Management Development. The Collabor8 Leadership programme, Cohort 1 ~~is continuing.~~ has closed and an evaluation is under way. A second Cohort is planned for Autumn 2023, which will be followed by a programme review. The review of a CAV Leadership Development Strategy is underway looking to develop the 'leadership principles' and competencies of CAVUHB. ~~Leadership development across the UHB is being mapped to identify gaps in provision, areas of duplication, and opportunities for collaboration.~~ A mapping exercise has been concluded and currently awaiting results of internal audit advisory piece which will springboard this piece of work. Education, Culture and OD Team (previously LED) ~~currently reviewing~~have scheduled the ~~leadership and~~ management development offer ~~to plan schedule from September 2023~~to December

			2023. Programmes for 2024 to be determined and communicated following outcomes of audit advisory piece and NHS Wales Staff Survey findings.
		July - November 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.~~ Development of the UHB coaching network continues. An organisational 'call out' for qualified coaches to take place Autumn 2023. A new role has been established within ECOD to support Coaching and Talent Management.
		~~June 2023~~ September – December 2023	
		~~June 202~~July – November 2023~~3~~	~~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.~~ Working with Worth Consulting and the Head of EDI in order to identify most effective means of supporting mentors. This work will link to SEP and Ani-Racist Action Plan. Networks to be engaged with in Autumn 2023 to decide how best to engage with and develop potential mentors.
		~~March-June~~June - October 2023	
		August – December 2023	~~3 Coaching supervisors have been identified, training delayed to June 2023 due to availability.~~ Staff turnover has impacted on delivery of Coaching Supervision – this need is being reviewed versus accessing external supervision for UHB coaches.
		~~May-June 2023~~July – December 2023	

		~~June 2023~~July – October 2023 ~~June 2023~~July 2023 July – December 2023	Simplified VBA process ~~has been~~continues to be communicated and training is ongoing to support ~~for~~ both managers and staff. Simplified paperwork has been agreed and is part of communication and training. 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. Update paper went to P&C Committee 13th July, recommendation to review again in November 2023.
		May-June 2023 May 2023	~~There has been an increase in the number of requests to facilitate cultural programmes/OD work within directorates and teams.~~ The ALAS Culture and Leadership Programme (CLP) discovery phase has been completed ~~utilising Culture and Leadership Programme and Framework~~. Analysis and recommendations ~~to be provided to DMT early May 2023~~have been presented and a whole team development session is scheduled for October 2023 to share findings and co-produce actions. This will then move on to the delivery phase. There has been an increase in the number of requests to facilitate cultural programmes/OD work within directorates and teams. The CLP approach shared with SLB and P&C Committee in August and September 2023. Executive Team to assess and identify priorities areas. Work in two additional areas already in development. Theatres (Starts 11th September), and CHfW (starts September 2023). OD support for UHB strategic programmes also requested, SOFH, SOFCS etc and challenges to capacity being discussed. Agreement of organisational priorities re OD

			support and conversations re capacity ongoing. HEIW ~~has reserved~~ provided 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.~~ Course has been completed and the learning incorporated into CAV approach. ~~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.~~ People and Culture Team are supporting EU with retention and wellbeing work. Scoping of programme underway. 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	~~June 2023~~September 2023	~~Review of showcase required.~~On pause.
3. Equality, Diversity and Inclusion Welsh Language Standard being implemented.	Rachel Gidman	~~July~~October 2023 Nov 2023 ~~May 2023~~December 2023	Equality Strategy Welsh Language Group under review. ~~To be discussed at People and Culture Committee July 2023.~~ Draft governance proposal agreed in principle by CEO and Exec Director of P&C. Discussion with Director of Corporate Governance September 2023. To be presented to P&C Committee Nov 2023. ~~Review of group TOR taking place to ensure all CBs are represented and appropriate governance is in place.~~ 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

Inclusion - Nine protected Characteristics		~~May-June~~July – September 2023 ~~2023~~ Sept-Dec 2023 Sept – Dec 2023 ~~Ongoing~~ ~~May-Sept 2023~~Sept 2023 – March 2024 December 2023 ~~May 2023~~ December 2023 ~~June 2023~~	through increasing in-house translation capacity. ~~To be presented May 2023.~~Currently under review with support from Finance colleagues. 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. . Welsh Language Clinical Consultation Plan published. 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. Training has been identified for mentors to support Inclusion Ambassadors at executive level. Step two will be identification / nominations for mentors, followed by training. Existing networks are collaborating to develop the scope and outline of an 'Ally Network'. Work ~~is at an early stage~~is progressing slowly due to capacity, initial proposal to be taken to ~~the ESWLSG meeting in June 202~~revised Epuity and Inlcusion Group in December 2023~~3~~. ~~Review of networks in light of 'Employee resource groups' discussions at Board Development with Race Equality First~~. 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~~for CAVUHB has been agreed and the Steering Group is in development to monitor delivery.. The draft proposal for a framework looking at Equality, Health Inequalities and Safety has been presented to SLB and is currently being reviewed based on feedback for presentation to BOard.~~.~~ ~~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.~~ The Equity, Inclusion and Welsh Language Team are working collaboratively with Dysgu Cymraeg as part of Welsh Government's More than just words strategy to develop the organisation's Welsh language capabilities. Mental Health CB and EU have been identified as initial areas of focus.
4. CAV Convention	Rachel Gidman	TBC	~~Action under review and date to be confirmed once known~~Action under review.
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~~g pandemic and the pressures now emerging in term of continued high levels of demand, staffing shortages and societal issues such as the cost of living crisis. ~~Which~~This, together with limited time to reflect and recover, will increase the risk of burnout in staff.		
Date added:	6th May 2021		
Cause – During Pandemic **Post-Pandemic**	• 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 demands of service delivery and staff wellbeing • ~~Continued e~~Exposure to psychological impact of ~~covid both at home and in work~~ increasingly complex and challenging demands of care / inability to deliver care to required standard due to short staffing (moral injury) • Ongoing demands ~~of the pandemic~~ over an extended period of time – addressing waiting lists / financial climate, minimising ability to take leave / rest / recuperate / attend learning and development • ~~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 on retention (negative) and attraction of staff into healthcare		
Impact Score: 5	**Likelihood Score: 44**	**Gross Risk Score:**	**200 (Extreme)**
Current Controls	• Self-referral to wellbeing services • Managerial referrals to occupational health • External support, e.g. Canopi • 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 currently under review • 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 and Financial Wellbeing 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 OD Manager - 'Wellbeing and Engagement' ~~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~~4**	**Net Risk Score:**	**~~15~~20 (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 • Continued increase in manager 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 Jul~~May~~ 2023**

1. ~~Health Intervention Coordinator (1) providing reactive and immediate support to employees directly affected by the ongoing impact of the COVID pandemic~~ Commissioning model introduced in People and Culture to ensure managers / teams can request support / advice / guidance and training which is delivered / supported by the most appropriate team / individuals and/or external partners. Includes representation from ECOD, People Services, Wellbeing Services, Equity and Inclusion.	Nicola Bevan	~~March 202~~July 2023 – March 2024~~3~~ ~~April – June 2023~~ ~~March June 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.~~ The OD Manager – Wellbeing and Engagement has moved into the Education, Culture and OD Team to ensure a holistic and integrated approach to staff wellbeing and engagement. This role will work in partnership with the EWS, People Services and Equity and Inclusion to support the creation and delivery of support and development in areas of need. This may not always be in the form of team development, and may involve manager coaching / addressing root problem. This approach will also support the shaping of the strategic wellbeing narrative through co-production and staff/TU involvement. ~~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.~~

		September 2023 – January 2024	~~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.~~ Continued signposting to cost of living support and development of resources in partnership with TU Partners and MaPS.
		September 2023 – Jan 2024	~~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.~~
		~~March-April 2023~~	~~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. EWS, ECOD and People Services will work with Ops during Autumn / Winter 2023/24 to support a series of roadshows for staff. The

			Winter Roadshows will include wellbeing advice and signposting, financial wellbeing, NHS Wales Staff Survey updates and general advice and guidance. ~~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 202~~developed and will form part of the roadshows in Autumn / Winter 2023~~3~~. 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~~ Employee Wellbeing Service working with the Occupational	Nicola Bevan	~~Interventions proposed implementation April 22 – 2023~~	The Health Intervention ~~team~~ Impact Report has been ~~shared with the Strategic Wellbeing Group.~~ utilised to shape

	Health Service, People Services and ECOD to identify insights from workforce data collated to shape strategic and operational response to themes / emerging trends.		April 2023 – March 2024 ~~April 2023~~ July 2023 – Jan 2024 ~~March-May 2023~~ ~~June 2023~~September 2023 ~~May 2023~~July – December 2023 ~~May 2023~~ November 2023	the year two priorities and actions within the People and Culture Plan. ~~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.~~ Development of a Health and Wellbeing Framework continues. A Working Group will be established by the Wellbeing Strategy Group in October 2023 to shape the Framework. This will be presented to WPG in January 2024. 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 re-scheduled ~~for May 2023~~for Autumn 2023 to review progress and next steps. 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. The StRaW Practitioner Network has been created and monthly network meetings established. An interim review to take place December 2023. Development of 'My Health Passport' to enable employees who believe they may need support or work adjustments due to a disability or long term health condition. This could be in relation to a pre-existing or new health condition. The passport is designed for the employee to share with their line manager to support effective conversations around support and performance. The passport will be soft-launched throughout the organisation in November to coincide with Disability Awareness Month.
3. Enhance communication methods across UHB - Social media platform - Regularity and accessibility of information and resources - Improve website navigation and resources	Nicola Bevan	~~May 2023~~July – December 2023 ~~June 202~~April 2023 – March 2024~~3~~	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 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.~~ The Financial Wellbeing Working group has now been stood down as it has delivered on the main actions. The remaining actions on the 'Action Plan' will be delivered and progress monitored via the Strategic Wellbeing group. A financial wellbeing flyer has been developed by the EWS team. Meeting being planned with key members of the comms team to discuss how to strengthen comms to support EWS ~~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~~

		~~May July 2023~~September – December 2023 ~~July 2023~~	~~hours worked on health roster. A discussion with Workforce Partnership Group is scheduled for May 2023. Implementation planned for June 2023.~~ Wagestream was implemented in August 2023. This platform provides financial education and guidance, along with the ability for staff working additional hours as over-time / bank to draw down payment on a weekly basis, supporting staff during the cost of living challenges, and reducing reliance on agency workers. Communication campaign to commence July 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.~~ Communication of engagement and wellbeing surveys continue with P&C team attending CB SMTs. ~~Three~~ Five attended so far, remaining sessions to be booked in Autumn 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~~form part of the engagement plan for NHS Wales Staff Survey.
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~~July – December 2023 ~~May – December 2023~~ September – December 2023 ~~September 2023~~November 2023 ~~March – June 2023~~September – November 2023	~~Leadership and Management development offerings to support staff health and wellbeing added to existing offerings.~~ Appointment of OD Manager, Wellbeing and Culture supporting and shaping Leadership and Management development offerings to sustained focus on staff wellbeing. Work being undertaken re Leadership Principles will also enhance this. Retention toolkit developed to support teams / CBs / managers. To include links and guidance to support at a local level. ~~Current work planned with Children and Women CB.~~ Acceler8 Cohort 2 completed. Current review and evaluation of leadership ~~training~~development to follow audit advisory feedback. ~~Futher cohorts planned for Autumn 2023.~~ ~~EWS working closely with Education, Culture~~

		~~May 2023~~August 2023	~~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.~~ Draft commissioning model agreed, to be communicated via WPG, SLB. Financial Wellbeing (FWB) lead working with P&C leads to look at embedding FWB into moments that matter such as staff induction. Meeting held and sign posted to staff induction leads
5. Wellbeing interventions and resources funding bid approved November 2021. Implementation to start December 2021 for completion March 2022. Wellbeing Strategy group to shape with feedback from CI Boards.	Claire Whiles	~~March - June 2023~~September 2023 – March 2024 ~~May August 2023~~ ~~May July 2023~~October 2023 – January 2024	~~Work on evaluation metrics underway with support from innovation and improvement team and public health. This will ensure effective monitoring, evaluation and planning of all wellbeing services and interventions.~~ Work on evaluation metrics underway within ECOD, EWS and OH. Current review of reporting and identification of dashboard to provide organisational insights and assurance. This will ensure effective monitoring, evaluation and planning of all wellbeing services and interventions. Work progressing slowly due to inability to fill vacant role.

		July2023 – March 2024 September – October 2023 ~~June 2023~~ ~~April-June 2023~~ September 2023 – March 2024	Wellbeing ~~Strategy and Framework draft~~ Framework draft presented to Strategic Wellbeing Group Feb 2023. ~~Further engagement with staff networks, TUs and CBs to follow.~~Following revised TORs for Strategic Wellbeing Group, work will re-commence in October 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.~~ Schwartz Round clinical leads identified. Facilitator Training took place on 18th July 2023. Steering Group established and intial meeting took place September 2023. Project plan in development, first round to take place October 2023, and will be held monthly. Schwartz Round Administrator role – currently no capacity to

		~~May - June 2023~~ July – October 2023 ~~May 2023~~	fill role, to review in Autumn 2023. Risk re Schwartz Round Administrator role – currently not assigned. Wellbeing Retreat Pilot completed, draft evaluation currently in review – delayed due to capacity. C~~ost 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.~~ Organisational approach to Cultural Assessment was presented to SLB in August 2023. Utilising NHSE tool which is an evidenced based model designed by NHSE, The King's Fund and Professor Michael West. Working with HEIW to implement and embed. Will support development of an

			inclusive, compassionate and healthy workplace. Cultural Assessment work currently being prioritised to support a range of CBs. This will require ~~C~~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. Schwartz Rounds- Facilitators, administrators and members of a Steering group have been identified. Training for the facilitators has been arranged for 18th July which is a joint session with ABUHB. Training for the administrators and members of the Steering Committee is being arranged with the 'Point of Care Foundation. The intentions is to roll out the rounds from October 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, Catherine Phillips and David Thomas)

The UHB delivers services from 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 based on a prioritised list.

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 and some community facilities 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 (assessed regularly on an all-Wales basis by NHS Shared Services Partnership). • 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 and efficient 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 order where possible, insufficient resource for new equipment or timely replacement • Staff facilities needed to support good staff wellbeing 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. The 2023/24 Capital Plan will be submitted for Board approval in July 2023.		

	• Medical Equipment prioritisation is managed through the Medical Equipment Group and there is a process in place for rapid decision making if there is a urgent need to replace a piece of equipment. • Business Case performance monitored through Capital Management Group every month and Finance & Performance Committee at each meeting, every month ~~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. Welsh Government has commissioned an independent review of the clinical model described in the PBC and we understand that approval to proceed with developing the SOC will be dependent on the findings of this independent review (which is concluding in early September). • 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. The latter 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. • The statutory compliance areas are monitored every month in the Capital Management Group to ensure that the key areas of risk are prioritised and reporting of estates risks to the Health and Safety Committee is being strengthened(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 Finance & Performance 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) • Finance & Performance 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 estate and digital infrastructure and medical equipment replacement services which requires the need to prioritise investment and resource allocation based on assessed level of risk and alignment with strategy and IMTP priorities. • In year requirements further impact and require the annual capital programme 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 ~~Jul~~May 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. Prioritised plan is signed off by CMG and SLB and Board.
3. An acute infrastructure group is overseeing the short – medium term priorities.		Abigail Harris	31.03.24	The group continues to meet to oversee the priorities and development of a number of business cases that have been prioritised to ensure they progress in a timely way 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. Further work was requested, and additional information was provided to WG in May 2023. Due to the financial deficit facing NHS in Wales (including C&V UHB) further work was required to look at options for reducing the deficit beyond the position set out in the annual plan. These options were considered by Board and submitted in August as required. 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. All Health Boards have been asked to develop further options that would achieve an improvement in the deficits set out in the annual plans.		
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 sustainably 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.		
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. We have submitted number of proposals against the WG Top Sliced Planned Care Recovery Fund aimed at improving our waiting times position in line with ministerial priorities and funding has now been confirmed which will enable our plans to proceed at pace. 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, monthly review meetings are held with each clinical board meetings with Clinical Boards and a series of summits have been led by the Chief Operating Officer to focus on focus on delivery 'hotspots' such as stroke. These are leading to improvement plans, and the		

	improved performance is tracked through the Integrated Performance Report that goes to the Finance and Performance Committee and the Board.
Current Assurances	Financial performance is a standing agenda item monthly on Senior Leadership Board with escalation to Management Executives Meeting [(1)]. In addition to this a Sustainability Board has been established to oversee the delivery of the financial plan. The financial position is reviewed by the Finance and Performance Committee which meets monthly and reports into the Board. [(1)] The Board receives 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 JulMay 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. Development of the Integrated Performance Report provides assurance on Ministerial Priorities	Abigail Harris	30/09/23	This will be presented to Finance & Performance Committee and Board in September 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	None identified.		

Actions	**Lead**	**By when**	**Update since JulMay 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.~~1. The organisation has identified 62% of the 2023/24 £32m savings target at the end of June with further opportunities identified to close the gap. Schemes will be further progressed through Q2 to ensure full delivery.	Catherine Phillips	30/09/23	On track by end of Q2.
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)~~ updated 12.09.23		
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 JulMay 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~~	~~Complete~~
~~10.~~1. Final report on the UHB's HIMSS digital maturity to be shared and discussed at DHIC and a summary brought to Board (private meeting) thereafter	DT	31.07.23	New action
~~11.~~2. 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
3. Cyber awareness raising webinar organised by WG and DHCW for board members held on 03/07/23. Cyber Imp plan to be developed and shared with Board, via DHIC	DT	30.09.23	New action
4. Update on Cyber Implementation plan to be discussed at private meeting of DHIC in October.	DT	01.10.23	New action
~~12.~~5. Board to be appriased of cyber position at private session of Board (Nov 23)	DT	30.11.23	New action
Impact Score: 5	**Likelihood Score: ~~4~~3**	**Target Risk Score:**	~~2015~~ **(Extreme)**

Key:

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

Report Title:	C&V Integrated Performance Report				Agenda Item no.	6.6
Meeting:	C&V UHB Board Development		Public	X	Meeting Date:	31/08/2023
			Private			
Status *(please tick one only):*	Assurance	x	Approval		Information	
Lead Executive:	Fiona Kinghorn, Jason Roberts, Rachel Gidman, Paul Bostock, Catherine Phillips					
Report Author (Title):	Information Manager					

Main Report
Background and current situation:

Public Health

Percentage of adult smokers who make a quit attempt via smoking cessation services: Increased rate for Q4 with similar trends in previous years with Q1 and Q4 routinely achieving higher rates - reflecting other influences throughout the year which impact on decisions to quit smoking.

Percentage of patients quitting smoking by accessing the Hospital HMQ programme: Increased rate for Q4 with similar trends in previous years

Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose): This is below the target of 95%; a Childhood Immunisation Plan 2023/24 is being implemented to increase uptake.

Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15: This is below the target of 90%. The move to the one dose schedule will give teams increased capacity to work more proactively to improve practice in terms of improving HPV vaccine uptake in our eligible groups.

Percentage uptake of the COVID-19 vaccination for those eligible: Spring 2023 Booster surveillance data shows uptake is below the 75% target, but is the same as the Welsh average. We are building on the learning from the Spring Booster in the planning for the Autumn 2023 Booster.

Operational Performance

We continue to see a high level of demand for our urgent and emergency care services. Despite this we have seen performance improvement in areas we have given operational focus. The focussed work on ambulance handovers through this year has led to significant reductions in the number of patients waiting more than 1 hour on an ambulance outside our Emergency Department, in addition to an overall reduction in the average handover time, surpassing our commitments.

However, for August there has been a deterioration in performance across our suite of EU metrics: the number of one hour ambulance handover breaches have increased, in addition to our average handover time. However, our ambulance performance remains in excess of our IMTP commitments and continues to show a considerable improvement from our historic performance.

The number of patients waiting 12 and 24 hours in our Emergency Department has also increased during August. The improvements resulting from the significant number of ward moves and redesign of our EU/AU footprint in July are taking time to fully imbed and will have impacted our performance, we continue to analyse breaches to better understand and improve our flow processes.

Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. However, the improvements are not necessarily reflected by the annualised KPI metrics. Rapid fracture pathway improvements have led to a significant reduction in the median time taken for patients to get to the ward and continued improvement in the door to ward and prompt surgery performance for July.

July also saw a reduction in our compliance against the SSNAP measures for our Stroke Pathway. The percentage of patients directly admitted to the stroke unit within 4-hours reduced to 53.7%, however, this remains above the all Wales average. Our percentage compliance and median time to ward and CT scan remains improved from our performance in 2022 and we continue to work across Clinical Boards to progress the Stroke Service Improvement Plan.

In terms of our compliance with the 62-day single cancer pathway standard, whilst we did not deliver the 75% standard as we had originally intended, our performance in July increased to 65.6% and has remained above 60% since February this year.

The numbers of patients waiting on an RTT waiting list has increased this month. We continue to focus on long-waiting cohorts and Cancer pathways with weekly scrutiny against the national standards and ministerial ambitions. A separate Paper from our Director of Planned and Specialist Care was presented to the Committee last month describing the current position and our approach for this year. This month a separate paper on Orthopaedic waiting lists has been submitted.

Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, including an increased presentation of patients with complex mental health and behavioural needs. Part 1a compliance for adults fell to below 50% in April following an exceptionally high number of referrals in March. However, the teams have managed to recover their waiting list position and June's reported compliance with the 28-day standard returned to 100% and remained high in July at 99.8%.

Since the last committee meeting we have made the changes to the Emergency Unit and Assessment Unit areas as described in July's paper. As described, we anticipated that this would impact our EU attendance and 4-hour performance, beginning in July, will full month effect from August's data. This has been evidenced this month with reported attendances falling to below 12000 and our 4-hour performance reducing by 6.8%. Welsh Government have been notified of the changes and our teams are working to ensure these changes will help to better align our reporting with ongoing national proposals. Cardiff and Vale have been asked to lead an All Wales task and finish group to explore how we capture and report activity from an emergency and urgent perspective nationally. The changes developed will part of the Welsh Emergency Care Data Set (WECDS) development which will replace EDDS. The Health Board are meeting with the Delivery Unit regularly to develop a dataset as an exemplar in Wales. The aim is that this will be adopted across the whole of Wales to ensure we can compare services in an equitable and fair way.

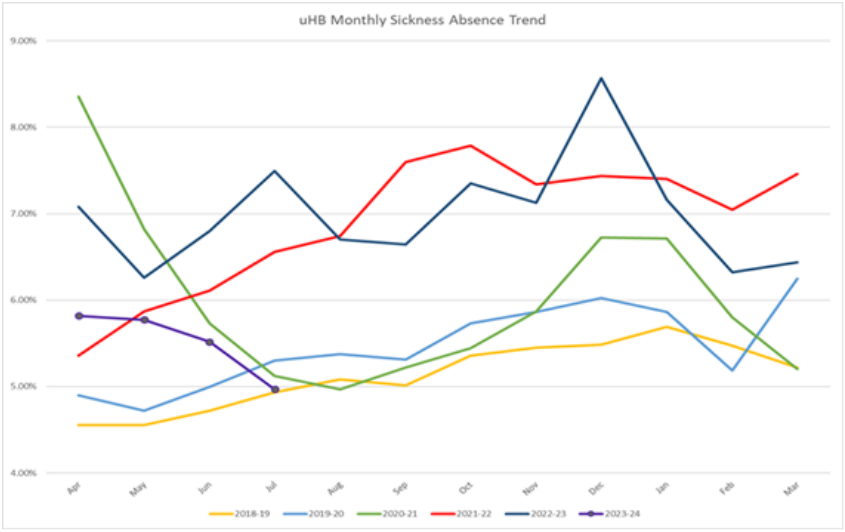
People and Culture

Section 2 of the attached Integrated Performance Report provides detailed information on the People and Culture key performance indicators, which include:

- Turnover
- Sickness absence
- Statutory and mandatory training
- Values-based appraisal
- Formal employee relations cases
- Job Planning
- Medical appraisal
- Staff in post and Variable pay.

In addition to the information in the attached report, there are a few points to bring to the Committee's attention:

- The sickness absence rate for Jul-23 was 4.97%. The last time the monthly rate was lower than this was Aug-20, and before that Jul-18, as can be seen in the chart below.



The 12-month cumulative sickness absence rate at Jul-23 was 6.53%, the lowest the rate has been since Jul-21.

- The calculation methodology for **values-based appraisal** compliance changed in July, staff who have commenced employment within the past 12 months are now excluded from the data reporting. The compliance rate as reported for July-23 using this revised methodology was 71.64%, if new starters had been included the rate would have been 67.69%.
- **Variable pay** – the workforce sustainability programme is focusing on significantly reducing variable pay through reducing reliance on agency workers, effective rostering, appropriate use of overtime and bank, etc.

Quality Safety and Experience

We are committed to implementing a strong QSE framework to deliver excellence, security, and an enhanced experience. This requires a systematic and repetitive approach. The data we have provided illustrates our integration of factors such as user experience, efficiency, risk reduction, and compliance with relevant regulations.

We are establishing a robust monitoring system to track the performance and effectiveness of the framework. We have established Key Performance Indicators (KPIs) and Quality Indicators (QIs) to measure its long-term effects. We actively seek feedback from users and stakeholders and use data-driven insights to identify areas for continuous improvement.

Indicators are reported and examined in more detail through the QSE-Quality ,Safety and Experience Committee.

Finance

At month 4, the UHB is reporting an overspend of £34.353m. This is comprised of £4.055m unidentified savings, £0.832m of operational overspend and the planned deficit of £29.467m (four twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan). £30.764m of green, amber and red savings were identified against the £32m savings target at month 4, leaving a further £1.236m (4%) schemes to be identified. Additional actions are progressing to recover the month 4 operational & CRP overspend to enable the UHB to deliver the planned £88.4m deficit.

Recommendation:
The Board / Committee are 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:

Cardiff and Vale
Integrated Performance Report

September 2023

Report Contents

Click on a hyperlink to navigate directly to the section required

Section 1: Ministerial Priorities

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The Minister for Health and Social Services has set out 6 priority areas to help address the immediate pressures and help to build a sustainable health and care service over the next year.

Section 1 provides an overview of the Health Boards performance in relation to the 16 measures that are included within these 6 priority areas. As many of the measures are not specific, detail is provided on the specific measurement(s) that has been used to monitor compliance.

For a more in depth view on performance for each priority, please follow the links in the NHS Performance Framework column.

Priority	Aim	C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link in Performance Report
Delayed Transfers of Care	**Reduction in backlog of delayed transfers** Measure: number of delayed transfers of care. Reporting period: monthly	217	Yes	June 2023	176 July	Hyperlink to section
Primary Care Access to Services	**Improved access to GP and Community Services** Measure: >95% achievement of core access to in-hours GMS Services Reporting: monthly	95%	Yes	June 2023	98% June	Hyperlink to section
	Increased access to dental services Measure: 50% of expected new patient target Reporting: monthly	50%	Yes	June 2023	tbc	Hyperlink to section
	Improved use of community pharmacy Measure: >90% of all eligible community pharmacies providing CCPS (June 2023) Reporting: monthly	90%	Yes	June 2023	98% June	Hyperlink to section
	Improved use of optometry services Measure: Reduce number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services Reporting: monthly	877	Yes	Dec 2023	846 June	Hyperlink to section
Urgent and Emergency Care	**Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales** Measure: Performance response time in NHS 111 Reporting: TBC	tbc	tbc	June 2023	tbc	Hyperlink to section
	Implementation of Same Day Emergency Care services Measure: Increase in SDEC attendances Reporting: monthly	1233	Yes	June 2023	1717 July	Hyperlink to section
	Honour commitments that have been made to reduce handover waits Measure: Eliminate 4 hour ambulance handover delays Reporting: monthly	0	Yes	June 2023	0 August	Hyperlink to section

Performance Key: Meeting standard / trajectory | over target/trajectory

Section 1: Ministerial Priorities

Performance Key: Meeting standard / trajectory | over target/trajectory

Return to Main Menu

Priority	Aim		C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link Performance Report
Planned Care, Recovery, Diagnostics and Pathways of Care	**Achieve RTT waiting time targets** Measure 1: 52 week new outpatient target by March 2024 Reporting: monthly		8999	No	Mar 2024	11138 July	Hyperlink to section
	Measure 2: 104 week treatment target by December 2023 Reporting: monthly		3788	Yes	Dec 2023	4164 July	Hyperlink to section
	Set foundations for achieving waiting list targets Measure: Reduce outpatient overdue follow by 25% against 2019/20 levels Reporting: monthly		37623	Yes	Mar 2024	45644 July	Hyperlink to section
	Implement regional diagnostic hubs Measure 1: progress reporting on regional diagnostic hub Reporting: quarterly		Go-Live	Yes	Sept 2024	On track	Hyperlink to section
	Measure 2: Achieve 8-week diagnostic Reporting: monthly		0	No	June 2025	10009 July	Hyperlink to section
	Implement straight to test model Measure: progress reporting on straight to test Reporting: quarterly		Go-Live	Yes	Sept 2024	On track	Hyperlink to section
Cancer	**Achieve SCP target** Measure: 75% of patients starting their first definitive cancer treatment within 62 days Reporting: monthly		75%	Yes	June 2024	62% June	Hyperlink to section
	Implement the national cancer pathways within the national target Measure: progress reporting on national cancer pathways Reporting: quarterly		Go-Live	Yes	Sept 2024	On track	Hyperlink to section
Mental Health and CAMHS	**Achieve waiting wait performance for Local Primary Mental Health Support Services and Specialist CAMHS** Reporting (for all): monthly	Measure 1: Part 1a (adults)	80%	Yes	June 2024	99.8%July	Hyperlink to section
		Measure 2: Part 1b (adults)	80%	Yes	June 2024	100%July	
		Measure 3: Part 2 (adults)	80%	Yes	June 2024	46.7%July	
		Measure 4: Part 1a (children)	80%	Yes	June 2024	84%July	
		Measure 5: Part 1b (children)	80%	Yes	June 2024	0% July	
		Measure 6: Part 2 (children)	80%	Yes	June 2024	90.2%July	
	Implement 111 press 2 on a 24/7 Measure: progress on implementing NHS 111 press 2 Reporting: quarterly		Go-Live	Yes	Sept' 2024	Delivered	Hyperlink to section

Section 2: Cardiff and Vale Performance Report

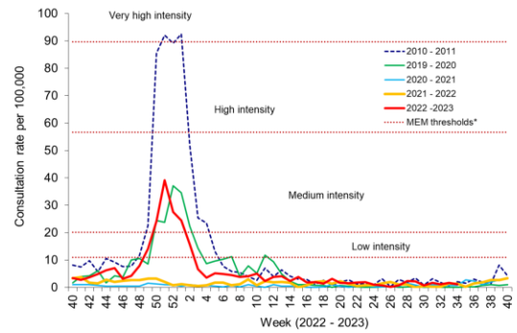
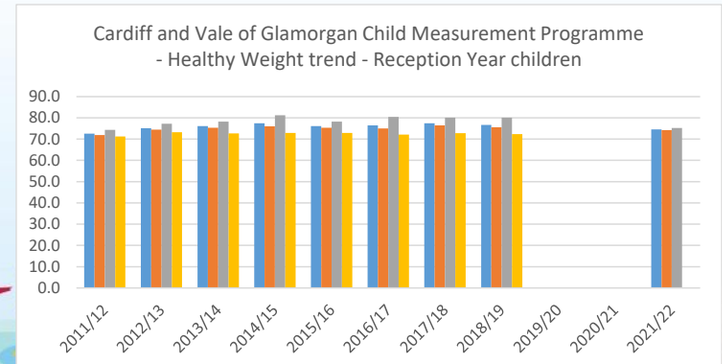
The Performance Report section provides detail of UHB performance across the quadruple aims.

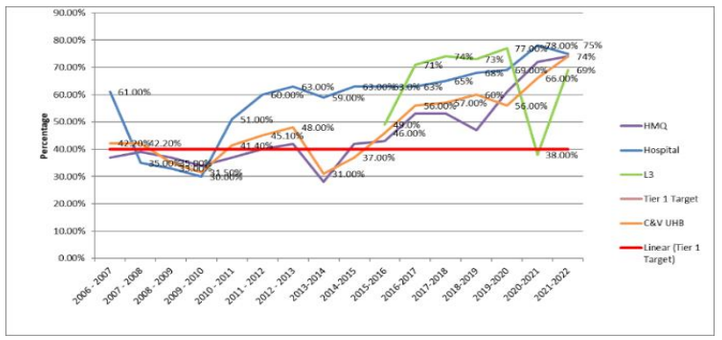
Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided against the priority UHB ambition under each aim, including detail of annual plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim (under development)

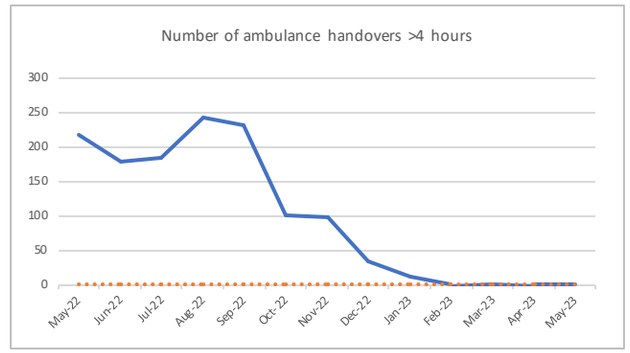
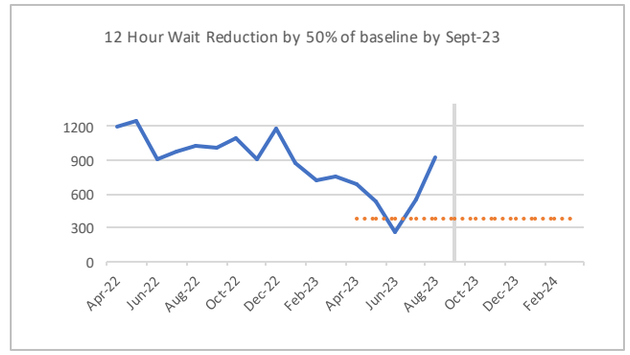
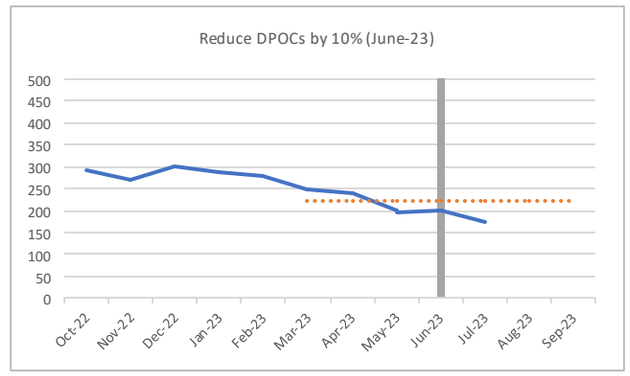
Return to Main Menu

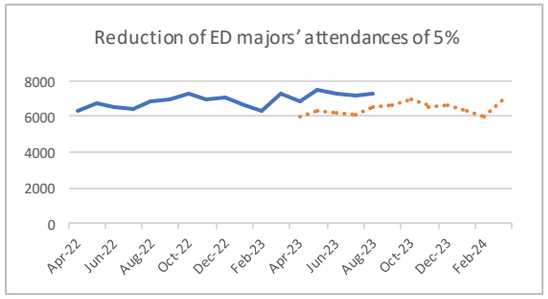
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care Inpatient Flow, Discharge and Front Door Alternatives to Admission Community and Urgent Primary Care Priority Services RTT Waiting Times Planned Care Cancer, Diagnostics and Therapies Primary and Community Care Whole System Evaluation and Supporting Patients Whilst Waiting Mental Health
Aim 3	The health and social care workforce in Wales is motivated and sustainable	People and Culture
Aim 4	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

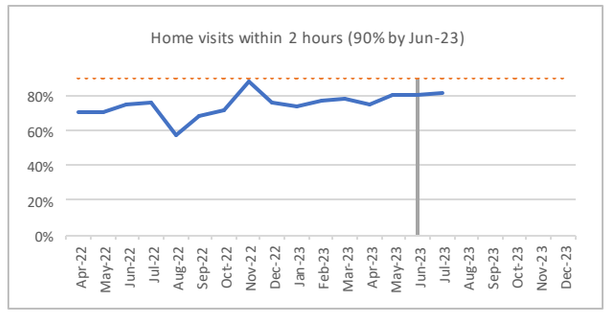
Priority	Performance Summary	Reported Period	Data
Health Protection Acute Respiratory Infections (ARI)	Acute Respiratory Infections (ARI) • Baseline (inter-seasonal) levels of influenza activity • Hospital admissions for Covid-19 have been increasing during August. A new sub-variant of omicron, BA.2.86, has recently been identified at low prevalence across a number of countries including the UK and has been designated a 'variant under monitoring' by the WHO. It is not yet clear what, if any, adverse impact this new variant will have on Covid-19 cases and morbidity. • RSV activity in children under 5 years is at levels which indicate the season has started, although there has been a decrease to low levels in the most recent week.	Week 34	 Source:10 (wales.nhs.uk)
Health Protection Immunisation	• Eligible cohorts have received the Covid-19 Spring Booster, with 37,253 doses given in Cardiff and Vale by 5 July 2023, and 69.15% uptake to date (cf Wales average 67.91% uptake). • Following JCVIs announcement on 6 April, the Covid-19 infant vaccination programme commenced on 22 May 2023, running alongside the Spring Booster Campaign. The latest available public data by Public Health Wales (accessed on 21/08/2023) for the whole of Wales shows 47,541 (18.6% of the eligible) 1st doses were administered to 5-11 year olds and 34,964 second doses (13.7% of the eligible). In the geographical areas of Cardiff and in the Vale this was respectively 26.8% and 24.5% for the first dose and 21.1% and 19.6% for the second dose. • Operational preparations are underway for the Winter Respiratory Vaccination Programme. Eligible groups have been identified and the vaccination campaign is due to start from the 11th of September 2023. • The Staff Winter Respiratory Vaccination campaign will also start concurrently and it will see the co-administration of Covid-19 and Influenza vaccinations via appointments at Mass Vaccination Centres, occupational health and with opportunistic vaccination through vaccination champions.	Q1 2023/24	Wales COVID-19 vaccination surveillance weekly report.pdf Infant covid 19 vaccination. https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/RapidCOVID-19virology-Public/Vaccination
Health Protection Health Protection System	• Planning for a regional, all hazards Integrated Health Protection Partnership continues, with expected full implementation by end of year • A draft Health Protection Plan has been developed with key partners. Consultation with stakeholders will take place in early Autumn.	Q2 2023/24	
Health Improvement Healthy weight	• 74.6% of reception aged children in Cardiff and the Vale of Glamorgan are categorised as healthy weight (CMP, 2021/22). Cardiff and Vale have the second highest proportion of healthy weight children compared to other Health Board areas based on the latest available data. • 40% of adults in Cardiff and the Vale of Glamorgan are of a healthy weight (NSfW, 2021/22+2022/23)*; 39% are eating five portions of fruit/vegetables a day (NSfW, 2021/22+2022/23)* and 68% are meeting physical activity guidelines of being active for at least 150 minutes per week (NSfW, 2021/22+2022/23)*. • Differences remain between our most and least deprived communities with levels of healthy weight lower, and consumption of fruit and vegetables/physical		

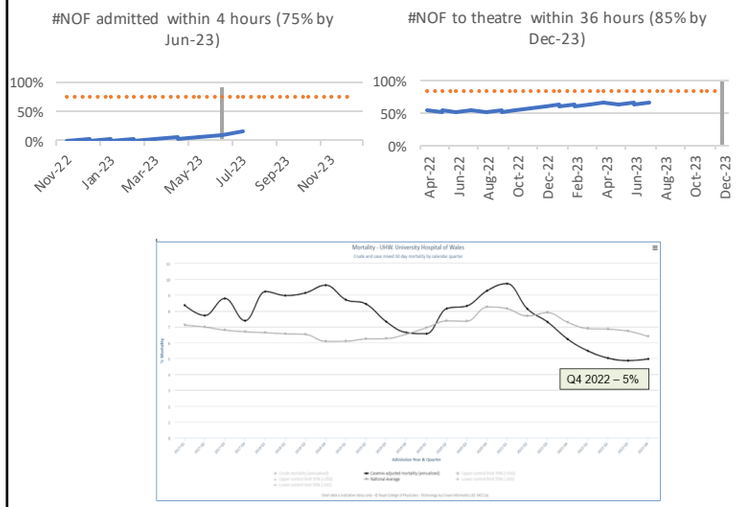
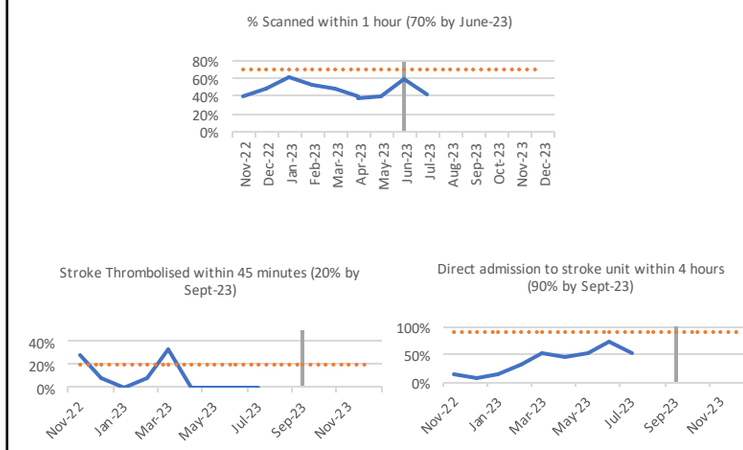
Priority	Performance Summary	Reported Period	Data
Health Improvement Tobacco	• 12% of Cardiff and Vale of Glamorgan smoke), one of the lowest prevalence rates in Wales • 2.3% of smokers set a firm quit date in 2022-2023 with 71% quitting smoking at 4 weeks • 9% of pregnant women smoke on booking – the lowest in Wales. 8% of pregnant women smoked on booking, Cardiff and Vale UHB, Qtr 4, 2022-2023) • 85% of patients quit smoking by accessing the Hospital HMQ programme, Qtr 4 2022-2023	Quarter 3 2022-2023	

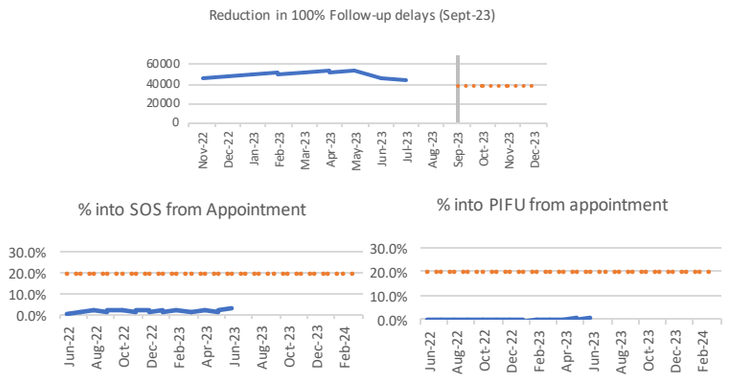
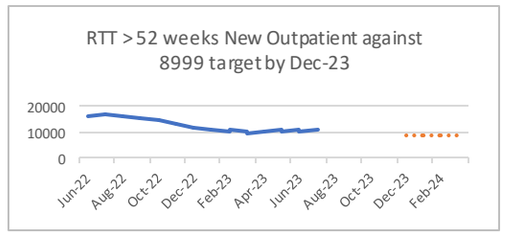
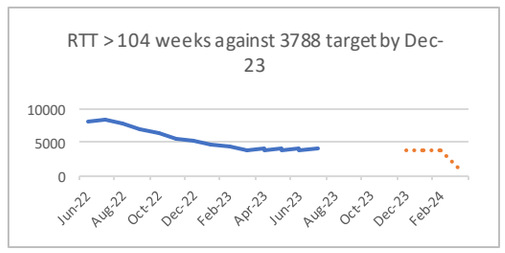
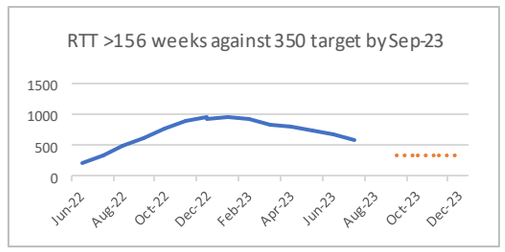
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
1.	Percentage of adult smokers who make a quit attempt via smoking cessation services	1 Jan 23 to 31 Mar 23	0.8% per quarter	**0.7%**	Q1: 0.50% | Q2: 0.50% | Q3: 0.40% | Q4: 0.70%
2.	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)		Improvement trend	Work in progress with substance misuse	
3.	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	1 Jan 23 to 31 Mar 23	95%	**84.8%**	Q1: 86.80% | Q2: 87.20% | Q3: 86.80% | Q4: 84.80%
4.	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15 (Applicable during: 01.04.2023 - 30.06.2023 and 01.01.2024 - 31.03.2024)	1 Jan 23 to 31 Mar 23	90%	**71.3%**	Q1: 72.00% | Q2: 72.60% | Q3: 70.30% | Q4: 71.30%
5.	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over (Applicable during: 01.09.2023 - 31.03.2024)	1 Sept 22 to 31 Mar 23	75%	**75.7%**	
6.	Percentage uptake of the COVID-19 vaccination for those eligible (Applicable during: Spring Booster 01.04.2023 - 30.06.2023) (Autumn Booster 01.09.2023 - 31.03.2024)	1 Apr 23 to 30 Jun 23	75%	**67%**	w/e 11/06: 64.00% | we 18/06: 65.00% | w/e 25/06: 66.00% | w/e 02/07: 67.00%
7.	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	Jun-23	90%	**4.7%**	Mar-23: 8.00% | Apr-23: 16.70% | May-23: 3.40% | Jun-23: 4.70%
8.	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Jun-23	90%	**97.7%**	Mar-23: 96.30% | Apr-23: 95.60% | May-23: 98.00% | Jun-23: 97.70%
9.	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	Jul-23	95%	**93.5%**	Apr-23: 93.70% | May-23: 95.10% | Jun-23: 97.30% | Jul-23: 93.50%

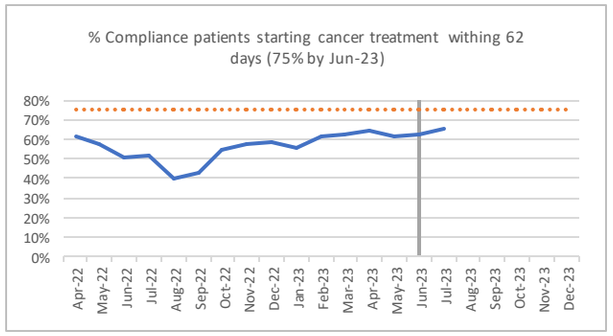
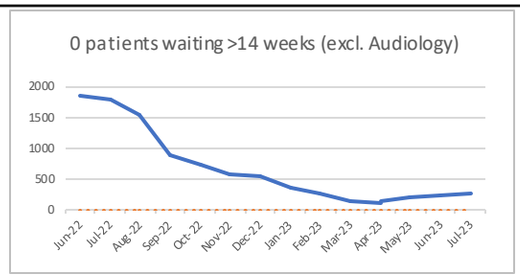
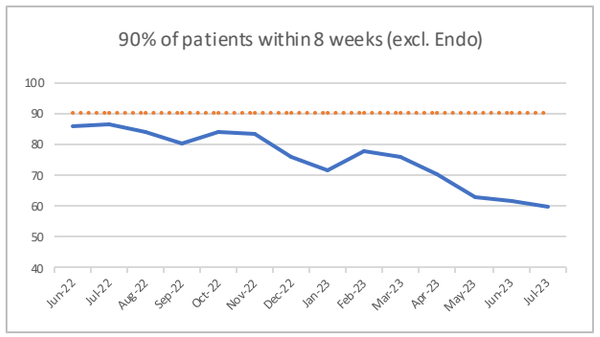
Priority	Performance Summary	Reporting Period	Data
Ambulance Handover Annual Plan Commitments: • Zero 4-hour ambulance delays (June 23) • Reduce average lost minutes to 30 (Sept 23)	• The number of ambulance handovers >4 hours has reduced from 230 in September 2022 to zero in June, July and August 2023. We are now giving the same focus to patients waiting 2-hours for an ambulance handover. In June there were two 2-hour holds, a reduction from 206 in March, in July we reported fifteen and in August twenty . • Average lost minutes per arrival remains reduced but increased to 26 minutes in August from 18 in June. This performance remains better than our annual plan commitment.	Aug-23	
Emergency Department Annual Plan Commitments: • Zero 24-hour ED waits (June 23) • Reduce 12-hour ED waits by 50% (Sept 23)	• In August, 41 patients waited 24-hours in the EU footprint without a stop-clock, an increase from the 0 patients reported in June and 23 in July • 12-hour ED waits increased from 548 in July to 924 in August.	Aug-23	
Delayed Pathways of Care, LOS and Beds Annual Plan Commitments: • Reduce DPOCs by 10% (June-23) • Reduce >21 day LOS by 5% (June-23) • Re-establish dedicated AOS beds (Sept)	• Delayed pathways of care remain a national challenge, the July 2023 census reported 176 delayed pathways a reduction from 202 in June • We are currently tracking the numbers of stranded (7-day LOS) and superstranded (>21-day LOS) patients in our Acute beds. This is a more operationally useful measure than LOS measures which include rehabilitation and integrated care beds. We will be monitoring these going forward against the standards of <40% stranded and < 20% superstranded. At the time of writing our analysis showed 34% and 56% respectively. • Work continues to evaluate the most appropriate and effective approach for the Acute Oncology Service (AOS), including consideration of dedicated beds following a recent pilot. An update and proposal is now planned for the beginning of Q3.	Jul-23	

Priority	Performance Summary	Reporting Period	Data
ED Attendances Annual Plan Commitment • Reduction of ED majors' attendances of 5% compared to same period 2022/23 (every quarter)	• In August 2023 we reported 11,717 EU attendances, a reduction from the 12,506 reported in July • The number of EU Majors attendances in August 2023 was 7239, an increase from July and above our ambition of 6507.	Aug-23	
Same Day Emergency Care Annual Plan Commitment • 10% increase in the total number of patients managed through SDEC (June 2023) • Reduced number of unplanned re-presentations within 7-days of SDEC attendance (September 2023) • Improve % of take managed in SDEC without requiring admission	• In July 2023 we saw 1,082 patients seen via surgical SDEC and 635 via the medical SDEC. In total 1,717 patients were seen, above our commitment of a 10% increase by the end of Q1. The number of attendances to medical SDEC had been increasing month on month since June 2022, but showed a small reduction from June to July. • A new process for national submissions has been undertaken and we hope to report on the other measures from September	Jul-23	

Priority	Performance Summary	Reporting Period	Data
Urgent Primary Care Annual Plan Commitments: • 80% appointment utilisation in UPCCs (June 2023), 85% (September 2023), 90% (March 2024) • All clusters to have adequate access to UPCC capacity (September 2023) • NHS 111 - >90% urgent calls logged and returned within 1 hr (December 2023) • Increased redirections from ED to UPCC (March 2024)	• Average utilisation of 89% achieved across Cardiff and Vale for August, a decrease from 91% in July. • Work in progress – Delivery plan in place to ensure full/equitable UPCC provision across all Cluster areas • Average rate for June 89% • Work in progress – Pilot commenced to re-direct ED patients to UPCC slots. Work ongoing to expand this to 24/7 and to include Paediatrics. Average referrals for Q1 = 21 (adults)	Jul-23	
Community Services • Home Visit (P2) f2f in 2 hrs >90% (June 2023)	• The Health Board was 75% compliant in July 2023 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 3 of 4 patients receiving their visit with one hour. • For patients that required an 'Emergency' appointment at a primary care center in July the Health Board was 100% compliant, with 2 of 2 patients receiving an appointment within 1 hour • The Health Board was 81% compliant against the commitment of 90% for 'Urgent' GP OOH patients requiring a home visit within 2 hours, with 78 of 98 patients receiving their visit within 2 hours	Jul-23	

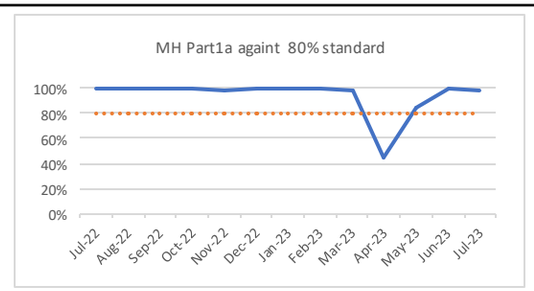
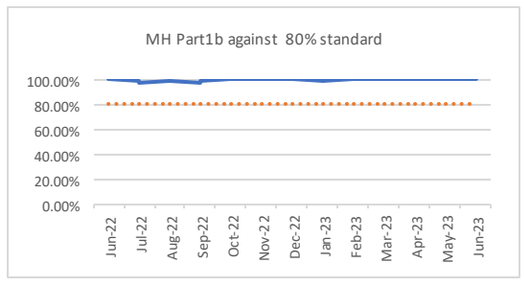
Priority	Performance Summary	Reporting Period	Data
Fracture Neck of Femur IMTP Commitments: • 75% admitted within 4 hours (June-23) • 85% to theatre within 36 hours (December-23)	Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. In July 2023 the annualised data shows 14.8% of patients were admitted to a specialist ward with a nerve block within 4 hours. In July, 67.6% of patients received surgery within 36 hours, this has been increasing since August 2022 and our performance is above the national average of 57% over the last 12 months. A third summit with key stakeholders was held in June with a follow up scheduled for the end of September. We have an 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 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 at 5% for Q4 22/23.	Jul-23	
Stroke IMTP Commitments: • 70% scanned within 1 hour (June-23) • 90% admitted within 4 hours (Sept-23) • 20% thrombolysis rate (Sept-23)	While overall Stroke performance remains below the standards set out in the Acute Stroke Quality Improvement Measures and The Sentinel Stroke National Audit Programme (SSNAP), we have seen recent improvements in compliance with the 4-hour door to Ward standard. In July: • 0% of patients were thrombolysed within 45 minutes of arrival, the All-Wales average was 3.9% • The percentage of CT scans that were started within 1 hour in July was 42.6%, the All-Wales average was 59.6% • The percentage of patients who were admitted directly to a stroke unit within 4 hours was 53.7% in July, the All-Wales average was 31.8% The UHB has held a number of internal Stroke summits and 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.	Jul-23	
Intensive Care Unit IMTP Commitments: • Patient at risk team 24/7 (Sept 23) • ITU - 1 additional staffed bed (Sept 23) • ITU - 2 additional staffed beds (March 24)	• The patient at risk team (PART) is due to move from a 12/7 service to a 24/7 service from the 1st October following successful staff recruitment. This change will be pivotal in supporting the wards and ITU with the save management and transfer of patients. • 3 additional ITU Level 3 beds will be resourced over the course of this financial year. The first of those beds is on-track to be resourced from September 2023 following successful recruitment of staff		

Priority	Performance Summary	Reporting Period	Data
Outpatient Follow-up Management Annual Plan Commitment • Follow up outpatients–reduce 100% delayed follow up by 25% on Jan'23 baseline of 50163 (September 2023) • SOS and PIFU –10% of appropriate outpatient appointments (September 2023); 20% (March 2024) • SOS and PIFU –20% of appropriate outpatient appointments	• In total there were 191,706 patients awaiting a follow-up outpatient appointment at the end of July • Of these, there were 45,644 patients who were 100% delayed for their follow-up outpatient appointment, a decrease noted from June • 2.7% of outpatient appointments saw patients moving into a See on Symptoms pathway • 0.4% of outpatient appointments saw patients moving into Patient Initiated Follow-up pathway	Jul-23	
52 Week New Outpatient Annual Plan Commitment • <8999 > 52 weeks (March 2024)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from September. Weekly assurance is provided to the Chair.	Jul-2023	
104 Week Treatment Annual Plan Commitment • 3788 patients > 104 week waits for treatment (December 2023) • 1263 patients > 104 week waits for treatment (March 2024)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from September. Weekly assurance is provided to the Chair. We are on track to meet our December commitment	Jul-2023	
156 Week Waits Annual Plan Commitment • <350 patients >156 week wait for treatment (September 2023) • 0 patients >156 week wait for treatment (December 2023)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from October. Weekly assurance is provided to the Chair.	Jul-2023	

Priority	Performance Summary	Reporting Period	Data
Cancer Annual Plan Commitment • >75% compliance with the 62-day SCP standard (June 2023), 80% (December 2023) • Develop draft UHB strategy to deliver national cancer pathways (June 2023)	• There continues to be an improvement against the Single Cancer Pathway and the backlog trajectories agreed with the Delivery Unit. July saw 65.6% of patients receiving treatment within 62 days. At the time of writing there are a total of 2423 suspected cancer patient on the SCP. 268 have waited over 62 days, of which 82 have waited over 104 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.	Jul-23 No date	
Therapies Annual Plan Commitment • 0 patients waiting over 14 weeks (excluding audiology) (June 2023)	• Excluding Audiology there were 255 patients waiting over 14-weeks for Therapy in at the end of July. In total there were 1282 patients waiting longer 14 weeks for Therapy, a small increase from June.	Jul-23	
Diagnostics Annual Plan Commitment • 90% of patients within 8-weeks (excl. endoscopy) (December 2023) • Endoscopy – urgent <6weeks; SCP<14days; 0 surveillance patients 100% past target date (December 2023) • Regional Diagnostic Centre go-live (December 2023)	• Excluding endoscopy there were 6880 diagnostic patients waiting longer than 8 weeks for a Diagnostic at the end of July. In total there were 10009 patients waiting longer than 8 weeks for a diagnostic test, a small increase from June. • 60% of patients seen within 8 weeks in July-23 (excluding Endoscopy), a small reduction from May and June • Planning for the Community Diagnostic Hub is underway following agreement of central funding from WG. Expected go-live is estimated to be Q1 2024/25. Plans are in development to provide additional diagnostic capacity through mobile units in advance of this.	Jul-23 No date	

Priority	Performance Summary	Reporting Period	Data
Community Pharmacy Annual Plan Commitment: • >90% of all eligible community pharmacies providing CCPS (June 2023) • 10% increase in pharmacy independent provider access (December 2023)	98% of all eligible community pharmacies providing CCPS • 102 Community Pharmacies currently eligible to provide CCPS • 101/103 Community Pharmacies signed up to deliver CCPS. 2,395 consultations undertaken in Q1, with 21% increase in PIP sites expected in Q2.	Q1-June 2023	
GMS Escalation Annual Plan Commitment: • >95% of practices reporting escalation levels (June 2023) • >95% achievement of core access to in-hours GMS Services (September 2023)	• 88% of Practices reporting escalation levels (Average for Q1 88%) - Number of escalations from practices reducing (of practices reporting of which 8% at Lvl3, 92% >Lvl3) • 98% achievement of core access standards to in hours GMS	Q1-June 2023	
Community Dental Annual Plan Commitment: • 50% of expected target for new patients, urgent and historic (June 2023); 90% (March 2024)	• % of Primary Care Dental Services Contract value (GDS) delivered for new patients seen - 46.07% • % of Primary Care Dental Services Contract value (GDS) delivered for new urgent patients seen - 21.96% • % of Primary Care Dental Services Contract value (GDS) delivered for historic patients seen – 16.03%	Q1-June 2023	
Optometry Annual Plan Commitment • >90% of eligible practices offering Clinical Community Optometry Services (CCOS) (June 2023); 95% (December 2023)	• Contract reform and implementation still in progress – Awaiting data • 12 Optometric Practices currently offer Optometry Independent prescribing service (18.75%)	Q1-June 2023	
Respiratory Annual Plan Commitment • 50% of backlog of suspected COPD patients receive spirometry (June 2023); 100% March 2024)	• Community Spirometry service available in both Cardiff and Vale regions. • 541 referrals received - 69.5% have attended appointments, 30.5% on waiting list	Q1-June 2023	

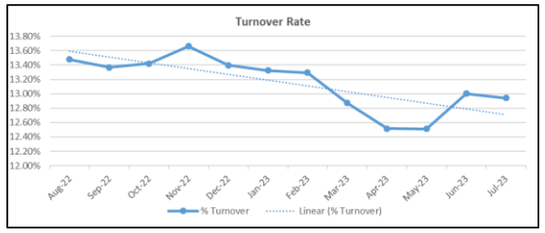
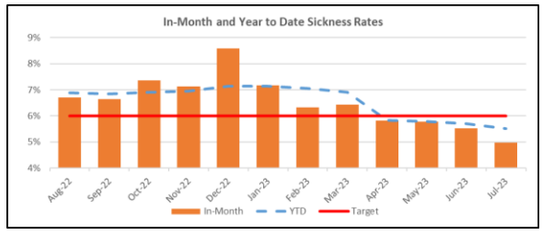
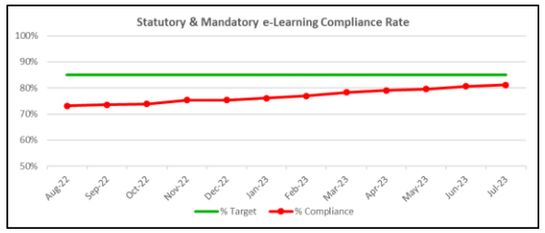
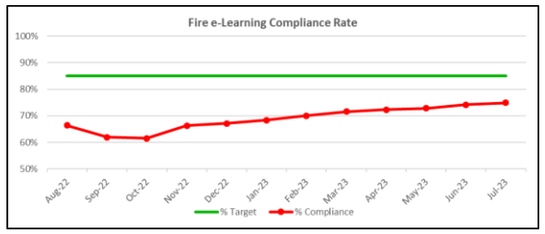
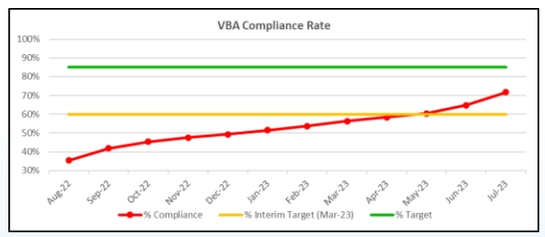
Priority	Performance Summary	Reporting Period	Data
Whole System Evaluation Annual Plan Commitment: • Undertake high impact evaluations of three key specialities (June 2023) • Undertake high impact evaluations of three key specialities (Sept 2023)	Evaluations completed in Therapies and Cardiac Services. At the Theatres Summit in September 3 specialties will present their evaluations. Work is ongoing to expand the evaluation process across specialties and we are refining how we approach this across the UHB.	Jun-23	
Supporting Patients Whilst Waiting Annual Plan Commitment: • Produce models of care (June 2023) • Develop pathways (Sept 2023) • Expand services (December 2023)	Models of care and pathways have so far been produced for 8 services including Prepare Well (Orthopaedics), ESCAPE Pain and Cancer Prehab2Rehab The expansion of services to include a single point of access is planned for delivery in this financial year.	Jun-23	

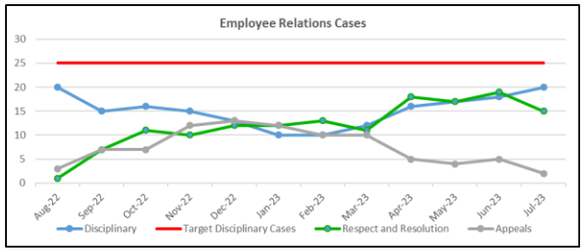
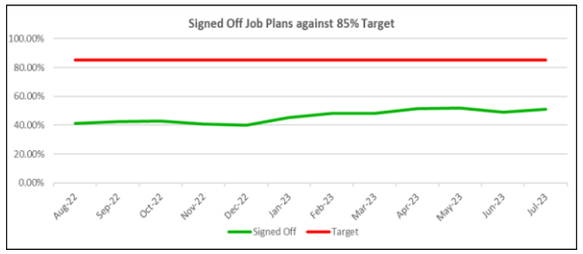
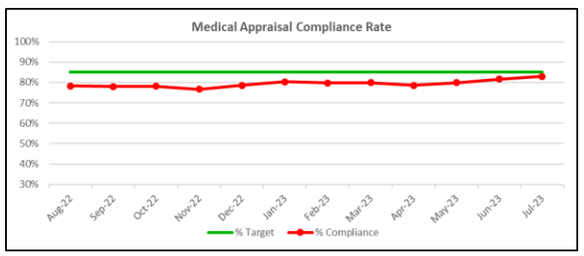
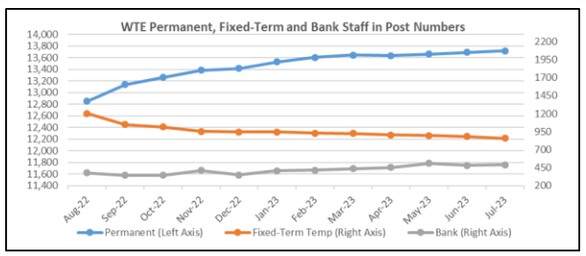
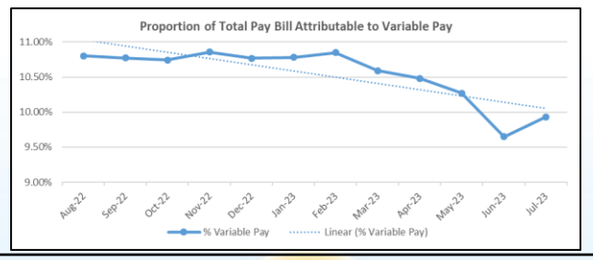
Priority	Performance Summary	Reporting Period	Data
Children's Mental Health Annual Plan Commitments: • >80% Part 1a performance – SCAMHS • Part 1b – 10% improvement (September 2023); further 10% (December 2023); achieve >80% compliance (March 2023) • Reduce SCAMHS Intervention longest wait to no longer than 6 weeks	Part 1a compliance remains above the 80% target at 84% in July. Part 1b performance was 0% due to additional assessment undertaken to meet Part 1a and high referral levels in June 23. The number waiting and longest wait for Part 1b has also increased due to the merge in data reporting for PMH and CAMHS. There have been data quality issues and a through improvement in the capture of data which has further impacted reported performance. In line with the new integrated model and focus on ensuring that children and young people access the most appropriate pathway under the mental health measure, we have redesigned the PARIS record keeping module and associated reporting to accurately capture the children and young people accessing and waiting for interventions for both Part 1b and Part 2 (SCAMHS). It is planned for this to go live in September so we expect to be able to provide accurate reporting from October.	Jul-23	Work in progress - Expected Oct-23
Adult Mental Health Annual Plan Commitments: • >80% Part 1a performance • >80% Part 1b performance	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 1216 referrals in July 2023. As highlighted at the previous Board meetings, this demand increase includes an increased presentation of patients with complex mental health and behavioral needs. Significant work has been undertaken to improve access times to adult primary mental health: • Part 1a: in July the percentage of Mental Health assessments undertaken within 28 days was 99.8% • Part 1b compliance remains at 100%	Jul-23	 

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
10.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	Jul-23	100%	98%	Reporting from Q2 – Expected Nov-23
11.	Percentage of primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Jul-23	30% (Sept 23) 100% (Mar 24)	New 64.1% New Urgent 29.5% Historic 27.5%	WIP – Expected Oct-23
12.	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services		Reduction by Mar 24	Work in Progress	WIP – Expected Oct-23
13.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Jul-23	Increase against 22/23	1106	WIP – Expected Oct-23
14.	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Jul-23	80%	**89.5%**	Apr-23: 88.90%; May-23: 95.70%; Jun-23: 93.70%; Jul-23: 89.50%
15	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	Jul-23	80%	**0%**	Apr-23: 0.00%; May-23: 0.00%; Jun-23: 0.00%; Jul-23: 0.00%
16	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Jul-23	80%	**99.8%**	Apr-23: 44.90%; May-23: 84.40%; Jun-23: 100.00%; Jul-23: 99.80%
17	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	Jul-23	80%	**100%**	Apr-23: 100.00%; May-23: 100.00%; Jun-23: 100.00%; Jul-23: 100.00%

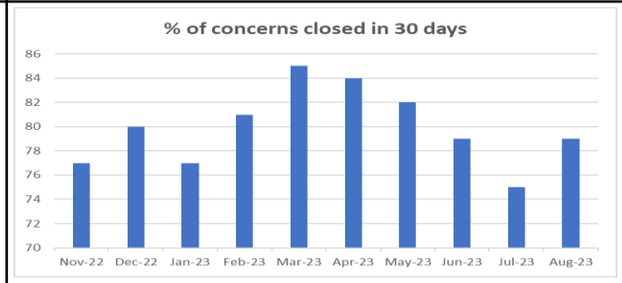
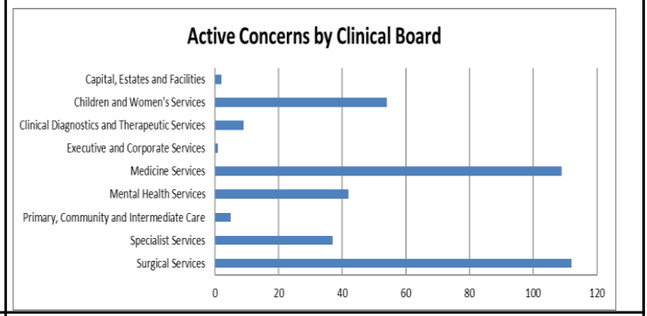
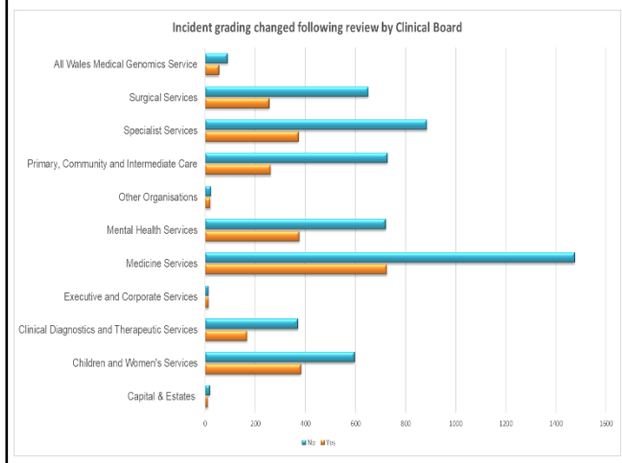
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
18.	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Aug-23	65%	**51%**	May-23: 59% / Jun-23: 60% / Jul-23: 57% / Aug-23: 51%
19.	Median emergency response time to amber calls		12m improvement trend	Work in Progress	WIP – Expected Oct-23
20.	Median time from arrival at an emergency department to triage by a clinician		12m reduction trend	Work in Progress	WIP – Expected Oct-23
21.	Median time from arrival at an emergency department to assessment by a senior clinical decision maker		12m reduction trend	Work in Progress	WIP – Expected Oct-23
22.	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Aug-23	95%	**69.8%**	May-23: 73.2% / Jun-23: 75.3% / Jul-23: 76.2% / Aug-23: 69.8%
23.	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	Aug-23	0 (Mar 2024)	**924**	May-23: 534 / Jun-23: 260 / Jul-23: 548 / Aug-23: 924
24.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Jun-23	80% (Mar 2026)	**62.0%**	Mar-23: 62.2% / Apr-23: 64.2% / May-23: 61.7% / Jun-23: 62.0%
25.	Number of patients waiting more than 8 weeks for a specified diagnostic	Jul-23	0 (Mar 2024)	**10009**	Apr-23: 6267 / May-23: 8113 / Jun-23: 9175 / Jul-23: 10009
26.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	Jul-23	Improvement trend	**85.2%**	Apr-23: 92.80% / May-23: 89.40% / Jun-23: 85.00% / Jul-23: 85.23%
27.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Jul-23	0 (Mar 2024)	**1282**	Apr-23: 1037 / May-23: 1121 / Jun-23: 1240 / Jul-23: 1282

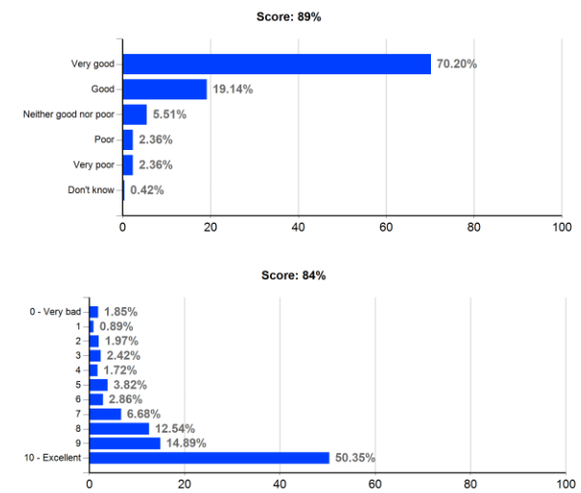
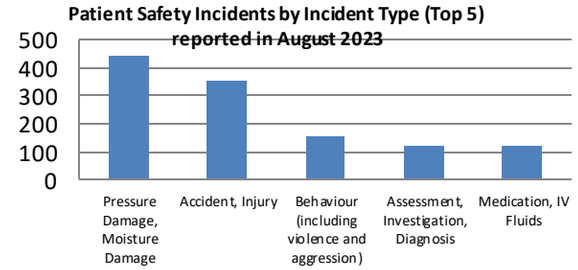
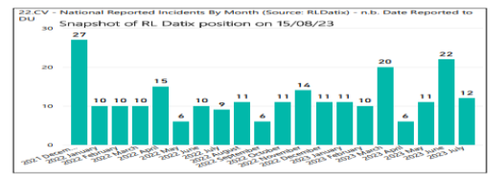
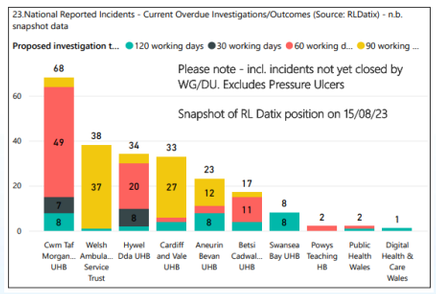
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
28.	Number of patients waiting more than 52 weeks for a new outpatient appointment	Jul-23	Improvement trajectory towards 0	**11138**	Apr-23: 10479; May-23: 10779; Jun-23: 10789; Jul-23: 11138
29.	Number of patients waiting more than 36 weeks for a new outpatient appointment	Jul-23	TbImprovement trajectory towards 0	**20580**	Apr-23: 19468; May-23: 19629; Jun-23: 19839; Jul-23: 20580
30.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Jul-23	Improvement trajectory towards 0	**45644**	Apr-23: 54064; May-23: 54788; Jun-23: 46981; Jul-23: 45644
31	Number of patients waiting more than 104 weeks for referral to treatment	Jul-23	Improvement trajectory towards 0	**4164**	Apr-23: 3983; May-23: 4107; Jun-23: 4133; Jul-23: 4164
32.	Number of patients waiting more than 52 weeks for referral to treatment	Jul-23	Improvement trajectory towards 0	**25653**	Apr-23: 23512; May-23: 24396; Jun-23: 24778; Jul-23: 25653
33.	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	Jul-23	80%	**84%**	Apr-23: 83%; May-23: 83%; Jun-23: 88%; Jul-23: 84%
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Jul-23	80%	**20%**	Apr-23: 31%; May-23: 29%; Jun-23: 26%; Jul-23: 20%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Jul-23	80%	**60%**	Apr-23: 62%; May-23: 59%; Jun-23: 58%; Jul-23: 60%

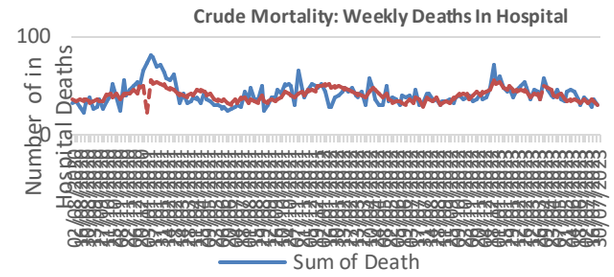
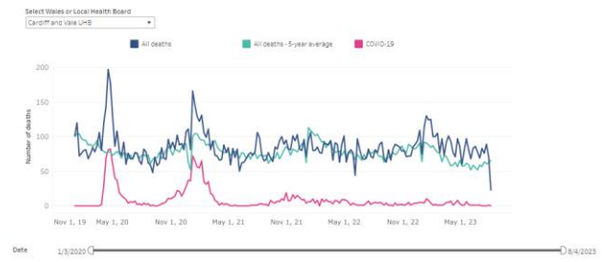
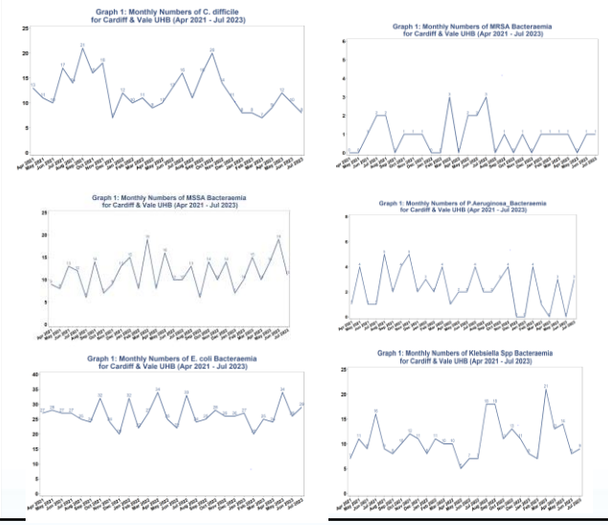
Priority	Performance Summary	Reported Period	Data
Turnover	The overall trend is downwards since Aug-22; the rates have fallen from 13.66% in Nov-22 (the highest rate of turnover in the past 12 months) to a low of 12.51% in May-23 UHB wide. The rate for Jul-23 is 12.94%. This is a net 0.72% decrease, which equates roughly to 99 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Retirement Age', 'Voluntary Resignation – Relocation', 'Voluntary Resignation – Work Life Balance' and 'Voluntary Resignation – Promotion'.	July 2023	
Sickness Absence	Rates remain high; although the rates appear to be the falling towards more 'normal' levels. The monthly sickness rate for Jul-23 was 4.97% after an all-time high of 8.58% for Dec-22. The 12-month cumulative rate has fallen steadily over the past 7 months to 6.53% (by comparison with Jul-22, which was 7.24%).	July 2023	
Statutory and Mandatory Training	Compliance rate has risen to 81.20% for Jul-23, 3.80% below the overall target. The compliance for the All-Wales Genomics Services, Capital, Estates & Facilities and Clinical Diagnostics & Therapeutics are all above the 85% target, and Children & Women's, PCIC, Corporate Executives and Specialist Services are above 80% compliance. Compliance with Fire training has also risen during Jul-23, to 74.87%. Again, Capital, Estates & Facilities and the All-Wales Genomics Services have exceeded the 85% compliance target, and Clinical Diagnostics & Therapeutics is above 80%.	July 2023	 
Values Based Appraisal	Compliance has more than doubled over the last year; the compliance at Jul-23 was 71.64%. 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 (91.77%) are the only Clinical Board to have exceeded the 85% target, but all of the Clinical Boards with the exception of Mental Health and the Corporate Executive group are now above the 60% transitory target.	July 2023	

Priority	Performance Summary	Reported Period	Data
Employee Relations	As can be seen in the graph the number of employee relations cases the People Services team are supporting has risen in the past three months but remains below the UHB Target. Further work is being undertaken to help embed the Just Culture principles within the UHB and a Just Culture Toolkit is being developed. The People Services Team continue to analyse trends of employee relations cases to develop bespoke training packages or additional toolkits/support services where appropriate.	July 2023	
Job Plans	91.14% of clinicians have engagement with job planning and have a job plan in the system, however only 51.25% of these plans are fully signed off. Focus continues to be on supporting the approval and sign off process.	July 2023	
Medical Appraisals	The rate of compliance with Medical Appraisal has risen during the past 12 months. At Jul-23 the compliance was 83.05%, by comparison with the target 85%.	July 2023	
Staff in Post	The overall Health Board Staffing Numbers have increased in the last 12 months by 522.29 WTE, to 14,573.19 WTE. The change in the split between permanent and fixed-term as shown in the graph below is largely due to validation of the ESR data held for staff contract type. The quantity of 'replacement' WTE by bank is increasing; in Aug-22 this represented 378.34 WTE, in Jul-23 this had risen to 488.93 WTE.	July 2023	
Variable Pay (Bank, Agency, Overtime..)	The trend of proportion of the pay bill spend on variable pay (Bank, Agency, overtime etc.) is falling. It has been as high as 10.85% of the total spend on pay, but in Jul-23 was 9.93%. It must however be borne in mind that the total pay bill is increasing.	July 2023	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
36.	Percentage of sickness absence rate of staff	Jul-23	6%	**4.97%**	Apr-23: 5.82%; May-23: 5.77%; Jun-23: 5.52%; Jul-23: 4.97%
37.	Staff turnover measure tbc starters and leavers and/or vacancies?	Jul-23	7%-9%	**12.94%**	Apr-23: 12.52%; May-23: 12.51%; Jun-23: 13.00%; Jul-23: 12.94%
38.	Agency spend as a percentage of the total pay bill	Jul-23	12 month reduction trend	**2.41%**	Apr-23: 2.48%; May-23: 1.86%; Jun-23: 1.99%; Jul-23: 2.41%
39.	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	Jul-23	85%	**72.37%**	Apr-23: 59.60%; May-23: 61.63%; Jun-23: 65.86%; Jul-23: 72.37%

Priority	Performance Summary	Reported Period	Data
Concerns 30 day performance	• **Welsh Government target for responding to concerns is 75% within 30 working days** • During July and August 2023, the Health Board received : • 697 Concerns • 77% closed within 30 working days (including Early Resolution) • 63 % closed under Early Resolution • 102 Compliments We currently have 371 active concerns Top 3 themes and trends 1. Communication 2. Concerns around appointments (waiting times/cancellations) 3. Clinical Treatment and Assessment	July and August 23	 
Duty of Candour	• 8409 incidents have been reported by staff across the Health Board, reflecting an open culture where staff feel comfortable to speak up. • Approximately 32% incidents regraded with feedback provided to reporter, investigating manager and investigator • Approximately 78 incidents reviewed per day • We have led 11 DOC awareness sessions across the Health Board so far and continue undertake these monthly and when requested. • Since 1st April 2023 we have triggered the DOC on 25 occasions		

Priority	Performance Summary	Reported Period	Data
Patient Feedback – Civica	• Went live on Friday 28th October 2022 and we are currently surveying up to 600 patients daily via SMS. As of the end of July 2023, we have contacted some 83,672 people for feedback via text messaging and are seeing a return rate of 18%. • In June, we contacted 8908 people via text and had 1615 completions (18% rr) • In July, we contacted 11312 people via text and had 1977 completions (17% rr) • Combined, we contacted 20220 people via text and had 3285 completions (18% rr). Of those who attended/discharged during June/July, 87% of those who answered the rating question were satisfied with our service. • Our return rate is 18% 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 ambitious aim for a minimum return of 25% by end of March 24.	Jun-23 Jul-23	
Incident Reporting	During August, 1676 patient safety incidents were reported, pressure damage was again the most common reported patient safety incident type, followed by accident injury (falls), behaviour (including v&a), assessment/assessment and diagnosis, and finally medication errors (see chart in side bar). <u>NRI performance</u> • Number of open NRIs – 65 • Number of closures submitted in August – 13 • Number of overdue NRIs – 26 This is an improved position on the previous month, which had 64 open NRIs, 11 NRI closures were sent and 32 were overdue in July.	Jul-23	  

Priority	Performance Summary	Reported Period	Data
Tier 1 Mortality	• 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 the rolling crude inpatient mortality rate compared to the 5-year average for the same reporting week (red line), with the exception of March 2020 and December 2020 to February 2021, the first and second waves of Covid-19.Inpatient crude mortality continues to track the five 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. An increase above the five year average has been noted across wales since April 2023 with a similar increase noted in Cardiff and Vale UHB with five year average crude mortality in week 28 being recorded as 76 compared with 63.6 for the previous five year average.	July-23 May-23	 
Infection Control	The WHC for the 2023/24 financial year has not yet been released. Therefore, the reduction expectations are based on those released for the 2022/23 financial year. • Between April 23 and July 23, there were 44 cases of ***Klebsiella sp* bacteraemia**. The reduction expectation for this period is 23 cases, thus the number of cases is 21 over the reduction expectation. • There were 6 cases of ***P. aeruginosa* bacteraemia**. The reduction expectation for this period is 8 cases, thus the number of cases is 2 below the reduction expectation. • There were 133 cases of **E. coli bacteraemia**. The reduction expectation for this period is 83 cases, thus the number of cases is 30 over the reduction expectation. • There were 57 cases of **S. aureus bacteraemia**. The reduction expectation for this period is 26 cases, thus the number of cases is 31 over the reduction expectation. • There were 39 cases of **C. difficile**. The reduction expectation for this period is 26 cases, thus the number of cases is 13 over the reduction expectation.	Apr-23 – July-23	

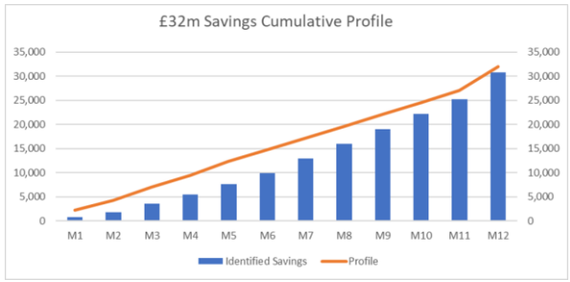
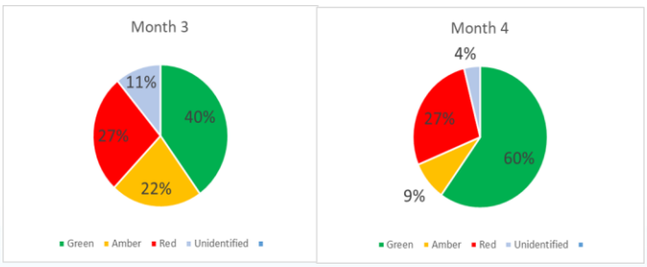
<table>
<tr><th>Priority</th><th>Performance Summary</th><th>Reported Period</th><th>Data</th></tr>
<tr><td>Deliver 2023/24 Draft Financial Plan</td><td>Financial Plan Approved by Board and submitted to Welsh Government

• Brought forward underlying deficit of £40.3m
• Local Covid Consequential costs of £34.2m
• Additional energy costs of £11.5m
• 23/24 Demand and cost growth and unavoidable investments of £48.8m
• Allocations and inflationary uplifts of £14.4m
• A £32m (4%) Savings programme

This results in a 2023-24 planning deficit of £88.4m.

The UHB is reporting a month 4 overspend of £34.353m. £29.467m of this being four months of the annual planned deficit. £4.055 deficit on the Savings Programme, being four months of red schemes and unidentified savings. 0.832m is an operational overspend in delegated and central positions.</td><td>Jul-23</td><td><table><tr><th></th><th>Forecast Month 4 Position £m</th><th>Forecast Year-End Position £m</th></tr><tr><td>Planned deficit</td><td>29.467</td><td>88.400</td></tr><tr><td>Savings Programme</td><td>4.055</td><td>0.000</td></tr><tr><td>Operational position (Surplus) / Deficit</td><td>0.832</td><td>0.000</td></tr><tr><td>Financial Position - Deficit £m</td><td>34.353</td><td>88.400</td></tr></table></td></tr>
<tr><td>Delivery of recurrent £32m savings target</td><td>At month 4, the UHB has identified £30.764m of green, amber and red savings against the £32m savings target leaving a further £1.236m (4%) schemes to be identified. The month 4 position includes a Savings Programme variance of £4.055m relating to a four month share of red and unidentified schemes.

Additional actions are progressing to recover the month 4 operational & CRP overspend to enable the UHB to deliver the planned £88.4m deficit

The UHB expects to be able to manage the balance of savings plans required to deliver the forecast deficit of £88.4m with the risk of non-delivery of savings shown in Graph 1 and the progress of reducing the risk via identification of schemes in Graph 2</td><td>Jul-23</td><td>Graph 1 – Profile of Savings Delivery and Unidentified Schemes
 
Graph 2 - Progress of Identification of Schemes
  </td></tr>
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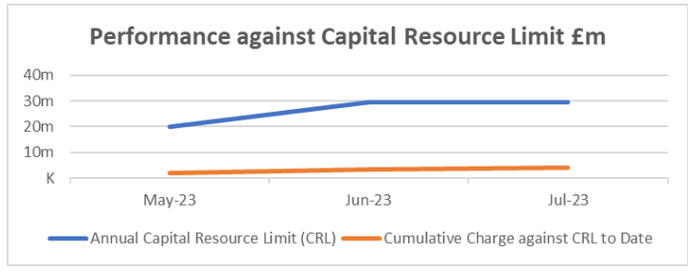
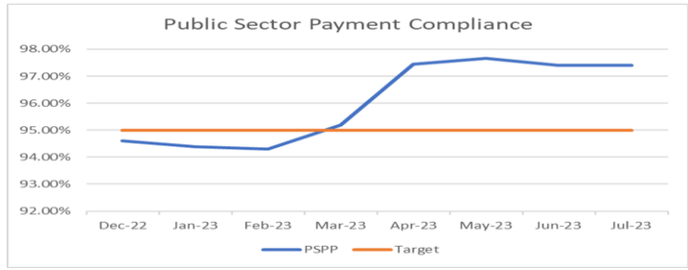
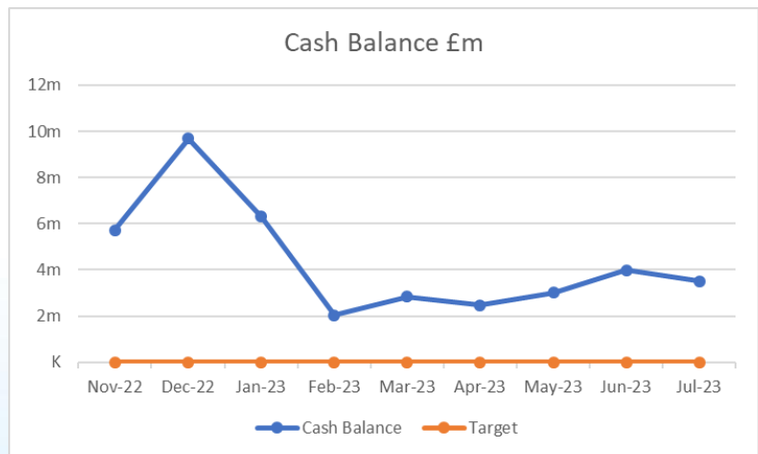
Priority	Performance Summary	Reported Period	Data
Remain within capital resource limits	The UHB forecasts to deliver within it's Capital Resource Limit.	July-23	
Creditor payments compliance 30 day Non-NHS	The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of July was **97.42%** and improvements are illustrated in the graph to the right.	July-23	
Remain within Cash Limit	The UHB's working capital requirement assumes that Welsh Government will provide support to movements in working capital from the 2022-23 Balance Sheet and for the £88.4m planning deficit in the UHB 2023-24 Financial Plan. Discussion is ongoing with Welsh Government to provide cash support for these areas which will total approximately £100m.	July-23	
Maintain Positive Cash Balance	The closing cash balance at the end of July 2023, was £3.498m. A detailed monthly cashflow forecast is included in the monthly monitoring return submission to Welsh Government. The UHB's working cash assumption for 2023-24 is based on the following key assumptions :- • Movements in working capital from the 2022-23 Balance Sheet to be assessed as the year progresses. • Additional 1.5% consolidated pay award (£11.5m) for which Resource cover was received from Welsh Government in 2022-23 but has been paid out in 2023-24 and requires cash support. • Cash support for the £88.4m deficit of the UHB 2023-24 Financial Plan. Discussion is ongoing with Welsh Government to provide cash support for these three areas which will total approximately £100m.	July-23	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
40.	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Apr-23	Improvement trend	70%	Jan-23: 59%; Feb-23: 56%; Mar-23: 44%; Apr-23: 70%
41.	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following		90%	Work in progress	
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)		17% or more	Work in progress	
43.	Number of Pathways of Care delayed discharges		12 month reduction trend	Work in progress	
44.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Jul-23	90%	**90.2%**	Apr-23: 89.40%; May-23: 88.10%; Jun-23: 89.20%; Jul-23: 90.20%
45.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	Jul-23	90%	**46.7%**	Apr-23: 50.30%; May-23: 49.10%; Jun-23: 47.30%; Jul-23: 46.70%
46.	Number of patient experience surveys completed and recorded on CIVICA *(Total partial/full survey completions, including SMS, Bedside and bespoke)*	Jun/Jul-23	Month on month improvement	**3760**	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
47.	Cumulative number of laboratory confirmed bacteraemia cases: *Klebsiella* sp and; *Pseudomonas aeruginosa*	Jul-23	*Klebsiella sp* - 23 *P. aeruginosa* – 8	**44** **6**	Work in progress
48.	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: *E-coli*; *S.aureus* (MRSA and MSSA)	Jul-23	*E. coli* - Tbc *S.aureus* – Tbc	**66.01** **33.30**	Work in progress
49.	Cumulative rate of laboratory confirmed *C.difficile* cases per 100,000 population	Jul-23	Work in progress	**22.60**	Work in progress
50.	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	May-23	Reduction against 22/23	Work in progress	Work in progress
51.	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Jul-23	95%	**58.12%**	Apr-23: 58.04%; May-23: 58.12%; Jun-23: 58.66%; Jul-23: 58.83%
52	Number of ambulance handovers over 1 hour	Aug-23	0 (Mar 24)	**1728**	May-23: 1395; Jun-23: 1558; Jul-23: 1473; Aug-23: 1728
53.	Number of patient safety incidents that remain open 90 days or more	Jul-23	12-month reduction trend	**4104**	Work in progress

Report Title:	Reinforced Autoclave Aerated Concrete (RAAC) – Structures and Condition within Cardiff and Vale University Health Board Estate				Agenda Item no.	6.8
Meeting:	Board		Public	X	Meeting Date:	28.09.23
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	DIRECTOR OF FINANCE					
Report Author (Title):	DIRECTOR OF CAPITAL, ESTATES AND FACILITIES					

Main Report

Background and current situation:

The purpose of this report is to provide assurance to the Board in relation to the extent and condition of Reinforced Autoclaved Aerated Concrete (RAAC) across the UHB estate. The requirement for the assessment is based upon the potential for RAAC panels to deteriorate and ultimately, collapse.

NWSSP Specialist Estates Service, on behalf of the Welsh Government, instructed all NHS Wales estate departments to identify all instances of RAAC construction and mitigate this risk, in providing a report to this affect by the 31st May 2023. The Health Board report was issued, in draft format only, to Shared Services by the 31st May 2023, the report was caveated as draft until such time that the Health Board had seen and agreed the content and any actions associated with the report.

Technical Information

RAAC planks are believed to have first been used in 1929 and are understood to have been used in the UK since the late 1950s. They were widely used for roofing but also for walls, partitions, and floors until 1982 when production in the UK ceased, reportedly for commercial reasons. The planks were made from a raw slurry comprising lime and cement mixed with fine grained sand and combined with admixtures. Air or gas was then introduced into the slurry, and the resulting foam-like liquid poured into a mould and allowed to take on an initial set, after which the large block was cut to size and steam cured under high temperature and pressure. Individual planks were then cut from the large block.

In late 2018 RAAC panel within a school collapsed suddenly which gave rise for the latest Standing Committee on Structural Safety (SCOSS) report published in May 2019. The 'Failure of Reinforced Autoclaved Aerated Concrete (RAAC) Planks'. The SCOSS report referred to, outlines details of sudden collapse and a number of warning signs to be aware of that indicates panels may be near failure.

These are as follows;

a) Significant cracking and disruption of the planks near the support
b) Any planks that have deflected more than 1/100 of the span, or a significant number of planks have deflections approaching this magnitude
c) A number of the planks have very small bearing widths (less than 40mm) The roof has been resurfaced since original construction; this is particularly an issue if the load has been increased or the resurfacing has a black finish, and the previous surface did not.
d) There is significant ponding on the roof
e) The roof is leaking or has leaked in the past

Capital Estates and Facilities have commissioned a study of the UHB Estate, by a company approved by NWSSP Specialist Estate Services, WSP, procured through the SBS framework, direct award, agreed by colleagues in procurement. The cost of the survey was circa £ 22,000.00 inclusive of VAT.

The following is a brief summary of the report describing the mechanism of how the report was concluded, the findings and the next steps.

The identification phase of the project was sub-divided into four sections, as follows:

- Initial Building review: Undertaken by CVUHB prior to WSP's involvement, this took the form of a review of all buildings to filter the estate down to either buildings of unknown construction date or those constructed during the period of extensive RAAC use within the UK.
- Desk Study: Undertaken by WSP, this involved a review of the pro-forma, publicly available information, and a number of record drawings to determine the likelihood of RAAC construction being present. The determination was based upon standardised parameters, a likelihood rating, which either warranted further investigation or discounted the building and, an action. Each category, description, rating, and action is described below:

    - Category 1:
        - Construction of building pre 1950s or post 2000s.
        - Rating: No RAAC
        - Action: No further action
    - Category 2:
        - Information obtained which evidence construction type not associated with RAAC panels, e.g., insitu concrete, traditional construction.
        - Rating: Unlikely RAAC
        - Action: No further action
    - Category 3:
        - Limited information obtained which evidence construction not associated with RAAC panels, e.g., insitu concrete, traditional construction.
        - Rating: Unlikely RAAC
        - Action: Request further information (RFI)
    - Category 4:
        - Building comprises unknown construction.
        - Rating: Possible RAAC
        - Action: Detailed / physical inspection required.
    - Category 5:
        - Evidence of likely RAAC panels
        - Rating: Highly Likely RAAC
        - Action: Intrusive inspection
    - Category 6:
        - Evidence of likely RAAC panels with signs of distress
        - Rating: RAAC with signs of distress
        - Action: Priority Site Visit & Intrusive inspection Required

- Request For Information (RFI): Following a review of all information obtained, WSP identified areas of missing information and requested further information where applicable. Much of the RFI process was carried out over email correspondence between CVUHB and WSP. Where possible, CVUHB provided further information to WSP which was reviewed further. In the event that the structure could not be determined via the RFI process a site visit was undertaken by a WSP engineer.

- Site Visit: Undertaken by WSP. The final stage of the identification phase was for WSP to undertake a site visit to a location to determine the form of construction. This process was instigated either for complicated sites, e.g., those with several buildings and / or complex roof systems (determined via the desk study) or for those buildings where the RFI process did not sufficiently determine the form of construction.

The summary of the outcome of the initial findings are as below;

Building	Location of RAAC	RAAC Category	Status
UHW – Main Hospital, Area E	Roof Panels	3	Existing information or Intrusive survey
UHW - Main Hospital, Area F	Roof Panels	3	Existing information or Intrusive survey
UHL – Block 06a	Roof Panels	**5**	**Intrusive survey to confirm PCU/ RAAC construction.** **Building may be demolished in the future**
UHL – Block 29	Structure	3	Sharp test to confirm concrete roof construction
CRI – LINK Building	Structure	4	Confirmation of LINK building demolition
Llanrumney CELT	Roof Panels	3	Sharp test to confirm concrete roof construction

The above areas were highlighted in the findings, two areas were scored higher. All the above areas have had further assessment and investigation. Unfortunately, this could not be completed in time to meet the requirements and deadline for the submission of the report to NWSSP Shared Services.

- Category 3 - Unlikely RAAC
- Category 4 - possibly containing RAAC
- Category 5 - highly likely RAAC

UHW Areas

HSDU/HQ/Boiler House and Estates Workshop - *Due to the construction type seen, it is **unlikely** that RAAC panels will be present, however, further information is required for confirmation.*

C Ward Block - *Steel extension evident across length of the building. RAAC panel **unlikely** to form existing roof/support plant due to low strength capacity properties.*

Tower Block 2 - *Steel extension evident across length of the building. RAAC panel **unlikely** to form existing roof/support plant due to low strength capacity properties.*

Lecture Theatre UHW – *….therefore **unlikely** that these are RAAC panels. However, this does not rule out the presence of RAAC in other sections. Therefore, further inspections required.*

Outpatients – *It is **unlikely** that RAAC panels are present due to the following reasons:*
- Extension supports plant room – RAAC panels are low grade and are likely to have insufficient strength to support plant loads
- RAAC panel construction does not lend itself to pitch roofs
Further on-site inspection is required.

Maintenance Department – *Based on limited external survey information, it is assumed that this construction type will be **unlikely** to contain RAAC panels, however, further information is required for confirmation.*

UHL Areas

Block 29 – containing Wards East 8 and East 9 - *Limited access above ceiling tiles. Concrete flat roof that needs further clarification.*

Block 24 – Radiology – *Flat roof construction previously extended. No access above ceilings*

Block 06a - this building houses Medical records and Orthopedic Theatres and has been rated as RAAC Category 5.

These areas could not be fully inspected internally due to the presence of asbestos above the ceiling and the structure could not be determined from the outside for the full area. Areas that could be viewed showed precast concrete units that were in good condition. The additional areas are currently being reviewed to see how this can be addressed and investigated as to the structure within to confirm or otherwise RAAC presence.

CRI Areas

The CRI Link Building - *This facility is currently empty and programmed for demolition. Further investigations will be completed.*

Community Health Centres

Llanrumney –– *Existing roof structure of timber pitch roof construction, flat roof construction needs further investigation.*

The above areas and additional buildings have been further assessed. With many iterations of the report provided. CEF have worked through the properties in category 3 to provide more information that would support a reduction to either a category 1 or category 2.

The current report, dated the 13 September 2023, shows one Category 3 building on the current UHW site, this is a building not owned by the UHB, but a building frequented by visitor's and staff on the UHW site, the Sports and Social Club.

A copy of the report will be provided if required, the report concludes that all UHB freehold buildings, or leased directly by the UHB, are either in Category 1 – "No RAAC", or Category 2 – "No evidence of RAAC being present" (this has been updated from "unlikely" due to the ambiguity this may have caused).

An extract from the Conclusions and Overall Assessment of the report is provided below;

CONCLUSIONS AND OVERALL ASSESSMENT

The original project brief required a strategy to be developed that would identify, investigate and assess any RAAC panels within the estate of CAVHUB.

Areas for ongoing investigation for the presence of RAAC panels;

- The **Sports & Social Club,** a single storey building appears to be of masonry construction with various flat roofs and steel framing over the gym and cafe.

  CAVUHB surveyor has confirmed the various forms of roof construction across the buildings as indicated in the photographs - Whilst unlikely that RAAC panels are above the timber boarding the information is inconclusive and will need further investigation – **RAAC Category 3 - More information required**.

For the remainder of CAVUHB Estate through the completion of the phased approach outlined throughout this report requirements have been met confirming that it is **no evidence of RAAC being present within the CAVHUB estate.**

The current surveys exclude Cardiff University freehold buildings on the UHB sites, the UHB have asked for confirmation from the University that they have completed their own surveys and for the feedback of such.

The UHB have also written to our commercial landlords, where we have a presence in their buildings, but no responsibility for the external envelope, to provide their RAAC assurance.

The UHB will be drafting a letter, in conjunction with NWSSP, for colleagues in Primary Care to issue to all primary care contractors, asking them to provide assurances around RAAC within their buildings

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

The content of the report and the summary as presented.

The conclusions and overall assessments of the report provides assurance that there is **no current evidence of RAAC being present within the UHB estate.**

The need to conclude the report for the areas in the Sports and Social Club, this will be assessed and outcomes reported back.

To note that external partners have/will be written to, asking for their confirmation of the presence or otherwise of RAAC in their buildings. If RAAC is present, the management action plans to maintain the safety of occupants.

That the Board will be made aware of any findings or concerns upon conclusion of the survey works.

Recommendation:

The Board / Committee are requested to:

NOTE the content and be **ASSURED** of the findings of the report, that there are very limited areas where RAAC could possibly be, however this is unlikely. That these areas are now known and that surveys will be completed to confirm or otherwise.

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

So far assessments of the existing estate structures have not raised any concerns.

Safety: Yes/No

So far assessments of the existing estate structures have not raised any concerns.

Financial: Yes

Costs associated with completed the surveys to date is circa £22,0000. There will be additional costs associated with completing the surveys, these are yet to be concluded.

Workforce: No
Legal: No
Reputational: No
The Health Board are addressing the risk of potential RAAC.
Socio Economic: No
Equality and Health: No
Decarbonisation: No
Not applicable to this report

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

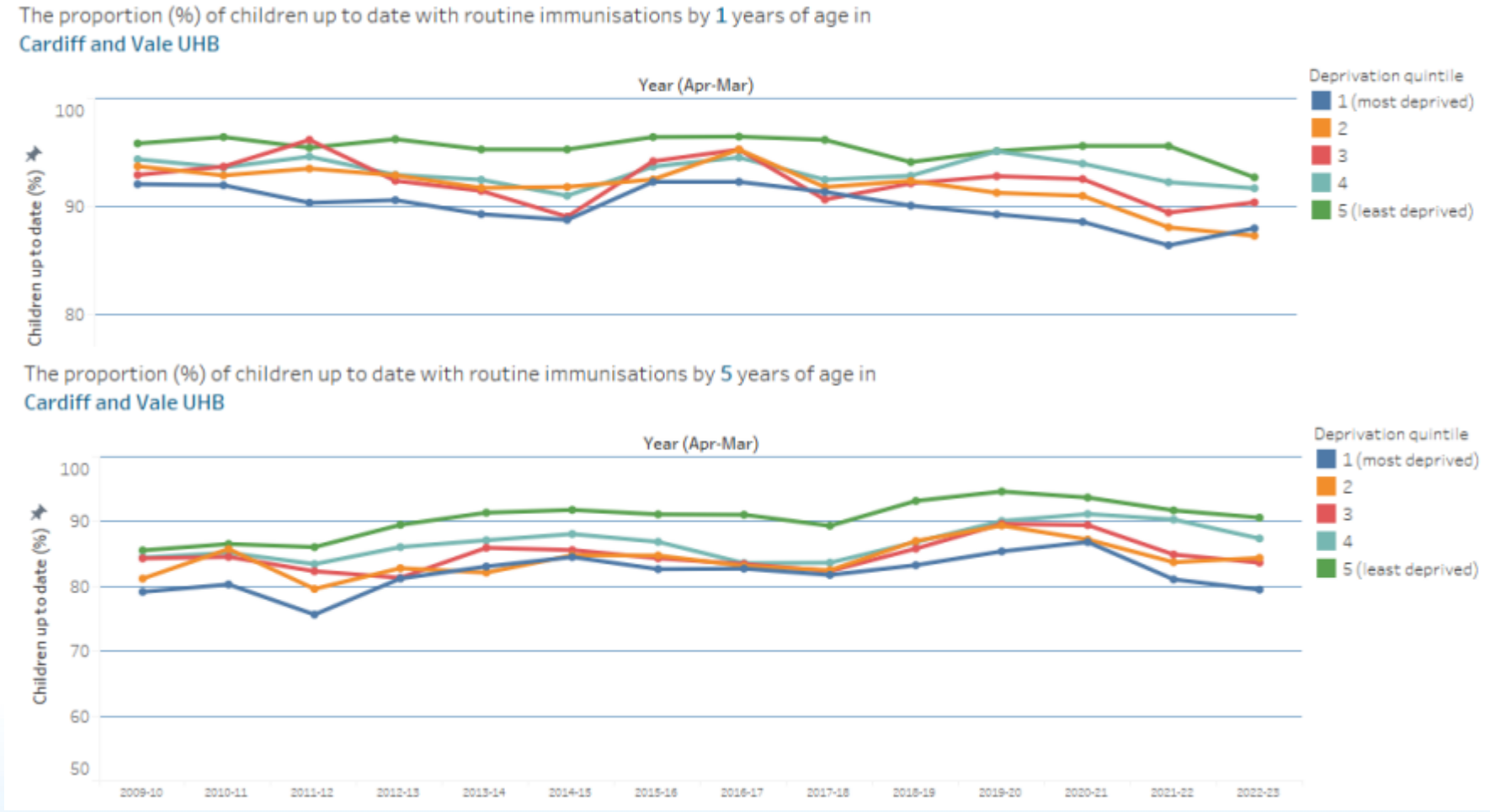
Deep Dive: Vaccination and inequities

Cardiff and Vale UHB Board Meeting
28 September 2023

Dr Dino Motti, Consultant in Public Health Medicine
Dr Suzanne Wood, Consultant in Public Health Medicine

Childhood vaccines

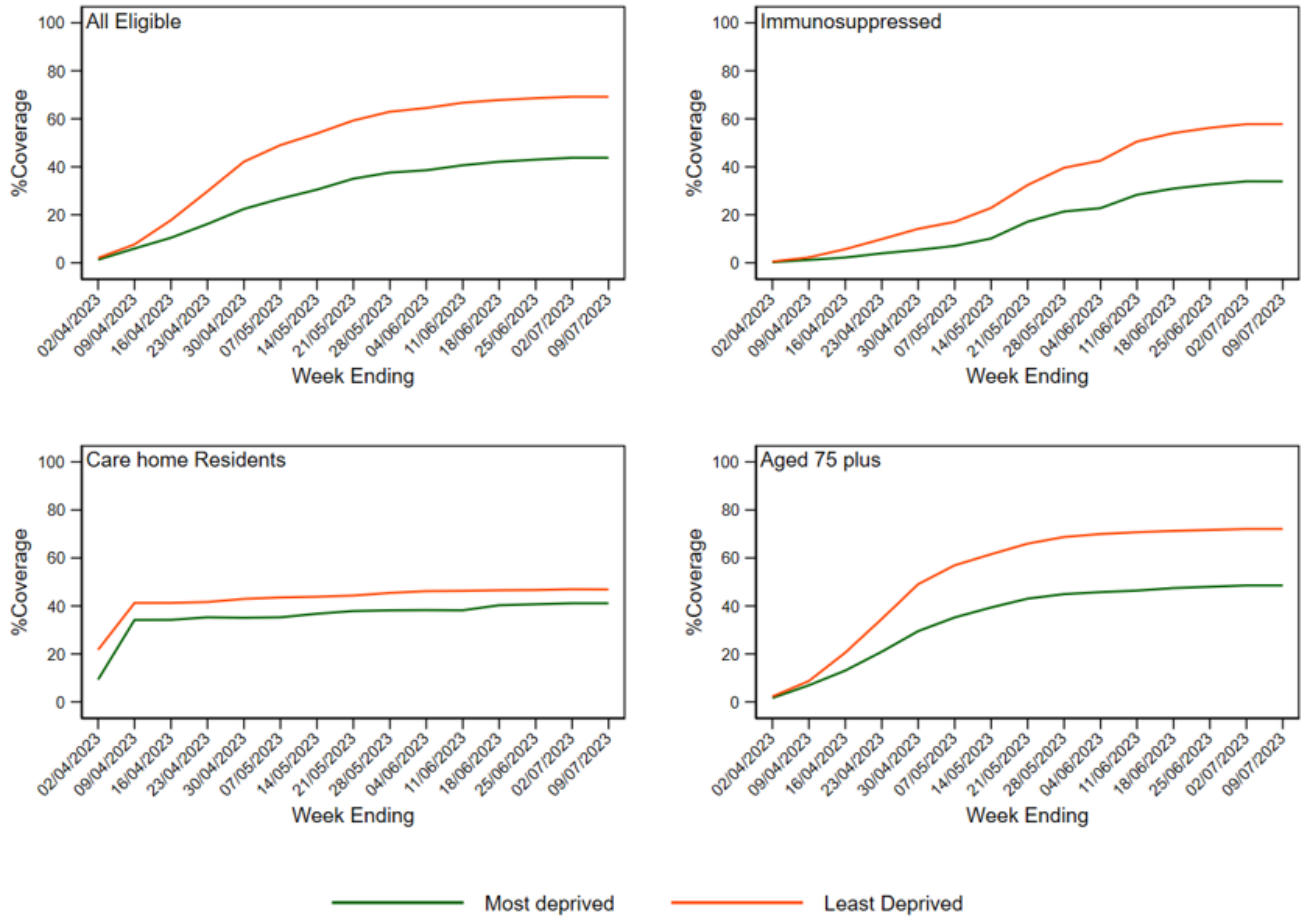
Gap in uptake between least and most disadvantaged



Socio-economic status

The most disadvantaged groups have consistently **“slower and lower”** uptake of vaccination

Figure 1.3 Trends in weekly coverage of the COVID-19 2023 Spring Booster in eligible groups most deprived quintile of LSOAs vs. least deprived quintile of LSOAs



Ethnic groups

- Covid vaccine uptake
  - Over 45% gap in the Spring booster campaign 2023 between white and black population

Cardiff and Vale UHB staff coverage by ethnic group for the COVID-19 Autumn booster 2022/23	
Any White Background, including Welsh, English, Scottish, Northern Irish, Irish, British	64%
White and Black Caribbean	48%
White and Black African	42%
White and Asian	59%
Any other mixed background / multiple ethnic background	57%
Indian (Asian or British)	60%
Pakistani (Asian or British)	47%
Bangladeshi (Asian or British)	53%
Any other Asian background	68%
Caribbean (Black/Black British)	58%
African (Black/Black British)	42%
Any other Black background	53%
Chinese	63%
Any other ethnic group	57%
Arab	25%
Not Given/Recorded/Specified	39%
Overall total	62%

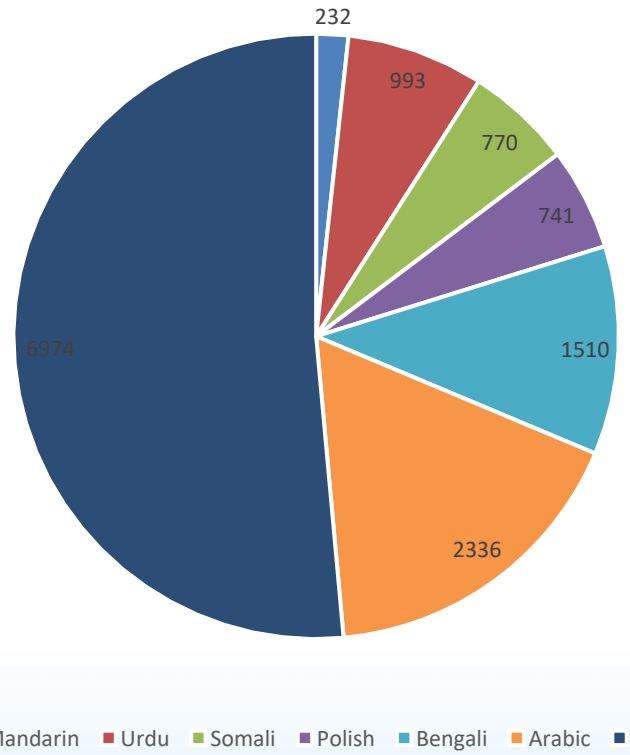
Table 1.4: Coverage of 2023 Spring Booster in eligible groups by ethnic group (eligibility groups are not mutually exclusive)

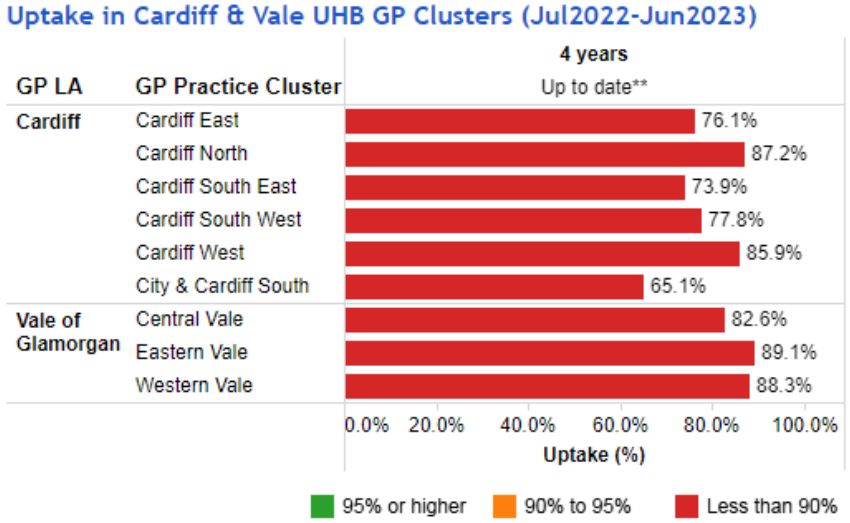
Cardiff and Vale data

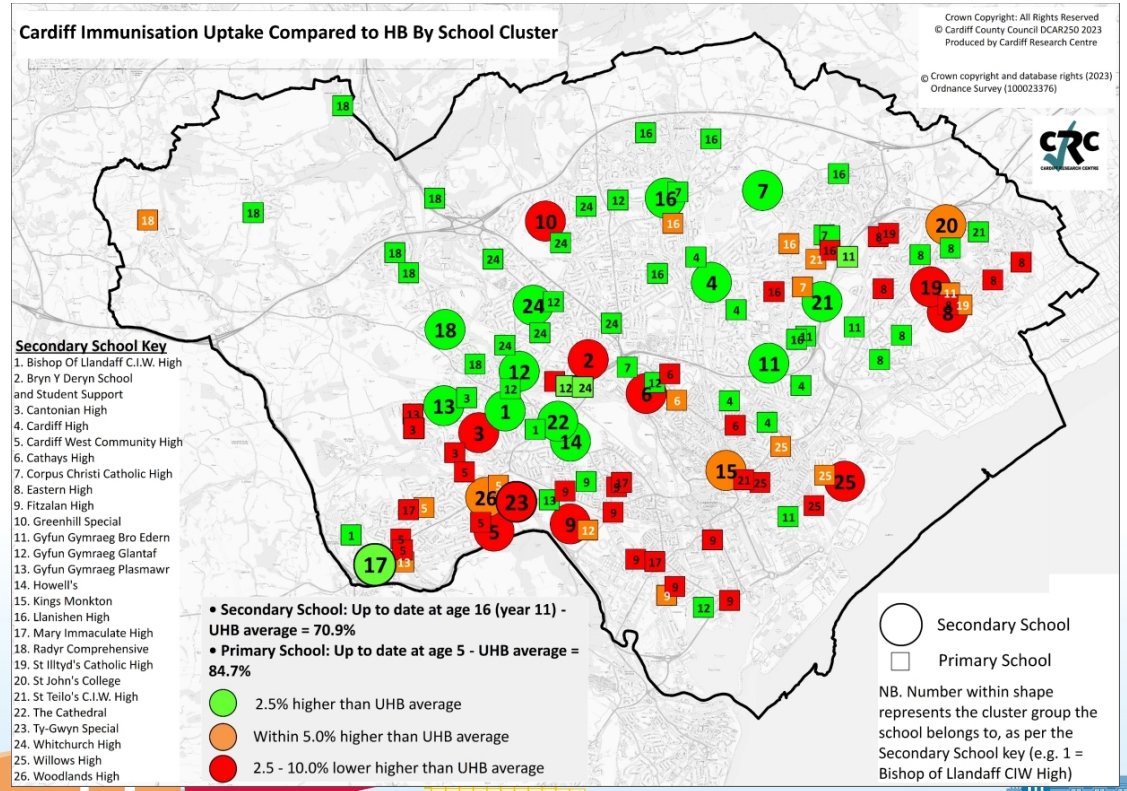
Eligible groups	Ethnic Group	Denominator	Uptake (%)	95% CI
Immunosuppressed	White	11,000	57.1	(56.8-58)
	Black	400	24.2	(22.5-29.3)
	Asian	700	33.0	(31.8-36.9)
	Mixed	400	28.3	(26.6-33.2)
	Other	200	25.5	(23.1-32.9)
	Unknown	1,200	37.9	(37-40.8)
Care home residents	White	2,300	77.3	(76.7-79.1)
	Black	100	46.1	(33.7-74.9)
	Asian	100	50	(42-69.4)
	Mixed	100	45.9	(39.2-63.1)
	Other	100	16.6	(4.7-64.1)
	Unknown	300	56.8	(54.6-62.9)
Aged 75 plus	White	37,500	79.2	(79.1-79.6)
	Black	300	32.9	(30.9-38.9)
	Asian	900	51.0	(49.8-54.5)
	Mixed	300	55.3	(53.2-61.3)
	Other	200	38.1	(35.5-45.6)
	Unknown	3,800	49.6	(49.1-51.3)
All Eligible	White	46,700	73.6	(73.5-74)
	Black	600	26.9	(25.7-30.8)
	Asian	1,500	42.2	(41.3-44.8)
	Mixed	700	38.9	(37.6-42.8)
	Other	400	32.0	(30.3-37.3)
	Unknown	4,900	45.7	(45.3-47.2)

What children's data tells us...

Foreign languages spoken in families of minority ethnic background pupils in CAV
(n=13,556)

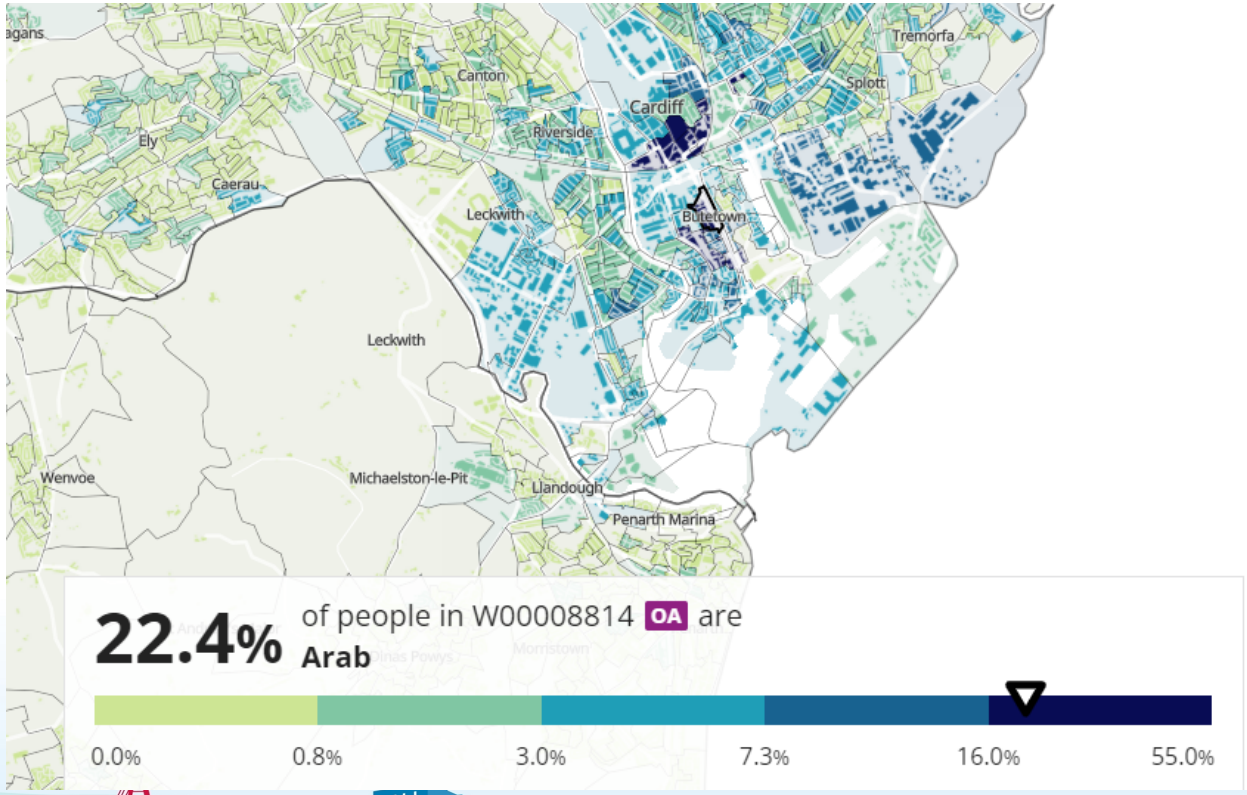


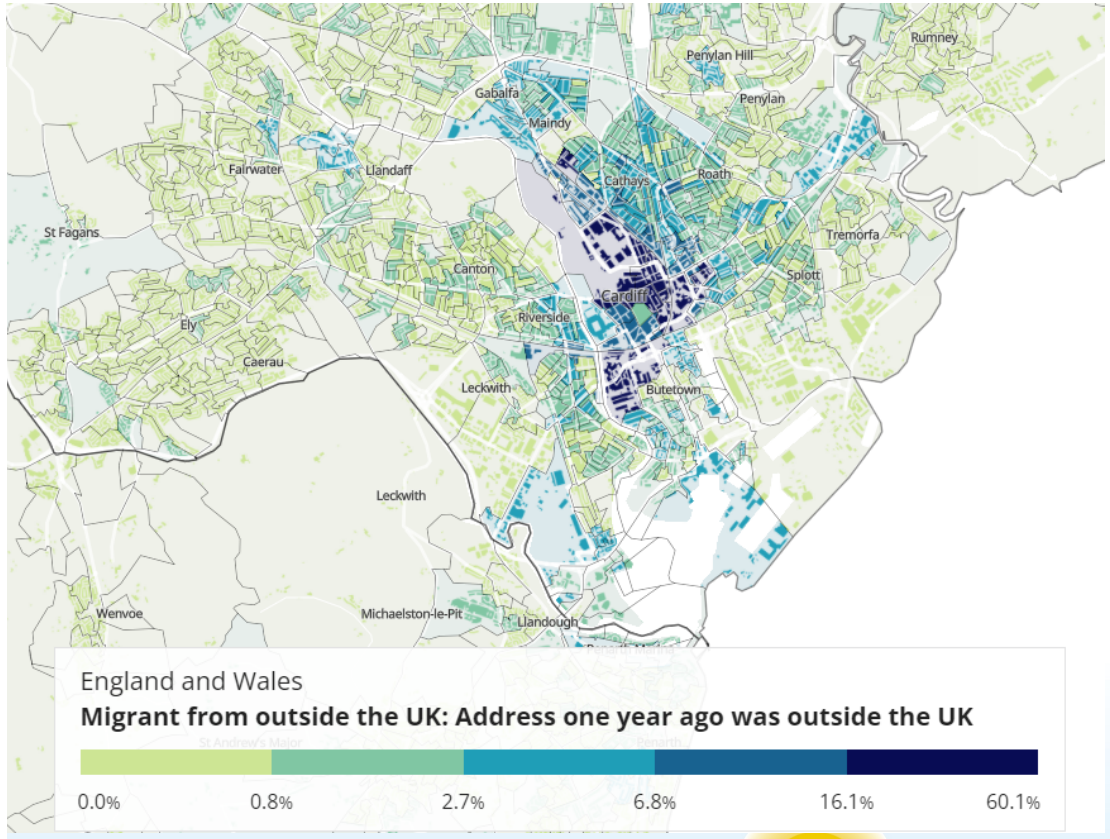




What the latest 2021 Census tells us

- We have a significant population of recent migrants
- Ethnic groups are concentrated in the South of Cardiff in particular





Vulnerable group – learning disabilities

Table 2: Uptake of influenza vaccination in the 2022/23 season in those with a read code listed on the PRIMIS COVID-19 specification for identifying people at risk because of a learning disability by Health Board, Wales at 30/04/2023

Health Board	Denominator	Immunised	Immunised (%)	95% Confidence Interval
Aneurin Bevan UHB	2,343	1,037	44.3	(42.2 - 46.3)
Betsi Cadwaladr UHB	2,780	1,397	50.3	(48.4 - 52.1)
Cardiff and Vale UHB	2,034	884	43.5	(41.3 - 45.7)
CTM UHB	2,079	971	46.7	(44.5 - 48.9)
Hywel Dda UHB	1,668	756	45.3	(42.9 - 47.8)
Powys THB	231	118	51.1	(44.5 - 57.7)
Swansea Bay UHB	1,848	854	46.2	(43.9 - 48.5)
Total	12,983	6,017	46.3	(45.5 - 47.2)

Table 3: Uptake of COVID-19 vaccination in those with a read code listed on the PRIMIS COVID-19 specification for identifying people at risk because of a learning disability by Health Board, Wales at 10/03/2023

Health Board	Denominator	Dose One	Dose One (%)	Dose One 95% CI	Dose Two	Dose Two (%)	Dose Two 95% CI	Booster Dose Autumn 2021	Booster Dose Autumn 2021 (%)	Booster Autumn 2021 95% CI	Booster Dose Autumn 2022	Booster Dose Autumn 2022 (%)	Booster Autumn 2022 95% CI
Aneurin Bevan UHB	2,295	2,119	92.3	(91.1 - 93.4)	2,085	90.8	(89.6 - 92.0)	1,924	83.8	(82.2 - 85.3)	1,425	62.1	(60.1 - 64.1)
Betsi Cadwaladr UHB	2,706	2,491	92.1	(91.0 - 93.0)	2,441	90.2	(89.0 - 91.3)	2,262	83.6	(82.1 - 85.0)	1,736	64.2	(62.3 - 66.0)
Cardiff and Vale UHB	1,981	1,777	89.7	(88.3 - 91.0)	1,735	87.6	(86.0 - 89.0)	1,550	78.2	(76.3 - 80.0)	1,178	59.5	(57.3 - 61.6)
CTM UHB	*	*	93.5	(92.3 - 94.5)	*	91.3	(90.0 - 92.5)	*	83.6	(81.9 - 85.2)	*	62.1	(60.0 - 64.2)
Hywel Dda UHB	1,634	1,471	90.0	(88.4 - 91.4)	1,434	87.8	(86.0 - 89.3)	1,327	81.2	(79.2 - 83.1)	931	57.0	(54.5 - 59.4)
Powys THB	*	*	93.7	(89.5 - 96.4)	*	91.0	(86.3 - 94.3)	*	85.2	(79.7 - 89.5)	*	71.3	(64.8 - 77.0)
Swansea Bay UHB	1,802	1,613	89.5	(88.0 - 90.9)	1,544	85.7	(84.0 - 87.3)	1,371	76.1	(74.0 - 78.0)	1,009	56.0	(53.7 - 58.3)
Total	12,674	11,581	91.4	(90.9 - 91.9)	11,299	89.2	(88.6 - 89.7)	10,324	81.5	(80.8 - 82.1)	7,701	60.8	(59.9 - 61.6)

* Data censored to comply with SAIL statistical disclosure control requirements

What has been delivered on vaccine inequity

Learning from the pandemic and improving COVID vaccination uptake

- **Partnership** approach through Ethnic Minority Sub-group – Strong leadership role
- **Communications:**
  - Leaflets were co-produced with communities and translated into 13 different languages then distributed by volunteers to local places with high footfall in the community, such as supermarkets and places of worship
  - Targeted social media campaigns in disadvantaged areas
  - Worked with ethnic minority community leaders
- **Pop-up clinics/outreach** were held at:
  - The India Centre supported by BAPIO
  - Dar Ull Isra Mosque
  - Madina Mosque (male/female)
  - The OASIS Centre (asylum seekers)
  - Butetown multi-cultural resource centre
  - Garden of the Lord (at the community's request)
  - Homeless hostels
- PHW **surveillance data** showed a closing of the gap between the white community and the Black, Asian, Mixed and Other communities following these interventions
- Health visitor dedicated to visiting Roma-Gypsy-Travellers sites

Childhood vaccination

- **Catch up sessions** offered within community settings
  - HPV offered at gypsy traveller site
  - Flu vaccination in Asda
- **Communications**:
  - FAQ produced in 6 languages
  - Animations on MMR, 4in1 and Rotavirus in 5 languages
  - Padlet developed with media resources
  - Targeted PR campaign in areas of low uptake
- **Primary care:**
  - Good practice toolkit developed for GP practices
  - Cluster QI projects to target children missing vaccines
  - Low uptake practices offered support to contact families missing vaccines
- **Research**:
  - Stakeholder experience review provided local evidence on barriers to uptake and provided recommendations for action

Vaccine equity strategic plan 2023/24

Figure 8: WHO root causes of vaccine hesitancy

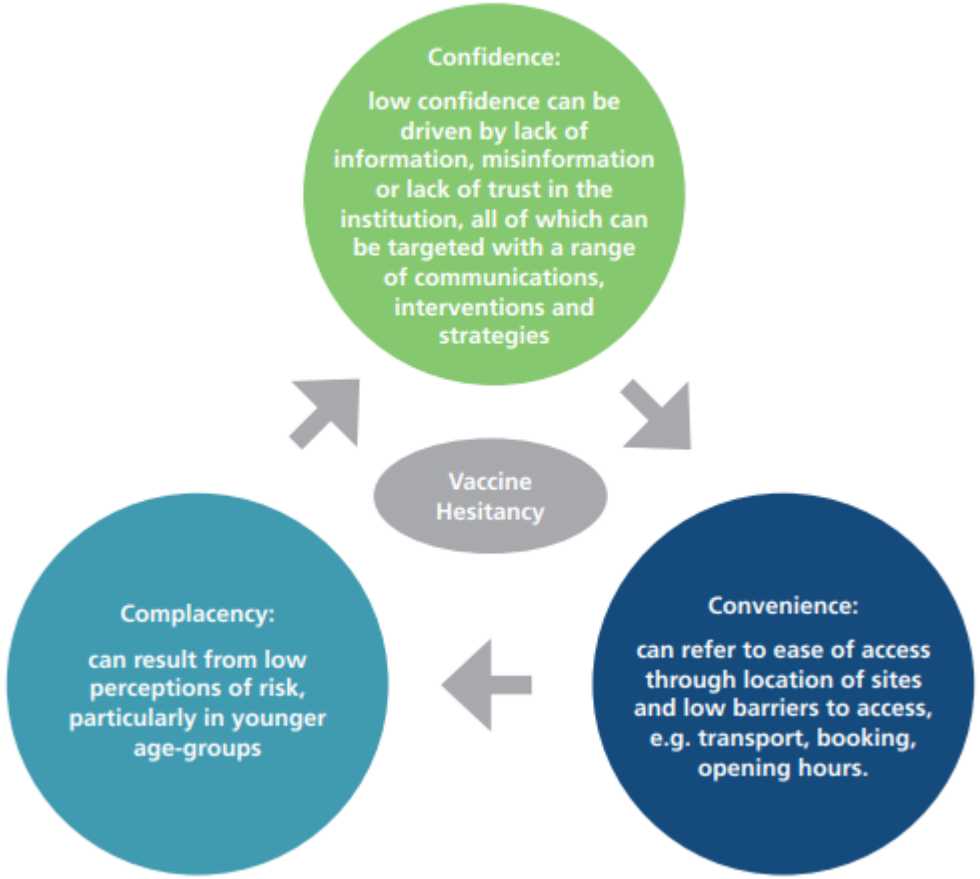
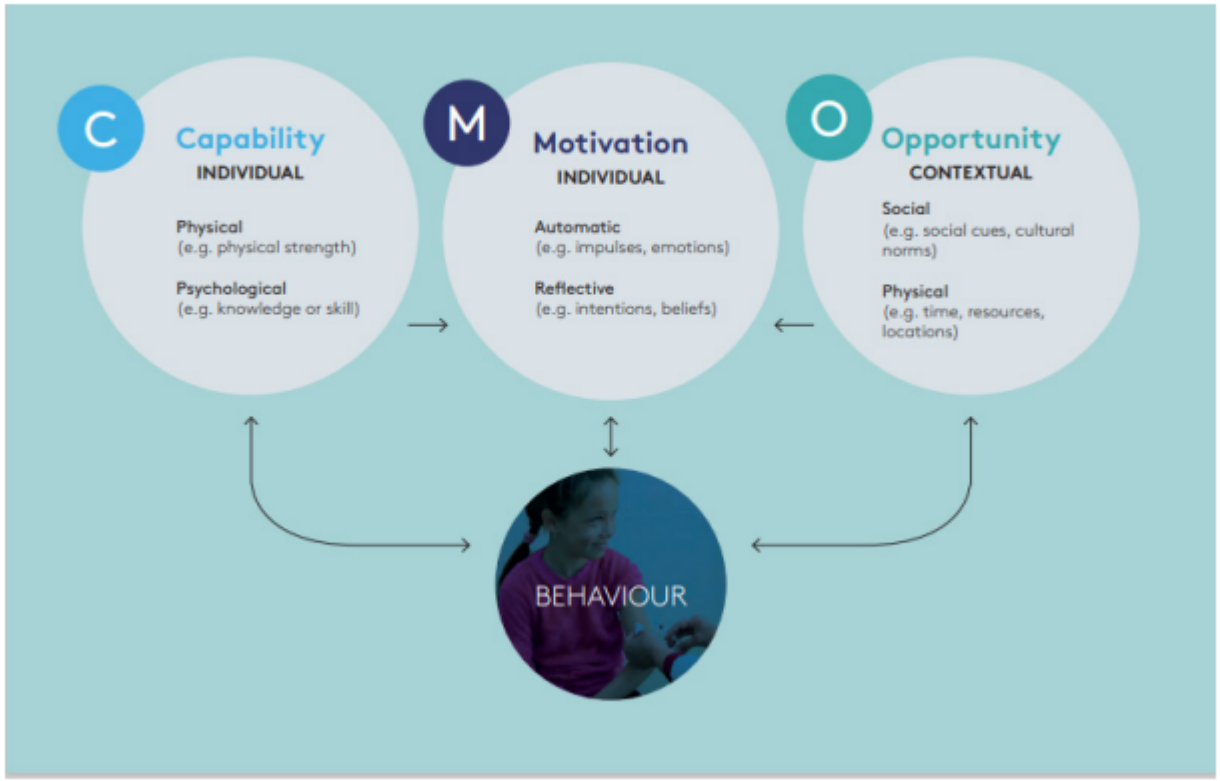


Figure 9: The COM-B Model

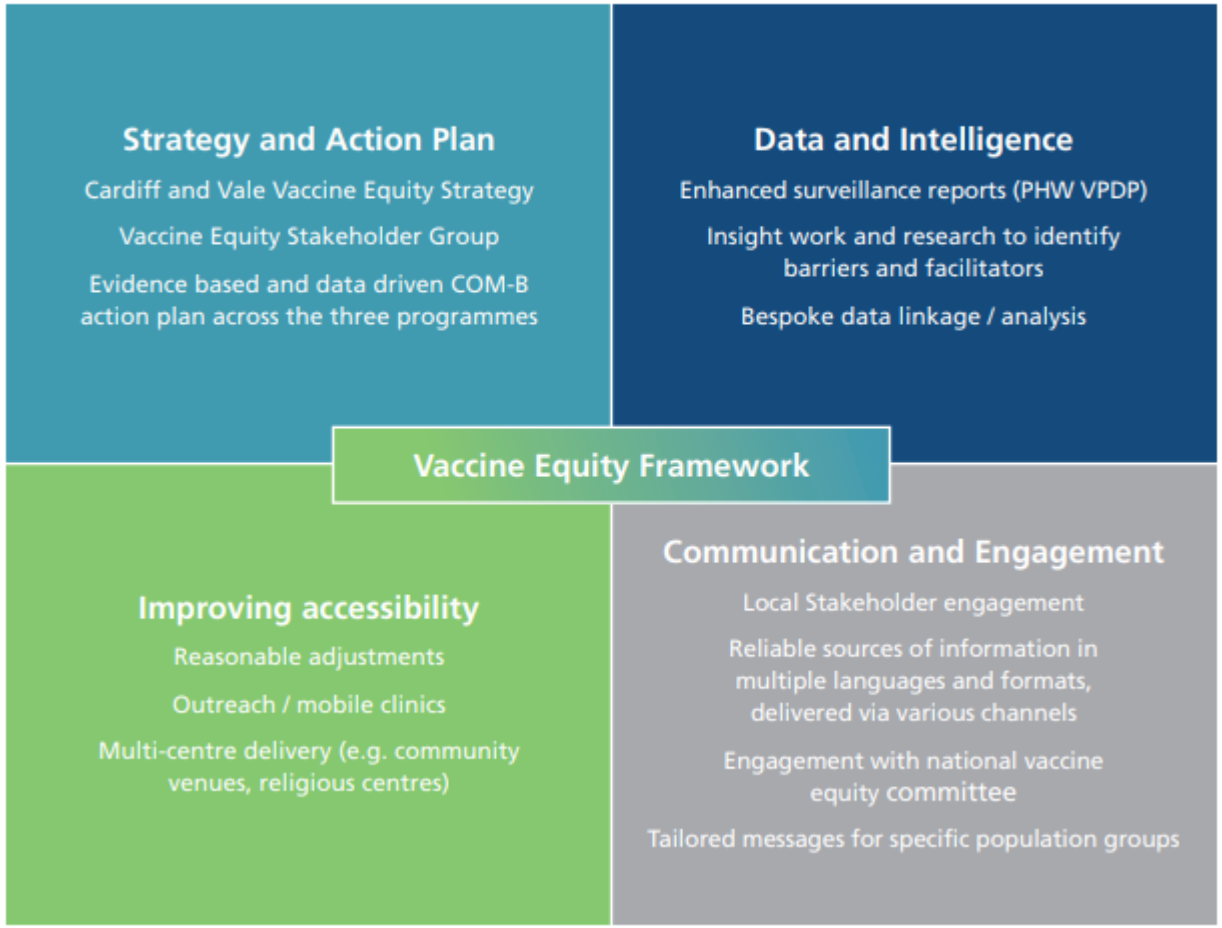


Vaccine equity strategic plan 2023/24

Partnership approach:

1. **A data informed approach**: using national and local data to agree a targeted approach to tackling inequity within defined populations to inform future effective delivery
2. **A Behavioural insights approach**: to address the three drivers of behaviour (Capability, Opportunity, Motivation) and barriers to uptake which address the root causes of vaccine hesitancy (Complacency, Confidence, Convenience) including improving access
3. **Stakeholder engagement**: engaging and co-producing with communities and settings (e.g. schools) to address barriers
4. **Communication:** ensuring that communications, education and training and engagement are culturally and linguistically appropriate and accessible
5. **Evaluation and Continuous Improvement:** learn by doing and sharing intelligence of what works

Figure 10: Cardiff and Vale Vaccine Equity Strategic Plan



Next steps

Winter planning:

The Winter Respiratory Vaccination Plan promotes uptake of vaccination in a targeted way, tailored to the needs of specific communities and/or seldom heard groups through:

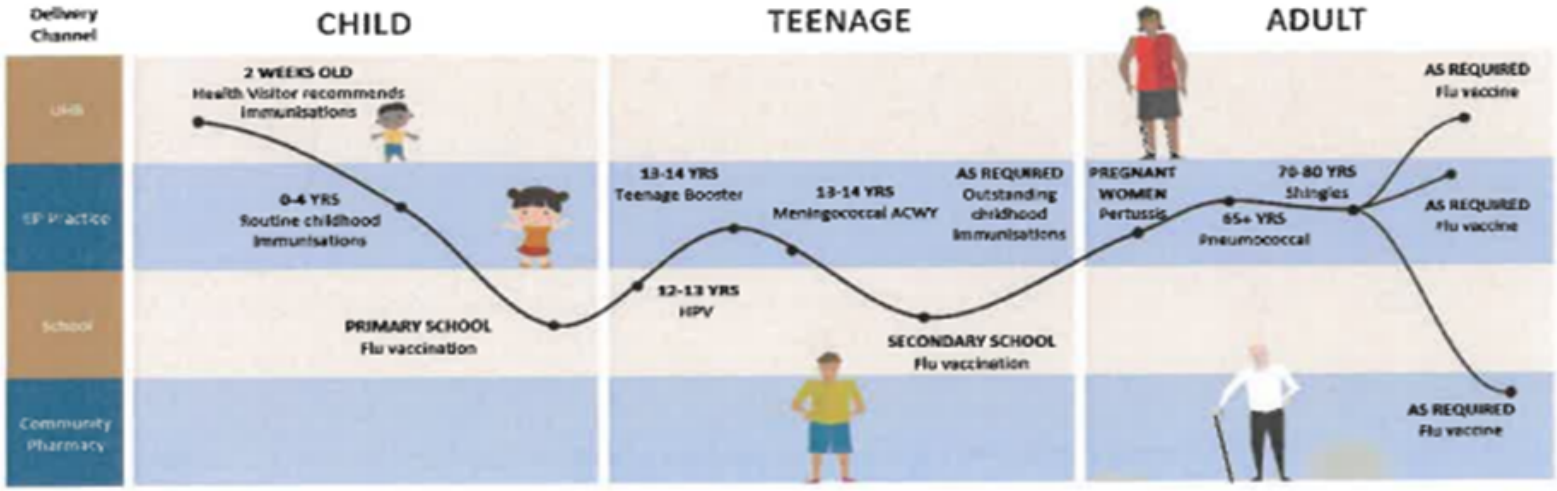
- Establishment of Winter Respiratory Vaccination Steering Group to engage with Stakeholders respresenting seldom heard groups
- Monitor uptake/activity data to inform uptake challenges
- Engaging with local communities/seldom heard groups to improve knowledge of vaccine hesitancy and barriers amongst seldom heard groups
- Work with local religious leaders to understand vaccine hesitancy amongst religious groups
- Provide language appropriate vaccination information and adapt any resources where needed for a particular group
- Provide opportunities for vaccinations for seldom heard groups such as people in sex work and people who are homeless
- Establish partnership working with internal partners to broaden access and opportunities for vaccination amongst seldom heard groups
- Timely and appropriate communications to advertise vaccination, through a variety of communication platforms, to increase attendance and improve vaccine uptake

Childhood vaccinations:

Childhood immunisation plan aligned with the vaccine equity strategic plan

- Childhood immunisation teaching resources in development and due to be piloted in schools
- School Immunisation team holding several parents information sessions in low uptake schools prior to flu roll out.
- Parents requesting gelatine-free vaccines to be contacted to support to access through their GP practices.
- Facilitating focus groups with parents and carers in Barry to explore barriers to vaccination, provide accurate information and dispel myths and misconceptions.
- Working with Cardiff Council to target focus groups in a low uptake area in Butetown to explore barriers and provide information.
- Supporting GP practices with low uptake to contact families missing vaccinations and providing materials and training.

Current vaccination delivery channels throughout the life-course (as at 2022):



Report Title:	The Cardiff and Vale UHB approach to Speaking Up Safely				Agenda Item no.	6.10	
Meeting:	Board		Public	x	Meeting Date:	28 September 2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Executive Director of People and Culture / Director of Corporate Governance						
Report Author (Title):	Head of People Assurance and Experience						

Main Report
Background and current situation:

Cardiff and Vale UHB's priority is to care for people and keep them well and this includes our staff as well as our patients. Safe, compassionate care is everyone's business and the way in which we respond to someone seeking to "speak up" or "raise a concern" is very important. We want our people to feel valued and respected at work and to know that their views are welcomed. To do that, we need to provide the best possible working environment – one where speaking up is not only welcomed, but valued as an opportunity to learn and improve.

Following the outcome of the trial of Lucy Letby (Countess of Chester Hospital NHS Foundation Trust), there is renewed interest in the avenues open to colleagues if they have a concern they wish to raise and in ensuring that they feel safe to speak up.

This paper describes for the Board the processes we currently have in place within Cardiff and Vale UHB. It also introduces the Speaking Up Safely Framework for NHS Wales and describes the actions we will be taking over the coming weeks in response to the Letby trial and launch of the Framework.

It is also important to note that 'making a disclosure in the public interest' or 'whistleblowing' gives the individual certain protections. This takes place when an individual discloses that they reasonably believe that one or more of the following is either happening, has taken place, or is likely to happen in the future, and it is in the public interest:

- Someone's health &/or safety has been put in danger by action or inaction
- Risk or actual damage to the environment
- A criminal offence has been committed
- A legal obligation has been breached
- Miscarriage of justice
- There's been a deliberate attempt to cover up one of these

These protections also cover 'workers' (e.g. people engaged by the Temporary Staffing Office), agency workers, volunteers, students etc., and therefore the avenues described below are open to these individuals as well as our employees.

THE CURRENT POSITION:

In NHS England 'Freedom to Speak Up Guardians' have been in place since the publication of the Francis Report in 2015, within NHS Wales there has been a more localised approach to date. The are many avenues available to Cardiff and Vale colleagues who wish to raise a concern currently, including:

- **NHS Wales Procedure for Staff to Raise a Concern** – this Procedure enables individuals to raise concerns about a danger, risk, malpractice or wrongdoing in the workplace. Colleagues are encouraged to raise it informally in the first instance, either with their line manager or the manager responsible for that area of work, but if this does not lead to

resolution or if the matter is too serious to be dealt with informally there is a formal process to be followed.

- **Respect and Resolution Policy** – this replaced the previous Dignity at Work and Grievance Policies in 2021. It ensures that individuals have access to a policy to help deal with any requests for resolution relating to their employment fairly, constructively and without unreasonable delay. It aims to encourage fairness and positive relationships within the workplace, preventing bullying, harassment and any form of unacceptable behaviour. The Policy recognises that conflict and disagreements in the workplace happen but argues that they should not always be viewed negatively as when conflict is managed well it leads to healthy, resilient and positive working relationships. It sets out a commitment to resolve issues at the earliest opportunity without resorting to a formal process, though as a last resort it may be necessary to use the formal part of this policy to resolve disputes or issues.

- **Freedom to Speak Up Helpline**– we know that not everyone feels able to raise concerns with their line manager or that they can feel that their concerns haven't been taken seriously or fully resolved. The F2SU telephone helpline is manned by the Concerns Team within Patient Experience and the inbox managed by the Corporate Governance team. Any concerns received by the Patient Experience team are shared with the Corporate Governance team to action. This process enables individuals to phone or email to report a concern or to ask for more information about the options available to them. The process followed on receipt of a call/email is described in Appendix 1. colleagues may choose to contact the Chair or a member of the Executive team directly to raise concerns and these are then followed up through the F2SU process (appendix 1).

- **Contacting an Executive Director or the UHB Chair directly** (previously Safety Valve) – the Safety Valve was set up by the previous UHB Chair as a means for staff to raise concerns directly with her about patient safety. Although this is no longer formally in place, some colleagues may choose to contact the Chair or a member of the Executive team directly to raise concerns and these are then followed up through the F2SU process (appendix 1).

- **Trade Unions** - All trade unions will help their members to raise their concerns either by supporting them individually through informal discussions or formal processes, or by speaking up on their behalf at the Local Partnership Forum or other partnership groups. They will also advise members on the most appropriate avenue available to them. Individuals can also contact the People and Culture team for advice and support.

- **External Agencies** - The aim of the Raising Concerns Procedure is to provide an internal mechanism for reporting, investigating and remedying any wrongdoing/inappropriate practices in the workplace. In most cases individuals should not find it necessary to alert external parties. However, it is recognised that in some circumstances it may be appropriate to report concerns to an external body and the Procedure states that it is preferable for the matter to be raised with the appropriate regulatory body than not at all. It will very rarely, if ever, be appropriate to alert the media. Any concerns raised with the UHB via an external body will be managed through the process outlined in Appendix 1.

- **Anonymous Concerns** - although anonymous reports will be considered, we encourage those raising concerns to provide their name if at all possible. If an individual chooses to raise a concern anonymously it will be much more difficult for the organisation to investigate the matter, to protect their position under the Public Interest Disclosure Act or provide

feedback. Any concerns raised with the UHB anonymously will be managed through the process outlined in Appendix 1.

- **DatixCymru Incident Reporting** - Reporting incidents helps us to understand how and why things go wrong, and how we can make our systems safer. DatixCymru is available to all colleagues to enable them to report any unintended or unexpected incident which could or did lead to harm for a patient receiving NHS Care as well as near misses that result in no harm. It is not designed to be used for raising concerns in the same way as the other avenues described in this paper (e.g. relationship issues, unfair practices or deliberate wrong doing). However, it is recognised that colleagues will not always know which route is the 'best' one, and it is important that any concerns raised through DatixCymru are followed up appropriately.

Since the outcome of the Lucy Letby case the neonatal unit have been visited by the Deputy Executive Nurse Director, the Medical Director and the Executive Nurse Director to provide support and reassurance to the staff that they will always be listened to if they raise concerns.

Since 2019 we have recorded 37 reports received via the Freedom to Speak Up process, broken down as follows, with 125 Grievances/Respect and Resolution Cases over the same period:

	2019	2020	2021	2022	2023
F2SU	8	8	15	2	4
Grievances	22	24	15		
Respect and Resolution *			7	23	34

(* increased numbers could reflect that under the Respect and Resolution Policy, Grievances are now combined with Dignity at Work cases)

NEXT STEPS:

Having multiple routes open to colleagues is important so that they feel that they have a choice when raising concerns, and feel safe to do so. However, there is the risk that this can result in concerns being dealt with very differently depending on the avenue through which an issue is received, and means that we do not have one central record and audit trail of staff concerns. Discussions are currently taking place between the Director of Corporate Governance and the Executive Director of People and Culture to determine how we can bring these routes closer together and ensure that the right people have the right information to be able to take appropriate action in a timely way.

This Autumn, Speaking up Safely: A Framework for the NHS in Wales will be launched by Welsh Government to support people to speak up safely and with confidence. This will provide a more consistent approach across NHS Wales but is an initiative which supports, rather than replaces, existing policy (including the Raising Concerns Procedure and Respect and Resolution Policy mentioned above). The Framework sets out the responsibilities of organisations, their executive teams and boards, along with those of managers and individual members of staff (and volunteers) in creating a culture in which 'Speaking Up', alongside timely and appropriate response to any concerns raised, is supported within a safe environment. It will be supported in its implementation by a series of toolkits.

Over the coming weeks the Corporate Governance and People and Culture teams will work with colleagues to review the Framework against our existing position and implement it to support the creation of a culture where individuals feel safe and able to speak up about anything that gets in the

way of delivering safe, high-quality care or which negatively affects their experience. The first step will be the completion of a self-assessment against the requirements for organisations set out in section 6 of the Framework. This will be presented to the Board at the Board Development Session on 26 October 2023.

As well as supporting staff to raise concerns and speak up there are systems in place to ensure adequate monitoring of mortality rates in order to identify issues around care and to manage safeguarding concerns relating to staff and volunteers.

Mortality Governance

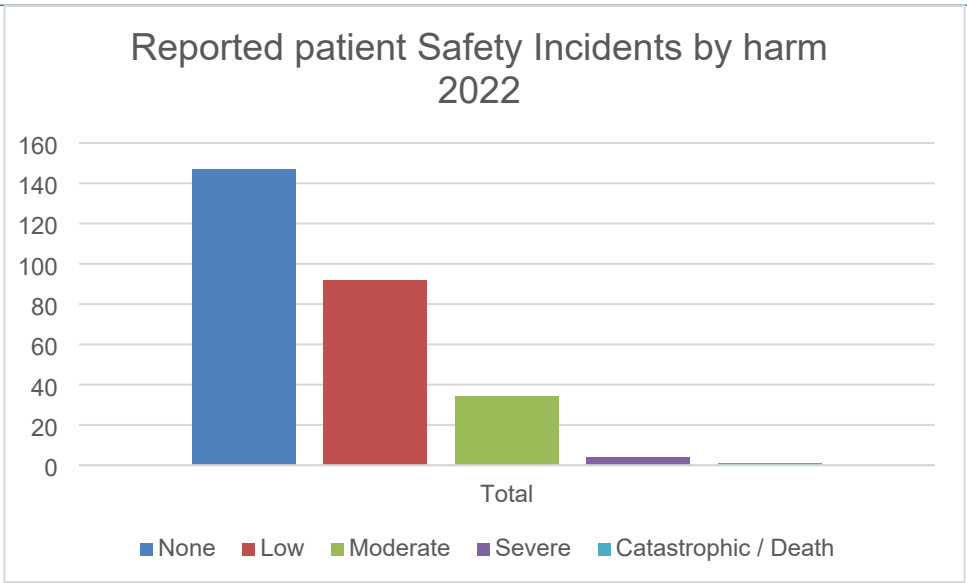
The neonatal unit undertakes a mortality review for all babies that die on the unit. The mortality reviews of babies that die within 28 days of their birth are submitted into the into a National Perinatal Mortality Review Tool (PMRT) and identifies both the cause of death of the baby and issues in care delivery that might have impacted. The same approach and rigor are applied to mortality reviews that sit outside the parameters of the National PMRT although these are not submitted to the national database. There is recognition that this process could be strengthened further with representation from the wider clinical teams including fetal medicine and Obstetrics at every review and this will be progressed at the Neonatal and Maternity Oversight Group. The development of a neonatal mortality dashboard is planned to support real time monitoring of crude mortality within the unit and at the Neonatal and Maternity Oversight Group.

Neonatal mortality is subject to multifaceted scrutiny. The Mortality rate is reported to the Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries (MBRACE) which supports benchmarking against other level three organsiation (those that care for the sickest and most complex babies) that undertake neonatal surgery. Adjusted neonatal mortality in 2021 was over 5% higher than the average although within the normal range expected for the unit. The unit is part of the Vermont Oxford Network (VON) which has 1200 participating organsiations globally and supports reporting and benchmarking of performance and long-term outcomes and the unit participates in the national neonatal Audit that provides reporting and benchmarking of a number of quality indicators in neonatal care.

The development of a Health Board Executive Chaired Maternity Neonatal Oversight Group, will provide oversight of the outcomes of all mortality reviews, patient safety incidents and nationally reportable incidents with a data driven approach to considering performance and quality.

There is an open and transparent approach to undertaking quality and safety reviews and identifying learning. External reviews of care are commissioned when independence is considered to be beneficial and this can include patient safety reviews and has previously led the Health Board to commissioned an external review of its response to an infection outbreak in the unit that occurred in 2015.

Patient Safety Incidents are reported on the Datix Cymru incident reporting platform. This platform supports identification of contributory factors and learning as well as improvements. There is a good reporting culture in the department, with a willingness to report patient safety incidents even when these do not result in harm, however there were historically delays in reviewing and managing incidents. Since early 2023 this process has changed and now the Neonatal Consultant Lead for Quality and Patient Safety and the Senior Nurse review and mange incidents in a timely manner and this it is anticipated that improved responsiveness will support increased reporting by staff.



The Paediatric Intensive Care Unit is subject to similar reporting and governance requirements as the neonatal arrangements. The National Paediatric Intensive Care Audit (PICAnet) reports and benchmarks Paediatric mortality. The 2022 PICAnet state of the Nation report identifies that the Health Board Mortality Rate is 1 which means performance is as expected. Individual mortality reviews of every child death and considered at the Acute Child Health mortality and Morbidity meeting and in addition all unexpected deaths undergo a multi-agency Procedural Response to an Unexpected death in Childhood (PRUDIC) and will be reported to the Coroner.

The introduction of the Medical Examiner Service in Wales will support independent scrutiny of every death that occurs in hospital and within the community once fully implemented and considers the views of the family and next of kin. At present over 80% of in-patient deaths are reviewed and it is anticipated that by this time next year the roll out will be complete. The Health Board is implementing a mortality scrutiny panel to consider the referrals from the Medical Examiner and to commission wider internal reviews where necessary. A review of mortality and morbidity meetings across the organisation is planned and will be overseen by the Health Board Learning from Mortality group. The purpose of the exercise is to ensure that there is equitable governance and reporting arrangements across the organisation.

The development of a mortality reporting framework has identified three tiers of mortality data that should be considered across the Health Board.
Tier 1 - UHB data and comprises crude inpatient mortality compared to the five-year average and all-cause mortality that includes combined inpatient and community crude mortality. This data is now regularly reported to Board.
Tier 2 – Clinical Board level data that includes clinical board specific indicators for example Emergency Unit mortality in medicine and 30-day post-operative mortality in Surgery Clinical Board. Work is underway to identify these indicators with each Clinical Board.
Tier 3 – specialty mortality indicators to include crude mortality and adjusted data from national audits and registries to be reviewed within mortality and morbidity meetings and directorate quality and patient safety meetings.

A bi-annual Health Board mortality report will be reported to the Quality and Patient Safety Committee to provide board oversight of governance and performance.

Professional Safeguarding
The Deputy Executive Nurse Director chairs monthly meetings with each Clinical Board, safeguarding and People Services to review all professional safeguarding concerns and this reports into an Executive Professional Concerns meeting to provide oversight, progress and consideration of risk.

Patient Experience

The Civica patient experience platform has been implemented across the Health Board this year with up to 600 patients surveyed daily and 63, 452 patients contacted by the end of March and mechanisms in place to support patients in providing real time patient experience information form the bedside.

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

There are a number of routes to support staff in raising concerns, however there is a risk that there could be a variation is approaches to responding to concerns.

Speaking up Safely will be launched this autumn to provide a more consistent approach while supporting existing processes.

UHB Mortality governance is multi-faceted and includes a data riven approach incorporating crude mortality data reporting, national audit and registries proving adjusted data and individual mortality reviews. In addition, independent scrutiny is provided by the medical examiner service.

Mortality governance is being strengthened, however further development with Clinical Boards to support the identification and oversight of tier 2 mortality indicators and standardization of mortality and morbidity groups is necessary.

There is a systematic approach to considering professional concerns that protects the individuals but also provides executive oversight and this includes all safeguarding concerns relating to members of staff.

There is a robust process to capture patient experience and to support patients in raising concerns.

Recommendation:

The Board is requested to:

- NOTE the assurance provided by existing processes to raise concerns, existing mortality governance and professional concerns process but NOTE the work that is underway to strengthen these further.

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		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

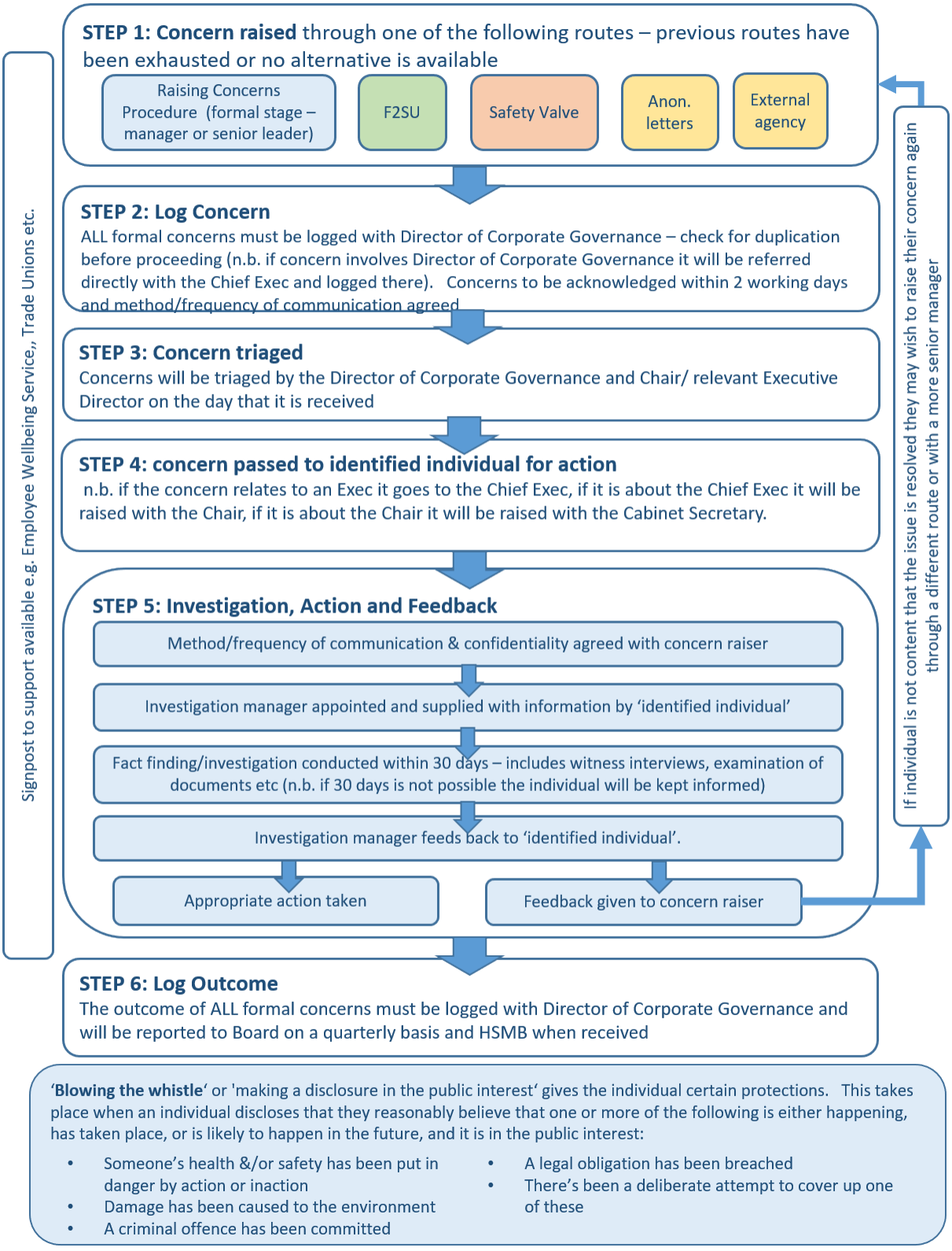
Prevention		Long term		Integration		Collaboration		Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.	
Risk: Yes/No	
The processes described in this paper enable staff to raise concerns if they believe there is a risk which needs to be mitigated	
Safety: Yes/No	
The processes described in this paper enable staff to raise concerns if they believe there is a patient or staff safety issue	
Financial: Yes/No	
The processes described in this paper enable staff to raise concerns if they believe there financial malpractice or fraud	
Workforce: Yes/No	
The processes described in this paper are in place to enable staff to raise concerns safely and without fear of detriment	
Legal: Yes/No	
The processes described in this paper take into consideration the requirement to protect individuals who make a disclosure in the public interest	
Reputational: Yes/No	
It is important that the UHB has a reputation for being an organization where individuals feel they can raise concerns safely and without detriment, and that they will be acted on	
Socio Economic: Yes/No	
no	
Equality and Health: Yes/No	
no	
Decarbonisation: Yes/No	
no	
Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Board	28.09.23

Appendix 1

Standard Operating Procedure for Managing Concerns from Staff



'**Blowing the whistle**' or 'making a disclosure in the public interest' gives the individual certain protections. This takes place when an individual discloses that they reasonably believe that one or more of the following is either happening, has taken place, or is likely to happen in the future, and it is in the public interest:

- Someone's health &/or safety has been put in danger by action or inaction
- Damage has been caused to the environment
- A criminal offence has been committed
- A legal obligation has been breached
- There's been a deliberate attempt to cover up one of these

Report Title:	Strategic Planning Update				Agenda Item no.	6.11	
Meeting:	UHB Board		Public	X	Meeting Date:	28.09.23	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Executive Director of Strategic Planning						
Report Author (Title):	Deputy 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 and includes progress in relation to the following areas:

- Strategy development and delivery, including strategic programmes.
- Integrated Medium Term Planning
- Regional planning work programme.

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 our refreshed strategy, our IMTP/annual plan and our regional and partnership plans.

1. **Strategy Refresh:** at its development meeting in August, the Board agreed the final updated draft subject to formal ratification of this approval at its formal Board meeting in September. The Board agreed that the strategy document should be launched at the Annual General Meeting on the 21st September.

2. **Strategic Programmes:**

Following the strategy refresh, the UHB's strategic objectives have been updated as follows:

Putting People First
We will be a great place to train, work and live, where we listen to and empower people to live healthy lives.
By 2035, colleagues would recommend us a great place to work, our workforce will reflect the diversity of our communities and more people will be living healthier lives.

Providing Outstanding Quality
We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them.
We will have reduced inequities in prevention, improved access to clinical services and clinical outcomes.

Delivering in the Right Places
By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing.
We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery.

Acting for the Future
We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments and techniques to provide the best possible health outcomes and sustainable health care into the future.
By 2030 we will have reduced the Health Board's carbon footprint by 34% and will have increased our research and clinical innovation activities.

Under each of these objectives there are three or four long-term, measurable priorities. Our strategic framework for delivering these long-term priorities will be developed so that each priority is underpinned by strategic programme plan describing:

- programme purpose
- critical planning activities
- planning governance
- interface with operational planning and delivery
- key strategic milestones and measures

As we now undertake a review our of our existing strategic programmes and strategic corporate plans, there may be an opportunity to combine some existing strategic programmes under a combined strategic 'portfolio' in order to streamline and align some of our planning governance arrangements. Management executives have considered this proposed approach and the early results of this revised approach will be brought to Board for consideration and input at the October Board Development session.

The Board is asked to support using time in the October Board Development session to shape the strategic framework design to deliver the refreshed strategy.

3. Integrated Medium Term/ Annual Planning

- **Annual Plan 2023-24**: Formal feedback in the form of an accountability letter on the 2023-34 Annual Plan was received on the 25th of August from Welsh Government (WG) acknowledging that the plan did not balance but that WG expected the UHB should continue to progress commitments set out in the plan, particularly in relation to Ministerial priorities and considering any material changes in response to delivering an improved financial position.

- In line with WG guidance, the Annual Plan Quarter 1 assurance report against the key delivery milestones is submitted as part of this month's Board agenda as a separate item and will be submitted to WG as part of our routine reporting, along with the Annual Plan mandatory, detailed minimum data set (MDS). The Annual Plan Q1 assurance report was prepared prior to the receipt of the formal letter regarding the Annual Plan on 25th August. The structure and content of the report for Q2 will be revised accordingly to focus on the conditions outlined in the accountability letter

- The accountability letter describes the requirement of the UHB to deliver on annual plan commitments alongside the improved financial position and to report quarterly to:

    - Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximise its improvement trajectory and develop robust mitigating actions to manage financial risks.
    - Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year.
    - Demonstrate actions are being taken to mitigate residual costs in relation to the legacy of COVID
    - Continue to make progress on the UHB's approach to allocative value and the population health resource agenda where possible.

Progress against these requirements will be incorporated into the Annual Plan Quarterly Assurance Report in future so that high level, triangulated assurance is provided across 1) the delivery of critical delivery milestones, 2) performance against ministerial priorities and 3) financial improvement. This will be reported to the Board and reviewed by Welsh Government officials as part of the ongoing 'Enhanced Monitoring' escalation arrangements through Joint Executive Team (JET) meetings, the Integrated Performance, Quality and Delivery (IPQD) meetings and submitted as a formal quarterly Board Assurance report.

Annual Plan 2024-25: The approach to the annual planning process for 2024-25 has been shared with Senior Leadership Board in August and also with Board describing the core planning assumptions and the approach to re-focusing and triangulating our delivery, performance and financial priorities. The milestones, governance and timelines for the development of the Annual Plan have been shared with Board and we will bring back the draft, prioritised deliverables and associated enablers and outcomes that will be proposed for inclusion in the 2024-25 Annual Plan for Board scrutiny and input at December's Board Development session.

4. Regional Planning

The South East Wales Regional Portfolio continues to make progress across all aspects of its work programme, with the prioritised areas being ophthalmology, orthopaedics, diagnostic and stroke services.
A review of the portfolio will be held on 11th October with members of the Regional Oversight Group including Medical Directors and the relevant regional clinical leads. The purpose of the event will be to (a) understand progress to date (b) consider priorities and approach for the coming year and beyond (c) given the event will be held in Llantrisant, provide oversight board members with the opportunity to take a walkaround the LHP site.

Work is being progressed by the three UHBs' Assistant Directors of Planning to consider alignment of all respective organisation's strategies and clinical plans to identify opportunities for regional working moving forward. Discussion on the emerging work will also form a key feature of the workshop.

In terms of the latest for each of the programmes:

- **Ophthalmology (led by ABUHB)**: The Regional Interim Cataracts project is now in implementation phase following funding allocation from the Regional Planned Care fund. Given the delay in funding confirmation, there has been a delay in recruiting to key posts and to implementation of the proposed model. Activity and costing has been reprofiled accordingly and it is important to note that the planned activity levels in the original business case will not be delivered. Cardiff and Vale continue to lead the use of the Vanguard Ophthalmology Theatres located at UHW as part of this interim plan. A 12-week regional engagement process will commence in early September to inform a sustainable regional cataracts solution.

- **Orthopaedics (led by CAVUHB):**

- In preparation for the development of the Llantrisant Health Park (LHP), an Orthopaedic working group has been established with the aim of developing the proposed clinical model and schedule of accommodation. The data and informatics group are in the process of developing an algorithm to help identify the appropriate cohort of patients suitable for the LHP. This will be discussed at the LHP working group and programme board along with the outcome of the analysis that will help identify the potential number of patients that could be potentially suitable for treatment at the LHP.

- Pre-operative assessment working group have collated the various processes and guidelines with the aim of identify ways of standardisation to enable patients to be treated efficiently across the region, with the same eligibility for access to surgery.
- Workforce issues across the service continues to be raised as a risk for addressing the current back log and future planning.
- Anaesthetic/pharmacy services in each UHB are in the process of reviewing current practices and implementing changes to their current short stay pathways. Each UHB has been asked to feed back their findings and outcomes in September and identify opportunities for standardisation that can be implemented in the LHP.
- **Diagnostics (led by CTMUHB):**
    - **Endoscopy:** The Project Definition Document was signed off by Project and Programme Board in August. Work has commenced on refreshing the demand and capacity analysis for the region (due to be presented in September) to inform the next steps regarding regional clinical model development.
    - **Community Diagnostic Hubs:** The agreed model across the region is the development of Community Diagnostic Hubs, within each Health Board boundary, aligned to areas of high socio-economic deprivation in order to provide additional diagnostic capacity closer to home. The Regional Project Board are engaged in a competitive dialogue process to identify potential suppliers to deliver a Managed Service solution. CAVUHB were successful in receiving funding as part of the Regional Planned Care Fund to progress a short-term solution in year (mobile capacity located on an existing health board site) and are developing longer term plans for a Community Diagnostic Hub to be operational in 2024/2025 aligned to this programme of work.
    - **Pathology:** Options to deliver a single site model for cellular pathology within the South East Wales region re being worked up and evaluated through the Regional Pathology steering group
- **Regional Stroke Programme (led by CAVUHB):** Good progress has been made with undertaking a gap analysis and modelling of two viable options for reconfiguration of service across the region. A regional clinical summit will be held on 10th October, whereby colleagues will help evaluate the options. Public engagement is underway across the CAVUHB/CTMUHB footprint.
- **Llantrisant Health Park**: Welsh Government has provided funding to enable Cwm Taf Morgannwg Health Board to develop the business case for the capital funding needed to develop the Llantrisant Health Park which it is envisaged will provide CTM, and regional health board partners with regional capacity to support planned care delivered in each health board. CTMUHB have appointed a Programme Director of oversee this significant programme fo work. Mechanisms for ensuring full and robust engagement with both regional programmes and other South East Wales Health Boards are under development.
- **Regional Cancer (led by ABUHB) -** Historic regional cancer planning arrangements have bene delivered by a regional cancer care leadership group (CCLG). Following a detailed review of this forum it was agreed by all SE Wales Health Boards and Velindre NHST to draw this regional cancer agenda into the wider regional planning mechanisms. The CCLG is to be recast as a regional cancer programme which ABUHB will formally host. Scoping of this programme will now take place in the coming months. This change saw VNHST formally become a member of the wider SE Wales regional planning collaborative.

Recommendation:

The Board is requested to:

a) **Note** the proposed approach to realigning and updating our strategic planning framework to deliver our refreshed strategic objectives.
b) **Support** the approach to Board engagement of the realigned strategic programme framework.
c) **Note** the proposed updated approach to a high-level but triangulated (finance, performance and delivery) Annual Plan Quarterly Assurance Report
d) **Note** the work in progress within the Regional Planning Programme.

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: No

No risk assessments relevant to the content of this report.

Safety: 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

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

There will be workforce implications relating to the introduction of regional service models

Legal: Yes

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: No

No specific risks to highlight.

Socio Economic: Yes
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 but we need to ensure that regional solutions which may require longer travelling distances do not negatively impact on any particular groups.
Equality and Health: Yes
EHIAs will be undertaken for the key plans described in this report. Appropriate engagement will need to be undertaken in relation to changes in the way we provide services across the region
Decarbonisation: Yes
Decarbonisation impact will need to be considered as each plan is developed. Decisions on prioritise must consider carbon impact and contribution to decarbonisation.

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

Report Title:	Integrated Annual Plan 2023/2024 Quarter 1 Report				Agenda Item no.	6.12	
Meeting:	Board		Public	X	Meeting Date:	28.09.2023	
Status *(please tick one only):*	Assurance	x	Approval		Information		
Lead Executive:	Abigail Harris- Executive Director of Strategic Planning						
Report Author (Title):	Head of Strategic Planning						

Main Report
Background and current situation:

Submission of a quarterly report providing in-year assurance to the Board on the progress of the Integrated Medium- Term Plan (IMTP) or Integrated Annual Plan is a formal requirement as part of the Health Board's accountability conditions.

The Health Board was unable to submit a 3-year IMTP in March 2023 due to the forecast financial deficit position and as per the conditions of the NHS Wales Finance Act (2014) produced and submitted an Annual Plan in a 3-year context.

Welsh Government requested further information to be submitted in May 2023, with further information requested on:

- Updated Planned Care Ministerial Templates
- Updated Urgent and Emergency Care Ministerial Templates
- Greater detail on Investment Cases; justification and benefits realisation
- A more assured Cost Improvement Programme
- An updated Minimum Data Set

These products were approved by Board and resubmitted to WG in May.

Most recently, Welsh Government requested that Health Boards submit scenarios to go further in reducing the deficit above and beyond the planned deficit position, and the Health Board responded by the submission date of 11th August.

As such, the Annual Plan 2023/2024 has not been formally accepted by Welsh Government to date.

However, as a Health Board, we have continued to develop a Quarter 1 Report to provide Board assurance on the progress of our plans, recognising the importance of collectively understanding our position and areas of challenge.

The attached report summarises the Quarter 1 position and demonstrates that against a challenging backdrop of significant operational and financial pressures, many of the milestones set out in our Integrated Annual Plan for Quarter 1 (74%) have been fully or partially achieved with high confidence in ability to get back on track for Quarter 2 in instances where a milestone hasn't been fully achieved as planned.

26% of the milestones were not achieved with low confidence in getting back to the original plan for Quarter 2, and the challenges underpinning these milestones are set out on the summary page within the report itself.

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

The format of the report for 2023/2024 has been refreshed.

The report focuses on whether or not we achieved the key milestones we set out in the plan for Quarter 1 and if not, makes an assessment on our confidence in recovering the original plan.

The report focuses specifically on the progress of our Strategic Programmes and Operational Delivery Priorities as set out in the plan.

The report aims to compliment, and not duplicate, other routine reports. In particular, this report signposts to the Integrated Performance Report- whilst the Quarterly Report is by design a retrospective review of progress for that quarter against planned milestones, the Integrated Performance Report gives a more dynamic and nuanced monthly view of trends and achievement of Ministerial Priorities.

The intention of this report is to make it easier for the organisation to assess *'at a glance'* the areas in which we have been able to make progress on our plans, and the themes of the challenges and barriers experienced, to enable strategic action to be taken on themes where appropriate in support of delivery for the remainder of the year.

The remaining quarterly reports are planned to be submitted to Board as below:

Quarter 2	November Board
Quarter 3	March Board
Quarter 4	TBC once Board calendar confirmed for 2024/2025

Recommendation:

The Board is requested to:

- **NOTE** the progress achieved in Quarter 1 towards the delivery of our Integrated Annual Plan 2023/2024

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: Yes/**No**
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**
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:

Integrated Annual Plan

Quarter 1 Report

April-June 2023

How to read this report

- This report provides a retrospective **overview** on achievements of **quarterly delivery milestones** as set out in our Integrated Annual Plan 2023/2024
- It gives an **assessment** of where the plan is off track and where action is needed to recover the position
- This report highlights the progress of our **strategic programmes:**

  - Shaping our Future Population Health
  - Shaping our Future Hospitals
  - Shaping our Future Clinical Services
  - Shaping our Future Community Services

and **our delivery priorities** as set out in the Integrated Annual Plan:

  - Urgent and Emergency Care
  - Planned Care, Cancer and Diagnostics
  - Specialist Services
  - Children and Women Services
  - Mental Health

- The report ***does not*** aim to cover all areas of business within the organisation for which there are existing reporting mechanisms
- This report should be read alongside the **Monthly Integrated Performance Report**, which gives a more nuanced and detailed view on performance trends for our each of key performance indicators and the 2023/2024Ministerial Priorities

Quarter 1 – Summary

Against a challenging backdrop of significant operational and financial pressures, many of the milestones as set out in our Integrated Annual Plan for Quarter 1 have been fully or partially achieved.

We set ourselves **50 specific milestones** aligned to our strategic programmes and operational delivery priorities for Quarter 1.

Of those:

- 24 were fully achieved as planned (48%)
- 13 milestones (26%) were rated as not fully achieved but had made progress towards achievement and rated a high confidence that plans would be recovered by Q2 – partial achievement was largely due to external funding decisions, recruitment challenges or operational issues that set timescales back
- 13 milestones (26%) were rated as not achieved with low confidence in plans returning to green by Q2

The key challenges underpinning milestones that were not achieved and with low confidence in return to green by Q2 are:

- Lack of certainty on funding for Shaping our Future Hospitals Programme which has limited progress with commencing the Strategic Outline Case (SOC)
- Requirement to consider public feedback regarding the Eastern Vale Wellbeing Hub to inform progression of the OBC therefore pushing back original timescales within the plan
- Ongoing conversations with Welsh Government regarding funding and capital investment required to enable the development of SARC @CRI
- Pause on release of WHSSC funding for Neuropsychiatry
- Challenges in achieving reduced Length of Stay and Reduction in ED attendances due to the national difficulties experienced within social care which negatively impact upon patient flow and the continued high demand for Urgent and Emergency Care Services experienced across NHS Wales
- Planned care- revised ministerial focus and ambition on tackling 2 and 3 year waits which has meant specialities have now revised trajectories for this new ministerial ambition

48 % milestones fully achieved

26% partially achieved with high confidence in return to green in Q2

26% rated as not achieved with low confidence in returning to green in Q2

Shaping Our Future Population Health / Local Public Health plan

Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Plan and deliver routine and mass vaccination programmes in response to JCVI and Welsh Government advice and recommendations, including Covid-19 Spring Booster programme	Y	To note - programmes have been successfully delivered; however, performance is below WG target for childhood immunisations and Covid-19 spring booster (see integrated performance report for detail)		
Identification of patient management system; systematised smoking status recording for all hospital in-patients to access smoking cessation support on admission	N	The Welsh Nursing Care Record (WNCR) has been identified as the patient management system to record smoking status on admission and referral to Smoking Cessation Services. Currently in development stage to draft the correct wording required to capture this	Wording for the relevant smoking status questions needs to be agreed in conjunction with the data definitions work which is being led by DHCW. Once approved, the WNCR will be amended to include the new smoking question	High
Implementation of Level 2 Healthy Travel Charter by C&V UHB to begin	N	Agreement was required on where capacity in organisation sits to co-ordinate implementation; now agreed, SLB paper drafted, for SLB in Sep/Oct	Finalise SLB paper, seek agreement to sign off Charter at SLB in Q2	High

Shaping Our Future Hospitals

Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Commence creating Strategic Outline Case (SOC) content (clinical service plan, digital, health planning and estates strategy refresh); recruit team; procure suppliers and concurrently secure resource to produce digital SOC	N	In the absence of requested funds from WG, work on the SOC has not started	There is a meeting at the end of August with WG to seek clarity on the timeline to receive funding for SOFH. WG have commissioned a review of the clinical strategy set out within the SOFH PBC written at the beginning on 2021. This review is being undertaken by the Nuffield Trust. At the time of writing the review is drawing to a close with a draft report expected in early September. It is CVUHB's impression that the report will recommend continuing to develop the clinical services plan, acknowledging and addressing the complexity of such an undertaking. It is expected that this report will be extremely helpful in identifying opportunities and risks to take forward.	Low

Shaping Our Future Clinical Services

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Programme governance	Develop Programme Plans, set up governance including programme workstreams, complete frameworks for learning and patient and public involvement	N	All complete apart from the framework for patient and public involvement. Following discussions with Llais and taking learning from co production this will now be developed as a co-production framework which is in early stages of development alongside Llais	Co production framework to be developed with Llais and UHB Co production leads in this next quarter and overseen by the comms, engagement and co-production workstream	High
Programme learning	Commence intelligence gathering and listening exercise (engagement phase 1)	Y			

Shaping Our Future Community Services

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Engagement and Planning for delivery of Integrated Community Care Service	Workforce and recruitment plans	N	Workforce model for Safer@Home is driving development, finalised model and plans yet to be agreed	Workforce and recruitment plan to be agreed once business case approved and funding secured in Q2	High
Engagement and Planning for delivery of Integrated Community Care Service	AHP collaborative established	Y			
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	Health & Wellbeing Centre @ CRI	N	Discussions ongoing with WG	FBC complete - To be considered by the UHB Board at its meeting on 28 September	High
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	Wellbeing Hub @ Park View	N	WG sign off of OBC delayed	Initial draft of FBC prepared for consultants. Awaiting confirmation of the appointment of the supply chain partners, project managers and cost advisors (expected - wc 21.08.23)	High
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	Wellbeing Hub @ Eastern Vale – Restart OBC Development	N	Public engagement meeting on 26.06.23 indicated community concerns	Review of potential sites proposed by public. Further public engagement sessions required.	Low
Developing Capital Infrastructure investment FBCs for Tranche 1 schemes	SARC @ CRI	N	Discussions ongoing with WG re: funding and capital investment required to deliver this scheme- in order to deliver SARC the safeguarding works and development of Wellbeing Centre need to be completed.	Continued discussions planned for Q2	Low

Urgent and Emergency Care

Aim: To enable people with urgent or emergency care needs to access safe and high-quality care at the right time, in the right place, by the right team

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Inpatient Flow, Discharge & Front Door	Maintain zero 4-hour ambulance handover delays	Y			
Inpatient Flow, Discharge & Front Door	No patient waits >24 hour in ED	Y	June was 0 but we have seen some breaches in July and August due to operational pressures and changes to EU footprint		
Inpatient Flow, Discharge & Front Door	Reduce the number of delayed transfers of care patients by 10% on January '23 baseline	Y			
Inpatient Flow, Discharge & Front Door	Cohort additional MFFD patients in Lakeside Wing	Y			
Inpatient Flow, Discharge & Front Door	Reduce 21-day length of stay by 5% from Q1 2022 baseline	N	Continued national difficulties with social care capacity and discharges	• Current focus on stranded (7d LOS) and super-stranded (21d LOS) patients • New definition of 'clinically optimised' patients allowing greater focus on discharges • Revised pathways of care within community settings • Continued partnership working around Delayed Pathways of Care	Low

Urgent and Emergency Care

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Alternatives to admission	Reduction of ED majors' attendances of 5% compared to same period 2022/23	N	Continued high demand for Urgent and Emergency Care services across Wales	Delivery of 6 Goals Programme including alternatives to ED attendances, Safer@home and SDEC.	Low
Alternatives to admission	10% increase in the total number of patients managed through SDEC	Y			
Community and Urgent Primary Care	80% appointment utilisation in UPCCs	Y			
Community and Urgent Primary Care	Home Visit (P2) f2f in 2 hours >90%	N	Workforce availability/shift fill for 2nd GP overnight.	Review of demand and capacity	Low
Priority Services	Stroke - 70% patients scanned within 1 hour	N	June was 59.2%, above the Wales average CT scan performance impacted by loss of EU scanning availability	• EU Scanner is fixed • Work ongoing to improve the stroke assessment pathway with stroke and EU teams • Specific focus on pathway for self-presenting patients - with NHS Exec input • Review of medical and CNS workforce models	High
Priority Services	Hip Fractures - 75% patients admitted to ward within 4 hours	N	High numbers of EU attendances. Challenging discharge picture leading to difficulties maintaining flow.	• We have seen improvements to the pathway and the median time to ward has reduced significantly • Rapid # neck of femur pathway (three ringfenced beds on trauma ward, new rapid #NOF protocol triggered via switch) • Introduce WAST Direct Pathway – working on new go-live date	Low

Planned Care, Cancer and Diagnostics

Aim: To recover, reset and transform planned care, cancer and diagnostic services

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Service Evaluation- Whole System	Undertake high impact evaluations of first three key specialities	N	Refocus of workstream	• Completed in Therapies and Cardiac services. • Three key surgical specialties to present their evaluations at Theatres summit in Q2	High
Cancer	>75% compliance with the 62-day Single Cancer Pathway Standard	N	Focus on reducing backlog of long waiting patients has impacted delivery of standard.	• Revised plan by tumour site for key stages of the pathway • Use of NHS Executive Cancer SharePoint resources to underpin revised D&C modelling • Standardised action plan across tumour sites • Weekly performance management by pathway stage – First contact Diagnosis and Treatment • Continued analysis of breach reports	Low
Cancer	Develop draft UHB strategy to deliver national cancer pathways	Y			
Planned Care Performance	New Outpatients- 0 patients waiting longer than 52-weeks in all specialties (excluding allergy, urology, rheumatology, general surgery, ophthalmology, orthopaedics and spines)	N	Revised focus from minister on tackling 2- and 3-year waits	Current focus of elective resources to reduce 2- and 3-year OP waits	Low

Planned Care, Cancer and Diagnostics

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Planned Care Performance	Total treatment- 0 patients waiting longer than 104 weeks in all specialities (excluding gynae, general surgery, urology, ENT, ophthalmology and spines)	N	Revised ministerial ambitions for 2- and 3-year waits. Industrial action Focus on urgent and Cancer patients	In line with revised ministerial ambitions: Specialties have trajectories for delivery of new minitrial ambition (<3% of patients waiting over 104w by December).	High
Planned Care Performance	Therapies-0 patients waiting over 14 weeks (excluding audiology)	N	Small number of breaches in 3 specialties	Clear long waiters in three specialities over the rest of the year.	Low
Primary Care Performance	>90% of all eligible community pharmacies providing Clinical Community Pharmacy Services (CCPS)	Y			
Primary Care Performance	>95% of practices reporting escalation levels	N	Delayed reporting by 2 practices	Increased to 96% in July	High
Primary Care Performance	>90% of eligible practices offering Clinical Community Optometry Services (CCOS)	N	Contract reform and implementation still in progress	Contract reform and implementation still in progress	Low
Supporting Patients Whilst Waiting	Co-Produced Model of care agreed, current services provision mapped, gap analysis complete	Y			

Specialist Services

Aim: To deliver exceptional specialist and tertiary services for our local, regional and national populations

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Waiting Times for Specialist Services	Cardiac & Thoracic Surgery - new outpatients <16 weeks, maintain <52-week treatment	N	Small number of patients >16w and >52w at end of June	Only 1 thoracic patient breaching the 16 weeks for OPA - appt booked 31st Aug 2023 4 thoracic patients breaching 52 weeks, 2 who require paediatric support for their surgery and can only be done in UHW - de-listed until we return to UHW 2 further thoracic patients have requested surgery end of August. 1 complex Cardiac Surgical case that requires family support for both pre-dental work and surgery. Clinical Board are working through the logistics and planning patients care.	High
Service Priorities	Submit thrombectomy options business case	Y			
JACIE accreditation - BMT/Haem	Submit strategic outline case to WG for consideration	Y			
Palliative Care	No Quarter 1 activities				

Children and Women Services

Aim: To ensure every child has the opportunity for the best start in life and to provide high quality, safe and patient centred women's services

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Maternity Services	Commence recruitment of additional roles following Ockenden review action plan	Y			
Paediatric Strategy and Waiting Times improvement	Maintain RTT waiting time performance - 52 weeks new outpatient and 104 weeks treatments	Y			
Neurodevelopment	No Quarter 1 activities				
Emotional Wellbeing & Mental Health (CAMHS & SCAMHS)	Maintain <80% of Part 1a for CAMHS and SCAMHS	Y			
Children Looked After	Recruitment of nursing staff	Y			
Child Healthy Weight and Childrens' Vaccinations	82.9% children up to date with vaccinations (at 4 years old)		Was 81.3% at the end of March 2023. Quarterly data for Apr-June not yet available		
Child Healthy Weight and Childrens' Vaccinations	Waiting time for child healthy weight services <14 weeks	Y			

Mental Health

Aim: To continue our mental health transformation with a focus on principles of home first, safe hospital care and improving access to psychological support and specialist teams

Key area of Focus	Quarter 1 - Measures of Success- What did we say we would do?	Delivered (Y/N)	Reasons off track?	Plan To get Back to Green	Rate confidence on ability to get back to green by next quarter?
Pathway redesign through co-production, partnerships and integration	111 Press 2 advertised nationally and evaluated	Y			
Pathway redesign through co-production, partnerships and integration	Launch of Sanctuary	N	Currently recruiting to posts and sourcing location from Local Authority	• Complete recruitment • Identify premises	High
Pathway redesign through co-production, partnerships and integration	Reporting of all intensive psychological therapy waiting times	Y			
Pathway redesign through co-production, partnerships and integration	Part 1a and 1b compliance	Y			
Pathway redesign through co-production, partnerships and integration	Planning and governance for new roles in mental health workforce	N	• Recruitment freeze on Peer Lead • Funding for key post • Awaiting HEIW strategy development	• Recruit peer lead • All other areas on track	High
Neuropsychiatry	Commence recruitment following WHSSC approval	N	WHSSC funding decision at Management Group has been paused due to current financial context	Await outcome of funding decision- risk assess impact of not progressing	Low
Safety and Stabilisation	WARRN replaces Form 4 risk assessment	Y			
Safety and Stabilisation	Commencement of Royal College of Psychiatry (RCP) review	N	Awaiting start date	Delays not due to C&V	High

Report Title:	Strategy Refresh Update				Agenda Item no.	6.13	
Meeting:	Board		Public	X	Meeting Date:	28th Sept 2023	
			Private				
Status *(please tick one only):*	Assurance	X	Approval		Information		
Lead Executive:	Abigail Harris – Executuve Director of Strategic Planning						
Report Author (Title):	Marie Davies – Deputy Director of Strategic Planning						

Main Report
Background and current situation:

The Strategy Refresh has undertaken extensive colleague, stakeholder, patient and public engagement seeking their input on the refreshed strategy's vision, purpose and key strategic priorities.

The UHB established a dedicated website to support the engagement process and awareness was raised and engagement undertaken using a range of platforms and approaches including local radio, posters at prominent public venues, public meetings (both face to face and virtual), facilitated focus groups and 1:1 sessions (supported through our integrating health and social care facilitators)

Phase 1 engagement on the proposed content of the strategy took place between 16th January and 20th March and a second phase of engagement to seek feedback on the draft strategy document took place between 15th May and 23rd June 2023.

The final strategy can be located under the supporting documents folder on AdminControl and on the Cardiff and Vale University Health Board website.

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

- The refreshed strategy – Shaping Our Future Wellbeing to 2035 sets at high level our direction of travel as a health board for the next decade and beyond. It articulates a clear vision for the differences we want to see by 2035, and the priorities we need to focus on to get us there.

- The stategy has been developed and updated in line with the key feedback themes that emerged through the extensive engagement exercises.The engagement process has been thorough and has afforded our health board colleagues, patients, partners and stakeholders the opportunity to provide feedback to us and to confirm what is important to them.

- The final version of the refreshed strategy document was reviewed at the Board Development session in August and the Board supported the proposal to launch the strategy at the Annual General Meeting on 21st September 2023 with formal approval to be given at formal Board meeting on 28th September.

Recommendation:

The Board / Committee are requested to:

1. Formally approve the strategy document agreeing the strategic objectives as our wellbeing objectives, as required under the Wellbeing of Future Generations Act.

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: Yes
The timeline poses a potential risk to delivery milestones
Safety: No
Financial: Yes
Some of the constraints are resource related – where there is a financial impact
Workforce: Yes/No
Not directly related to this report, but workforce engagement will for a core component of responses to the strategy refresh survey
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: Yes
the survey has been designed with the nine protected characteristics in mind. Our Health & Social Care Facilitators are targeting the protected characteristic groups. The Strategy Refresh programme has at its core tacking the health inequalities we see in our population. The EHIA that we have completed will be reviewed by the Consultation Institute.
Decarbonisation: Yes – considered within the strategy document

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:14th March 2023
Board	

Report Title:	**Cardiff and Vale Winter Plan 2023/2024**			Agenda Item no.	7.1
Meeting:	**Board**	Public	X	Meeting Date:	**28/09/2023**
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive:	**Chief Operating Officer**				
Report Author (Title):	**Director of Ops: Six Goals and Financial Improvement**				

Main Report

Situation

Winter planning forms an integral part of the Health Board's annual priorities. Pressure on health services typically fluctuate throughout the year and winter leads to increased demands that require mitigating action and additional support. Undertaking this planning has become increasingly complex due to seasonal pressures, workforce pressures, covid/respiratory spikes and variables associated with a challenging financial agenda.

In order to meet the challenges that Winter presents, the Health Board has historically retained a small financial reserve of £1.5m that has been provided on a non-recurrent basis to specific winter schemes each year. As we approach Winter 2023/24 there is a desire to review and refresh how we manage our approach with an opportunity to embed the winter plan into our annual planning framework and the IMTP. As part of this approach it is proposed that some of the priority winter schemes should be recurrently funded to help improve our approach of delivering affordable, safe, patient focused and effective care.

The winter priorities have been considered in the context of our six-goals and planned care programmes, with clear aims for both emergency, urgent and planned care. A number of key priorities have emerged:

a) Flexing capacity (ambulatory and bed capacity) to mitigate increases in demand
b) Stepping-up social, intermediate and primary care capacity when necessary.
c) Focusing on SAFER and "home-first" to facilitate timely and safe discharge for our patients
d) Aligning our workforce to times of increased demand
e) Phasing resources/budgets to account for the seasonal variation

This brief, the associated winter slides, sets out the key considerations for the operational winter plan and requests the recurrent allocation of the winter reserve (£1.5m) within operational budgets.

Assessment

This year the Health Board has undertaken a number of workshops within clinical boards and also held a winter summit with internal and external stakeholders. Through this workshop and discussions, the drivers influencing the winter plan have been identified and include; peaking virus demands, the cost of living/energy crisis, ongoing operational pressure, workforce availability/morale, and the potential for medical industrial action.

In addition to the impact on urgent and emergency care pathways, the UHB also plans for the maintenance of critical services during the winter period. Through the aforementioned forums a number of key priorities have been identified including cancer performance, long waiting patients, paediatric services, mental health services, tertiary services, primary care sustainability, critical care capacity and partnership working to support social care.

In relation to the acute hospitals, the UHB has undertaken an internal demand and capacity exercise to compare the available bed base against best, worst and pre-covid average scenarios. The detail is provided in Table 1 and indicates that there is a 90-bed gap in January 2023.

Table 1. Predicted Bed Gap

Cardiff & Vale Projected Gap (Excluding Mental Health)								
Clinical Board	**Year**	**Scenario**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**
Medicine	2022-2023	Predicted Worse case	114	120	152	147	148	137
Medicine	2023-2024	Predicted Worse case	**56**	**67**	**90**	**82**	**76**	**56**

GAP

Figures exclude critical care

In order to address this challenge, the UHB has worked to define key actions that can be taken to mitigate the gap. Many of these actions are already in progress with increased benefits likely to be realised in the months ahead. Examples of these have been included in the winter presentation and clearly indicate the significant work undertaken by clinical boards, supporting the six goals urgent and emergency care agenda. The presentation has been added to this covering paper as supporting information.

A number of additional schemes have also been proposed which will help either close the potential bed gap or act as a critical enabler to ensure the UHB is able to achieve its key priorities. This approach and the schemes which are encompassed will need approval from the UHB Senior Leadership Board.

A summary of those schemes which have been developed to address the pressure within the acute bed base is provided in Table 2.

Table 2. Actions to Deliver Winter Plan 2023-2024

No.	Scheme	Clinical Board	Summary	Beds/Bed Equiv.	Winter Mths	Start	23/24 (£'000)	Delivery RAG
1	**EU Redesign**	Medicine	Revised footprint across EU to include develop on a xx space clinical decision unit	8	5	Nov-23	£417	
2	**Acute Beds**	Med/Surgery	Acute Winter beds - UHL (Medicine 24) UHW (Medicine - supported by Sugery 19)	43	3/5	Nov 23/Jan 24	£700	
3	**Medical SDEC**	Medicine	Increase operating hours for medical SDEC to further allievate inappropriate admissions	-	6	Oct-23	-	
4	**ICAU - (Nursing Home)**	Specialist	Increased ICAU beds if needed by 13 beds	13	3	Jan-24	£250	
5	**Critical care**	Specialist	Increase capacity in critical care by three beds / further enhance PART	6	5	Nov-23	-	
6	**Develop short stay area for trauma**	Surgery	Enhance short stay area for trauma patients to support increased trauma activity both general and MTC		5	Nov-23	-	
7	**Extend virtual ward pathways**	Surgery/Medicine	Enhance the virtual ward pathways in both surgery and medicine linked to SDEC models		4	Dec-23	-	
8	**Virtual Ward**	Medicine/Surgery	Extend virtual ward opportunities		5	Nov-23	-	
9	**Protect Elective Surgery for Children**	Children and Women	Use planned care recovery resource from WG to ringfence capacity and deliver stable levels of paediatric operations throughout the winter months		6	Oct-23	-	
10	**Trusted Assessors**	IDS/LA	Develop plans to introduce trusted assessors in hospital setting		4	Dec-23	-	
11	**Super stranded patients**	Operations	Clinical board/IDS and Ops work on implementation plan to reduce LOS in key specialities	26	4	Dec-23	-	
12	**10% reduction in Green patients**	IDS/LA	IDS and LA team develop and implement plan to reduce green POCD by 10%	10	3	Jan-24		
13	**UPPC coverage**	PCIC	100% coverage and improved utilisation for UPCCs		5	Nov-23		
14	**Safe @ Home**	PCIC/Social	First step to create crisis MDT team to support alternatives to EU attendances and admissions		3	Jan-24	-	
15	**Patient Flow & Site support**	Patient Flow Team	Transport and staffing costs to boost resources and support processes through winter		4	Dec-23	£100	
16	**Health Inclusion service**	PCIC	Expand inclusion service for people who struggle to access health services within our communities	2	6	Oct-23	£100	
			Total Beds	**108**			**£1,567**	

Finance

The indicative costs have been developed in conjunction with the finance team with further work underway with Clinical Boards and their business partners. The work is being overseen by the Director of Operations for Six Goals and the Deputy Director of Finance. Over the next few weeks, through the operational planning group, a more detailed costings will be signed off operationally, however the funding available will need to sit within the £1.5m reserve. As detailed in Table 2, some schemes are already funded or are being absorbed within the clinical boards, others are requested for recurrent funding as previously noted.

As part of the ongoing work, there will be an assessment of released resources through the bed reduction programme to cost re-opening of beds. There is clarity that the organisation cannot resource additional beds over and above the resources released as part of the savings plan and clinical boards will need to ensure services are delivered accordingly.

Conclusion

The Health Board and its partners recognise the challenges facing the health system through winter months. It is critical that we plan and implement schemes that can in part mitigate these pressures. This paper, and the associated winter planning slides, outlines the pressures and the schemes that we believe will mitigate these to keep our population safe. Finally, it sets out the aim to integrate winter planning into our annual planning cycle ensuring consistency and clarity of approach and delivery. In order to facilitate this the recurrent allocation of the winter reserve is requested. Key issues and recommendations are laid out below

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

Significant system wider pressure presents an unprecedented challenge for the UHB winter plan:

1. Winter planning has commenced in conjunction with our partner organisations
2. There is ongoing uncertainty as to the impact of a number of variables including covid, respiratory viruses, workforce pressure and industrial action
3. The UHB estimates a potential capacity gap of 90 beds, peaking in January 24
4. A number of actions have been implemented, with more proposed, across Health and Social Care to mitigate the winter pressures
5. The actions have been agreed through the Operational Delivery Group
6. The total cost of is **£1.57m** which can be off-set against the health board winter reserve.
7. There is no expectation of additional central funding for winter pressures
8. Senior Leadership Board has recommended that the operational and financial teams progress with the winter plan as described, subsequent is agreeing the correct mechanism for the recurrent allocation approach

Recommendation:

Board are asked to:

- **NOTE** the UHB Winter Plan 23/24.
- **APPROVE** a revised approach to seasonal planning, including the recurrent allocation of the £1.5m winter reserve

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	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		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:	
Senior Leadership Board	7th September 2023
Finance Committee	20th September 2023
Board	28th September 2023

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

Winter Plan 2023-2024

Board

28th September 2023

INTRODUCTION

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Cardiff and Vale University Health Board

Each year the UHB delivers a winter plan to strengthen our services in this challenging period. We would like to….

Scene Setting	Demand Challenges	The last year	Proposals
What are our operational priorities What are the key factors impacting on winter	What is our bed gap based on our modelling. What is the pressure facing our emergency unit.	What have we done in the last year that we need to celebrate. How has it impacted on patient care and delivered a better quality service	What are we proposing to do this winter to help with the challenges we will face

Scene Setting

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Cardiff and Vale University Health Board

Operational Priorities

Urgent & Emergency	Cancer	Planned Care	Mental Health	Critical Care
Primary & Community Care Acute Medicine & Frailty Model SDEC Models Protect Tertiary Services and MTC	Focus on backlog in pathways (>62 days) Focus on bottlenecks e.g. diagnostics Specific tumour site improvements	All but eliminate two year waits Reduce children long waits	Managing pressures in inpatient services Community demand in CYP and adults	Paediatric Intensive Care Adult Intensive Care Neonates

Scene Setting

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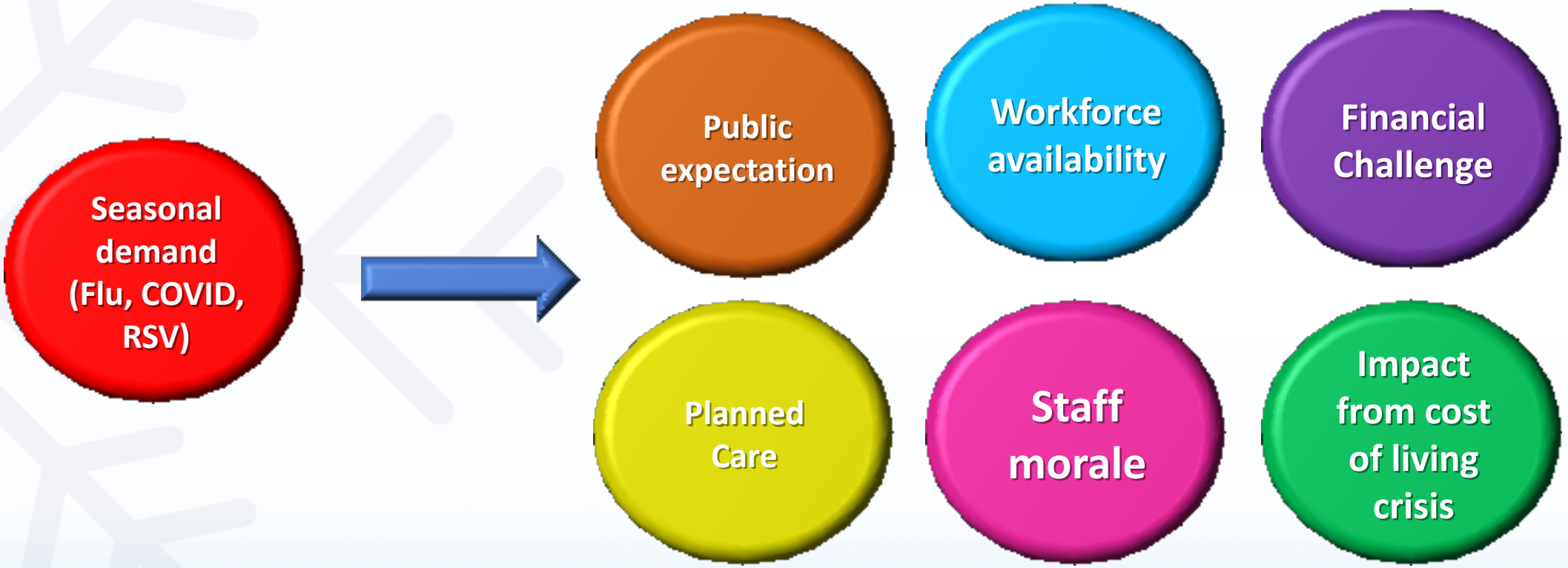
Key Factors impacting on Winter



The key factors that influence patient safety, quality and experience

Seasonal Demand Challenges & Assumptions

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Cardiff and Vale University Health Board

Bed Gap

Cardiff & Vale Projected Gap (Excluding Mental Health)

Clinical Board	Year	Scenario	Nov	Dec	Jan	Feb	Mar	Apr
Medicine	2022-2023	Predicted Worse case	114	120	152	147	148	137
	2023-2024	Predicted Worse case	**56**	**67**	**90**	**82**	**76**	**56**

Critical Care

5% busier with a peak in Jan '23

-6 bed gap

Emergency Unit Attendances

The emergency unit attendance will remain relatively stable

The seasonal bed capacity gap this year has reduced when comparing with last years figures. The next slides will highlight the service improvements helping our position

What we have been working on?

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FRONT DOOR & ACUTE CARE

- Frailty area in UHW helping patients get home quicker
- Ringfenced our Acute Medicine Short Stay Unit
- Focus on reducing delayed ambulance handovers
- GPs talking directly to an acute physician for patients needing urgent care
- Creation of "virtual wards" where nurses and physicians monitor patients at home
- "Same day emergency care units- SDEC" for medicine and surgical patients
- Redesign our acute medicine model (90 bedded acute assessment and short stay unit)
- Moved out site hub into the emergency unit to support joint working and flow

What we have been working on?

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Cardiff and Vale University Health Board

LOCAL AUTHORITY, HOSPITAL AND COMMUNITY (PARTNERSHIP WORKING)

- Opened sixty seven integrated assessment care beds (LAKESIDE)
- Building relationships between partners (LA / IDS teams)
- Working with local authorities increasing spot placement beds
- Focus on understanding delays for patients in hospital
- Creating additional out of hospital support through our community teams (CRT/VCRS)
- Increase therapies support to help re-able patients in our community beds
- Discharge to recover and assess with rapid response domiciliary care
- Further development of trusted assessors over wide range of areas to speed up assessment

What we have been working on?

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Cardiff and Vale University Health Board

PRIMARY & INTERMEDIATE CARE AND MENTAL HEALTH

- Urgent care centres now covering 76% of our population
- CAV 24/7 seeing over 3000 patients face to face monthly
- GPs working together to support our most vulnerable patients in the community
- Setting up a service for patients to call with mental health concerns (111-2)
- Mental health crisis teams working closely with third sector
- Mental Health Matters – Supporting early discharge for our older people
- Protecting our population and our staff through immunisation

What's the impact been?

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Cardiff and Vale University Health Board

FRONT DOOR & ACUTE CARE

	Ambulance (Lost Hours per day)	SDEC (Patients see per day)		Frailty (Discharge)	Acute Medicine (A1 LOS)	Virtual Ward (Patients looked after at home)
Last Year	98 hours	8	22	3 – 4 Extra discharges per day	5-6	40
This Year	20 hours	25	37		3-4	
		Medical	Surgery			

What's the impact been?

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Cardiff and Vale University Health Board

PRIMARY AND COMMUNTIY CARE / MENTAL HEALTH / PLANNED CARE

	Clinically Optimised	Planned Care Long Waits (Patients waiting over 2 years)	Cancer (Patients waiting over 62 days)	Urgent Primary Care (Daily appointments available)	Mental Health 111-2 (Calls per week)
Last Year	291	9000	712	118	130
This Year	329	4000	225	214	
	100				
	229				

Proposals to address the challenge

Clinical Boards	Proposals	Beds	£'000
Medicine	The emergency unit redesign for adults and children	8	416
	Acute winter beds: UHW C5 - 19 UHL - 24	43	700
	Extend opening hours in medicine SDEC		
Specialist Services	Additional integrated assessment Care Beds (LAKESIDE)	13	250
	Critical care action plan to combat demand with outreach services running 24/7	3	
	Three commissioned critical care beds from Nov '23	3	
	Focus on critical care delayed transfer of care patients		
Surgery	Develop short-stay and SDEC trauma pathway		
	Further develop virtual ward model & direct pathways from WAST		
Children	Protected elective surgery unit for children		
Site Services	Additional site support to enhance flow		100

Proposals to address the challenge

Clinical Boards & Partners	Proposals	Beds	£'000
Local Authority & Integrated Discharge Services	Further develop trusted assessors to support secondary care		
	Super stranded patient review (1% equates to 13 beds)	26	
	10% reduction in pathway of care delays (Joint work with LA partners)	10	
	Caring for patients in the right area that meets there needs		
Primary and Community Care & Local Authority	Cardiff and Vale will aim to have 100% coverage for urgent primary care		
	Safer @ home – Partnership working to keep people at home		
	Health Inclusion service	2	100
Mental Health	"Bed-in" 111 press 2		
	Dedicated help for frequent callers ringing 111-2		
	Total	108	1,566

STAFF WELLBEING

Employee Wellbeing Support Pathway

PEOPLE HEALTH & WELLBEING SERVICE
Occupational Health
Occupational Physiotherapy
Employee Wellbeing
Health Intervention

How am I feeling?	What might help me?

I feel well and want to stay emotionally healthy

Free online resources
- Mind UK: www.mind.org.uk
- Dewis Cymru: www.dewis.wales
- Centre for Clinical Interventions: www.cci.health.wa.gov.au

Wellbeing apps
- Headspace
- Unmind
- Calm
- Worry Tree

Wellness initiatives
- Doing Our Bit: doingourbit.org.uk
- Reading Well: reading-well.org.uk

I am beginning to struggle with my emotional wellbeing

- Chat with your line manager or a wellbeing champion in your team

Free courses
- EWS workshops: sign up on Eventbrite and follow us on Twitter @EWS_CAVUHB to hear about upcoming workshops
- Recovery College courses: www.recoverycollegeonline.co.uk
- Stepiau courses: www.stepiau.org
- Silver Cloud: nhswales.silvercloudhealth.com

I am struggling with my emotional wellbeing

Self-refer to
- Employee Wellbeing Service: Email:employee.wellbeing@wales.nhs.uk Call: 02921 844 465
- Canopi: canopi.nhs.wales
- Contact your GP

Workplace advice and support
- Remploy: www.remploy.co.uk
- ACAS: www.acas.org.uk
- HSE: www.hse.gov.uk/stress
- Health and Safety policies
- Trade Unions

I am really struggling with my emotional wellbeing

In crisis?
- Call Samaritans on 116 123
- Text 'SHOUT' to 85258 for the Crisis Text Line
- Contact your GP or NHS out of hours service by calling 111

Keeping yourself safe
- Staying Safe website: stayingsafe.net
- #StayAlive app: www.stayalive.app

How can I support others?

- 'CAV a coffee' with a colleague
- Train to become a 'Wellbeing Champion'
- End of shift check ins
- Comerados: www.camerados.org
- Contact EWS for support on your ward/department
- Suicide Awareness Training: www.zerosuicidealliance.com
- Mindful employer

Financial Wellbeing and support with the cost of living

A financial wellbeing pathway, including links and signposting, can be found on the CAV internet: Employee Wellbeing Service - Cardiff and Vale University Health Board (nhs.wales) This includes:

Information on Staff Benefits: Staff Benefits - Cardiff and Vale University Health Board (nhs.wales)

The Credit Union offers savings accounts and affordable loans to anyone living in Cardiff or the Vale of Glamorgan or working anywhere in Wales: Cardiff & Vale Credit Union | Home (cardiffcu.com)

Free courses and advice on budgeting and support available via: Free and impartial help with money, backed by the government | MoneyHelper

Find out if you are accessing all you are entitled to: Benefits - Citizens Advice

If you are a member of a trade union, help may also be available to you in the form of a grant.

HOW WE COMMUNICATE

Joanne Brandon, Director of Communications

COMMUNICATIONS AND ENGAGEMENT WINTER PLANNING 2023/4

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Cardiff and Vale University Health Board

SEP	OCT	NOV	DEC	JAN	FEB	MAR
Winter Awareness Raising Student Campaign (Put your health First) Flu Primary Choice Help us to Help You	Student Campaign (Put your health First) Seasonal Flu Primary Choice Roadshows Student (Phase 2 - Tinder) Healthcare Services in the Community	Seasonal Flu / Immunisation Keeping winter well Primary Choice - Healthcare Services in the Community Media engagement - winter packages Mental Health Recovery College	Seasonal Messaging and Night Time Economy Awareness Flu / Immunisation Keeping winter well Primary Choice - Healthcare Services in the Community Recovery College / NHS 111 Press 2	Intensified communications in relation to peak period	Primary Choice – Healthcare Replenishing medicine cabinet / over the counter medication Services in the Community NHS 111 Press 2	Primary Choice – Healthcare Help us to Help You Services in the Community
Operational Pressures	Minor Injuries Out of Hours Urgent Care / GP Service	Service Disruption due to adverse weather Outbreak of infectious diseases Patient Flow / Capacity	Service disruption due to adverse weather Patient Flow / Capacity EU & Critical Care Pressures Outbreak of infectious diseases Personal Safety Seasonal Messaging around the holidays and events e.g. Black Friday Night time Economy	Service Disruption due to adverse weather Patient Flow / Capacity EU & Critical Care Pressures Outbreak of infectious diseases Increased paediatric demand leading to delays in assessment and admission	Service Disruption due to adverse weather Demand on Ambulatory Services	Service Disruption due to adverse weather

COMMUNICATIONS AND ENGAGEMENT WINTER PLANNING 2023/4

GIG CYMRU NHS WALES
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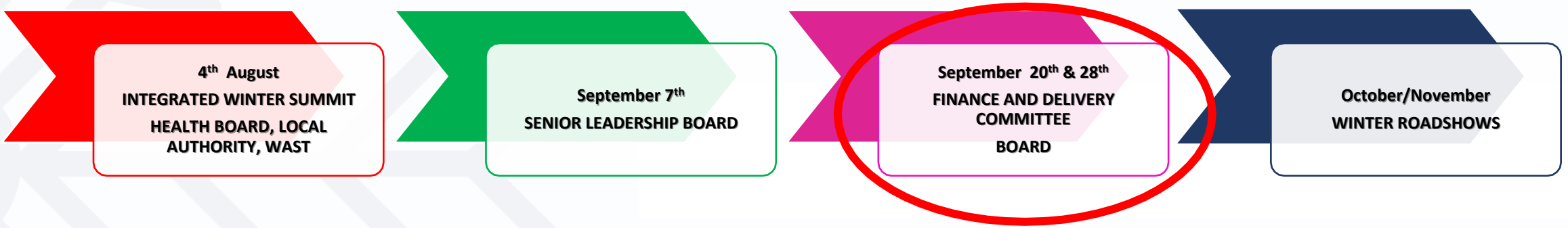
Cardiff and Vale University Health Board

Internal Communications	Stakeholder Communications	External Communications & Campaigns	Proactive Communications
Ask Suzanne Winter Communications Toolkit Personalised Messaging via Sharepoint CAV Connects Roadshows Screensavers Social Media	Stakeholder Briefings Political Briefing Chief Executive Connects Senior Leadership Board Local Partnership Forum Individual Stakeholder Meetings	Public Health Winter Prevention & Safety Messaging Winter Vaccination & Immunisation Strategy	Media Roundtable BBC Saving Lives Individual Case Studies Ministerial / VIP Visits

NEXT STEPS

INTERNAL TIMELINE



- Support from Senior Leadership Board
- Further co-production to solidify plans with all stakeholders through weekly operational meetings
- Firm up dates with Local Partnership Forum
- Sign-off approach and utilisation of Winter reserve through Finance and Performance committee (20th September 2023)
- Share and sign-off through Board (28th September 2023)
- Undertake series of Roadshows both within organisation and with partners to socialise plan

Report Title:	Tissue and Organ Donation Annual Report			Agenda Item no.	7.2
Meeting:	UHB Board	Public	X	Meeting Date:	28 Sept 2023
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Meriel Jenney				
Report Author (Title):	Richard Skone				

Main Report
Background and current situation:

Organ donation saves and enhances lives but is complex to coordinate and highly emotive. NHS Blood and Transplant (NHSBT) are responsible for auditing organ donation and transplant outcomes and produce an annual report for both deceased and live organ donation. The annual reports for 2022-23 that C&V are referring 100% of potential Donation after Brain Death (DBD) patients, and 92% of Donation after Cardiac Death (DCD) patients.

During 2022-23 there were 25 proceeding deceased organ donors in UHW (19 previous year), producing lifesaving transplants for 51 patients. A further 6 patients consented for organ donation but did not proceed (2 DBD, and 4 DCD).

There were also 41 live kidney donor transplants performed in the Cardiff Transplant Unit (29 previous year) including several via the UK Kidney Sharing Scheme. This is the highest number of live donor transplants ever performed in Cardiff.

The live donor report shows that Cardiff Transplant Unit has again achieved the highest rate of pre-emptive live donor transplants in the UK. Pre-emptive (meaning before dialysis) live donor transplantation offers the very best outcomes for patients with advanced kidney disease.

UHW is a level one centre for organ donation (12 or more proceeding donors per year). The NHSBT detailed report shows the Health Board is performing ‘exceptionally’ in the referral of potential donors to the Specialist Nurses for Organ Donation (SNODs). Other comparative data is within the benchmark UK range for measured parameters. The greatest room for improvement is the SNOD presence when families are first approached. This is the only parameter in the amber category (below average), but still within the funnel plot.

Paediatric numbers for organ donation are smaller (reflecting a national picture) with only 1 DBD and 1 DCD case for this time frame. However, a referral rate of 98% DBD and 88% DCD demonstrates that the department is actively offering organ donation appropriately.

The Cardiff Organ Retrieval Team are one of only 4 teams in the UK capable of performing an innovative organ retrieval technique called Normothermic Regional Perfusion (NRP). We also retrieve Livers on behalf of another transplant centre so that NRP can be used for Liver transplants. This technique has been shown to significantly improve outcomes for the recipients of the retrieved organs and is likely to become the standard technique in the future, but requires additional training for the surgeons and theatre team and also new equipment. Cardiff are now well positioned to help train other UK units as this technology rolls out across the rest of the country.

The Cardiff Transplant Unit were the first UK transplant unit to transplant organs from hepatitis C positive organ donors into hep C negative recipients. This programme continues and Cardiff and Vale remain UK leaders in this field. This has required strong collaborative working between the transplant team, infectious diseases and virology teams, and specialist pharmacists. This approach now accounts for 7% of the deceased donor transplant numbers in Cardiff.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:
Cardiff is providing a UK leading organ donation and transplantation service. Overall numbers of donor and transplants have increased, and the unit is a positive outlier in respect of the live donor programme.

Recommendation:
The Board / Committee are requested to: **Note the 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	
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	X

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: 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:

NHS Blood and Transplant

Tissue Donation Report

April 2022 – February 2023

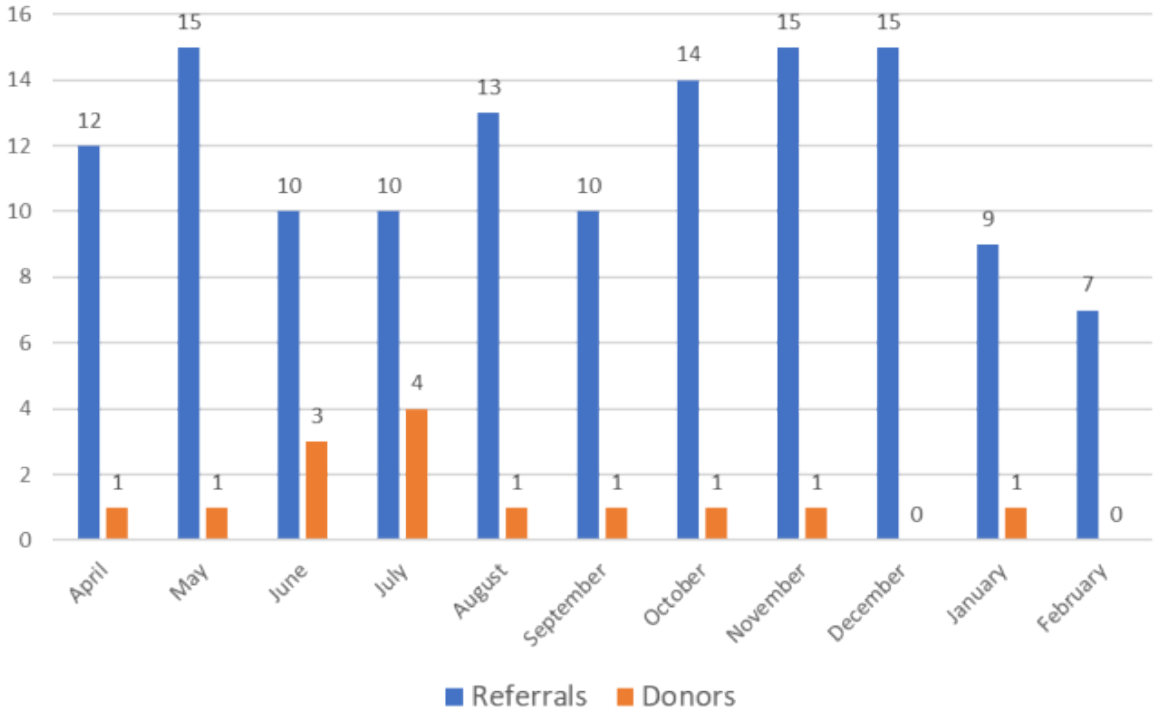
University Hospital of Wales

Marion Jones RN, QN

Regional Tissue Donation Nurse Specialist

UHW April 2022 – February 2023

NHS Blood and Transplant



NHS
Blood and Transplant

Activity

Total Referrals	130
Total Donors	14 11 eye donors = 22 corneas 3 heart valve donors
Overall conversion rate % (KPI 10%)	11%

Please note: 1 cornea has the potential to help up to 5 individuals

Update

- Increase in referrals noted from SNOD colleagues
- Alliance site on hold, NHSBT- TES not proceeding with Alliance sites at present
- Stoke referral model discussed with SNOD team and NHSBT OTDT Together team – ruled out due to SNOD capacity. (MJ not informed or involved in discussions, later informed by NHSBT Sue Duncalf)
- Continue with traditional telephone referrals or referrals via SNOD team. Availability of pre-emptive information leaflets important – SNOD team aware of where to access these, if not, please contact MJ
- For your information - The role of the Regional Tissue Donation Specialist Nurse has changed slightly and whilst I continue to provide a point of contact for hospitals and will continue to provide a report for the committee, my time now is focused working with hospices

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2022 - 31 March 2023

Cardiff And Vale University Health Board

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Health Board metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record. Issued May 2023 based on data meeting PDA criteria reported at 9 May 2023.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2022 and 31 March 2023, Cardiff And Vale University Health Board had 25 deceased solid organ donors, resulting in 51 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2021/22. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

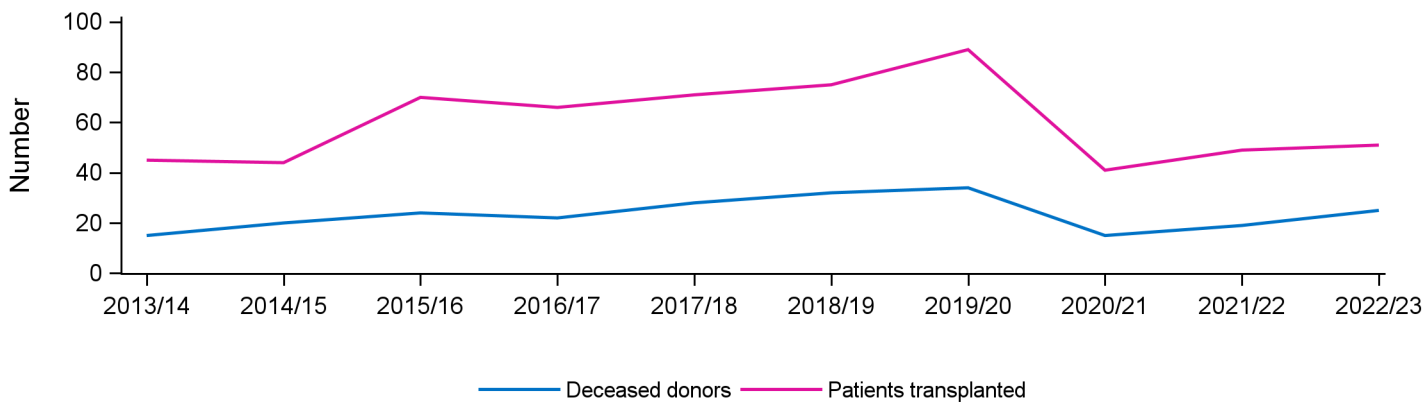
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Health Board		UK	
DBD	14	(12)	32	(36)	2.7	(3.7)	3.5	(3.4)
DCD	11	(7)	19	(13)	2.5	(2.9)	2.9	(2.7)
DBD and DCD	25	(19)	51	(49)	2.6	(3.4)	3.2	(3.1)

In addition to the 25 proceeding donors there were 6 additional consented donors that did not proceed, 2 where DBD organ donation was being facilitated and 4 where DCD organ donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	24	(21)	1	(1)	8	(12)	0	(3)	0	(2)	0	(2)
DCD	15	(12)	0	(1)	4	(1)	2	(0)	0	(0)	0	(0)
DBD and DCD	39	(33)	1	(2)	12	(13)	2	(3)	0	(2)	0	(2)

Figure 1.1 Number of donors and patients transplanted, 1 April 2013 - 31 March 2023



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for Cardiff And Vale University Health Board.

Performance in your Health Board has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2022/23 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2022 - 31 March 2023

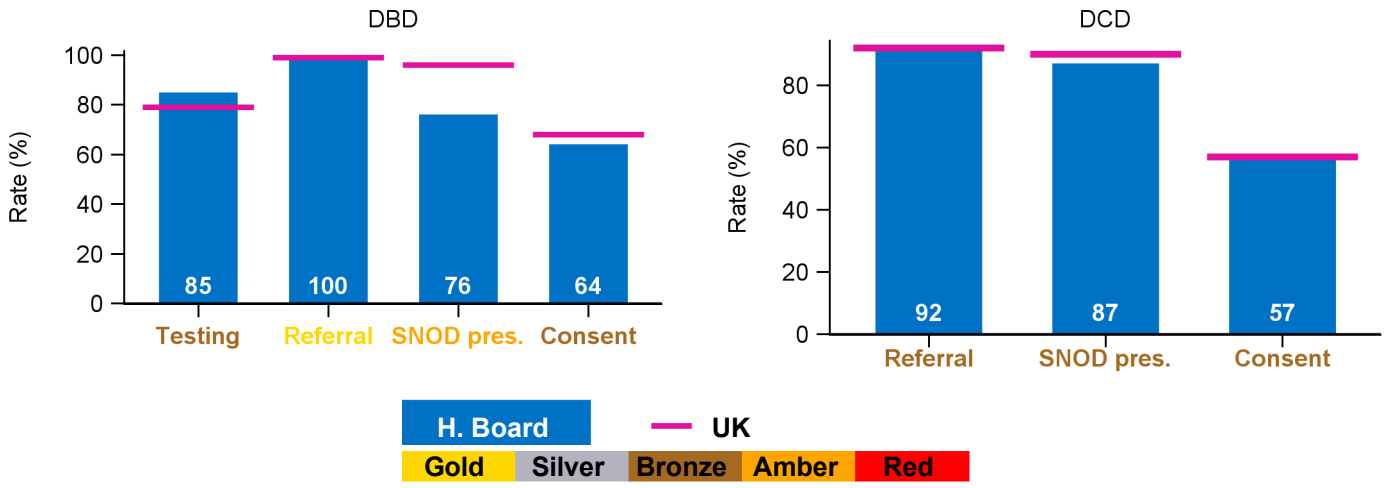


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2018 - 31 March 2023

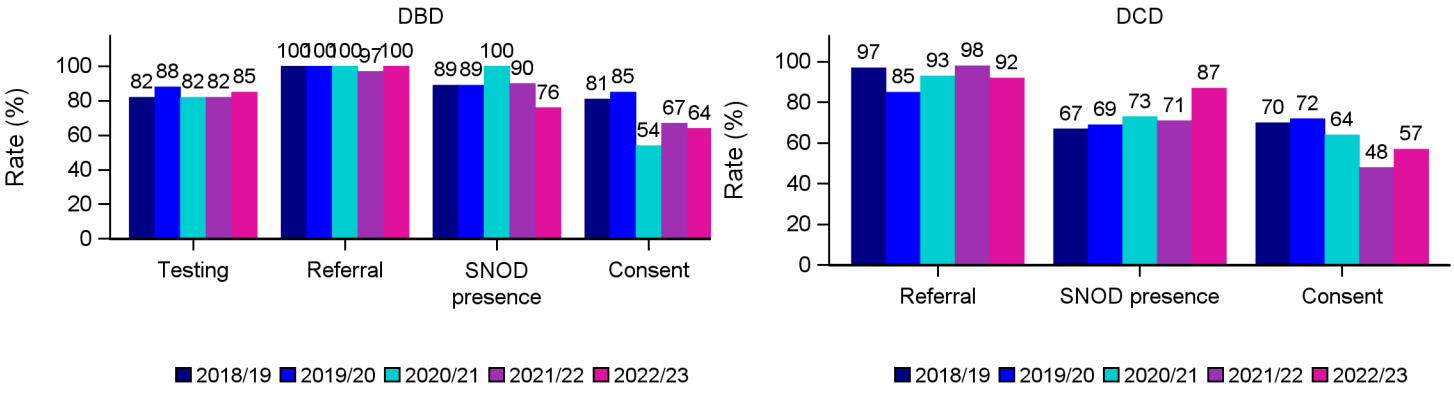


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	33	1980	71	5307	99	6910
Referred to Organ Donation Service	33	1965	65	4886	93	6482
Referral rate %	G *100%*	*99%*	B *92%*	*92%*	B *94%*	*94%*
Neurological death tested	28	1556				
Testing rate %	B *85%*	*79%*				
Eligible donors[2]	27	1439	51	3467	78	4906
Family approached	25	1244	23	1691	48	2935
Family approached and SNOD present	19	1190	20	1526	39	2716
% of approaches where SNOD present	A *76%*	*96%*	B *87%*	*90%*	B *81%*	*93%*
Consent ascertained	16	846	13	959	29	1805
Consent rate %	B *64%*	*68%*	B *57%*	*57%*	B *60%*	*61%*
- Expressed opt in	10	476	10	578	20	1054
- Expressed opt in %	*100%*	*95%*	*83%*	*84%*	*91%*	*89%*
- Deemed Consent	5	284	3	306	8	590
- Deemed Consent %	*63%*	*63%*	*43%*	*52%*	*53%*	*57%*
- Other*	1	86	0	74	1	160
- Other %*	*33%*	*60%*	*N/A*	*38%*	*33%*	*47%*
Actual donors (PDA data)	14	783	11	636	25	1419
% of consented donors that became actual donors	*88%*	*93%*	*85%*	*66%*	*86%*	*79%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Health Board at the key stages of organ donation. The ambition is that your Health Board misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2018 - 31 March 2023

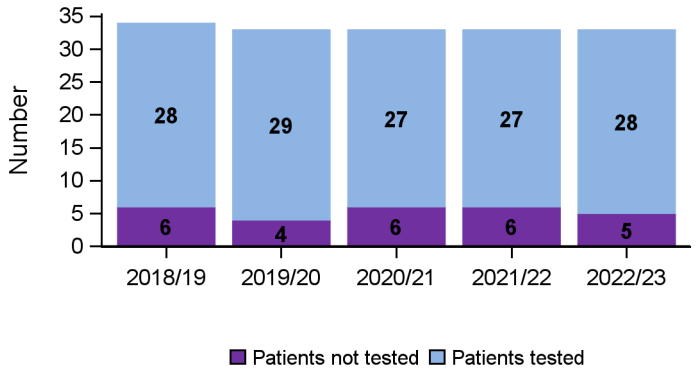


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2022 - 31 March 2023

	Health Board	UK
Biochemical/endocrine abnormality	-	29
Clinical reason/Clinician's decision	-	62
Continuing effects of sedatives	-	6
Family declined donation	-	28
Family pressure not to test	1	48
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	43
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	4	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	8
Treatment withdrawn	-	18
Unknown	-	3
Total	**5**	**424**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2018 - 31 March 2023

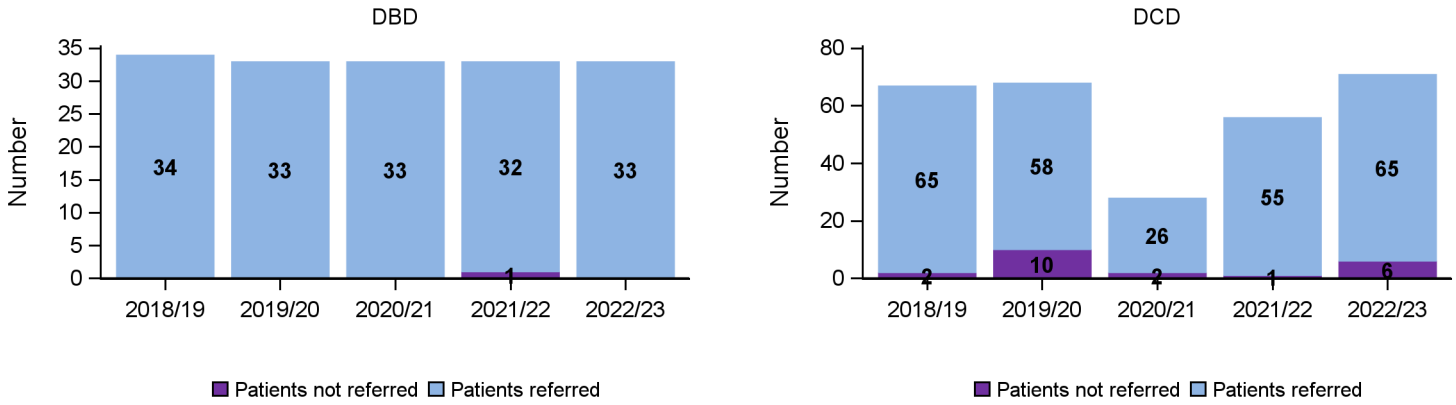


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Family declined donation following decision to remove treatment	-	1	1	15
Family declined donation prior to neurological testing	-	1	-	1
Medical contraindications	-	-	-	28
Not identified as potential donor/organ donation not considered	-	6	3	271
Other	-	-	1	27
Patient had previously expressed a wish not to donate	-	-	1	3
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	1	-	2
Thought to be medically unsuitable	-	1	-	53
Uncontrolled death pre referral trigger	-	5	-	16
Total	**-**	**15**	**6**	**421**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2022/23 there were 12 potential donors in your Health Board with an ACI reported, 0 DBD and 12 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

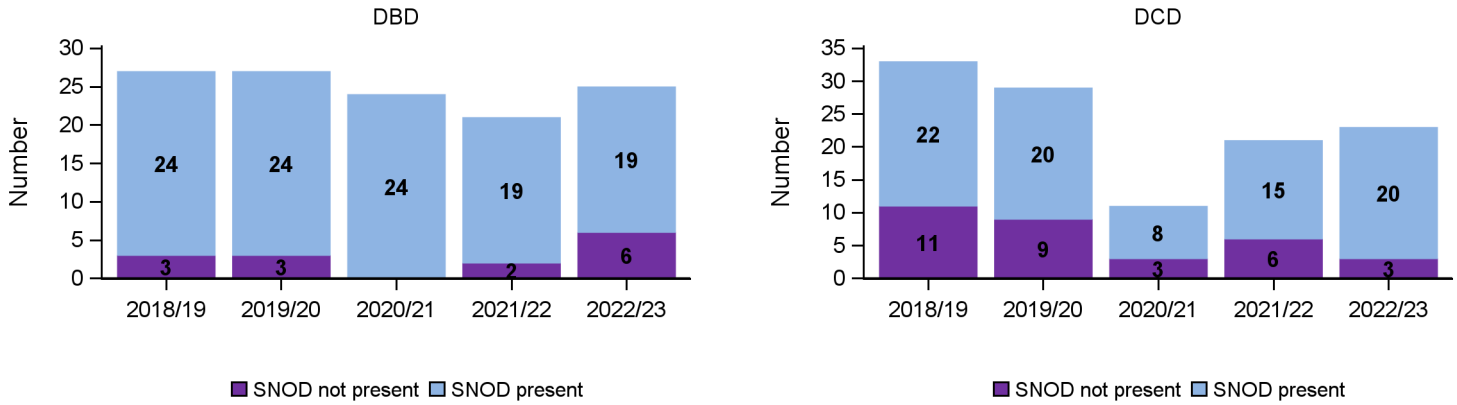
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2022/23, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 31% and 19%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 61%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2018 - 31 March 2023



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2023]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2023]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2023]

3.5 Consent

In 2022/23 the DBD and DCD consent rates in your Health Board were 64% and 57%, respectively.

Figure 3.4 Number of families approached, 1 April 2018 - 31 March 2023

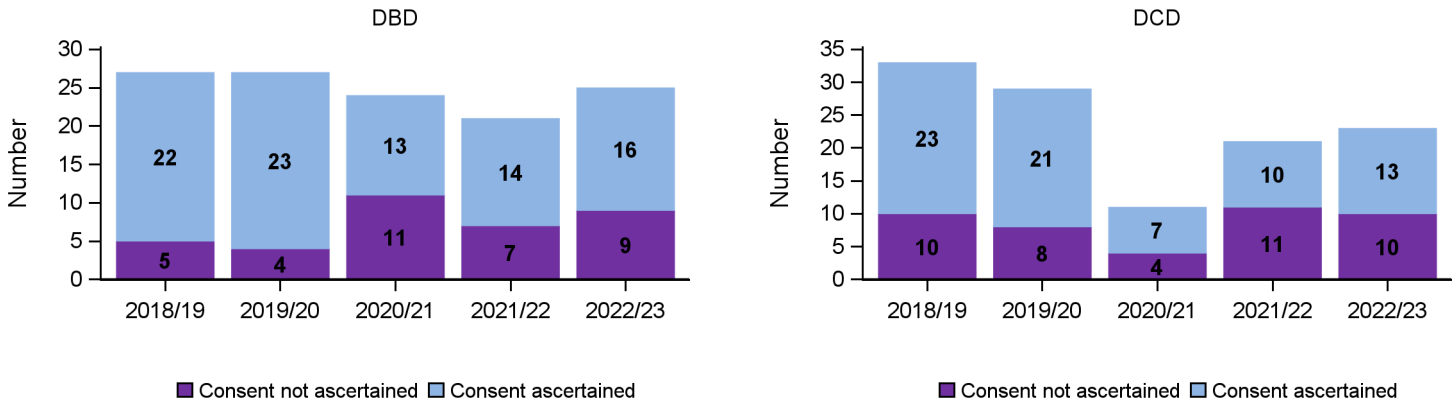


Table 3.3 Reasons given why consent was not ascertained, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Health Board	UK	Health Board	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	2	-	1
Family concerned other people may disapprove/be offended	-	1	-	2
Family concerned that organs may not be transplantable	-	1	-	7
Family did not believe in donation	-	4	-	12
Family did not want surgery to the body	1	38	-	51
Family divided over the decision	1	21	-	18
Family felt it was against their religious/cultural beliefs	-	40	-	24
Family felt patient had suffered enough	1	22	-	62
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	20	-	13
Family felt the length of time for the donation process was too long	-	17	1	126
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	2	2	16
Family were not sure whether the patient would have agreed to donation	2	44	2	90
Other	-	22	1	73
Patient had previously expressed a wish not to donate	2	121	1	175
Patient had registered a decision to Opt Out	2	22	3	31
Strong refusal - probing not appropriate	-	17	-	31
Total	**9**	**398**	**10**	**732**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinical - Absolute contraindication to organ donation	1	10	-	8
Clinical - Cardiac arrest during referral	-	2	-	-
Clinical - Considered high risk donor	-	7	-	8
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	6	1	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	10	-	51
Clinical - Organs deemed medically unsuitable on surgical inspection	1	7	-	3
Clinical - Other	-	3	-	10
Clinical - PTA post WLST	-	-	-	165
Clinical - Patient actively dying	-	4	-	19
Clinical - Patient asystolic	-	1	-	-
Clinical - Patient's general medical condition	-	2	-	3
Clinical - Positive virology	-	1	-	3
Clinical - Predicted PTA therefore not attended	-	-	-	3
Consent / Auth - Coroner/Procurator fiscal refusal	-	5	-	10
Consent / Auth - NOK withdraw consent / authorisation	-	5	1	24
Logistical - Other	-	-	-	3
Total	**2**	**63**	**2**	**323**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Health Board with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Health Board is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Health Board, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

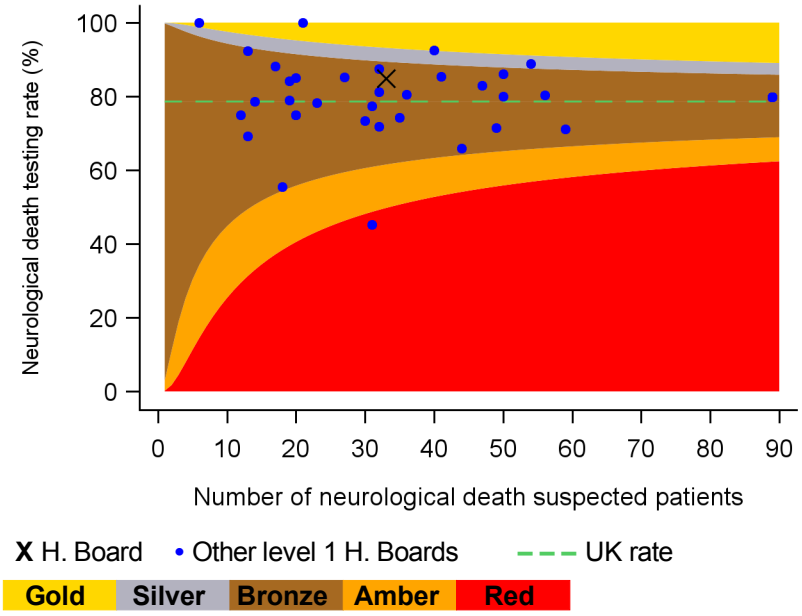
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 8.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2022 - 31 March 2023

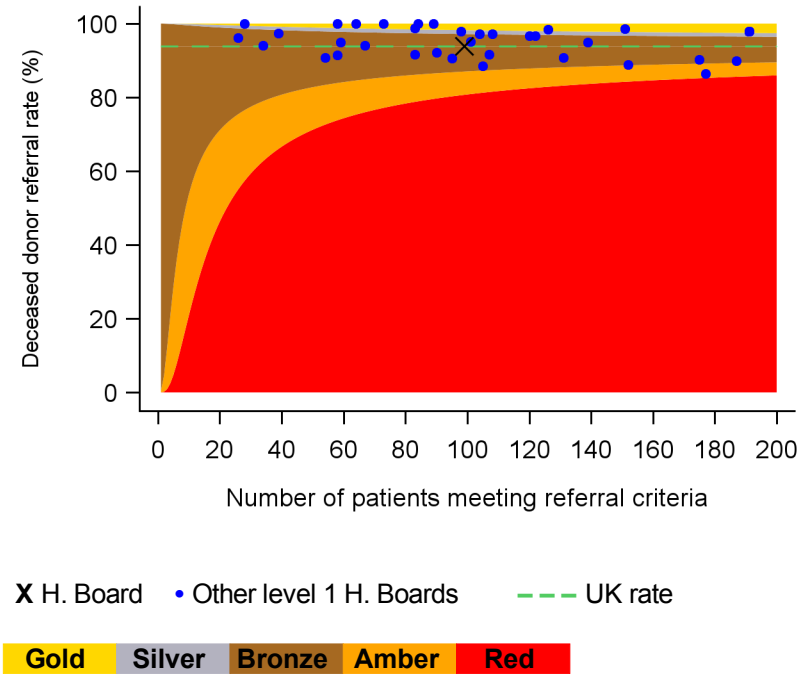


When compared with UK performance the neurological death testing rate in Cardiff And Vale University Health Board was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2022 - 31 March 2023

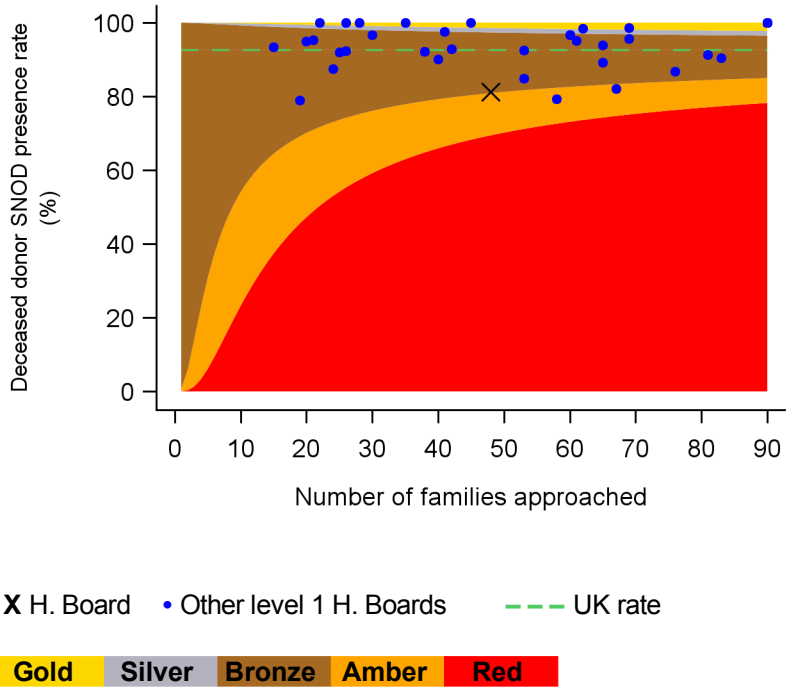


When compared with UK performance Cardiff And Vale University Health Board was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

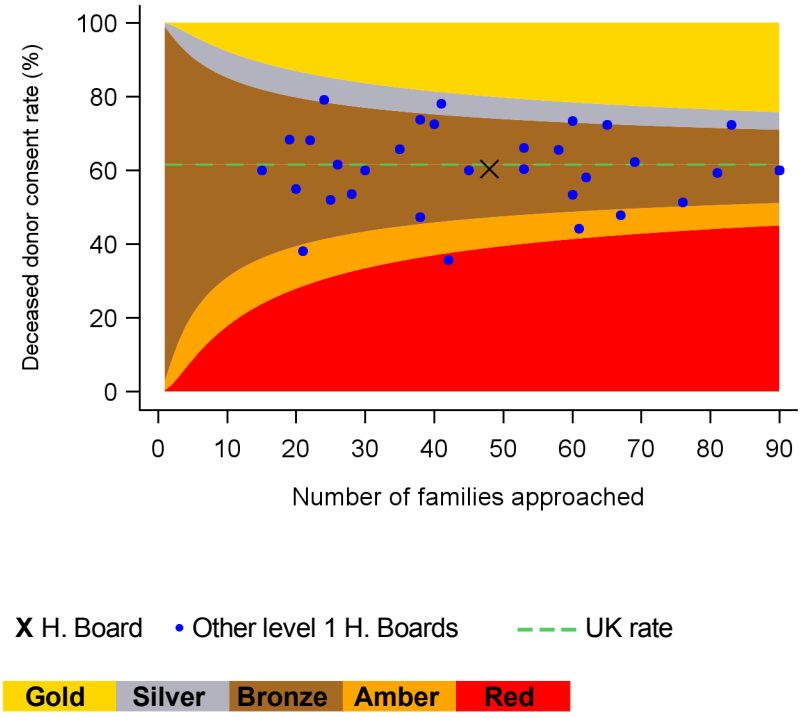
Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2022 - 31 March 2023



When compared with UK performance Cardiff And Vale University Health Board was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2022 - 31 March 2023



When compared with UK performance the consent rate in Cardiff And Vale University Health Board was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Cardiff, University Of Wales Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General/neuro ICU	32	27	84	32	100	26	26	24	19	79	16	67	14
ICU - paediatric	1	1	-	1	-	1	1	1	0	-	0	-	0
Other, please specify	0	0	-	0	-	0	0	0	0	-	0	-	0
Penarth, Llandough Hospital													
General ICU/HDU	0	0	-	0	-	0	0	0	0	-	0	-	0
Other, please specify	0	0	-	0	-	0	0	0	0	-	0	-	0

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Cardiff, University Of Wales Hospital											
A & E	8	3	-	8	7	0	0	-	0	-	0
General/neuro ICU	61	60	98	56	43	22	19	86	12	55	10
ICU - paediatric	1	1	-	1	0	0	0	-	0	-	0
Other, please specify	1	1	-	1	1	1	1	-	1	-	1
Penarth, Llandough Hospital											
General ICU/HDU	0	0	-	0	0	0	0	-	0	-	0
Other, please specify	0	0	-	0	0	0	0	-	0	-	0

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Cardiff And Vale University Health Board in 2022/23 there were 1 such patients. For more information regarding the Emergency Department please see Section 7.

6. Paediatric ICU data

A summary of key numbers for paediatric ICUs

Data in this section is obtained from the National Potential Donor Audit (PDA)

End of life care guidance and practice for paediatric patients does differ and care of the family unit as a whole is a core key principle. Paediatric Intensive Care Units (PICU) systems should never prevent families being offered the opportunity to donate if this is a possibility.

This section provides information on the quality of care for patients that died in your PICU at the key stages of organ donation. The ambition is that your PICU misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

6.1 Key numbers for the PICU

Table 6.1 PICU key numbers comparison with national rates, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	H. Board	UK	H. Board	UK	H. Board	UK
Patients meeting organ donation referral criteria[1]	1	88	1	219	2	270
Referred to Organ Donation Service	1	86	1	192	2	243
Referral rate %		*98%*		*88%*		*90%*
Neurological death tested	1	50				
Testing rate %		*57%*				
Eligible donors[2]	1	46	0	173	1	219
Family approached	1	35	0	54	1	89
Family approached and SNOD present	0	27	0	44	0	71
% of approaches where SNOD present		*77%*		*81%*		*80%*
Consent ascertained	0	20	0	17	0	37
Consent rate %		*57%*		*31%*		*42%*
Actual donors (PDA data)	0	19	0	13	0	32
% of consented donors that became actual donors		*95%*		*76%*		*86%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

6.2 Neurological death testing in the PICU

Goal: neurological death tests are performed wherever possible.

Figure 6.1 Number of patients with suspected neurological death in the PICU, 1 April 2018 - 31 March 2023

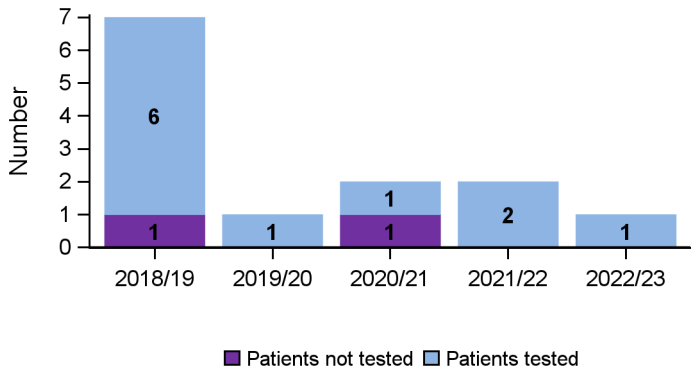


Table 6.2 Reasons given for neurological death tests not being performed in the PICU, 1 April 2022 - 31 March 2023

	Health Board	UK
Biochemical/endocrine abnormality	-	3
Clinical reason/Clinician's decision	-	5
Family declined donation	-	4
Family pressure not to test	-	11
Inability to test all reflexes	-	2
Other	-	4
Patient haemodynamically unstable	-	5
Treatment withdrawn	-	4
Total	**-**	**38**

If 'other', please contact your local SNOD or CLOD for more information, if required.

6.3 Referral to Organ Donation Service in the PICU

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 6.2 Number of patients meeting referral criteria in the PICU, 1 April 2018 - 31 March 2023

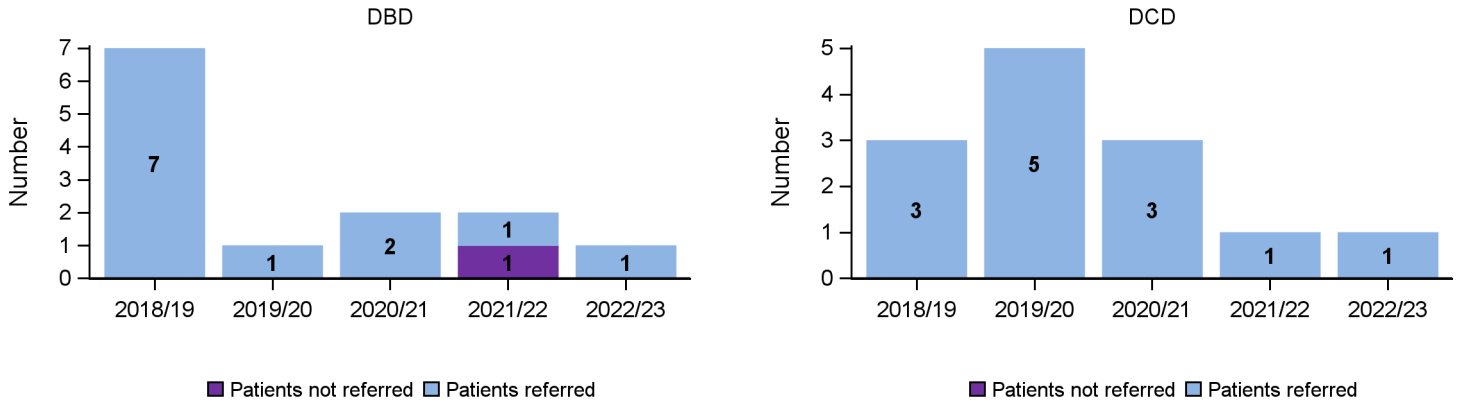


Table 6.3 Reasons given why patient not referred to Organ Donation Service in the PICU, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Health Board	UK	Health Board	UK
Family declined donation following decision to remove treatment	-	1	-	1
Medical contraindications	-	-	-	1
Not identified as potential donor/organ donation not considered	-	1	-	17
Other	-	-	-	2
Thought to be medically unsuitable	-	-	-	4
Uncontrolled death pre referral trigger	-	-	-	2
Total	**-**	**2**	**-**	**27**

If 'other', please contact your local SNOD or CLOD for more information, if required.

6.4 Contraindications in the PICU

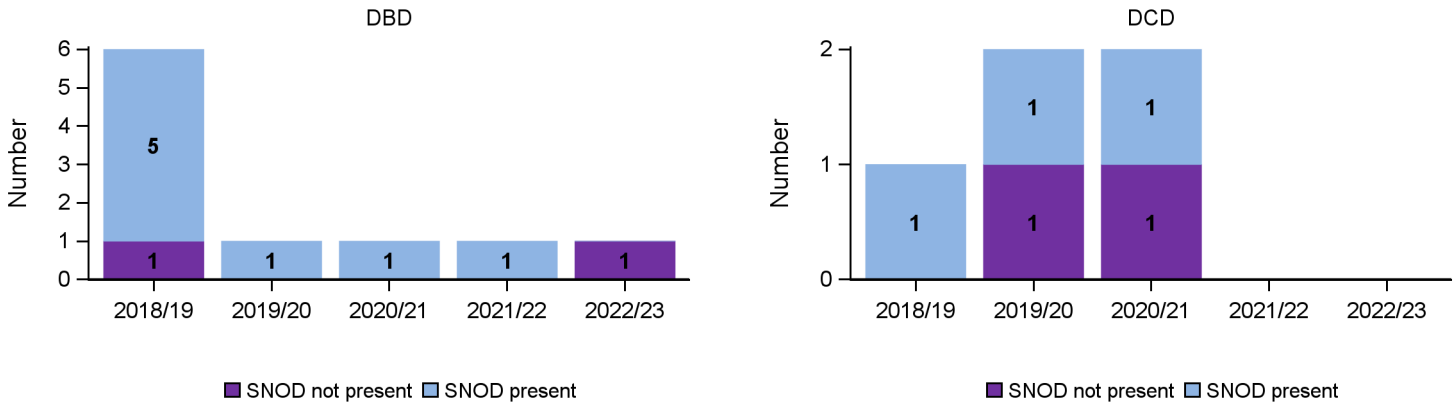
In 2022/23 there was 1 potential donor in your Health Board with an ACI reported, 0 DBD and 1 DCD donor. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

6.5 SNOD presence for patients in the PICU

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

Figure 6.3 Number of families of PICU patients approached by SNOD presence, 1 April 2018 - 31 March 2023



6.6 Consent for patients in the PICU

In 2022/23 less than 10 families of eligible donors, facilitated in the PICU, were approached to discuss organ donation in your Health Board therefore consent rates are not presented.

Figure 6.4 Number of families of PICU patients approached, 1 April 2018 - 31 March 2023

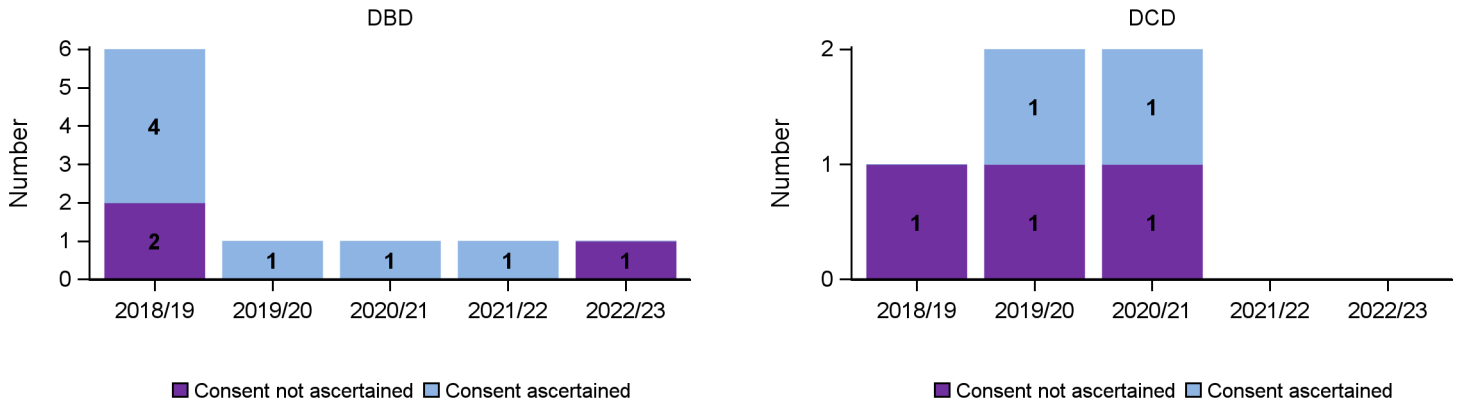


Table 6.5 Reasons given why consent was not ascertained for PICU patients, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Health Board	UK	Health Board	UK
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family did not believe in donation	-	2	-	2
Family did not want surgery to the body	-	-	-	3
Family felt it was against their religious/cultural beliefs	-	-	-	4
Family felt patient had suffered enough	1	2	-	5
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	2	-	1
Family felt the length of time for the donation process was too long	-	-	-	4
Family had difficulty understanding/accepting neurological testing	-	1	-	-
Family wanted to stay with the patient after death	-	-	-	5
Family were not sure whether the patient would have agreed to donation	-	-	-	1
Other	-	3	-	6
Patient had previously expressed a wish not to donate	-	2	-	-
Patient had registered a decision to Opt Out	-	-	-	1
Strong refusal - probing not appropriate	-	2	-	5
Total	**1**	**15**	**-**	**37**

If 'other', please contact your local SNOD or CLOD for more information, if required.

6.7 Solid organ donation in the PICU

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 6.6 Reasons why solid organ donation did not occur in the PICU, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Health Board	UK	Health Board	UK
Clinical - Organs deemed medically unsuitable by recipient centres	-	-	-	1
Clinical - PTA post WLST	-	-	-	2
Consent / Auth - NOK withdraw consent / authorisation	-	1	-	1
Total	**-**	**1**	**-**	**4**

If 'other', please contact your local SNOD or CLOD for more information, if required.

7. Emergency Department data

A summary of key numbers for Emergency Departments

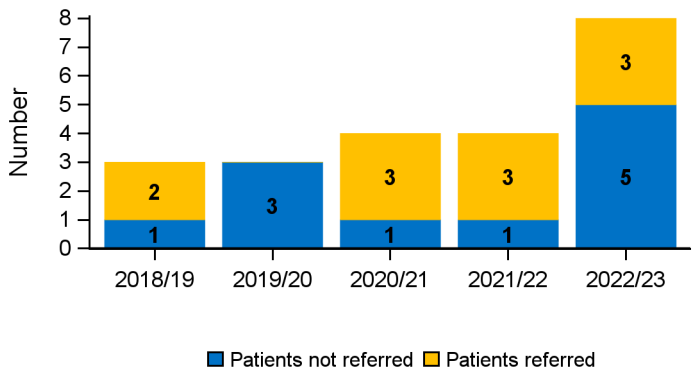
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

7.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

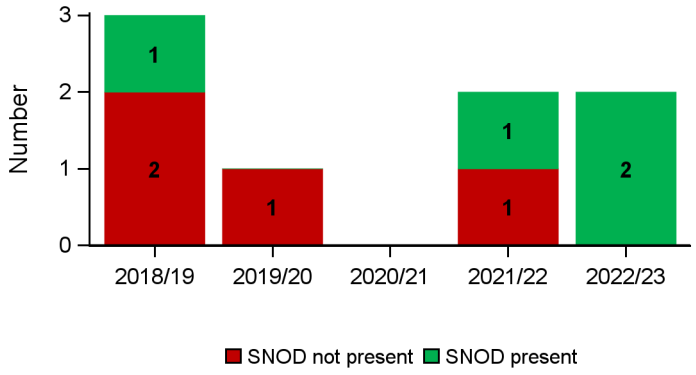
Figure 7.1 Number of patients meeting referral criteria that died in the ED, 1 April 2018 - 31 March 2023



7.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 7.2 Number of families approached in ED by SNOD presence, 1 April 2018 - 31 March 2023



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2023]

8. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

8.1 Supplementary Regional data

Table 8.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Wales*	UK
1 April 2022 - 31 March 2023		
Deceased donors	64	1,429
Transplants from deceased donors	155	3,589
Deaths on the transplant list	25	441
As at 31 March 2023		
Active transplant list	243	6,959
Number of NHS ODR opt-in registrations (% registered)**	1,402,291 (45%)	28,567,574 (44%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 3.1 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

8.2 Trust/Board Level Benchmarking

Cardiff And Vale University Health Board has been categorised as a level 1 Health Board. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 8.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 8.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 8.3 and 8.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 8.3 National DBD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	33	28	85	33	100	27	27	25	19	76	16	64	14
Level 1	1133	896	79	1124	99	879	831	714	677	95	474	66	438
Level 2	441	340	77	439	100	331	307	267	259	97	182	68	171
Level 3	287	229	80	283	99	224	216	188	184	98	135	72	124
Level 4	119	91	76	119	100	90	85	75	70	93	55	73	50

Table 8.4 National DCD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

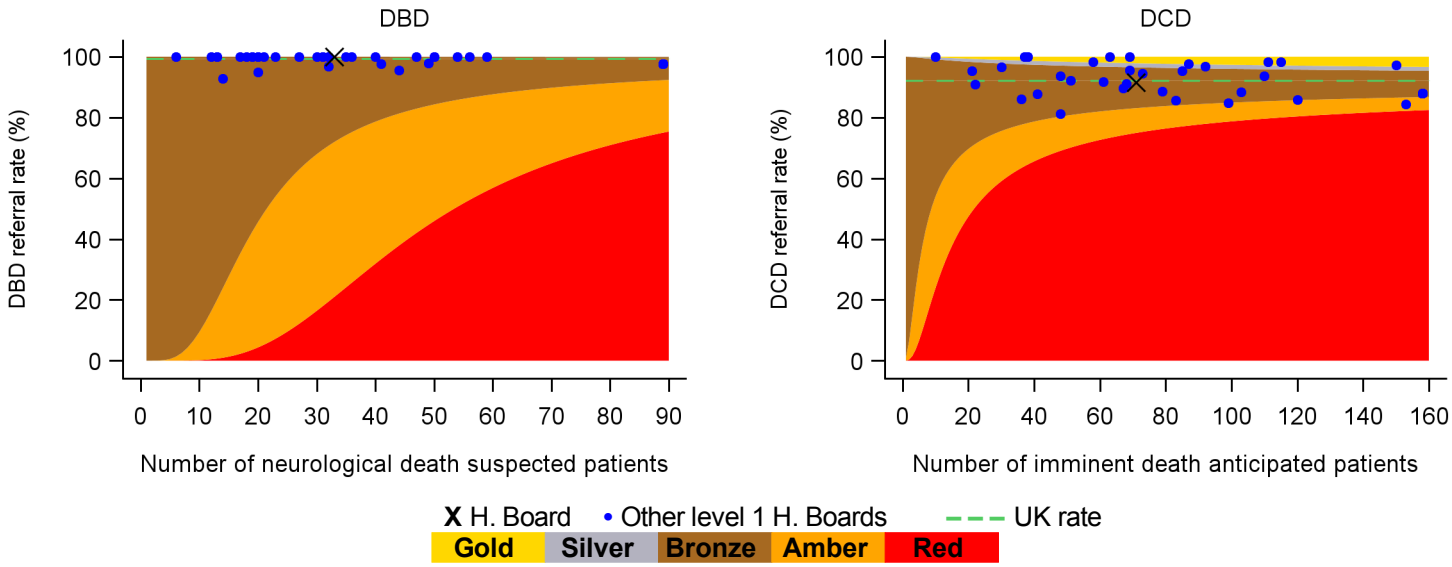
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	71	65	92	66	51	23	20	87	13	57	11
Level 1	2564	2370	92	2464	1772	941	856	91	537	57	369
Level 2	1346	1239	92	1313	841	373	333	89	209	56	132
Level 3	979	910	93	944	571	269	241	90	155	58	97
Level 4	418	367	88	408	283	108	96	89	58	54	38

8.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Health Board against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

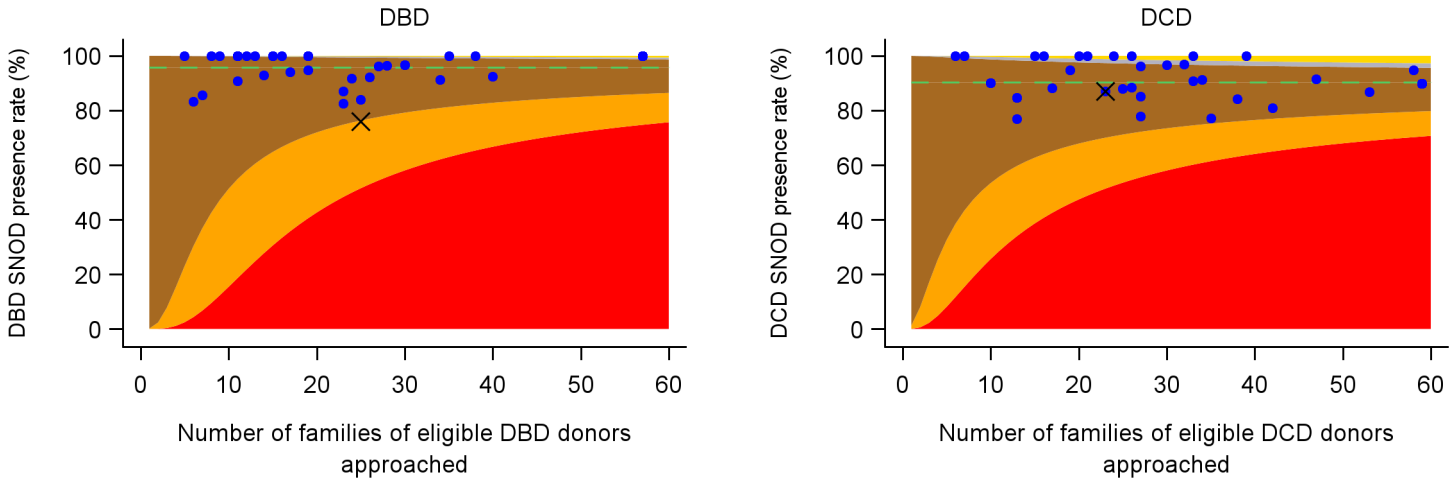
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

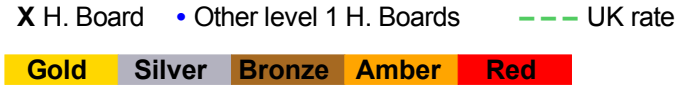
Figure 8.1 Funnel plots of referral rates, 1 April 2022 - 31 March 2023



When compared with UK performance Cardiff And Vale University Health Board was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

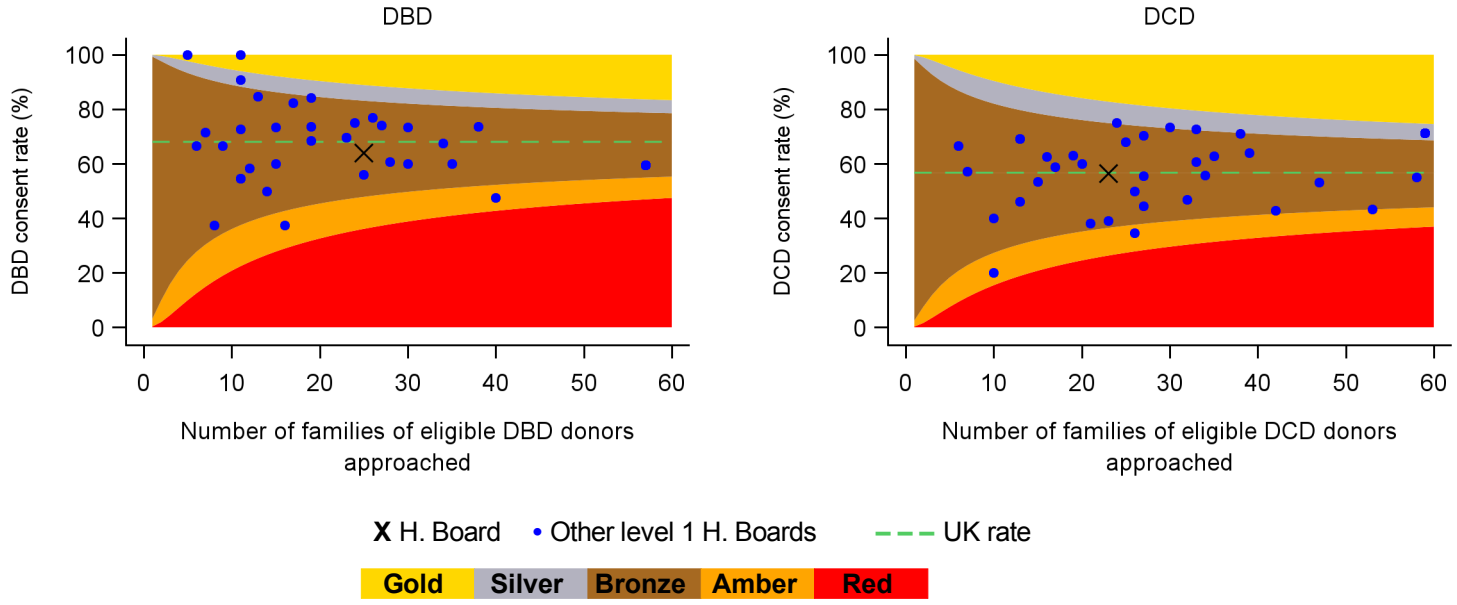
Figure 8.2 Funnel plots of SNOD presence rates, 1 April 2022 - 31 March 2023





When compared with UK performance Cardiff And Vale University Health Board was below average (amber) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 8.3 Funnel plots of consent rates, 1 April 2022 - 31 March 2023



When compared with UK performance the consent rate in Cardiff And Vale University Health Board was average (bronze) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data

Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit

Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Paediatric ICU data

Table 6.1	A summary of DBD, DCD and deceased donor data and key numbers for paediatric ICUs have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used.
Figure 6.1	A stacked bar chart displays the number of paediatric ICU patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 6.2	The reasons given for neurological death tests not being performed for paediatric ICU patients in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 6.2	Stacked bar charts display the number of DBD and DCD paediatric ICU patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.

Table 6.3	The reasons given for not referring paediatric ICU patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 6.4	The primary absolute medical contraindications to solid organ donation for DBD and DCD paediatric ICU patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 6.3	Stacked bar charts display the number of families of DBD and DCD paediatric ICU patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 6.4	Stacked bar charts display the number of families of DBD and DCD paediatric ICU patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.
Table 6.5	The reasons why consent/authorisation was not ascertained for solid organ donation in paediatric ICU patients in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 6.6	The reasons why solid organ donation did not occur in paediatric ICU patients in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

7 Emergency department data

Figure 7.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 7.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

8 Additional data and figures

Table 8.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 8.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 8.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 8.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 8.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 8.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 8.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

Report Title:	Equity, Equality, Experience and Patient Safety Framework			Agenda Item no.	7.3
Meeting:	Board	Public	x	Meeting Date:	28.9.2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Executive Director of Public Health, with Executive Director of People and Culture, and Executive Nurse Director				
Report Author (Title):	Deputy Director of Public Health, with a team from Patient Experience, Patient Safety, Workforce and Organisational Development, and Medicine.				

Main Report
Background and current situation:

Our refreshed Cardiff and Vale University Health Board strategy and our annual plan include clear ambitions to reduce inequalities in health; promote and improve our approach to equality and inclusion and drive forward an approach to improving quality in care and reduce harms to people in primary, community and hospital services but also people on waiting lists and to improve health equity at the population level.

With regard to the improving safety and reducing harm agenda, there is growing UK-level and international evidence that ethnic minority status or socioeconomic status could be associated with increased hospital acquired infections or adverse drug events in the former, and higher rates of mortality due to delayed access to healthcare in the latter. This is yet to be fully understood in Wales.

A team from across the organisation was tasked by three Executive Directors to explore the benefit of creating an Equity, Equality, Experience and Patient Safety Framework to deliver improvement action on this agenda across the organisation, on the premise that we have challenges in this regard that need to be acted upon. There are already distinct programmes of work in each arena. However, it is clear that, whilst we have some elements of overlapping work, there are interconnections and dependencies where, with better data collection and health intelligence analysis, and joined up conversations, we could:

1. Identify the largest areas of health gain in these overlapping arenas that could be focused upon to have the biggest impact on improved health, at the population level in the community, in our access to clinical services arena including planned care access, in our hospital services with regard to safety and harm, and with a linked lens and attention to the equality agenda and the protected characteristics.
2. Create a common framework with a core set of principles within which such prioritised action could be progressed.
3. Develop and track a measurable set of indicators to assess impact.

The group reviewed twenty-two existing models and found five that had resonance to Cardiff and Vale University Health Board, from these five the important elements were distilled and used to create a Framework for our organisation. The group agreed that a framework would support action, but that to assist staff with making tangible and practical changes a support tool would also be required. Following feedback, it was agreed that this should be co-produced *with* staff *for* staff. A draft has therefore been prepared to be shared with the Clinical Boards that can be iterated and improved based on their engagement over the next few months when the framework is socialised with the Clinical Boards.

The framework sets out the processes that should be followed, noting that this is a cyclical process and continuous improvement is needed to build success over time. The framework highlights the need to systematically improve data collection across the organisation on the protected characteristics but also to engage with local people to understand their experience, unmet needs and barriers to accessing services in a timely way.

If this is to be successfully implemented equity must be considered as an essential element of providing a quality service by every member of staff in the organisation this will require a cultural shift for staff that will take time.

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

Three products have been developed as a result of this work:

- The Framework
- The Guiding Principles
- The Support Tool (drafted but to be further co-produced with staff)

In addition to developing the Framework, Guiding Principles and Support Tool there is a need to identify a suite of projects across the organisation that will deliver change on equality, equity, experience and patient safety. A number of projects have therefore been identified as being of strategic importance and are described in the presentation, and following feedback on early versions of this suite of projects these been further developed and expanded to include prevention, patient safety, planned care, unscheduled care, maternity, representation, equitable employee experience, mental health, and analytics. This list is not exclusive and further arenas could be added over time.

Recommendation:

Board is requested to:

- **APPROVE** the Framework and
- **SUPPORT** and champion the progression of the work as outlined

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: Yes
UK-wide data shows differences in patient safety in people with protected characteristics, this work aims to reduce this differential.
Financial: No
Preventative action targeted at improving the health equity between advantaged and disadvantaged communities and their timely access to health services could help reduce a £322 million healthcare gap, especially in emergency admissions and A&E attendance across Wales (Public Health Wales, 2021)
Workforce: Yes
This work supports workforce aims to improve equity, equality and representation in C&VUHB.
Legal: No
Reputational: No
Socio Economic: Yes
This work will assist in fulfilling the Socio-economic Duty.
Equality and Health: No
This work specifically aims to reduce health inequities in Cardiff and Vale University Health Board population.
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
Senior Leadership Board	June 2023
Board Development	June 2023
Local Partnership Forum	August 2023

Equity, Equality, Experience and Patient Safety Framework

Cardiff and Vale University Health Board (C&VUHB)

Equity, equality experience and patient safety

Health inequity is a difference in health that is **unnecessary**, **avoidable**, unfair or unjust; such differences are **amenable to action**.

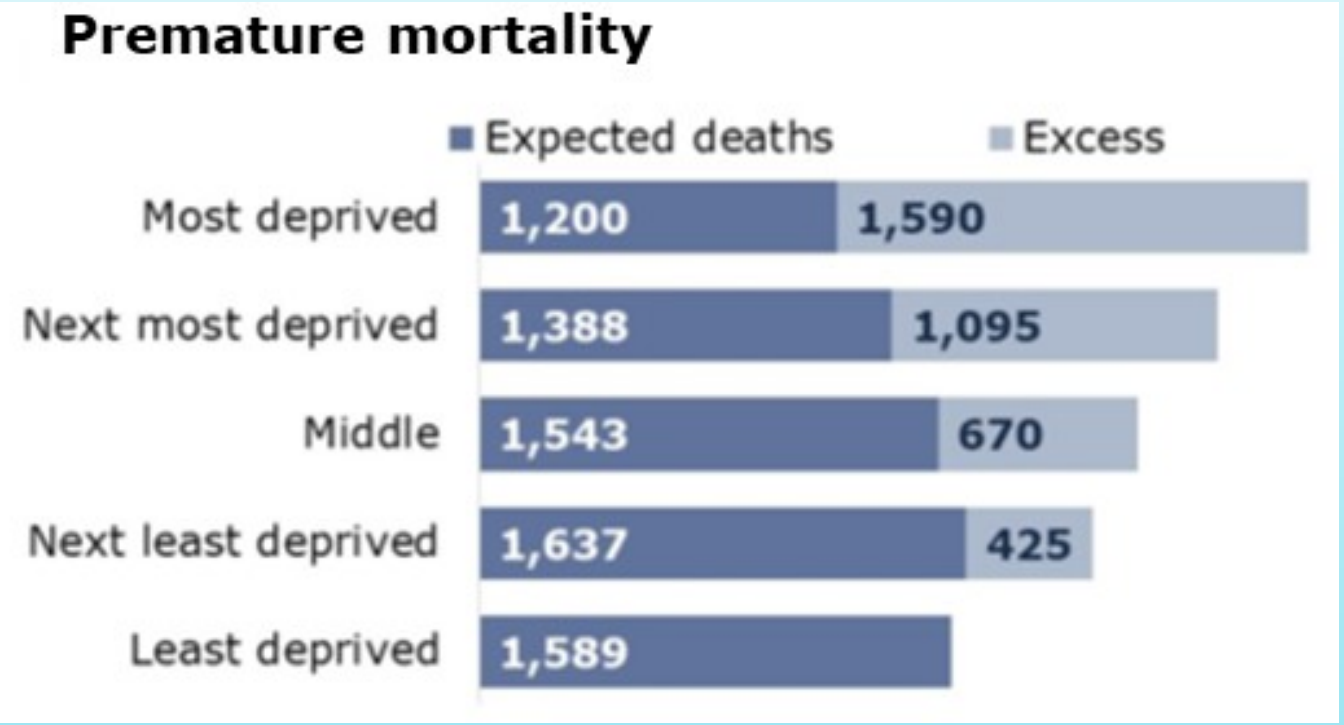
Health inequalities are **preventable**, unfair, and unjust differences in health between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies. These determine the chances of people getting ill, their ability to prevent illness, or opportunities to act and access healthcare when ill health occurs.

Experience is what it **feels like** to be a user of the NHS.

Patient Safety is the **avoidance of** unintended or unexpected **harm** to patients during the provision of health care.

The impact of inequalities on lives

Deprivation is associated with an increased risk of dying in both adults and children



- There are large and persistent health inequalities in Wales and locally which lead to **worse health outcomes** and **lower life expectancy** in the most disadvantaged areas.
- **Infant mortality has risen** over the last 4 years, particularly among families in more disadvantaged areas.
- Extending the age range to under 5 mortality, in 2019 the **UK ranked 22 out of 23 Western European countries.**

References

Years of Life Lost - Public Health Wales (nhs.wales)

https://ncmd.info/wp-content/uploads/2021/05/NCMD-Child-Mortality-and-Social-Deprivation-report_20210513.pdf

Equity, experience and patient safety

Patient experience and patient safety events are not evenly distributed

- Women and black patients are more likely to experience patient safety events in primary care[1]
- Patient safety incidents are experienced unequally[2]
- Harm from health care exacerbate inequalities[2]
- There is clear evidence of barriers to seeking help for mental health problems in many ethnic minority groups[3]
- Maternal deaths are not evenly spread across the UK population[4]

References

1. Social disparities in patient safety in primary care: a systematic review | SpringerLink
2. https://www.bmj.com/content/376/bmj-2021-067090#ref-9
3. https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_Summary_v.4.
4. Report highlights 'striking' inequalities in UK maternal deaths (rcm.org.uk)

The aim: To deliver equitable and excellent preventative and clinical services/ approaches.

The objectives:

- To reduce variation in health outcomes
- To reduce variation in access to services
- To reduce variation in quality of services
- To have a workforce that is representative of the population, who have an equitable experience of work, career development and personal growth at CAVUHB

The Framework: (next page) sets out actions each Clinical Board or Team could take on their journey to delivering equity and excellence as part of a quality approach

The Support Pack: provides resources and worked examples to inspire action

Guiding principles: Support and describe the ethos

The Framework

The 3I Framework

Beynon, Scott, Whiles, Hughes, Jones, and Roberts, 2023

Identify:
Acknowledge and understand the differential experience, access to health services, health inequity and inequality for local people and our employees

Output- summary of equity and excellence priorities

Intelligence for action:
Use community engagement and qualitative insights to understand lived experience and improve quantitative data collection on equity and use both sources to co-produce service improvements that deliver equity and excellence

Output- co-produced interventions based on data and evidence

Interventions tailored to need:
Integrate equity, equality experience and patient safety improvements into existing and new work programmes, staff development initiatives and policies

Output- interventions integrated into routine practice

System Application 1

First steps on this journey...

Planned Care

- Examining waiting lists by postcode (Welsh Index of Multiple Deprivation- WIMD) to aid prioritisation
- Analysis of PROMS by protected characteristics
- Supporting Patients Whilst Waiting work

Analytics

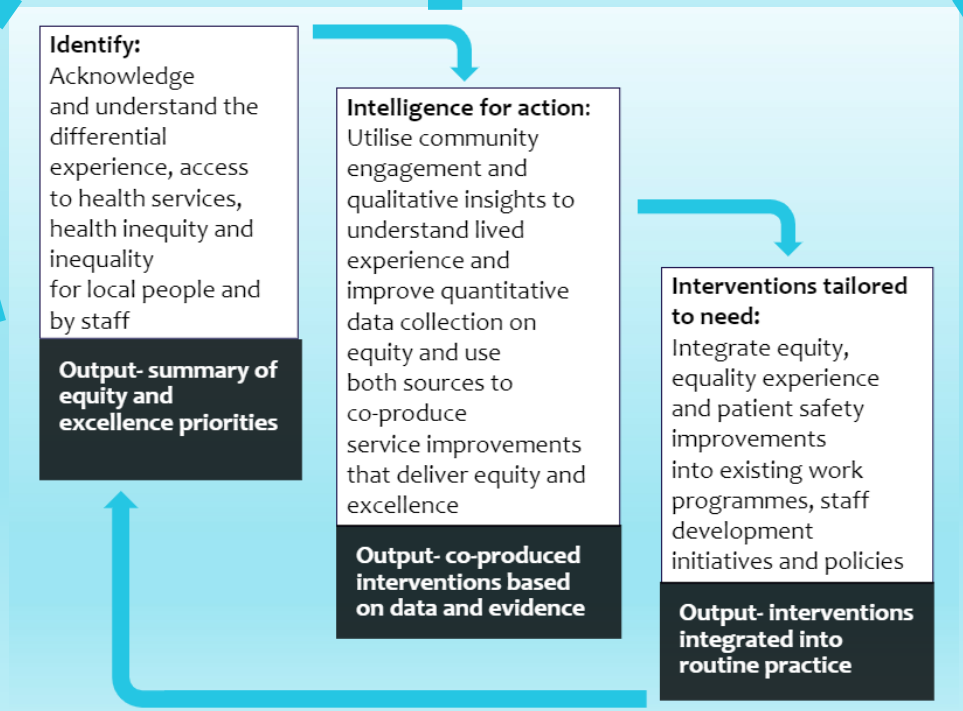
- Identification of potential indicators
- Development of a Dashboard

Unscheduled Care

- Examining EU waits by demographics e.g. ethnicity to support 6 goals of urgent and emergency care
- Analysis of frequent users by postcode (WIMD)
- New model for inclusion health based on need

Maternity Care

- Understanding needs of ethnic minority people
- Supporting people with obesity in pregnancy



Prevention

- Using 'Amplifying Prevention' to increase uptake of screening, immunisation and reduce obesity

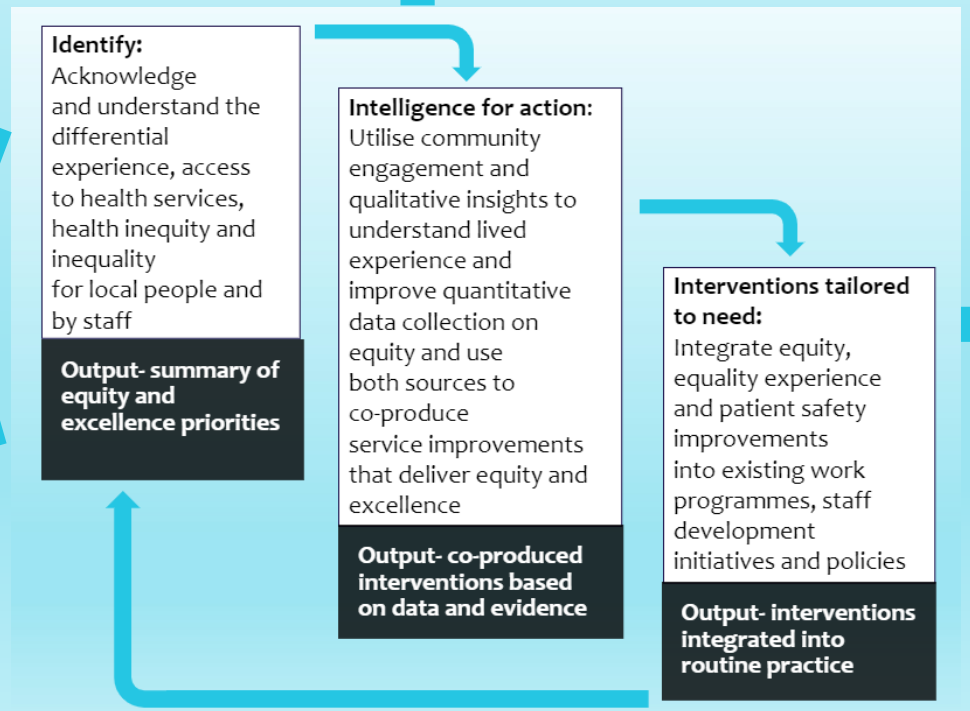
System Application 2

First steps on this journey...

Representation
- Understanding current workforce demographics (WRES)
- Proactive community outreach to promote as an employer
- Listening to understand barriers, challenges and views

Mental Health
- Training and self-certification commissioned from Diverse Cymru
- Work with Police and Crisis Care Concordat to improve and understand shared ethnicity recording

Equitable Employee Experience
- Embedding and enaction of the Anti-Racist Action Plan (e.g. policy review)
- Establishing and growing Employee Resource Groups (Networks)
- Benchmarking and progress monitoring (e.g. ENEI)

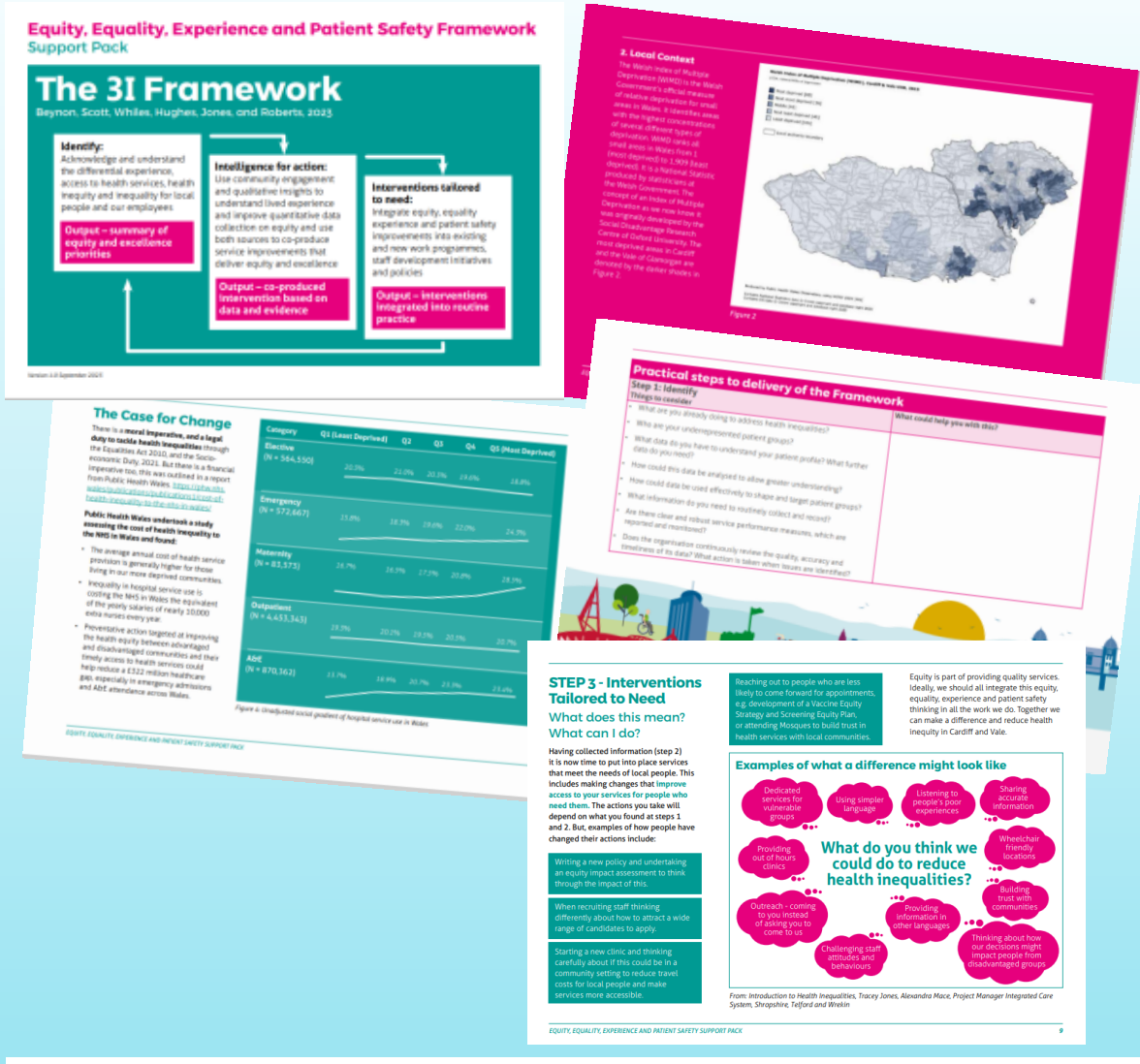


Patient Safety
- Understand variation in quality and patient safety reporting
- Scope a pilot of variation in Medical Examiner Referrals by postcode
- Undertake a baseline assessment of National audit data set to identify measures of inequity

Primary Care
- Scope how to identify unmet need e.g. cardiovascular risk
- Consider diabetes prevention programme expansion

The support pack provides the practical support needed to act. This includes:

- **Resources** to understand health inequalities, inequity, experience and patient safety issues with links to evidence and examples of best practice
- **Tools** that have been tried and tested by others that could help a team or Clinical Board address issues that have been uncovered through the quantitative or qualitative data
- Worked **examples** to inspire action and spark new ideas that might be appropriate for our local population



Support Pack

To support the implementation of the 3I Framework

1. Equality, equity, experience and patient safety are fundamental to **every employee** of Cardiff and the Vale University Health Board
2. The equality, equity, experience and patient safety **challenge is real**, must be acknowledged and addressed at every opportunity
3. We are all **on a journey** to improving equality, equity, experience and patient safety **together** and will need to keep improving continuously
4. Quantitative **data improvements** are needed to help **understand** the issues faced by our population
5. Qualitative data such as insights, **lived experience and stories are equally valuable** to improving equality, equity, experience and patient safety

Guiding Principles

Specific to the implementation of the 3I framework

Framework Conceptualised *by* C&VUHB Employees *for* C&VUHB Employees

Main input from:
Claire Beynon,
Alexandra Scott,
Claire Whiles,
Angela Hughes,
Mitchell Jones and
Aled Roberts
With thanks to all staff who have contributed

Thank you

claire.beynon@wales.nhs.uk

Report Title:	Interventional Neuro-Radiology Replacement Project – Procurement of Two IR Suites			Agenda Item no.	7.4
Meeting:	Board	Public	X	Meeting Date:	28th September 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	Information	
Lead Executive:	Director of Finance				
Report Author (Title):	Assistant Director of Procurement Services and Executive Procurement Lead for C&V				

Main Report
Background and current situation:

Interventional Radiology is a minimally invasive alternative to open surgery or medical intervention using fluoroscopy radiological guided imaging. The IR service at the University Hospital of Wales supports patients who present with emergency and planned care, Vascular and Neuro requirements. The existing equipment was installed in November 2015 and both existing rooms are currently in the 8th year of operation. The maintenance contract is currently held with the Original Equipment Manufacturer, Siemens. There have been some significant issues with the existing machines that were identified in a recent SBAR and reported to the Executives Board to consider and explore funding opportunities available for the full replacement of both rooms.

In June 2023, Welsh Government confirmed the Award of funding to Cardiff & Vale University Health Board in respect of the Urgent Replacement of Interventional Neuroradiology Equipment at University Hospital of Wales within the 2023-24 Capital plan at a total cost envelope of £7.2m.
The purpose of the funding is to enable the replacement of two interventional radiology systems in both existing intervention rooms at UHW.

A mini competition against a Framework Procurement exercise was completed with two providers submitting a response that met the requirement. It was agreed under the terms of the framework that the opportunity would be put out as a 2 stage process, with the first stage to evaluate and identify the preferred supplier of the imaging solution, and the second stage being for the preferred supplier to work with the end users and in house Estates team to prepare the enabling works design and then use the suppliers processes to seek bids for the works. To ensure there in openness and transparency for Phase 2, suppliers were requested to commit to the UHB that the details of the enabling works proposals would be shared to evidence a compliant, and affordable contract to be entered into for the final award.

Site Visits were arranged in July and attended by members of the evaluation team who also scored the written submissions. it was concluded that the bidder scoring the most in the evaluation was Philips for the Azurion 7B20-15 kit.

The Procurement Report attached outlines the associated capital and revenue costs that have been agreed and signed off within the CD&T Clinical Board Finance Team. Summary provided of Total Whole Life Costs of Equipment

	Max Score	Philips Azurion 7 B20-15	Siemens Artis Icono Biplane
Technical Evaluation Score	65%	4358	4007
Highest Score get max marks		65	35
Total Tendered Whole Life Costs	35%	£3,924,316.00	£4,321,580.00
Lowest Price gets max marks		35	31.78
Total Score		**100**	**91.55**

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

The award of this procurement will allow the Health Board to replace the existing aging interventional radiology equipment with x2 industry leading technology units in both the intervention rooms in UHW. The funding from Welsh Government is approved and will be reported and monitored via the Capital Management Group.
NB: *It should be noted that the Project team were made aware of a 'potential indirect' risk to the delivery of this procurement on the morning of 1st September 23. Philips confirmed on a call that as a Business they had made the decision to withdraw the Angio CT offering from the market to consolidate and put focus onto their*

core business solutions. This directly impacts the Hybrid Theatre project but also raises potential concerns around the financial stability and longevity of the other areas of their business. The project team would like to continue at this stage with the recommendation to award with the understanding that further analysis will be completed on a risk assurance basis prior to the formal award of contract.

Recommendation:

The Board / Committee are requested to:

- Approve the Contract Award to Philips for the replacement of the 2 existing IR Suites with their proposed Azurion 7 B20-15 units and associated maintenance from years 2 to 7. Upon award of the capital kit procurement, Philips will then instruct their construction suppliers to provide costs for the associated works and implementation plan which will be agreed and signed off by the Health Board to prove value for money.

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

There are associated works and lead times that will affect the delivery of this project in line with financial year commitments that will need to be monitored and escalated if required. The benefit of getting the kit signed off will be that the lead times will be protected and implementation plans can be worked up and shared alongside the associated works plan

Safety: Yes

The availability and reliability of this equipment is key to providing these services, but prolonged loss of this equipment would have wider consequences on tertiary services, some of which are not provided elsewhere in Wales. In addition, the potential loss of interventional workforce if these services can no longer be provided would be catastrophic in terms of their re-establishment.

Financial: Yes

The funding has been agreed by Welsh Government – funding letter attached. Contract Negotation has resulted in a fixed price maintenance for 10 years thus avoiding annual increases.

Workforce: No

Legal: No

Reputational: No

Several services would be significantly impacted by the loss or repeated failure of this equipment, with associated reputational and service delivery risks to the patients across Wales.

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

PROCUREMENT REPORT

CONTRACT TITLE	**INTERVENTIONAL NEURO-RADIOLOGY REPLACEMENT PROJECT PROCUREMENT OF TWO IR SUITES**
CONTRACT REFERENCE	**ITT_103459**
PERIOD	**Capital Purchase of Kit and associated Turnkey works to commence December 2023 and complete March 2024**
CLINICAL BOARD	**CD&T – INTERVENTIONAL NEURO RADIOLOGY**
TENDER CLOSING DATE	**6TH JULY 2023**

1. INTRODUCTION

Interventional Radiology is a minimally invasive alternative to open surgery or medical intervention using fluoroscopy radiological guided imaging. The IR service at the University Hospital of Wales supports patients who present with emergency and planned care, Vascular and Neuro requirements. The existing equipment was installed in November 2015 and both existing rooms are currently in the 8th year of operation. The maintenance contract is currently held with the Original Equipment Manufacturer, Siemens. There have been some significant issues with the existing machines that were identified in a recent SBAR and reported to the Executives Board to consider and explore funding opportunities available for the full replacement of both rooms.

Several services would be significantly impacted by the loss or repeated failure of this equipment, with associated reputational and service delivery risks to the patients across Wales.

- Neuro interventional service
  - Patient transfer to Bristol at cost for the referral of each patient.
  - Poor service for patients presenting with sub arachnoid haemorrhage or cerebral AVM, leading to permanent injury or worsening condition, resulting in poor patient outcomes and future healthcare costs.
  - The proposed introduction of a regional mechanical thrombectomy service at UHW would not be possible without these machines, disadvantaging patients in South Wales.

- Vascular interventional service
  - No major trauma service provision resulting in an inability to support acute polytrauma patients with intervention procures. Life and/or limb limiting.
  - Regional vascular network service for South Wales would require reallocation to a centre that is able to meet the needs of these patients.
  - Hepatology intervention would require referral for Bristol i.e., TIPPs, PTC etc.
  - No provision for liver cancer patients for TACE treatments or hilar liver cancer patients with obstructions.
  - Renal patients would not have support to site tunnelled lines resulting in a loss of treatment.
  - Gynae referrals for uterine fibroids and advanced emergency post-partum bleeds would require reallocation to another centre.
  - ERCP service would have no interventional back up so would not be able to facilitate complex procedures.
  - Complex cancer biopsies would be impacted as they would not have access to interventional back up to arrest bleeding which is a known risk when undertaking complex biopsies.
  - Urology referrals for complex cancer patients requiring stents would be impacted.
  - Lack of support to deal with complex vascular access issues.
  - PICC line insertion would be impacted. Recent activity demonstrated 105 PICC lines were inserted which treated septic patients and cancer patients for chemotherapy.

The availability and reliability of this equipment is key to providing the services above, but prolonged loss of this equipment would have wider consequences on tertiary services, some of which are not provided elsewhere in

Wales. In addition, the potential loss of interventional workforce if these services can no longer be provided would be catastrophic in terms of their re-establishment.

In June 2023, Welsh Government confirmed the Award of funding to Cardiff & Vale University Health Board in respect of the Urgent Replacement of Interventional Neuroradiology Equipment at University Hospital of Wales within the 2023-24 Capital plan at a total cost envelope of £7.2m.
The purpose of the funding is to enable the replacement of two interventional radiology systems in bot of the existing intervention rooms at UHW.

A project team was established to ensure the project was manged at pace via a compliant process and update reports provided at the Capital Management Group for monitoring the risk against delivery and timescales in line with the overall Capital Plan.

- Andrew Ward, Senior Programme Manager Specialist Diagnostic and Therapies Equipment, NWSSP SES Estates Development
- Sarah Yellen, Assistant Head of Operational Procurement, NWSSP CVU Frontline
- Mike Bourne, Consultant Radiologist
- Sarah Lloyd, Director of Operations

NB: It should be noted that the Project team were made aware of a 'potential indirect' risk to the delivery of this procurement on the morning of 1st September 23. Philips confirmed on a call that as a Business they had made the decision to withdraw the Angio CT offering from the market to consolidate and put focus onto their core business solutions. This directly impacts the Hybrid Theatre project but also raises potential concerns around the financial stability and longevity of the other areas of their business. The project team would like to continue at this stage with the recommendation to award with the understanding that further analysis will be completed on a risk assurance basis prior to the formal award of contract.

2. BACKGROUND

NHS Wales Shared Services Partnership Procurement team at Bridgend posted the opportunity for mini competition against the NHS Supply Chain Framework for bidders to submit proposals and offer site visits for the evaluating panel. Cardiff and Vale Frontline procurement team were linked into the procurement process to ensure the correct governance and sign off was met and to liaise with the Clinical teams and Estates to ensure this project met the tight timescales it was challenged with.

It was agreed under the terms of the framework that the opportunity would be put out as a 2 stage process, with the first stage to evaluate and identify the preferred supplier of the imaging solution, and the second stage being for the preferred supplier to work with the end users and in house Estates team to prepare the enabling works design and then use the suppliers processes to seek bids for the works. To ensure there in openness and transparency for Phase 2, suppliers were requested to commit to the UHB that the details of the enabling works proposals would be shared to evidence a compliant, and affordable contract to be entered into for the final award.

Site Visits were arranged in July and attended by members of the evaluation team who also scored the written submissions. The evaluation team consisted of the following members.

- Marie Gyn Jones, Deputy General Manager, Radiology
- Dr William Rhodri Thomas, Consultant Radiologist
- Emma Olivier, IR Superintendent Radiographer
- Jamie Williams, Senior Nurse
- Dr Anand Sastry, Consultant Neuroradiologist

The proposals received were evaluated and scored in line with the published criteria and justification comments provided around the scores given for each provider.

The table below outlines the scores given with the recommended provider being Philips for the Azurion 7 B20-15

	Max Score	Philips Azurion 7 B20-15	Siemens Artis Icono Biplane
Technical Evaluation Score	65%	4358	4007
Highest Score get max marks		65	35
Total Tendered Whole Life Costs	35%	£3,924,316.00	£4,321,580.00
Lowest Price gets max marks		35	31.78
Total Score		**100**	**91.55**

3. CONTRACT FINANCIALS

a. CURRENT ANNUAL CONTRACT VALUE (Revenue Budget)

Asset Number	Manufacturer	Manufacturer Serial Number	Description	Location	Current Annual Maintenance Value
114549	SIEMENS	006-AXA0045290	Artis Q Biplane	NVA1	£43,661.60
114550	SIEMENS	006-AXA0045280	Artis Q Biplane	NVA2	£43,661.60

	Excluding VAT	Including VAT
Annual Contract Value (2022/2023 Financial Year) covering x 2 units	£87,323.20	£104,787.84

b. NEW CONTRACT VALUE (Capital Cost of Kit and Revenue cost for Support)

	Qty	Philips (Azurion 7 B20)		Qty	Siemens	
		Excluding VAT	Including VAT		Excluding VAT	Including VAT
Capital Cost of Kit only	2	£2,300,000.00	£2,760,000.00	2	£2,681,600.00	£3,217,920.00
Recurring **Revenue** from Year 2 for Maintenance Prices Fixed for 10 Years		£88,862.00 PA	£1,599,516.00 Total over 10 years		£91,110.00 PA	£1,639,980.00 Total over 10 years
Total Whole Life Costs			£3,924,316.00			£4,321,580.00

NB: There will be a UPS Service cost of £3,100 per annum from years 2 to 5 to be forecast in the revenue budget.

c. CASH RELEASING SAVING

There will be a non-recurring cash releasing saving in Year 1 equating to £87,323.20 exc. vat , as the replacement units will be supplied with a 12 month warranty.

d. COST PRESSURE

From year 2, there will be a cost pressure of £1,538.80 for the difference in the current maintenance charges to the proposed, however as the costs have been fixed for 10 years the HB will avoid any annual RPI increases which will be recorded as a cost avoidance.

Financial Notes

Cost Centre: Capital Kit costs
Revenue Ongoing Support costs

4. ANY OTHER RELEVANT INFORMATION

During neuro interventions, the goal is to see clearly, while managing safety for all involved. The Philips Neuro Suite complete with the industry leading Azurion 7 20" and 15" detector X-ray system is designed to enhance treatment and support effective guidance as you work. The suite will provide seamless control of all relevant applications from a single touch screen at table side, to help make fast, informed decisions in the sterile field.

5. BENEFITS REALISED FROM AWARD

All software updates will be provided as part of the on-going support contract.
The contract price includes a 4-year Technology Maximizer Pro-Neuro contract for each system.
Philips Healthcare offers a guaranteed 7-day, 8am to 8pm customer service offering as standard. This service will include back-office staff, technical helpdesk, engineer on-site support and parts/delivery/logistics. This service is included at no extra cost.

6. RECOMMENDATION

On the basis of the foregoing, it is recommended that the preferred bidder following kit evaluation for the replacement of the IR Rooms is Philips for the Azurion 7 B20-15. The recommendation is that following approval of this preferred bidder, we will now instruct them to provide the associated works costs and implementation plan to replace the rooms in line with the financial year deadlines.

Prepared By;	
Name:	Sarah Yellen
Contact Details:	02921508261
Date:	16/08/2023
Assistant Head of Operational Procurement Approval	
Approved By:	
Date:	

I confirm that the expenditure has an identified budget and will not cause any financial pressure which could result in the Clinical Board/Department not delivering its financial breakeven duty.

Marie Glyn Jones

SIGNED .....

Marie Glyn Jones

PRINT NAME .....

(Marie Glyn Jones,
Deputy General Manager)

01-Sep-23

DATED .....

I confirm that the expenditure has an identified budget and will not cause any financial pressure which could result in the Clinical Board/Department not delivering its financial breakeven duty.

Sarah Lloyd

SIGNED .....

Sarah Lloyd

PRINT NAME .....

(Sarah Lloyd,
Director of Operations)

01-Sep-23

DATED .....

I confirm that the expenditure has an identified budget and will not cause any financial pressure which could result in the Clinical Board/Department not delivering its financial breakeven duty.

Robert Gordon

SIGNED .....

Robert Gordon

PRINT NAME .....

(Robert Gordon,
Senior Finance Business Partner)

01-Sep-23

DATED .....

Report Title:	**OMBUDSMAN ANNUAL LETTER 2022/23**				Agenda Item no.	7.5	
Meeting:	Board	Public	X		Meeting Date:	28/09/2023	
		Private					
Status *(please tick one only):*	Assurance		Approval		Information		X
Lead Executive:	Executive Nurse Director						
Report Author (Title):	Assitant Director of Patient Experience						

Main Report
Background and current situation:

The Public Service Ombudsman for Wales annually writes to each Health Board in Wales and provides an overview of trends, performance and key messages arising from activity in the Ombudsman's office over the previous year. The letters are published on the Ombudsman's website

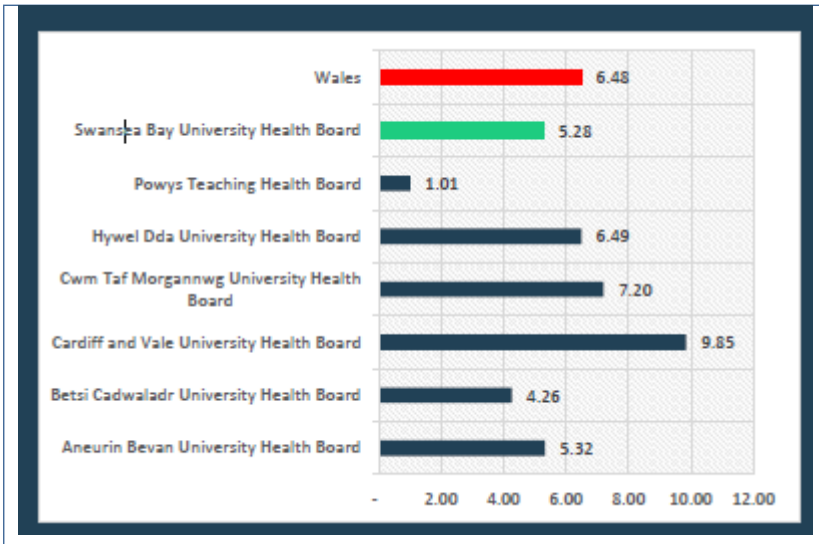
A copy of the letter which is published on the PSOW Website Annual Letters (https://www.ombudsman.wales/?s=Annual+letters) section on website

It is pleasing to note that the Health Board was below the average for complaints received and investigated with Health Board average adjusted for population distribution.

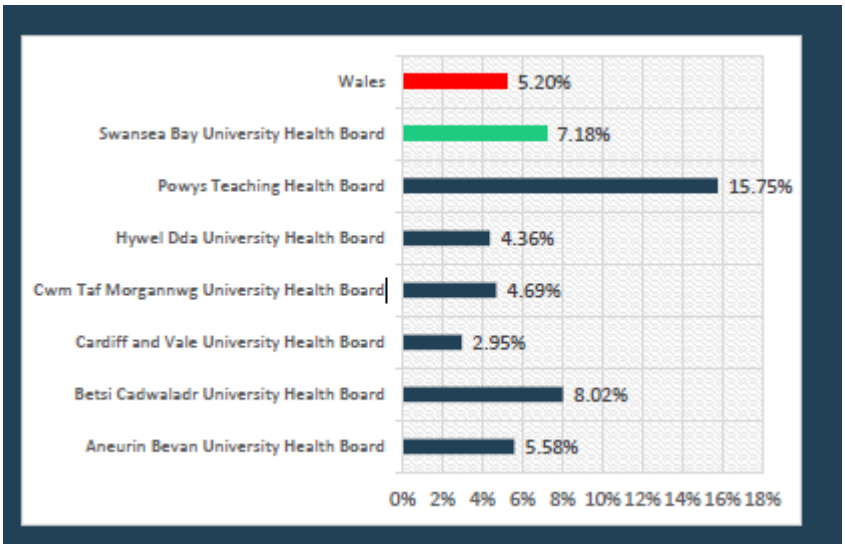
Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	166	0.28
Betsi Cadwaladr University Health Board	225	0.33
Cardiff and Vale University Health Board	137	0.28
Cwm Taf Morgannwg University Health Board	134	0.30
Hywel Dda University Health Board	104	0.27
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	137	0.36
Total	926	0.30

This is particularly pleasing when considered in the context of the numbers of concerns the Health Board received in relation to other organisations. We received some 4866 in this period and the percentage of people who approach the Ombudsman is 0.66% of people who raise concerns with the Health Board.

This graph shows the volume of complaints received by Welsh Health Boards themselves in 22/23, adjusted by per 1,000 population.



This graph shows the volume of complaints received by PSOW about Welsh Health Boards in 22/23, as a proportion of all the complaints closed



The themes of the 137 concerns referred to the Ombudsman by Subject are

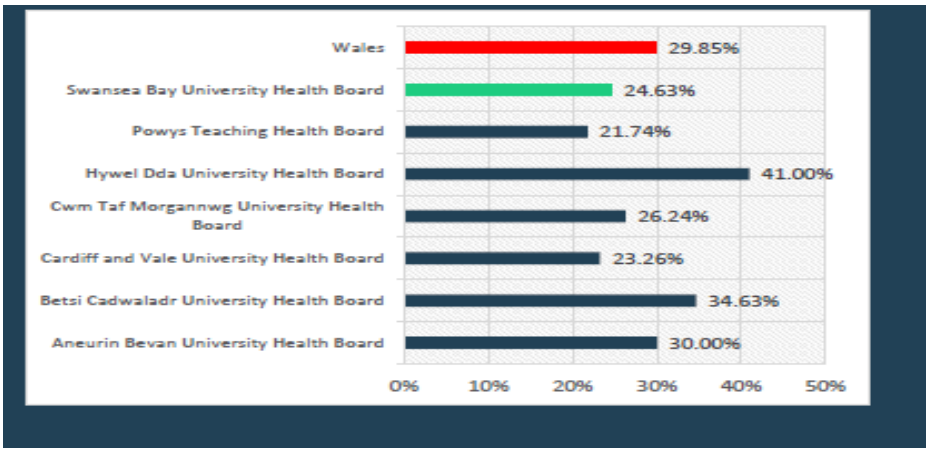
Cardiff and Vale University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	5	4%
Clinical treatment in hospital	71	52%
Clinical treatment outside hospital*	10	7%
Complaints Handling	22	16%
Confidentiality	0	0%
Continuing care	0	0%
COVID19	4	3%
De-registration	0	0%
Disclosure of personal information / data loss	1	1%
Funding	0	0%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	0	0%
Mental Health	14	10%
NHS Independent Provider	0	0%
Non-medical services	0	0%
Nosocomial COVID	2	1%
Other	0	0%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	3	2%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Referral to Treatment Time	2	1%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Total	137	

Of the 137 concerns only 13 were processed for full investigation by the Ombudsman

Appendix C - Complaint Outcomes
(* denotes intervention)

Cardiff and Vale University Health Board		% Share
Out of Jurisdiction	27	21%
Premature	13	10%
Other cases closed after initial consideration	55	43%
Early Resolution/ voluntary settlement*	21	16%
Discontinued	0	0%
Other Reports - Not Upheld	4	3%
Other Reports Upheld*	8	6%
Public Interest Reports*	1	1%
Special Interest Reports*	0	0%
Total	**129**	

This graph shows the PSOW intervention rate for Welsh Health Boards in 22/23
Intervention is where PSOW upholds a complaint, or suggests Early Resolution or Voluntary Settlement.



We had one Public interest report [copy of the report (https://www.ombudsman.wales/reports/cardiff-and-vale-university-health-board-202102028/)](https://www.ombudsman.wales/reports/cardiff-and-vale-university-health-board-202102028/)

IN the Public report the Ombudsman made a number of recommendations, which the Health Board accepted, including an apology and carrying out a case review to discuss assessment and diagnosis of strangulated hernias. The Health Board also met with the patient's family following publication of the report.

Annual Letter actions

In response to the annual letter the Health Board has been asked to take the following actions and these will be reported in detail through the Quality Safety and Experience Committee

- *review the resources available to your complaints team*
- *review arrangements for accurately compiling complaints data*
- *consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis*
- *reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling*
- *ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality*

The further actions are

Further to this letter can I ask that Cardiff and Vale University Health Board takes the following actions:

- *Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.*
- *Update my office on how the Health Board has complied with the recommendations in our report: Groundhog Day 2: an opportunity for cultural change? by 1 December 2023.*
- *Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.*
- *Inform me of the outcome of the Council's considerations and proposed actions on the above matters at your earliest opportunity.*

The Ombudsman has been advised of the Board Meeting date and the review of the organisation's compliance with the recommendations in the report Groundhog Day 2: an opportunity for cultural change? This review will be shared through the Quality Safety and Experience Committee and the Ombudsman's office advised as per the request.

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

The recommendations and review of the resources available to the Complaints Team and the compliance with the *recommendations in the report Groundhog Day 2* will be shared at the November Quality Safety and Experience Committee meeting.

Recommendation:

The Board is requested to: Note the the contents of the Annual Letter

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	
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 review of compliance with recommendations will be undertaken

Safety: Yes

The Ombudsman provides an independent scrutiny of cases

Financial: Yes
The ombudsman can offer financial redress to people raising concerns
Workforce: No
Legal: No
Reputational: Yes
There is significant reputational risk from Public interest reports
Socio Economic: No
Equality and Health: No
Decarbonisation: No

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

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Ombudsman
Cymru • Wales

Ask for: Communications
01656 641150
Communications
@ombudsman.wales

Date: 17 August 2023

Charles Janczewski
Cardiff and Vale University Health Board
By Email only: charles.janczewski@wales.nhs.uk

Annual Letter 2022/23

Dear Charles

I am pleased to provide you with the Annual letter (2022/23) for Cardiff and Vale University Health Board which deals with complaints relating to maladministration and service failure, and the actions being taken to improve public services.

This letter coincides with my Annual Report – "A year of change – a year of challenge" – a sentiment which will no doubt resonate with public bodies across Wales. My office has seen another increase in the number of people asking for our help – up 3% overall compared to the previous year, and my office now receives double the number of cases we received a decade ago.

Last year, I met with public bodies across Wales last year – speaking about our casework, our recommendations, and our proactive powers. The current climate will continue to provide challenges for public services, but I am grateful for positive and productive way which Health Boards communicate with my office.

926 complaints were referred to us regarding Health Boards last year – an increase of 21% compared to the previous year. During this period, we intervened in (upheld, settled or resolved at an early stage) 30% of Health Board complaints - a similar proportion to previous years.

Supporting improvement of public services

Our *Groundhog Day 2: An opportunity for cultural change in complaint handling?* report issued in June, highlighted the complaint handling failings we identified in cases involving health boards across Wales during the preceding 12 months.

Our recommendations to the Health Board were aimed at ensuring that, as the new Duties of Candour & Quality are introduced within your organisation, that the opportunity for a cultural change is taken - to promote openness and candour with service users and ensure there is systemic learning when things have gone wrong.

I trust that, in line with our recommendations to the Health Board, the report has or will soon be considered by your Quality & Patient Safety Committee and it will:

- review the resources available to your complaints team
- review arrangements for accurately compiling complaints data
- consider whether the option to provide staff investigating complaints with independent medical advice, is considered on a case by case basis
- reflect upon the lessons highlighted in this report when scrutinising their performance on complaint handling
- ensure that lessons learned from the PSOW's findings and recommendations are included in their Health Board's annual report on the Duty of Candour and Quality.

Despite the challenges of last year, we have pushed forward with our proactive improvement work and launched a new Service Quality process to ensure we deliver the standards we expect.

Last year, we also began work on our second wider Own Initiative investigation – this time looking into carers assessments within Local Authorities. This investigation will take place throughout the coming year, and we look forward to sharing our findings.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year, with more than 50 public bodies now operating our model policy. We've also now provided more than 400 training sessions since we started in September 2020.

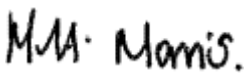
We continued our work to publish complaints statistics into a second year, with data now published twice a year and we included information about Health Boards for the first time in 22/23. This data allows us to see information with greater context – for example, last year 3% of Cardiff and Vale University Health Board's complaints were referred to PSOW.

I would encourage Cardiff and Vale University Health Board, to use this data to better understand your performance on complaints.

Further to this letter can I ask that Cardiff and Vale University Health Board takes the following actions:

- Present my Annual Letter to the Board at the next available opportunity and notify me of when these meetings will take place.
- Update my office on how the Health Board has complied with the recommendations in our report: *Groundhog Day 2: an opportunity for cultural change?* by **1 December 2023**.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Council's considerations and proposed actions on the above matters at your earliest opportunity.

Yours sincerely,



Michelle Morris
Public Services Ombudsman

cc. Suzanne Rankin, Chief Executive, Cardiff and Vale University Health Board.
By Email only: suzanne.rankin@wales.nhs.uk

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Factsheet

Appendix A - Complaints Received

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	166	0.28
Betsi Cadwaladr University Health Board	225	0.33
Cardiff and Vale University Health Board	137	0.28
Cwm Taf Morgannwg University Health Board	134	0.30
Hywel Dda University Health Board	104	0.27
Powys Teaching Health Board	23	0.17
Swansea Bay University Health Board	137	0.36
Total	926	0.30

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Appendix B - Received by Subject

Cardiff and Vale University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	5	4%
Clinical treatment in hospital	71	52%
Clinical treatment outside hospital*	10	7%
Complaints Handling	22	16%
Confidentiality	0	0%
Continuing care	0	0%
COVID19	4	3%
De-registration	0	0%
Disclosure of personal information / data loss	1	1%
Funding	0	0%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	0	0%
Mental Health	14	10%
NHS Independent Provider	0	0%
Non-medical services	0	0%
Nosocomial COVID	2	1%
Other	0	0%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	3	2%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	0	0%
Referral to Treatment Time	2	1%
Rudeness/inconsiderate behaviour/staff attitude	0	0%
Total	**137**	

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Appendix C - Complaint Outcomes
(* denotes intervention)

Cardiff and Vale University Health Board		% Share
Out of Jurisdiction	27	21%
Premature	13	10%
Other cases closed after initial consideration	55	43%
Early Resolution/ voluntary settlement*	21	16%
Discontinued	0	0%
Other Reports - Not Upheld	4	3%
Other Reports Upheld*	8	6%
Public Interest Reports*	1	1%
Special Interest Reports*	0	0%
Total	**129**	

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Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	48	160	30%
Betsi Cadwaladr University Health Board	80	231	35%
Cardiff and Vale University Health Board	30	129	23%
Cwm Taf Morgannwg University Health Board	37	141	26%
Hywel Dda University Health Board	41	100	41%
Powys Teaching Health Board	5	23	22%
Swansea Bay University Health Board	33	134	25%
Total	**274**	**918**	30%

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Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2022/23. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2022/23. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Heath Boards in 2022/23. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

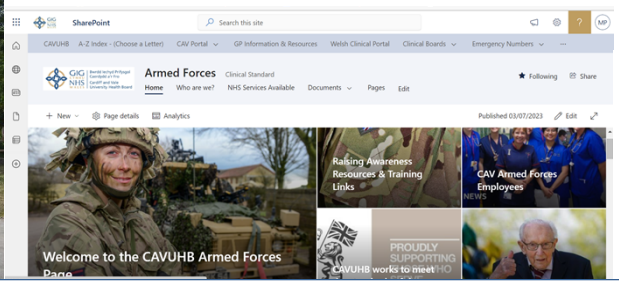
Report Title:	Armed Forces Covenant				Agenda Item no.	7.6	
Meeting:	Board	Public	X		Meeting Date:	28.09.2023	
		Private					
Status *(please tick one only):*	Assurance		Approval	X	Information		X
Lead Executive:	Fiona Jenkins, E DoTHS, Armed Forces and Veterans Executive Lead						
Report Author (Title):	Maisy Provan- Armed Forces Covenant and Veterans Healthcare Collaborative Lead						

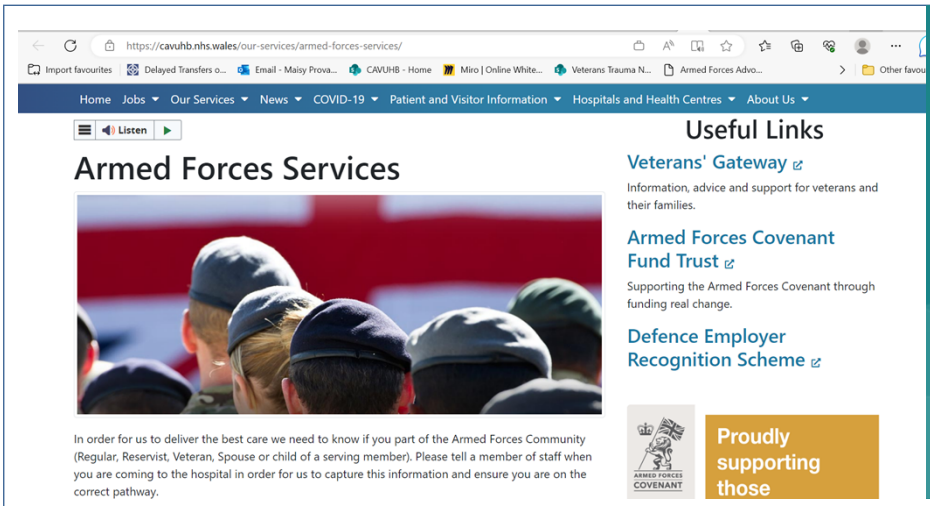
Main Report
Background and current situation:

Signing the Armed Forces Community is a pledge that we will not disadvantage members of the Armed Forces Community as a result of their service. We have a duty as an NHS provision to do this.

Work currently being done in the Health Board to support the Armed Forces Community:

- Digital- recording of veteran status, work in process with a coding element on Patient Management System.
- Poppy programme, roll out to commence- poppy magnets on wards to easily identify armed forces status.
- Armed Forces Awareness Training being delivered to different staff groups.
    - What is the covenant?
    - What are the implications to care and treatment.
- Promoting the RGCP Veterans friendly GP practice scheme- ensuring practices have opportunity for training to receive accreditation
- Defence Medical Welfare Services (DMWS) input
- Engagement events; during armed forces week we did a 'Raising of the Flag' on site at UHW with some of our local air and sea cadets and the Lord Mayor of Cardiff was also in attendance. We also ran a series of webinars throughout the week on different aspects of the Armed Forces Community; forces friendly schools, experience of a military spouse, experience of a reservist and a talk from Fighting with Pride- the only LGBTQ+ military charity.
- Engagement of Armed Forces staff who CAV employ- Breakfast morning running in September at UHW funded by the V4P charity collaboration.
- Looking at our recruitment of the Armed Forces Community and pledging with Step into Health and Forces Families Jobs however both require us to have signed the covenant.
- Work is being done to re-accredit our Employer recognition scheme Gold Award- this runs out at the end of 2023 and we need to sign the covenant as one of the tasks.
- Work is being done to re-accredit our Veteran Aware Status- we will need to sign the Armed Forces Covenant for this accreditation.





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

Cardiff and Vale UHB signed the Armed forces Covenant several years ago, and it is now time for us to re-commit our pledge and for the Chair to re-sign the covenant document.

We were one of the first LHBs in Wales to be granted Armed Forces Employer recognition gold status.

Cardiff and Vale UHB has shown its commitment to support armed forces, veterans and their families, chairing the Cardiff and Vale armed forces forum, bringing together local authorities and third sector services to deliver the Covenant aims.

We host Veterans NHS Wales mental health service and also the Veterans trauma network for Wales. WE have recently appointed an Armed Forces Covenant and Veterans Healthcare Collaborative Lead on a fixed term externally funded contract, who is driving forwards a wide range of elements to further deliver the Covenant commitments.

Re-signing of the Covenent (copy attached as Agenda item 7.7a) is recommended to the Board for approval.

Recommendation:

The Board is requested to:

a) **Note** the report highlighting the work being done to support the Armed Forces and Veterans Community.

b) **Approve** the signing of Armed Forces Covenant (undertaken by the Chair on 8th September 2023)

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		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	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention	X	Long term		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
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:
Senior Leadership Board	24/8/23

Company / Organisation Name

We, the undersigned, commit to honour the Armed Forces Covenant and support the Armed Forces Community. We recognise the value Serving Personnel, both Regular and Reservists, Veterans and military families contribute to our business and our country.

Signed on behalf of:

Company / Organisation Name

Signed:

Name:

Position:

Date:

Add company logo

The Armed Forces Covenant

An Enduring Covenant Between

The People of the United Kingdom
His Majesty's Government

– and –

All those who serve or have served in the Armed Forces of the Crown

And their Families

The first duty of Government is the defence of the realm. Our Armed Forces fulfil that responsibility on behalf of the Government, sacrificing some civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our Armed Forces. In return, the whole nation has a moral obligation to the members of the Naval Service, the Army and the Royal Air Force, together with their families. They deserve our respect and support, and fair treatment.

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

Section 1: Principles of The Armed Forces Covenant

1.1 We **Company Name** will endeavour in our business dealings to uphold the key principles of the Armed Forces Covenant, which are:

- *no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizen*
- *in some circumstances special treatment may be appropriate especially for the injured or bereaved.*

Section 2: Demonstrating our Commitment

The following are suggested draft pledges covering the range of Defence personnel for whom support may be given. Delete, add or change any of the pledges to show how you can pledge support for Defence personnel in ways best suited to you. Pledges may be changed at any time in the future to reflect your changing circumstances.

2.1 We recognise the value serving personnel, reservists, veterans and military families bring to our business and to our country. We will seek to uphold the principles of the Armed Forces Covenant, by:

- **Promoting the Armed Forces:** promoting the fact that we are an Armed Forces-friendly organisation, to our staff, customers, suppliers, contractors and wider public.
- **Veterans:** supporting the employment of veterans, recognising military skills and qualifications in our recruitment and selection process; working with the Career Transition Partnership (CTP) to support the employment of Service leavers;
- **Service Spouses & Partners:** supporting the employment of Service spouses and partners; partnering with the Forces Families Jobs Forum (https://www.forcesfamiliesjobs.co.uk/); and providing flexibility in granting leave for Service spouses and partners before, during and after a partner's deployment.
- **Reserves:** supporting our employees who are members of the Reserve Forces; granting additional paid/unpaid leave for annual Reserve Forces training; supporting any mobilisations and deployment; actively encouraging members of staff to become Reservists;
- **Cadet Organisations:** supporting our employees who are volunteer leaders in military cadet organisations, granting additional leave to attend annual training camps and courses; actively encouraging members of staff to become volunteer leaders in cadet organisations; supporting local military cadet units; recognising the benefits of employing cadets/ex-cadets within the workforce.
- **National Events:** supporting Armed Forces Day, Reserves Day, the Poppy Appeal Day and Remembrance activities;
- **Armed Forces Charities:** supporting Armed Forces charities with fundraising and supporting staff who volunteer to assist;
- **Commercial Support:** offering a discount to members of the Armed Forces community;
- **Any additional commitments the company wishes to make.**

2.2 We will publicise these commitments through our literature and/or on our website, setting out how we will seek to honour them and inviting feedback from the Service community and our customers on how we are doing. [Amend as appropriate]

Report Title:	GPW Cardiff Edge CD1 Building Name			Agenda Item no.	7.7
Meeting:	UHB Board	Public	X	Meeting Date:	28th Sept 2023
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive:	Abigail Harris				
Report Author (Title):	Michaela John (Head of Programme, Genomics Partnership Wales)				

Main Report

Background and current situation:

Genomics Partnership Wales (GPW) received Welsh Government funding to develop a building (CD1) at Cardiff Edge Business Park to co-locate key genomics service and research partners (All Wales Medical Genomics Service, Pathogen Genomics Unit and Wales Gene Park). The refurbishment programme was managed by the C&V Capital Estates team and the refurbished facility will be a Cardiff and Vale asset.

Each partner has an existing brand and identity, alongside GPW that represents the genomics programme in Wales and all of the partners involved in delivering it. The naming of the building has previously been discussed in a number of forums and had engagement from several groups of stakeholders including GPW Governance Board, GPW Estates Senior team, GPW Patient & Public Sounding Board and staff groups from the partner organisations.

Some of the key messages around a name have included:

- It needs to clearly articulate what the building is for and where it is (i.e. Wales)
- Naming after an individual – there is a risk of people not knowing who they are

The Sounding Board and staff groups were given three (slightly different) choices and asked which they prefer – the advisory outputs were as follows with the majority preference in **bold**:

Sounding Board

- **Genomics Centre for Wales**
- Genomics Wales
- Sir Peter Harper Centre for Genomics

Staff

- Genome Centre for Wales
- Harper Genome Centre for Wales
- **Genomic Medicine Centre for Wales**

This information was discussed at GPW Governance Board on 21st July. After discussion by all members it was agreed that the name that best reflects the nature of the services provided at the site and reflects the preferred names of the GPW sounding board and staff groups from the partner organisations is:

"Canolfan Iechyd Genomig Cymru / Wales Genomic Health Centre"

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

This proposed name was recommended for approval at the UHB's Senior Leadership Board (SLB) on 21st September 2023.

Recommendation:

The Board is requested to:

Approve the following name for the new genomics hub at Cardiff Edge Business Park, following SLB endorsement on the 21st September.

Canolfan Iechyd Genomig Cymru / Wales Genomic Health Centre

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		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		Collaboration	x	Involvement	x

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
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
The refurbishment programme is on target to achieve BREEAM 'Very Good' (Minimum Score 55%; Current Score (August 2023) 57.26%)

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:
GPW Governance Board	21st July 2023

Report Title:	Corporate Risk Register				Agenda Item no.	8.1	
Meeting:	Board Meeting		Public	x	Meeting Date:	30.09.2023	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	Director of Corporate Governance						
Report Author (Title):	Risk and Regulation Officer						

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 2023 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 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.

September 2023 Update

Assurance Strategy Update:

Following the July 2023 Board Meeting the Team have continued to work with Clinical Board Triumvirates and Corporate Directorates to refine the Corporate Risk Register Assurance Map so that it is able to accurately reflect what Assurance can be taken in relation to those risks included within the Register. The Assurance Map can 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 tool 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 17 risks rated amber where we are able to report that that there is reasonable assurance that risks are being adequately mitigated and 24 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 CRR 8, 12, 13, 16, 17, 18, 32, 33, 34, 35, 36, 37, 38, 39, 40);
2) Where limited assurance external reviews have been shared (CRR, 19, 24, 25, 26, 27, 29, 30 and 31); 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.

Corporate Risk Register Update:

There are currently 40 Extreme Risks recorded on the Register. Nine risks reported at the July Board meeting will be removed (8, 9, 10, 11, 12, 17, 19, 20 and 35) following the September Board meeting. Five of the risks being removed are from the Medicine Clinical Board following a robust review of their register. These risks will be removed because they have been superseded or because they have been mitigated to a score below 20/25 and will continue to be managed locally. The risks to be removed from the register are coloured grey for ease of identification.

Risks CRR 8, 11, 12, 23, 33, 35, 36, 38, 39 and 40 have been added for the current meeting.

The Board are asked to note that some of the risks within the Corporate Risk Register are amalgamations of separate risks:

- Risks CRR1, CRR4, CRR5 and CRR7 on the Corporate Risk Register are amalgamations of risks within the Capital Estates and Facilities Risk Register; and
- Risk CRR26 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 and Facilities, Medicine, Children and Women, CD&T, PCIC, Surgery and Mental Health Clinical Boards. The People and Culture Corporate Team reported no Extreme Risks. No returns were received from Specialist Services and Digital Health.

The present position is therefore as follows:

July 2023	September 2023
• 36 Risks rated 20 (Extreme Risk). 7 of which are new entries.	• 40 Risks rates 20 (Extreme Risk). 10 of which are new entries.

Trend Analysis

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.

It is hoped that Capital and Estates facilities risks will be mitigated as Capital Projects are undertaken and completed throughout the year, however it should be noted that there are significant operational and financial pressures that mean that the Health Board's ability to address estates issues is restricted.

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, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 32, 33, 35, 26, 37, 38, 39, and 40
Capital Assets	1, 2, 3, 4, 6, 7, 8, 13, 14, 23, 26, 27 and 28, 31 and 40

Workforce	4, 10, 11, 12, 18, 19, 23, 24 and 34
Financial Sustainability	5, 29, 30
Staff Wellbeing	4, 23, 24
Critical Care	24, 25, 26
Planned Care	9, 10
Cancer	9, 10
Maternity	14, 17
Urgent and Emergency Care	8, 11
Digital Strategy and Road Map	6, 31
Delivery of IMTP 22-25	29, 30

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	10.10.2023
Finance and Performance Committee	27.09.2023

CORPORATE RISK REGISTER SUMMARY July 2023

Risk Ref	Risk (for more detail see individual risk entries)	Clinical Board / Corporate Directorate	Link to BAF	Initial Risk Score	Risk Score May 23	Risk Score July 23	Risk Score September 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 Service Interuption and patient harm due to an inability to remotely connect into the Building Management System	Estates	Capital Assets Patient Safety Digital Strategy and Road Map	4x5=20		4x5=20	4x5=20	4x1=4
CRR7	Risk of patient harm, reputational damage, regulatory penalty and service interruption due to limited asset identification and inspection or maintenance of Health Board Ventillation, Smoke/Fire Dampners and Fire Doors	Estates	Capital Assets Patient Safety	5x4=20		5x4=20	5x4=20	5x3=15
CRR8	Risk of Power Outage as automatic changeover system to start low voltage generator is not functioning.	Estates	Capital Assets Patient Safety				5x4=20	5x1=5
	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	5x4=20	5x4=20		5x3=15
	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		5x3=15
	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		5x2=10
	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
	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		5x2=10
CRR9	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	5x4=20	5x2=10
CRR10	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	5x4=20	5x2=10

CRR11	Risk of patient harm due to delays receiving timely assessment for Thrombolysis.	Medicine	Patient Safety Workforce Urgent and Emergency Care	5x5=25			5x4=20	5x2=10
CRR12	Risk of patient harm due to delays providing Home Parenteral Nutrition services and treatment.	Medicine	Patient Safety Workforce	5x5=25			5x4=20	5x2=10
CRR13	Risk of patient harm due to inadequate midwifery and medical staffing issues on obstetric assessment unit	Children and Women	Patient Safety Workforce	5x5=25			5x5=25	5x3=15
CRR14	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	5x4=20	5x2=10
CRR15	Risk of serious adverse outcomes due to delayed or moved antenatal appointments and inadequate senior obstretic staffing levels.	Children and Women	Patient Safety Workforce	5x4=20			5x4=20	5x1=5
CRR16	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	4x5=20	4x2=8
CRR17	There is a risk of patient harm due to the increased demand fo PCCU and NICU beds.	Children and Women	Patient Safety	4x5=20			4x5=0	4x2=8
	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
CRR18	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
	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
	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	Patient Safety 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	5x4=20	5x4=20	5x2=10
CRR22	Risk of regulatory penalty and repuational damage due to potential non-compliance with regulatory accreditation requirements	CD&T	Patient Safety	5x5=25		5x4=20	5x4=20	5x2=10
CRR23	Risk of air conditioning not providing adequate air cooling, which has failed, in the biochemistry lab and is unable to maintain a consistent temperature and has the potential to produce erroneous results.	CD&T	Patient Safety	4x5=20			4x5=20	4x2=8
CRR24	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
CRR25	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
CRR26	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

CRR27	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
CRR28	Risk of patient harm due to reduced access to Epilepsy Telemetry Services	Specialist Services	Patient Safety Capital Assets	5x5=25	5x4=20	5x4=20	5x4=20	5x1=5
CRR29	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
CRR30	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
CRR31	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
CRR32	Risk of patient harm due to a potential inability to support patients with Monitored Dosage Systems in their own homes	PCIC	Patient Safety	4x5=20		4x5=20	4x5=20	4x2=8
CRR33	There is a risk that the Healthcare Dept at HMP Cardiff will unable to meet the needs of patients due to a high number of vacancies in the nursing team.	PCIC	Patient Safety	5x5=25			5x4=20	5x3=15
CRR34	Risk of Service Interuption due uncomprehensive and inconsistent Business Continuity procedures and processes across the Health Board	Strategic Service Planning	Workforce	5x5=25		5x4=20	5x4=20	5x3=15
	Risk of patient and public harm due to an inability to discharge patients from Mental Health Services.	Mental Health	Patient Safety	5x4=20		5x4=20	5x4=20	5x2=10
CRR35	Risk of patient harm due to inability to comply with European Working Time Directive.	Mental Health	Patient Safety	4x5=20			4x5=20	4x1=4
CRR36	Risk of patient harm to severe high risk eating disorder patients due to delays providing access to inpatient beds	Mental Health	Patient Safety	5x4=20			5x4=20	5x2=10
CRR37	Risk of patient harm due to cancellation of Paediatric Scoliosis lists caused by staffing and operational pressures	Surgery	Patient Safety	4x5=20		4x5=20	4x5=20	4x2=8
CRR38	Risk of serious patient harm due to and inability to provide a core Resuscitation service at all times in all areas.	Surgery	Patient Safety	5x4=20			5x4=20	5x1=5
CRR39	Risk that centralisation of OG Services will require 24 hour cover for provision of care. This will impact on a reduction of workforce for other services.	Surgery	Patient Safety	5x4=20			5x4=20	5x2=10
CRR40	Risk of patient harm, due to limited maintenance of Health Board Ventillation Services.	Surgery	Patient Safety	4x5=20			4x5=20	5x2=10

	CRR Reference as at 8.09.23	Corporate Risks as at 8.09.2023	Current Risk Score as of 8.09.23	First Line of Defence Management Controls: Operational Processes and Management Reviews	First Line of Defence Management Controls: Management information and data	First Line of Defence Management Controls: 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 Oversight functions, e.g. Compliance and quality sub-groups and risk management: Health and Safety / Estates	Second Line of Defence Oversight functions, e.g. Compliance and quality sub-groups and risk management: 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, External Audit and other regulators and independent assurance providers.: Internal Audit/NWSSP Estates	Third Line of Defence Internal Audit, External Audit and other regulators and independent assurance providers.: 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	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		
CEF	CRR6	Risk of Service Interuption and patient harm due to an inability to remotely connect into the Building Management System	5x4=20	x	x		x	x	x		x		
CEF	CRR7	Risk of patient harm, reputational damage, regulatory penalty and service interruption due to limited asset identification and inspection or maintenance of Health Board Ventillation, Smoke/Fire Dampners and Fire Doors	5x4=20	x	x	x	x	x	x		x		
CEF	CRR8	Risk of Power Outage as autormatic changeover system to start low voltage generator is not functioning	5x4=20	x	x	x	x	x	x				
Med	CRR9	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	CRR10	Risk of patient harm due to workforce and capacity constraints across Gastroenterology & Endoscopy.	5x4=20	x	x		x	x	x				
Med	CRR11	Risk of patient harm due to delays receiving timely assessment for Thrombolysis	5x4=20	x	x	x	x		x	x			
Med	CRR12	Risk of patient harm due to delays providing Home Parenteral Nutrition services and treatment	5x4=20	x	x		x		x				
C&W	CRR13	Risk of patient harm due to inadequate midwifery and medical staffing issues on obstetric assessment unit	5x5=25	x	x		x		x				
C&W	CRR14	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	CRR15	Risk of serious adverse outcomes due to delayed or moved antenatal appointments and inadequate senior obstretic staffing levels.	5x4=20	x	x		x	x	x	x	x		
C&W	CRR16	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	CRR17	There is a risk of patient harm to C&YP due to the increased demand fo PCCU and NICU beds.	5x4=20	x	x	x	x	x	x				
C&W	CRR18	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	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	

CD&T	CRR22	Risk of regulatory penalty and reputational damage due to potential non-compliance with regulatory accreditation requirements	5x4=20	x	x	x	x	x	x	x		x	
CD&T	CRR23	Risk of air conditioning not providing adequate air cooling, which has failed, in the biochemistry lab and is unable to maintain a consistent temperature and has the potential to produce erroneous results.	5x4=20	x	x	x	x	x	x	x		x	
Spec Serv	CRR24	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	CRR25	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	CRR26	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	CRR27	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	CRR28	Risk of patient harm due to reduced access to Epilepsy Telemetry Services	5x4=20	x	x	x	x		x	x	x		
Fin	CRR29	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	CRR30	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	CRR31	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	x	
PCIC	CRR32	Risk of patient harm due to a potential inability to support patients with Monitored Dosage Systems in their own homes	4x5=20	x	x		x		x				
PCIC	CRR33	There is a risk that the Healthcare Dept at HMP Cardiff is unable to meet the needs of patients due to a high number of vacancies in the nursing team.	5x4=20	x	x		x		x				
Strategic SP	CRR34	Risk of Service Interuption due uncomprehensive and inconsistent Business Continuity procedures and processes across the Health Board	4x5=20	x	x		x		x				
Mental Health	CRR35	Risk of patient and public harm due to an inability to discharge patients from Mental Health Services.	5x4=20	x	x		x		x				
Mental Health	CR36	Risk of patient harm to do severe high risk eating disorders getting timely access to inpatient beds	5x4=20	x	x		x		x				
Surgery	CRR37	Risk of patient harm due to cancellation of Paediatric Scoliosis lists caused by staffing and operational pressures	5x4=20	x	x		x		x				
Surgery	CRR38	Risk of serious patient harm due to the core function of the Resuscitation service unable to be fulfilled at all times.	5x4=20	x	x		x		x				
Surgery	CRR39	Risk that centralisation of OG will require 24 hour cover for provision of care. This will impact on a reduction of workforce for other services.	5x4=20	x	x		x		x				
Surgery	CRR40	Risk of patient harm, due to limited maintenance of Health Board Ventillation	4x5=20	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

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	18 July 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/meetings-and-papers/july-2023/

- The minutes of the EASC meeting held on 16 May 2023 were approved.

PERFORMANCE REPORT

The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan. In presenting the report, Ross Whitehead highlighted a number of key areas.

Members noted that:

- The latest Ambulance Service Indicators (ASIs) https://easc.nhs.wales/asi/ would be published on Thursday 20 July, reporting the June position
- 999 call volumes were 8% lower than in May 2022
- 4% reduction in incidents
- Hear and treat rates continued to improve
- See and treat rate back to the historical norm
- Improvements in response times – all on an improving trajectory as well as for those patients waiting the longest in the red and amber categories, although there was still a long way to go before the performance would be considered satisfactory (but in the right direction)
- An increase in the number of patients conveyed to hospital compared to the same period last year – this needed to be analysed further and would be presented to the EASC Management Group
- Improvement in handover delays and the number of patient waiting over 4 hours has reduced, in some areas this has been eradicated while others, though showing signs of improvement, required continued attention
- EASC Action Plan was being updated and, although it was no longer required to be submitted monthly, would be used at the Integrated Quality, Planning and Delivery meetings with Welsh Government.

Discussion took place and Members raised the issue of variation both across Wales but also within health boards. Members welcomed the dashboard approach in providing clarity and sought assurance that the data was being validated, particularly in relation to red release. Members noted that the weekly dashboard was constantly under review and enhancements would continue where members identified additional requirements.

Members discussed the impact of reducing handover delays and the expectation that this would affect performance although this had not yet been seen with performance in red consistently at the mid 50% level.

Jason Killens was asked to forecast where and when improvements would be seen and whether the assumptions made in the IMTP would be realised. Further discussion took place in relation to variation and Members noted good performance improvement in some areas whereas others were stubbornly at unacceptable levels. Further improvements were anticipated with the roll out of the Cymru High Acuity Response Units (CHARUs) and the improved utilisation of the ambulance fleet.

Stephen Harrhy raised the role of the Community First Responders, particularly in rural areas and also the variation in conveyance rates across health boards which would be important areas for the deployment of Advanced Paramedic Practitioners (APPs) in trying to avoid conveyance. Jason Killens explained that additional CFRs had been recruited & trained.

It was agreed that additional work would be required to retrospectively analyse the data from the electronic patient clinical record (ePCR) and other sources to correctly categorise the work; this would be included in the next report and would have the alternative services identified.

Members noted:

- Modelling suggested 4% of WAST activity could be dealt with in the Same Day Emergency Care (SDEC) units; this was currently at 0.2%
- The aim to make more use of video consultation, and to use to best effect
- The development of directories of services in health boards and the importance of ensuring access for WAST staff
- For lower acuity chest pain patients and some care homes analyse the data for potential opportunities to create services and track through actions (real time access)
- The importance of driving out variation in an environment of improving performance.

The version of data presented to the Committee was raised in view of the requirement for StatsWales to publish the Ambulance Service Indicators before any publication of the information. Ross Whitehead explained that ongoing meetings were taking place with the aim to resolve the issue and be agile as commissioners of the ambulance service. The aim would be to try and make progress in some areas with a view to ensuring the Committee had the most current information. Members noted that the Office of National Statistics (ONS) had been tasked to produce cross UK measures for health, which in view of the four different operating models was a complex request.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received.

In presenting the report, Ross Whitehead highlighted the presentation of the revised quality report in light of the requirements of the Duty of Candour and Duty of Quality.

Noted that:

- 25 ongoing investigations under the Joint Framework in May
- Work continuing to identify key themes in meetings with WAST and health boards

- The Welsh Risk Pool were supporting the work and seeking improvement opportunities for the tracking and reporting of joint investigations
- Reduction in the number of patients waiting over 12 hours in the community, although still a large number, the trajectory was one of improvement
- Improvement in the compliance of the clinical indicators within the Ambulance Service Indicators
- A technical error had been identified within the STEMI bundle and this would be rectified back to June 2020
- The published levels for the return of spontaneous circulation (ROSC) was 20% (the highest level achieved)
- The latest information was not available in respect of patients arriving as 'walk ins' but in the triage category one. This would be rectified as it was agreed this was an important metric for patient safety. Joint work was underway with the NHS Wales Delivery Unit (NHS Executive) to analyse those self-presenting and included stroke patients (high level of patients presenting at emergency departments).

Members responded asking about:
- learning from the North East Ambulance Service review and the potential to undertake a gap analysis to secure any insight or learning – noted that the EASC Team currently analysing the review and would report to EASC Management Group on any findings
- other reviews of ambulance services and noted that the EASC Team constantly scan for any ambulance service reviews and consider any learning. This would again be reported initially via EASC Management Group. Jason Killens also confirmed that WAST routinely undertake a gap analysis approach to any significant report on ambulance services.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received. This included:
- Integrated Medium Term Plan 2023-26
- Current EASC Integrated Medium Term Plan (IMTP) Tracker
- Non-Emergency Patient Transport Services (NEPTS) Strategic Direction
- Integrated Commissioning Action Plans (ICAPs)

Members noted that:
- Work had commenced on reviewing the Non-Emergency Patient Transport Services Commissioning Framework as per the agreed commissioning cycle
- The work to develop a longer-term strategy for NEPTS following the completion of the business case and adapting to the ongoing changes within the service. The final report would be presented at a future meeting
- In relation to the EASC IMTP Tracker some of the performance ambitions had been achieved including:
  - longest red – 95th percentile 30 minutes by the end of Quarter 1 – this had been achieved and it was suggested to review Quarter 2 ambition to <18 minutes
  - longest amber – 95th percentile 8 hours by the end of Quarter 1; this had been achieved and suggested revising the Quarter 2 ambition to 4.5 hours and Quarter 3 to 3.5 hours.

Agreed to: Revise the performance ambitions as outlined above

FOCUS ON – EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS) SERVICE REVIEW

Stephen Harrhy gave an overview of the work to date and introduced Lee Leyshon, Deputy Director of Communications and Engagement to deliver the presentation on the emerging themes.

Noted:

- Discussed the factors for developing options for the service and the weightings as previous used for EMRTS developments
- In relation to the EMRT Service:
  - General support and appreciation
  - Local bases mean local services for the people who live near
  - Some consider it a 'fast ambulance'
  - Understanding of a problem to fix
  - Important about effectiveness of working with other services and agencies
  - Implications for hours of operation, for air and road, with staffing implication
  - The small mutual aid implications
- In terms of wider issues and the original service development proposal:
  - Another rural loss – like banks, dentists, GP practices, post offices etc
  - Lack of understanding of 'unmet need'
  - The rationale for the original base locations; the coastal locations and the importance of rapid response vehicles RRVs
  - That the critical care staff would want to treat as many patients as possible
  - The impact of the weather on services
- In reference to the Wales Air Ambulance Charity:
  - Potential reputational damage with a risk to funding
  - Perception of cost saving
  - Accepted the findings of the original Service Development Review
- For rural and coastal areas the following issues were regularly raised:
  - Remote and lone working in high risk occupations
  - Seasonal population variations
  - Impact of rural geography, road infrastructure and topography
  - Mobile phone coverage
  - Patient road transfer experiences and outcomes
  - Impact of climate change affecting access
- Public perception that services prioritised in urban areas when using services per head of population and the respective needs were different in rural and urban areas
- Response times was a major concern, of increased response times, losing the 'golden hour' and the impact of adverse weather. The proximity to emergency department in urban areas was raised regularly
- Data was an area of focus regularly raised in sessions including:
  - The initial data period involving the Covid period
  - The significance of the average response times
  - Using historical and forecasting data
  - Seasonal and population variation and projected demographics for rural areas
  - Understanding the under-utilisation data
- In terms of the factors and weightings:
  - Regular questions related to cost saving perception
  - Cross over between the factors suggested

- Importance of defining the factors
- That clinical skills and sustainability needed a higher score and a reduction to the value for money weighting.

- With regard to the engagement process:
  - Understood a complex matter
  - Questionnaire available at all sessions and online
  - Increased and regular communications
  - Commissioner trusted and the public confidence in the approach
  - Responses received included 'balanced, fair, comprehensive and diligent'; not a 'fait accompli'
- Suggestions received included:
  - Same bases different hours; all bases 24/7; base investments; all 4 into one base
  - Variations on the issues above with RRV usage
  - Make either (or both) Welshpool and Caernarfon 24/7 instead of Cardiff
  - More RRVs to be available
  - Move the South Wales bases
  - That WAST provide similar critical care skilled staff
  - Make more incremental changes from aviation contract
  - Opportunities to work with Fire and Rescue
- Broader system issues included appreciation of the scale and landscape, the vulnerabilities and the context of other services
- Concerns about WAST in out of area; handover delays, triaging of 999 calls and recruitment of staff
- For health boards – primary and secondary care in terms of loss of access to services; sustainability of services (local) and how people can have a say (want to be involved)
- For public services – need to be more integrated; recognise local service loss and its impact; involve the local populations more and more raise more awareness
- For policy and decision makers – understand the current pressures; reliance on charitable donations; road infrastructure important and involving the public in decision making.

Members raised the following:

- Thanked the CASC and the EASC Team for their thorough exemplar process; lots of learning for the system on the strength of the approach
- The timescales for the independent analysis, keen to ensure the collective perspective considered
- Sharing the data, modelling and information received from the engagement process
- The importance of the next phase.

Stephen Harrhy explained the next phase of work in terms of sharing data, learning from the approach and responding to the concerns by formally reporting at the next meeting to provide the facts for the Committee to consider. Further modelling would be available for members to scrutinise at the next meeting.

Members noted that there was a strength of feeling in the locality of the Welshpool and Caernarfon bases in their desire to maintain the status quo.

Areas for further consideration would include:

- Making the best use of resources (mindful of the very different levels of utilisation of the current service)
- Whether the EMRT Service is too specialised and what opportunities could exist for different patient groups
- How rural areas receive health care and the issues with time sensitive requirements

- The options for a new base and whether this could be delivered by the Charity in terms of infrastructure – some assurance for the next phase
- Adapting the approach in light of the comments received and amending the weightings on clinical skills and value for money
- Options for closer working between WAST and EMRTS
- The wider picture – local areas primarily mentioned bases; Stakeholder Reference Groups across health board areas did not have major concerns if the service would be improved for all of the population, and in particular providing more ability to deliver to patients in the unmet need category.

Stephen Harrhy explained that further work was required in order to make a recommendation to Members and that Members in turn would make a fully informed decision no earlier than the meeting in November. Members noted the risk of reputational damage to the Charity and the potential impact on donations. Members agreed the importance of making the best use of the commissioning allocation for EMRTS and WAST.

A factual report including data and the independent analysis of the responses received would be provided at the September meeting.

It was reiterated that it was too early to make a recommendation to EASC and **no decision had been made.**

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received. Lee Leyshon presented the report and gave an overview of work to date in the phased approach.

Noted:
- Suggestions to slightly amend the weightings
- Plans for next report at the September meeting
- Continuation of the approach including planning of Phase 2 and maintaining work with the All Wales Communications and Engagement leads in health boards and trusts; and planning & informatics colleagues.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received. In presenting the report, Jason Killens highlighted:

- The use of the Clinical Safety Plan - WAST were at escalation level 2 (4 is the maximum) and in May 2023, WAST spent 1% of the time at Clinical Safety Plan (CSP) level 3b (the third highest level). The levels of escalation and CSP were significantly lower than those seen in the depths of winter, which was reflected in the lower levels of patient cancellations and "no sends"
- Red Performance and the continued roll out of the Cymru High Acuity Resource Units (CHARU), about half had been commenced and more staff are being recruited, trained and deployed with an aim to build on the roster rota work and ensure the right fleet mix across Wales. This would improve red performance and the already seen increase in the return of spontaneous circulation (ROSC) rate.

- Ambulance production levels against the plan for the latest four months at 97% against the ambition of 95%
- The progress made by health boards in reducing handover delays at emergency departments and the consequential impact on the ambulance service
- The numbers of patients conveyed at 41% into EDs in May 2023 (27% in December 2022, with the Clinical Safety Plan affecting this)
- The Non-Emergency Patient Transport Services (NEPTS) and meeting the targets for kidney patients in arriving within 30 minutes of the appointment time (performance at 75% to the target of 70%). Also, an amendment had been made for the service provided to oncology patients moving from -30/+30mins to -45/+15mins to provide a better service for this group of patients
- The first meeting of the Strategic Demand and Capacity Review had taken place at WAST with the aim of making the best use of resources available and continuing the approach.

Stephen Harrhy raised the issue of **red release** and confirmed the ongoing work to study the impact of the immediate release on the service provided. This would include validating the data before this was shared in the public domain, although it was acknowledged that this would potentially lead to a short time lag as this was a manual process. The work to develop confidence in the information included the health board Chief Operating Officers and their teams who receive the unvalidated report and therefore can challenge the data with respect to their areas. Further updates would be provided as the work progresses.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received. In presenting the report, Stephen Harrhy highlighted key areas which included:

- Six Goals for Urgent and Emergency Care Programme (latest highlight report shared) work continuing to deliver Goal 4 and locally based work captured through the Integrated Commissioning Action Plan (ICAP) meetings.
  - A new clinical lead, Dr Tim Rogerson, had been appointed by the Six Goals for Urgent and Emergency Care Programme. Collaborative work had started on what a good emergency department would look like and a clinical event had been planned.
  - Specific work was planned in Swansea Bay and Betsi Cadwaladr UHBs to pilot an approach undertaken in Bristol 'the continuous flow work' as well as learning the system lessons from the experience in Cardiff & Vale and more recently Cwm Taf Morgannwg UHBs.
- Connected Support Cymru (previously known as Night Sitting Service) An update report would be provided on progress at the next meeting
- Data linking – the plan to hold a workshop was still in place although it was not yet scheduled as further steps were required to ensure all information sources would be available and reliable. At that stage, a workshop would be held with all relevant health boards, WAST and Digital Health and Care Wales (DHCW) staff. Members noted that DHCW had also been commissioned by Welsh Government to develop an urgent and emergency care dashboard
- Health Education and Improvement Wales (HEIW) – Education commissioning of Paramedics and Advanced Paramedic Practitioners (APPs). Positive conversations had taken place with the EASC Team and it was suggested and agreed that Alex Howells, CEO of HEIW would be invited to periodically attend the Committee

meeting. Members suggested the importance of the timescales for this work to meet academic timetables.

EASC FINANCIAL PERFORMANCE REPORT MONTH 12 2022/23

The EASC Financial Performance Report at month 3 in 2023/24 was received. There were no variances to report on the financial position given the very early point in the financial year.

SUMMARY OF THE EASC MANAGEMENT GROUP MEETING HELD ON 22 JUNE 2023

The first summary from a meeting of the EASC Management Group was received. The aim of the report was to ensure consistency of issues identified at the ongoing meetings.

Members noted:

- Ongoing discussions on a health board by health board basis re operational matters of WAST staff undertaking supporting duties within EDs to help flow and get the balance right
- Work to ensure the consistency of data, especially in relation to immediate release.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved:

- EASC Management Group 20 April 2023
- Non-Emergency Patient Transport Services Delivery Assurance Group notes 13 April 2023
- Emergency Medical Retrieval and Transfer Service Delivery Assurance Group 6 March 2023

EASC GOVERNANCE

The report on EASC Governance was received which included the:

- EASC Risk Register and suggested approach to risk appetite
- EASC Assurance Framework
- EASC Key Organisational Contacts
- Welsh Language Commissioner – Final Report and Decision Notice
- Letter to host in relation to the statutory Duty of Quality and Candour.

Noted that:

- The Risk Register had five red risks in total, three scoring the highest level at 25.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register
- The latest EASC Key Organisational Contacts report was presented and Members asked to review their organisational representatives at EASC and its sub groups
- The Welsh Language Commissioner – Final Report and Decision Notice and ongoing work
- Letter to host in relation to the statutory Duty of Quality and Candour - Stephen Harrhy had signed on behalf of the Committee to confirm that EASC would use reasonable endeavours to comply with the legislation and activities where appropriate and cooperate and provide any necessary data and/or information it requires, as Host Health Board to discharge its duties under the Health and Social Care (Quality and Engagement) (Wales) Act.
  A formal report on the EASC compliance would be included in next year's Annual Governance Statement (Added to Action Log).

Members **agreed** to the use of **CTMUHBs Risk Appetite Statement** for commissioning risks until arrangements could be developed for the new Joint Committee.
FORWARD LOOK AND ANNUAL BUSINESS PLAN The Forward Look and Annual Business Plan was received and approved.
Key risks and issues/matters of concern and any mitigating actions
• Red and amber performance • Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on services provided to HB local communities and to WAST • The ongoing formal engagement process for the EMRTS Service Review, further meetings planned for later in the year
Matters requiring Board level consideration
• Opportunity for health boards to take part in the public engagement process related to the potential changes to EMRTS Cymru working in partnership with the Wales Air Ambulance Charity. • To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive
Forward Work Programme and Annual Business Plan
Considered and agreed by the Committee.

Committee minutes submitted	Yes	√	No	
Date of next meeting	**19 September 2023**			

Report Title:	Local Partnership Forum Report			Agenda Item no.	
Meeting:	UHB Board	Public	x	Meeting Date:	
		Private			
Status *(please tick one only):*	Assurance		Approval		Information x
Lead Executive:	Executive Director of People and Culture				
Report Author (Title):	Head of People Assurance and Experience				

Main Report
Background and current situation:

The UHB has statutory duty to "take account of representations made by persons who represent the interests of the community it serves". This is achieved in part by three Advisory Groups to the Board and the Local Partnership Forum (LPF) is one of these.

LPF is co-chaired by the Chair of Staff Representatives and the Executive Director of People and Culture. Members include Staff Representatives (including the Independent Member for Trade Unions) and the Executive Team and Chief Executive. The Forum usually meets 6 times a year.

LPF is the formal mechanism for the Health Board and Trade Union/Professional Organisation Representatives to work together to improve health services. Its purpose, as set out in the Terms of Reference, fall into four overarching themes: communicate, consider, consult and negotiate, and appraise.

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

Key items discussed at the meeting held on 10 August 2023 can be summarised as follows:

The Chief Executive provided an update report to the Forum. Key points included:

- The strategy refresh work has continued, engagement has concluded, and the draft high-level strategy document has been shared with Board. It has predominantly been agreed, with alterations to be made around the language used. Following Board approval, engagement is required surrounding delivery and how this will be mobilised across the organisation. The challenge of this taking place simultaneously alongside the unprecedented financial challenge the UHB is facing was noted
- The UHB has articulated an £88 million forecast deficit position, including a £32m savings programme, though at the current trajectory we anticipate ending the year £16 million short. Following the First Minister's statement, the UHB has also been asked to look at additional savings, and the significance of the ask was noted. Work has been completed on scenarios given by Welsh Government (WG) and are now awaiting feedback from WG following a review of this information. The areas of focus to identify the remaining savings were discussed.
- Staff representatives Members were thanked for their continued support and willingness to engage in partnership working. The Chief Executive further extended her thanks to all staff for taking care of patients and each other as new challenges are faced, including increasingly high levels of patient demand and complex patient needs.

Staff representatives highlighted the significance of compassionate leadership, and the way staff are managed especially around sickness and work-related stress. The Chief Executive acknowledged that the culture in the organisation is falling short of expectations in some areas, and that culture will be major contributor in achieving the ambitions set out within the Strategy. Staff representatives appreciated the transparency shown, but also raised concerns around the confusion surrounding the

vacancy scrutiny process and asked to be involved at earliest opportunity to help shape the language used moving forward. Staff representative members felt that the shape of workforce and structural change is what will make UHB fit for the future, and that short-term initiatives can only go so far in steering the changes which are needed. The Chief Executive acknowledged that changes had to be implemented at pace and agreed that Forum engagement was necessary.

The Executive Nurse Director and Nurse Staffing Levels Lead presented the Annual Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act (2016) which had previously been received by Board. The following points were noted:

- SafeCare highlights opportunities for staffing levels to be levelled out, allowing for quick action and assessment of the causes and justification for shortages where wards are understaffed.
- During rostering processes, managers are rostered as supernumerary, however it was acknowledged that this is not always the case in practice. Although this is a requirement for section 25B wards the UHB approach at present is to apply this across all wards.
- Executive Nursing Directors in Wales are campaigning for a review of this legislation with an aim for it to be less prescriptive about who is responsible for caring for a patient.
- The importance of finding balance between supporting the organisation with financial recovery through efficient rostering and enabling staff to benefit from a healthy work/life balance, and supporting the retention of experienced staff, was acknowledged.
- The enthusiasm and passion of the Trade Unions on this subject was noted. Staff representative members of the Forum asked to be involved, highlighting the staff development initiatives and policies as key areas where involvement would be appreciated.

The Local Partnership Forum received a copy of the Integrated Performance Report which had previously been considered by Board.

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

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term		Integration		Collaboration	x	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
Patient Safety, Quality and Experience is included in the Integrated Performance Report
Financial: Yes/No Yes
The financial situation is included in the Integrated Performance Report and was also referred to in the CEO Update
Workforce: Yes/No Yes
Key WOD KPIs and workforce actions are included in the Integrated Performance Report
Legal: Yes/No No
Reputational: Yes/No No
Socio Economic: Yes/No No
Equality and Health: Yes/No Yes
The Strategic Equalty Plan was included on the agenda
Decarbonisation: Yes/No No

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

Schedule 4.2

MODEL STANDING ORDERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Schedule forms part of, and shall have effect as if incorporated in the Local Health Board Standing Orders

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006. When agreeing SOs Local Health Boards must ensure they are made in accordance with directions as may be issued by Welsh Ministers. Each Local Health Board (LHB) in Wales must agree Standing Orders (SOs) for the regulation of the Emergency Ambulance Services Committee's (the EASC or the Joint Committee) proceedings and business.

These EASC Standing Orders (EASC SOs) form a schedule to each LHB's own Standing Orders, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014 No.566 (w.67)) and LHB Standing Order 3 into day to day operating practice. Together with the adoption of a Schedule of decisions reserved to the Joint Committee; a Scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Joint Committee.

These documents, together with the Memorandum of Agreement dated [26 September 2017] made between the Joint Committee and the seven LHBs in Wales that defines the respective roles of the seven LHB Accountable Officers and a hosting agreement dated [26 September 2017] between the Joint Committee and **[Insert name of host]** (the host LHB), form the basis upon which the Joint Committee governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All LHB Board members, Joint Committee members, LHB and Emergency Ambulance Services Team (EAST) staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Committee Secretary of the Joint Committee will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements for the Joint Committee.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/ .

Contents (note – to be updated following agreement of amendments)

Section: A – Introduction

Statutory framework

i) The Emergency Ambulance Services Committee (the Joint Committee) is a joint committee of each Local Health Board (LHB) in Wales, established under the **Emergency Ambulance Services Committee (Wales) Regulations 2014** (the EASC Regulations). The functions and services of the Joint Committee are listed in the **Emergency Ambulance Services Committee (Wales) Directions 2014,** (EASC Directions) and are subject to variations to those functions agreed from time to time by the Joint Committee**.** The Directions were amended by the **Emergency Ambulance Services Committee (Wales) Amendment Directions 2016.** The Joint Committee is hosted by the **[insert name of host]** on behalf of each of the seven LHBs.

ii) The principal place of business of the EASC is **[insert address]**

iii) All business shall be conducted in the name of the Emergency Ambulance Services Committee on behalf of LHBs.

iv) LHBs are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions.

v) Sections 12 and 13 of the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on LHBs and to give directions about how they exercise those functions. LHBs must act in accordance with those directions. Most of the LHBs' statutory functions are set out in the Local Health Boards (Directed Functions) (Wales) Regulations 2009.

vi) However in some cases the relevant function may be contained in other legislation.

vii) Each LHB's functions include planning, funding, designing, developing and securing the delivery of primary, community, in-hospital care services, and specialised services for the citizens in their respective areas. The EASC Directions provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance and non-emergency patient transport services and for the purpose of jointly exercising those functions will establish the joint committee.

viii) Under powers in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006 the Minister has made the EASC Regulations, which set out the constitution and membership arrangements of the Joint Committee. Certain provisions of the **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** (the Constitution Regulations) will also apply to the operations of the Joint Committee, as appropriate.

ix) In addition to directions the Welsh Ministers may from time to time issue guidance relating to the activities of the Joint Committee which LHBs must take into account when exercising any function.

x) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour); and,
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The guidance outlines the responsibilities of Local Health Board when commissioning services for their population. EASC shall ensure they consider these responsibilities in the discharge of their duties.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

xi) The **[insert name of host]**, as the host LHB shall issue an indemnity to the Chair, on behalf of the LHBs.

NHS framework

xii) In addition to the statutory requirements set out above, the Joint Committee, on behalf of each of the LHBs, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xiii) Adoption of the principles will better equip the Joint Committee to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiv) The overarching NHS governance and accountability framework within which the Joint Committee must work incorporates the LHBs SOs; Schedule of Powers reserved for the Board; and Scheme of Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xv) The Welsh Ministers, reflecting their constitutional and legal obligations under the **Well-being of Future Generations (Wales) Act 2015 (2015 No.02)**, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

xvi) The **Well-being and Future Generations (Wales) Act** also places duties on LHBs and some NHS Trusts in Wales. Sustainable development in the context of the act means the process of improving the economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

xvii) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Minister's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

xviii) Directions or guidance on specific aspects of LHB business are also issued electronically, usually under cover of a Welsh Health Circular.

Joint Committee Framework

xix) The specific governance and accountability arrangements established for the Joint Committee are set out within:

- These EASC Standing Orders (SOs) and the Schedule of Powers reserved for the Joint Committee and the Scheme of Delegation (The Cwm Taf University LHB Scheme of Delegation has been adopted for use by the Committee in November 2016) to others;
- The EASC SFIs (The Cwm Taf Standing Financial Instructions have been adopted for use by the Committee in November 2016);
- A Memorandum of Agreement defining the respective roles of the seven LHB Accountable Officers; and
- A hosting agreement between the Joint Committee and the host LHB in relation to the provision of administrative and any other services to be provided to the Joint Committee.

xx) **Annex 2** to these SOs provides details of the key documents that, together with these SOs, make up the Joint Committee's governance and accountability framework. These documents must be read in conjunction with these EASC SOs.

xxi) The Joint Committee may from time to time, subject to the prior approval of each LHB's Board, agree operating procedures which apply to Joint Committee members and/or members of the EAS Team and others. The decisions to approve these operating procedures will be recorded in an appropriate Joint Committee minute and, where appropriate, will also be considered to be an integral part of these EASC SOs and SFIs. Details of the Joint Committee's key operating procedures are also included in **Annex 2** of these SOs.

Applying EASC Standing Orders

xxii) The EASC SOs (together with the EASC SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any Joint Committee Sub Groups established by the Joint Committee, including any Advisory Groups. The EASC SOs may be amended or adapted for the Joint Committee Sub Groups or Advisory Groups as appropriate, with the approval of the Joint Committee. Further details on Joint Committee Sub Groups and Advisory Groups may be found in Annexes 3 and 4 of these EASC SOs, respectively.

xxiii) Full details of any non-compliance with these EASC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Committee Secretary, who will ask the nominated Audit Committee at **[insert name of host]** to formally consider the matter and make proposals to the Joint Committee on any action to be taken. All Joint Committee members and Joint Committee officers have a duty to report any non-compliance to the Committee Secretary as soon as they

are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with EASC SOs is a disciplinary matter.**

Variation and amendment of EASC Standing Orders

xxiv) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the Joint Committee determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the Joint Committee, advised by the Committee Secretary, shall submit a formal report to each LHB Board setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the seven LHBs are in favour of the amendment; or
- In the event that agreement cannot be reached, Welsh Ministers determine that the amendment should be approved.

Interpretation

xxv) During any Joint Committee meeting where there is doubt as to the applicability or interpretation of the EASC SOs, the Chair of the Joint Committee shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Committee Secretary.

xxvi) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these EASC SOs when interpreting any term or provision covered by legislation.

Relationship with LHB Standing Orders

xxvii) The EASC SOs form a schedule to each LHB's own SOs, and shall have effect as if incorporated within them.

The role of the Committee Secretary

xxviii) The role of the Committee Secretary is crucial to the ongoing development and maintenance of a strong governance framework within the Joint Committee, and is a key source of advice and support to the Chair and Joint Committee members. Independent of the Joint Committee, the Committee Secretary acts as the guardian of good governance within the Joint Committee:

- Providing advice to the Joint Committee as a whole and to individual Committee members on all aspects of governance;
- Facilitating the effective conduct of Joint Committee business through meetings of the Joint Committee, Joint Committee Sub Groups and Advisory Groups;

- Ensuring that Joint Committee members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Joint Committee acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the Joint Committee's compliance with the law, EASC SOs and the framework set by the LHBs and Welsh Ministers.

xxix) As advisor to the Joint Committee, the Committee Secretary's role does not affect the specific responsibilities of Joint Committee members for governing the Committees operations. The Committee Secretary is directly accountable for the conduct of their role to the Chair of the Joint Committee.

Section: B – EASC Standing Orders

1. THE JOINT COMMITTEE

1.1 Purpose and Delegated functions

1.1.1 The Joint Committee has been established for the purpose of jointly exercising those functions relating to the commissioning of emergency ambulance and non-emergency patient transport services on a national all-Wales basis, on behalf of each of the seven LHBs in Wales.

1.1.2 LHBs are responsible for those people who are resident in their areas. Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the duty on individual LHBs remains, and they are ultimately accountable to citizens and other stakeholders for the provision of emergency ambulance and non-emergency patient transport services for residents within their area.

1.1.3 Each LHB will have appropriate arrangements to equip the Chief Executive to represent the views of the individual Board and discharge their delegated authority appropriately.

1.1.4 The Joint Committee's role is to:

- Determine a long-term strategic plan for the development of emergency ambulance services and non-emergency patient transport services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance and non-emergency patient transport services;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of emergency ambulance and non-emergency patient transport services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the EAS Team) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the commissioning risks;
- Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance and non-emergency patient transport services and take appropriate action.

1.1.5 The Joint Committee must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each LHB shall be bound by the decisions of the Joint Committee in the exercise of its roles. In the event that the Joint Committee is unable to reach agreement, then the matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the Joint Committee shall lead and scrutinise the operations, functions and decision making of the EAS Team undertaken at the direction of the Joint Committee.

1.1.7 The Joint Committee shall work with all its partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the Joint Committee

1.2.1 The membership of the Joint Committee shall be 9 voting members and three associate members, comprising the *Chair* (appointed by the Welsh Ministers) and the *Vice-Chair* (appointed by the Joint Committee from existing chief officer (executive) or nominated representatives of the seven LHBs), together with the following:

Chief Officers or nominated representative

1.2.2 A total of 7, drawn from each Local Health Board in Wales. (Where a Chief Officer intends to nominate a representative the nomination must be an Officer Member (Executive Director) of the LHB, must be in writing addressed to the Chair of the Joint Committee and must specify if the nomination is for a specific length of time.

Officer Member

1.2.3 An officer member employed by [**insert name of host**] (the host LHB) to undertake the functions of the Chief Ambulance Services Commissioner. In addition,

1.2.4 Where a post of Chief Ambulance Services Commissioner is shared between more than one person because of their being appointed jointly to a post:

i. Either or both persons may attend and take part in Joint Committee meetings;
ii. If both are present at a meeting they shall cast one vote if they agree;
iii. In the case of disagreement no vote shall be cast; and
iv. The presence of both or one person will count as one person in relation to the quorum.

Associate Members

1.2.5 The following three Associate Members who will attend Joint Committee meetings on an ex-officio basis, but will not have any voting rights:

- Chief Executive of Velindre NHS Trust;
- Chief Executive of the Welsh Ambulance Services NHS Trust;
- Chief Executive of Public Health Wales NHS Trust.

In attendance

1.2.6 The Joint Committee Chair may invite other members of the EAS Team or others to attend all or part of a meeting on an ex-officio basis to assist the Joint Committee in its work.

1.3 Member Responsibilities and Accountability

1.3.1 The Joint Committee will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the Joint Committee.

1.3.2 All members must comply with the terms of their appointment to the Committee. They must equip themselves to fulfil the breadth of their responsibilities on the Joint Committee by participating in relevant personal and organisational development programmes, engaging fully in the activities of the Joint Committee and promoting understanding of its work.

The Chair

1.3.3 The Chair is responsible for the effective operation of the Joint Committee:

- Chairing Joint Committee meetings;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all Joint Committee business is conducted in accordance with EASC SOs; and
- Developing positive and professional relationships amongst the Joint Committee's membership and between the Joint Committee and each LHB's Board.

1.3.4 The Chair shall work in close harmony with the Chair of each LHB and, supported by the Committee Secretary, shall ensure that key and appropriate issues are discussed by the Joint Committee in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.5 The Chair is directly accountable to the Minister for Health and Social Services in respect of their performance as Chair, to each LHB Board in

relation to the delivery of the functions exercised by the Joint Committee on its behalf and, through the host LHB's Board, for the conduct of business in accordance with the defined governance and operating framework.

The Vice-Chair

1.3.6 The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

1.3.7 The Vice-Chair is accountable to the Chair for their performance as Vice-Chair.

Officer Members

1.3.8 Officer members are accountable to the Chair for their performance.

1.4 Appointment and tenure of Joint Committee members

1.4.1 The ***Chair,*** appointed by the Minister for Health and Social Services shall be appointed for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. The Chair may be reappointed but may not serve a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.2 The ***Vice-Chair*** shall be appointed by the Joint Committee from amongst the Chief Executives or their nominated representatives of the seven Local Health Boards for a period of no longer than two years in any one term. These members may be reappointed but may not serve a total period of more than four years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.

1.4.3 Reference to the tenure of office of the Vice-Chair are to this appointment and not to their tenure of office as a member of the Joint Committee.

1.4.4 The appointment process for the Vice-Chair shall be determined by the Joint Committee, subject to the approval of each LHB Board and any directions made by the Welsh Ministers. In making these appointments, the Joint Committee must ensure:

- A balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the Joint Committee;
- That wherever possible, the overall membership of the Joint Committee reflects the diversity of the population; and

- Potential conflicts of interest are kept to a minimum.

1.4.5 All Joint Committee members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they applicable, and as specified in the relevant regulations. Any member must inform the Joint Committee Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

2. RESPONSIBILITIES AND RELATIONSHIPS WITH EACH LHB BOARD, THE HOST LHB AND OTHERS

2.0.1 The Joint Committee is not a separate legal entity from each of the LHBs. It shall report to each LHB Board on its activities, to which it is formally accountable in respect of the exercise of the functions carried out on their behalf. The Joint Committee shall also be held to account by the Welsh Government through the NHS performance management system.

2.0.2 The Board of the host LHB will not be responsible or accountable for the planning, funding and securing of emergency ambulance or non-emergency patient transport services, save in respect of residents within the areas served. The Board of the host LHB shall be responsible for ensuring that the EAS Team acts in accordance with its administrative policies and procedures.

2.0.3 Each LHB Board may agree that designated board members or LHB officers shall be in attendance at Joint Committee meetings. The Joint Committee Chair may also request the attendance of Board members or LHB officers, subject to the agreement of the relevant LHB Chief Officer.

2.0.4 The LHBs jointly shall determine the arrangements for any meetings between the Joint Committee and LHB Boards.

3. RESERVATION AND DELEGATION OF JOINT COMMITTEE FUNCTIONS

3.0.1 Within the framework approved by each LHB Board and set out within these EASC SOs - and subject to any directions that may be given by the Welsh Ministers - the Joint Committee may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Joint Committee must set out clearly the terms and conditions upon which any delegation is being made.

3.0.2 The Joint Committee's determination of those matters that it will retain,

and those that will be delegated to others shall be set out in a:

i. Schedule of matters reserved to the Joint Committee;
ii. Scheme of delegation to Joint Committee Sub Groups and others; and

Scheme of delegation to Officers all of which must be formally adopted by the Joint Committee.

3.0.3 The Joint Committee retains full responsibility for any functions delegated to others to carry out on its behalf.

3.1 Chair's action on urgent matters

3.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Joint Committee need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Joint Committee. In these circumstances, the Joint Committee Chair and the Chief Ambulance Services Commissioner, supported by the Committee Secretary, may deal with the matter on behalf of the Joint Committee - after first consulting with at least one other Joint Committee Member. The Committee Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Joint Committee for consideration and ratification.

3.1.2 Chair's action may not be taken where either the Joint Committee Chair or the Chief Ambulance Services Commissioner has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair and/or Assistant Chief Ambulance Services Commissioner will take a decision on the urgent matter, as appropriate.

3.2 Delegation to Joint Committee Sub-Committees and Others

3.2.1 The Joint Committee shall agree the delegation of any of their functions to Joint Committee sub-Committees or sub-Groups or others, setting any conditions and restrictions it considers necessary and following any directions agreed by the LHBs or the Welsh Ministers.

3.2.2 The Joint Committee shall agree and formally approve the delegation of specific powers to be exercised by Joint Committee sub-Committees or sub-Groups which it has formally constituted or to others.

3.3 Delegation to Officers

3.3.1 The Joint Committee will delegate certain functions to the Chief Ambulance Services Commissioner (CASC). For these aspects, the CASC, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other

officers to undertake the remaining functions. The CASC will still be accountable to the Joint Committee for all functions delegated to them irrespective of any further delegation to other officers.

3.3.2 This must be considered and approved by the Joint Committee (subject to any amendment agreed during the discussion). The Chief Ambulance Services Commissioner may periodically propose amendments to the Scheme of Delegation and any such amendments must also be considered and approved by the Joint Committee.

3.3.3 Individual Chief Officers are in turn responsible for delegation within their own teams in accordance with the framework established by the Chief Ambulance Services Commissioner and agreed by the Joint Committee.

4. JOINT COMMITTEE SUB-COMMITTEES AND SUB-GROUPS

4.0.1 In accordance with EASC Standing Order 4.0.3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Ministers must, appoint sub-Committees and sub-Groups of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

4.0.2 These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

4.0.3 The Joint Committee shall establish a Joint Committee sub-Committee and sub-Groups structure that meets its own advisory and assurance needs and in doing so the needs of the constituent LHBs. As a minimum it shall establish joint –sub-Committee which cover the following aspects of Joint Committee business:

- Quality and Safety
- Audit

4.0.4 The Joint Committee may make arrangements to receive and provide assurance to others through the establishment and operation of its own Joint Committee sub-Committee or sub-Groups or by placing responsibility with the host LHB or other designated LHB. Where responsibility is placed with the host LHB or other designated LHB, the arrangement shall be detailed within the hosting agreement between the Joint Committee and the host LHB or the agreement between the seven LHB Accountable Officers (as appropriate).

4.0.5 Full details of the Joint Committee sub-Committee or sub-Groups structure

established by the Joint Committee, including detailed terms of reference for each of these Joint Committee sub-Committees or sub-Groups are set out in **Annex 3** of these EASC SOs.

4.0.6 Each Joint Committee sub-Committee or sub-Group established by or on behalf of the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.0.7 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Joint Committee Sub-Groups, keeping any such aspects to the minimum necessary.

4.0.8 The membership of any such Joint Committee sub-Committee or sub-Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements, regulations or directions agreed by the LHBs or the Welsh Ministers. Depending on the Joint Committee sub-Committees' or sub-Groups' defined role and remit; membership may be drawn from the Joint Committee, LHB Board or committee members, staff (subject to the conditions set out in EASC SOs 4.0.9) or others.

4.0.9 Members of the EAS Team should not normally be appointed as Joint sub-Committee Chair, nor should they be appointed to serve as members of any sub-Committee set up to review the exercise of functions delegated to officers. Designated EAS Team officers shall, however, be in attendance at Joint sub-Committees/groups as appropriate.

4.1 Other Groups

4.1.1 The Joint Committee may also establish other groups to help it in the conduct of its business.

4.2 Reporting activity to the Joint Committee

4.2.1 The Joint Committee must ensure that the Chairs of all Joint Committee

sub-Committees and sub-Groups and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the Joint Committee on their activities. Joint Committee sub-Committee and sub-Group Chairs' shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.2.2 Each Joint Committee sub-Committee and sub-Group shall also submit an annual report to the Joint Committee through the Chair within - six weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

5. EXPERT PANEL AND OTHER ADVISORY GROUPS

5.0.1 The Joint Committee may, and where directed by the LHBs jointly or the Welsh Ministers must appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the Joint Committee, including detailed terms of reference are set out in **Annex 4** of the EASC SOs.

5.0.2 Any Expert Panel or Advisory Group established by the Joint Committee must have its own terms of reference and operating arrangements, which must be formally approved by the Joint Committee These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.0.3 In doing so, the Joint Committee shall specify which aspects of the EASC SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

5.0.4 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Joint Committee, subject to any specific requirements or directions agreed by the LHBs or the Welsh Ministers.

5.1 Reporting activity

5.1.1 The Joint Committee shall ensure that the Chairs of any Sub Group reports formally, regularly and on a timely basis to the Joint Committee on their activities. Sub Group Chairs shall bring to the Joint Committees specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.1.2 Any Sub Group shall also submit an annual report to the Joint Committee through the Chair within six weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

6. MEETINGS

6.1 Putting Citizens first

6.1.1 The Joint Committee's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The Joint Committee, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read, where requested or required, and in electronic formats;
- Requesting that attendees notify the Committee Secretary of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g. Disability Discrimination Act, as well as its Communication Strategy and the provisions made by the host body in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

6.1.2 The Joint Committee Chair will ensure that, in determining the matters to be considered by the Joint Committee, full account is taken of the views and interests of all citizens served by the Joint Committee on behalf of

each LHB, including any views expressed formally.

6.2 Working with Llais

6.2.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs and Trusts in relation to the engagement and involvement of Llais in their operations.

6.2.2 The 2020 Act places a statutory duty on LHBs and Trusts to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

6.2.3 The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.2.4 The 2020 Act also places a statutory duty on LHBs and NHS Trusts to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. LHBs and Trusts must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant).

6.2.5 The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.2.6 The LHBs, Welsh Ambulance Services NHS Trust and Joint Committee will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning, developing, considering proposals for service change and commissioning services.

6.2.7 The Joint Committee shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretary, on behalf of the Joint Committee Chair, shall produce an Annual Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Plan shall also set out any standing items that shall appear on every Joint Committee agenda.

6.3.2 The plan shall set out the arrangements in place to enable the Joint Committee to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Joint Committee members to contribute in either English or Welsh languages, where appropriate.

6.3.3 The plan shall also incorporate formal Joint Committee meetings, regular Committee Development sessions and, where appropriate, the planned activities of Joint Committee sub-Committees or sub-Groups, Expert Panel and Advisory Groups.

6.3.4 The Joint Committee shall agree the plan for the forthcoming year by the end of March, and this plan shall be published on the organisations website.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the Joint Committee, the Joint Committee Chair may call a meeting of the Joint Committee at any time. Any LHB may request that the Chair call a meeting, or an individual committee member may also request that the Joint Committee Chair call a meeting provided that in either case at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from Joint Committee members, then those Joint Committee members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The Joint Committee Chair, in consultation with the Committee Secretary and the Chief Ambulance Services Commissioner, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Joint Committee business; any standing items agreed by the Joint Committee; any applicable items received from Joint Committee Sub Group and other groups as well as the priorities facing the Joint Committee. The Joint Committee Chair must ensure that all relevant matters are brought before the Joint Committee on a timely basis.

6.5.2 Any Joint Committee member may request that a matter is placed on the Agenda by writing to the Joint Committee Chair, copied to the Committee Secretary, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of Joint Committee business.

Notifying and equipping Joint Committee members

6.5.3 Joint Committee members should be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Joint Committee meeting. This information may be provided to Joint Committee members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Joint Committee Chair is satisfied that the Joint Committee's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the Joint Committee unless the Joint Committee Chair is satisfied (subject to advice from the Committee Secretary, as appropriate) that the information contained within it is sufficient to enable the Joint Committee to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Joint Committee, and the outcome of that assessment shall accompany the report to the Joint Committee to enable the Joint Committee to make an informed decision.

6.5.5 In the event that at least half of the Joint Committee members do not receive the Agenda and papers for the meeting as set out above, the Joint Committee Chair must consider whether or not the Joint Committee would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Joint Committee Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.5.6 In the case of a meeting called by Joint Committee members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.5.7 Except for meetings called in accordance with EASC Standing Order 6.4,

at least 10 calendar days before each meeting of the Joint Committee a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On each LHB's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Joint Committee's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, each LHB shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

6.6 Conducting Joint Committee Meetings

Admission of the public, the press and other observers

6.6.1 The Joint Committee shall encourage attendance at its formal Joint Committee meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the Joint Committee. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility.

6.6.2 The Joint Committee shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter affecting an EAS team member or a patient. In such cases the Chair (advised by the Committee Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Joint Committee shall resolve:

> *'That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].'*

6.6.3 In these circumstances, when the Joint Committee is not meeting in public session it shall operate in private session, formally reporting any decisions taken to the next meeting of the Joint Committee in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Joint Committee meeting held in public session.

6.6.4 The Committee Secretary, on behalf of the Joint Committee Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.6.5 In encouraging entry to formal Joint Committee Meetings from members of the public and others, the Joint Committee shall make clear that attendees are welcomed as observers. The Joint Committee Chair shall take all necessary steps to ensure that the Joint Committee's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

6.6.6 Unless the Joint Committee has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Joint Committee, its Joint Committee Sub-Groups, Expert Panel or Advisory Groups

6.6.7 The Joint Committee shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the Joint Committee, its Joint Committee sub-Committees or sub-Groups, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Joint Committee will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Joint Committee (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business.

Chairing Joint Committee Meetings

6.6.8 The Chair of the Joint Committee will preside at any meeting of the Joint Committee unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice-Chair shall preside. If both the Chair and Vice-Chair are absent or disqualified, the Chief Executives present will agree who will preside.

6.6.9 The Chair must ensure that the meeting is handled in a manner that enables the Joint Committee to reach effective decisions on the matters before it. This includes ensuring that Joint Committee members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Joint Committee must have access to appropriate advice on the conduct of the meeting through the attendance of the Committee Secretary. The Chair has the final say on any matter relating to the conduct of Joint Committee business.

Quorum

6.6.10 At least four voting members, whom are LHB Chief Executives, must be present to allow any formal business to take place at a Joint Committee meeting.

6.6.11 If a LHB Chief Executive is unable to attend a Joint Committee meeting they may nominate a representative/deputy to attend on their behalf. The nominated representative/deputy should be an Officer Member (Executive Director) of the same organisation. Nominated representatives/deputies will formally contribute to the quorum and will have delegated voting rights.

6.6.12 If the Chief Ambulance Services Commissioner or another Associate Member is unable to attend a Joint Committee meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, their voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Joint Committee member in their own right, e.g. a person deputising for the Chief Ambulance Services Commissioner will usually be the Assistant Chief Ambulance Services Commissioner, they will not have any voting rights.

6.6.13 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Joint Committee member or their nominated deputy/representative disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.14 In the normal course of Joint Committee business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Joint Committee member may put forward a motion proposing that a formal review of that service area is undertaken. The Committee Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Joint Committee unless moved by a Joint Committee member or their deputy/representative and seconded by another Joint Committee member or their deputy/representative (including the Joint Committee Chair).

6.6.15 **Proposing a formal notice of Motion –** Any Joint Committee member wishing to propose a motion must notify the Joint Committee Chair in

writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Joint Committee Chair has determined that the proposed motion is relevant to the Joint Committee's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the Joint Committee Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.16 The Joint Committee Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Joint Committee business.

6.6.17 **Amendments –** Any Joint Committee member or their deputy/representative may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Joint Committee alongside the motion.

6.6.18 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e., the substantive motion.

6.6.19 **Motions under discussion** – When a motion is under discussion, any Joint Committee member or their deputy/representative may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Joint Committee member may not be heard further;
- The Joint Committee decides upon the motion before them;
- An ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.6.20 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.6.21 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Joint Committee Chair.

6.6.22 **Motion to rescind a resolution –** The Joint Committee may not consider a motion to amend or rescind any resolution (or the general substance of

any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Joint Committee members.

6.6.23 A motion that has been decided upon by the Joint Committee cannot be proposed again within six months except by the Joint Committee Chair, unless the motion relates to the receipt of a report or the recommendations of a Joint Committee sub-Committee or sub-Group /EASC Director to which a matter has been referred.

Voting

6.6.24 The Joint Committee Chair will determine whether Joint Committee members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Joint Committee Chair must require a secret ballot or recorded vote if the majority of voting Joint Committee members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted. Associate Members may not vote in any meetings or proceedings of the Joint Committee.

6.6.25 In determining every question at a meeting the Joint Committee members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of citizens in Wales.

6.6.26 The Joint Committee will make decisions based on a two thirds majority view held by the voting Joint Committee members present. In the event of a split decision, i.e., no majority view being expressed, the Joint Committee Chair shall have a second and casting vote.

6.6.27 A nominated deputy/representative of a LHB Chief Executive may vote. In no circumstances may a nominated deputy of the Chief Ambulance Commissioner vote. Absent Joint Committee members may not vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal Joint Committee meetings (and any other meetings of the Joint Committee where the Joint Committee members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Joint Committee member attendance (including the Joint Committee Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Joint Committee, where any discussion shall be limited to matters of accuracy. Any agreed

amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with Joint Committee members' wishes, and, where providing a record of a formal Joint Committee meeting shall be made available to the public on each LHB's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Freedom of Information Act, the Joint Committee's Communication Strategy and the [**Insert host body]** Welsh language requirements.

6.8 Confidentiality

6.8.1 All Joint Committee members (including Associate members), together with members of any Joint Committee sub-Committee or sub-Group, Expert Panel or Advisory Group established by or on behalf of the Joint Committee and Joint Committee and/or LHB officials must respect the confidentiality of all matters considered by the Joint Committee in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Joint Committee Chair or relevant Joint Committee sub-Committee or sub-Group or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework or legislation such as the Freedom of Information Act 2000, etc.

7. VALUES AND STANDARDS OF BEHAVIOUR

7.0.1 The Joint Committee must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Joint Committee, including Joint Committee members, EAS Team officers and others, as appropriate. The framework adopted by the Joint Committee will form part of the EASC SOs. The Values and Standards of Behaviour document is the same as the Welsh Health Specialised Services Joint Committee.

7.1 Declaring and recording Joint Committee members' interests

7.1.1 **Declaration of interests –** It is a requirement that all Joint Committee members should declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Joint Committee member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Joint Committee's business. Joint Committee members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations.

Joint Committee members must notify the Joint Committee of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Joint Committee members.

7.1.2 Joint Committee members must also declare any interests held by family members or persons or bodies with which they are connected. The Committee Secretary will provide advice to the Joint Committee Chair and the Joint Committee on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Joint Committee members are in any doubt about what may be considered as an interest, they should seek advice from the Committee Secretary. However, the onus regarding declaration will reside with the individual Joint Committee member.

7.1.3 **Register of interests –** The Chief Ambulance Services Commissioner, through the Committee Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Joint Committee members. The register will include details of all Directorships and other relevant and material interests which have been declared by Joint Committee members.

7.1.4 The register will be held by the Committee Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Joint Committee members. The Committee Secretary will also arrange an annual review of the register, through which Joint Committee members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the Joint Committee's commitment to openness and transparency, the Committee Secretary must take reasonable steps to ensure that citizens served by the Joint Committee are made aware of, and have access to view the Joint Committee's Register of Interests. This will include publication on the EASC website.

7.1.6 **Publication of declared interests in Annual Report –** Joint Committee members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each LHB Board's Annual Report.

7.2 Dealing with Members' interests during Joint Committee meetings

7.2.1 The Joint Committee Chair, advised by the Committee Secretary, must ensure that the Joint Committee's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Joint Committee members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales.

7.2.2 Where individual Joint Committee members identify an interest in relation to any aspect of Joint Committee business set out in the Joint Committee's meeting agenda, that member must declare an interest at the start of the Joint Committee meeting. Joint Committee members should seek advice from the Joint Committee Chair, through the Committee Secretary before the start of the Joint Committee meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Joint Committees minutes.

7.2.3 It is the responsibility of the Joint Committee Chair, on behalf of the Joint Committee, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i. The declaration is formally noted and recorded, but that the Joint Committee member should participate fully in the Joint Committee's discussion and decision, including voting. This may be appropriate, for example where *[insert relevant example];*

ii. The declaration is formally noted and recorded, and the Joint Committee member participates fully in the Joint Committee's discussion, but takes no part in the Joint Committee's decision;

iii. The declaration is formally noted and recorded, and the Joint Committee member takes no part in the Joint Committee discussion or decision;

iv. The declaration is formally noted and recorded, and the Joint Committee member is excluded for that part of the meeting when the matter is being discussed. A Joint Committee member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Joint Committee.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Joint Committee member is compatible with an identified conflict of interest.

7.2.5 Where the Joint Committee Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice-Chair, on behalf of the Joint Committee.

7.2.6 In all cases the decision of the Joint Committee Chair (or the Vice-Chair in the case of an interest declared by the Joint Committee Chair) is binding on all Joint Committee members. The Joint Committee Chair should take

advice from the Committee Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a Joint Committee member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Joint Committee including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Joint Committee may determine that the Joint Committee member concerned shall be excluded from that part of the meeting.

7.2.8 The **Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2009** define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. The EASC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a Joint Committee meeting, an individual Joint Committee member may establish a clear conflict of interest between their role as a Joint Committee member and that of their professional role outside of the Joint Committee. In any such circumstance, the Joint Committee shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Committee Secretary.

7.3 Dealing with officers' interests

7.3.1 The Joint Committee must ensure that the Committee Secretary, on behalf of the Chief Ambulance Services Commissioner, establishes and maintains a system for the declaration, recording and handling of EAS Team officers' interests in accordance with the Values and Standards of Behaviour Framework. This will be done in conjunction with the declarations of interest recorded by the Welsh Health Specialised Services Committee which is also hosted by **[Insert name of Host Body]**

7.4 Reviewing how Interests are handled

7.4.1 The Joint Committee's Audit Committee will review and report to the LHBs upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

7.5 Dealing with offers of gifts[2], hospitality and sponsorship

7.5.1 The Values and Standards of Behaviour Framework [the **insert title of EASC policy/and or procedure]** adopted by the Joint Committee prohibits Joint Committee members and EAS Team officers receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any Joint Committee member or EAS Team officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Joint Committee member or EAS Team officer. Failure to observe this requirement may result in disciplinary and/or legal action.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Committee Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;
- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Joint Committee;
- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);
- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Joint Committee; and

[2] The term gift refers also to any reward or benefit.

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Sponsorship

7.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

7.6.2 All sponsorship must be approved prior to acceptance in accordance with the **Values and Standards of Behaviour Framework** [LHB to insert title of relevant policy] and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

7.7 Register of Gifts, Hospitality and Sponsorship

7.7.1 The Committee Secretary, on behalf of the Joint Committee Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts, hospitality and sponsorship made to Joint Committee members. The EAS Team officers will adopt a similar mechanism in relation to **[Insert name of host body]** staff working within their areas.

7.7.2 Every Joint Committee member and EAS Team officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship made in their capacity as Joint Committee members, including those offers that have been refused. The Committee Secretary, on behalf of the Joint Committee Chair and Chief Ambulance Services Commissioner, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship is kept under active review, taking appropriate action where necessary.

7.7.3 When determining what should be included in the register with regards to gifts and hospitality, individuals must apply the following principles, subject to the considerations in EASC Standing Order 7.5:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value would not usually need to be recorded, e.g., seasonal items such as diaries/calendars with normally fall within this category.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

7.7.4 Joint Committee members and EAS Team Officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- Acceptance would further the aims of the Joint Committee;
- The level of hospitality is reasonable in the circumstances;
- It has been openly offered; and,
- It could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.7.5 The Committee Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Joint Committee to be submitted to the designated Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the LHBs jointly upon the adequacy of the Joint Committees arrangements for dealing with offers of gifts, hospitality and sponsorship.

8. GAINING ASSURANCE ON THE CONDUCT OF JOINT COMMITTEE BUSINESS

8.0.1 The Joint Committee shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to LHBs jointly on the conduct of Joint Committee business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

8.0.2 The Joint Committee shall ensure that its assurance arrangements are operating effectively, advised by the Joint Committee's Audit Committee.

8.1 The role of Internal Audit in providing independent internal assurance

8.1.1 The Joint Committee shall ensure the effective provision of an

[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any others requirements determined by the Welsh Ministers.

8.2 Reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups

8.2.1 The Joint Committee shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Joint Committee Sub Group, expert panel and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated.

8.2.2 Each Joint Committee Sub Group and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the Joint Committee through the Chair within six weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

8.2.3 The Joint Committee, and in turn the LHBs jointly shall use the information from this evaluation activity to inform:

- The ongoing development of its governance arrangements, including its structures and processes;
- Its Committee Development Programme, as part of an overall Organisation Development framework; and
- Inform each LHBs report of its alignment with the Welsh Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

8.3 External Assurance

8.3.1 The Joint Committee shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the LHB's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

8.3.2 The Joint Committee may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Joint Committee itself may commission specifically for that purpose.

8.3.3 The Joint Committee shall keep under review and ensure that, where

appropriate, the Joint Committee implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee and other appropriate bodies.

8.3.4 The Joint Committee shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

9. DEMONSTRATING ACCOUNTABILITY

9.0.1 Taking account of the arrangements set out within these EASC SOs, the Joint Committee shall demonstrate to the LHBs jointly, citizens and other stakeholders and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of the citizens it serves, its officers and healthcare professionals.

9.0.2 The Joint Committee shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

9.0.3 The Joint Committee shall ensure that within the Emergency Ambulance Services Team (EAST), individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

9.1 Support to the Joint Committee

9.1.1 The Committee Secretary, on behalf of the Joint Committee Chair, will ensure that the Joint Committee is properly equipped to carry out its role by:

- Overseeing the process of nomination and appointment to the Joint Committee;
- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Joint Committee Chair on the conduct of its business and its relationship with LHBs, the host LHB and others;

- Ensuring the provision of secretariat support for Joint Committee meetings;
- Ensuring that the Joint Committee receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups;
- Ensuring an effective relationship between the Joint Committee and its host LHB; and
- Facilitating effective reporting to each LHB

enabling each LHB Board to gain assurance on the conduct of business carried out by Joint Committee on its behalf.

10. REVIEW OF STANDING ORDERS

10.0.1 The EASC SOs shall be reviewed annually by the Joint Committee, which shall report any proposed amendments to the LHBs jointly for consideration and approval. The requirement for review extends to all documents having the effect as if incorporated in EASC SOs, including the appropriate impact assessment.

Annex 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS FOR THE EMERGENCY AMBULANCE SERVICES COMMITTEE

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Introduction

As set out in EASC Standing Order 3, the Emergency Ambulance Services Committee (the Joint Committee) - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Joint Committee may be carried out effectively, and in a manner that secures the achievement of the Joint Committee's aims and objectives. The Joint Committee may delegate functions to:

i) A sub-Committee of the Joint Committee e.g., Audit Committee;

ii) A Group, Expert Panel or Advisory Group, e.g., with other LHBs established to take forward certain matters relating to specialist services; and

iii) Officers of the Joint Committee (who may, subject to the Joint Committee's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Joint Committee is notified of any matters that may affect the operation and/or reputation of the Joint Committee.

The Joint Committee's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Joint Committee;
- Scheme of delegation to Joint Committee sub-Committee or sub Group and others; and
- Scheme of delegation to officers.

all of which form part of the EASC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Joint Committee will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- **Everything is retained by the Joint Committee unless it is specifically delegated in accordance with the requirements set out in EASC SOs or EASC SFIs**

- **The Joint Committee must retain that which it is required to retain (whether by statute or as determined by the Welsh Government) as well as that which it considers is essential to enable it to fulfil its role in setting the Joint Committee's direction, equipping the Joint Committee to deliver and ensuring achievement of its aims and objectives through effective performance management**

- **Any decision made by the Joint Committee to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility**

- **The Joint Committee must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development**

- **The Joint Committee must take appropriate action to assure itself that all matters delegated are effectively carried out**

- **The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes**

- **The Joint Committee may delegate authority to act, but retains overall responsibility and accountability**

- **When delegating powers, the Joint Committee will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.**

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Joint Committee

The Joint Committee will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Ambulance Services Commissioner

The Chief Ambulance Services Commissioner will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Joint Committee must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Ambulance Services Commissioner will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in EASC SFIs);
- The Memorandum of Agreement agreed with the seven LHBs and approved by the Joint Committee; and
- The Hosting Agreement agreed with the host LHB and approved by the Joint Committee.

The Chief Ambulance Services Commissioner may re-assume any of the powers they have delegated to others at any time.

The Committee Secretary

The Committee Secretary will support the Joint Committee in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Joint Committee is presented to the Joint Committee for its formal agreement;
- Effective arrangements are in place for the delegation of Joint Committee functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Joint Committee for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Joint Committee of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[Joint Committee to insert details]** of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner or reallocate powers, e.g., to a Committee or another officer.

The Quality and Safety Committee [Committee name to be inserted]

The Quality and Safety Committee [title to be inserted] will provide assurance to the Joint Committee of the effectiveness of its arrangements for managing quality and safety.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Joint Committee's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter

delegated to them, they must notify **[Joint Committee to insert details]** of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the Joint Committee has set out alternative arrangements.

If the Chief Ambulance Services Commissioner is absent their nominated Assistant may exercise those powers delegated to the Chief Ambulance Services Commissioner on their behalf. However, the guiding principles governing delegations will still apply, and so the Joint Committee may determine that it will reassume certain powers delegated to the Chief Ambulance Services Commissioner or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Joint Committee. The Scheme is to be used in conjunction with the system of control and other established procedures within the Joint Committee.

SCHEDULE OF MATTERS RESERVED TO THE JOINT COMMITTEE[4]

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
1	FULL	GENERAL	The Joint Committee may determine any matter for which it has statutory or delegated authority, in accordance with EASC SOs
2	FULL	GENERAL	The Joint Committee must determine any matter that will be reserved to the whole Joint Committee. These are: • Collaborative Commissioning Framework Agreement(s) • EAS Integrated Medium Term Plan
3	FULL	GENERAL	Approve the Joint Committee's Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Vary, amend and recommend for approval to the Boards of the Local Health Boards: ▪ EASC SOs ; ▪ EASC SFIs; ▪ Schedule of matters reserved to the Joint Committee; ▪ Scheme of delegation to sub-Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[4] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Ambulance Services Commissioner in accordance with EASC Standing Order requirements
6	NO – Nominated Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Committee Secretary on any non-compliance with EASC Standing Orders, making proposals to the Joint Committee on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with EASC Standing Orders, and where required ratify in public session any instances of failure to comply with EASC SOs
8	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's Values and Standards of Behaviour framework [EASC to insert title of relevant policy]
9	NO – Chair on behalf of Joint Committee/Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Joint Committee members' interests, in accordance with advice received, e.g. From Audit Committee or Committee Secretary
10	FULL	STRATEGY & PLANNING	Determine the long term strategic plan, for the development of emergency ambulance services and non-patient transport services in Wales, in conjunction with the Welsh Ministers.
11	FULL	STRATEGY & PLANNING	Approve the Joint Committee's key strategies and programmes related to: ▪ Commissioning Plan and Population Health Needs Assessment

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
			▪ The development and delivery of emergency ambulance and non-emergency patient Transport services for the population of Wales ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
12	FULL	STRATEGY & PLANNING	Approve the Joint Committee's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
13	FULL	STRATEGY & PLANNING	Approve the Joint Committee's budget and financial framework (including overall distribution of the financial allocation and unbudgeted expenditure)
14	FULL	OPERATING ARRANGEMENTS	Approve the Joint Committee's framework and strategy for performance management.
15	FULL	STRATEGY & PLANNING	Approve the Joint Committee's framework and strategy for risk and assurance.
16	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Joint Committee, including standards/requirements determined by Welsh Government, regulators, professional bodies/others, e.g., National Institute for Health and Care Excellence (NICE)
17	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Joint Committee determines it so based upon its contribution/impact on the achievement of the Joint Committee's aims, objectives and priorities

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of officer member of the Joint Committee employed by the host Local Health board (Chief Ambulance Commissioner) in accordance with the provisions of the Regulations and in accordance with Ministerial Instructions.
19	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Joint Committee level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Committee Secretary.
20	FULL	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
21	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Joint Committee sub-groups, including any joint sub-groups directly accountable to the Joint Committee
22	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Joint Committee sub-groups, or Group set up by the Joint Committee
23	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Joint Committee on outside bodies and groups
24	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Joint Committee sub-groups, and groups established by the Joint Committee
25	FULL – except where Chapter	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Ambulance Services

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
	6 specifies appropriate to delegate to Officers.		Commissioner and officers
26	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Joint Committee
27	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Ambulance Services Commissioner set out in the EASC SFIs
28	FULL	PERFORMANCE & ASSURANCE	Approve the Joint Committee's audit and assurance arrangements
29	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Joint Committee's EAS Team on progress and performance in the delivery of the Joint Committee's strategic aims, objectives and priorities and approve action required, including improvement plans
30	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the Joint Committee sub-groups, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans
31	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Joint Committee's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc.) that raise issue or concerns impacting on the Joint Committee's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Joint Committee sub-groups (as appropriate)
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Joint Committee's Chief Internal Auditor and approve action required, including improvement plans
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Joint Committee's external auditor and approve action required, including improvement plans

THE JOINT COMMITTEE		AREA	DECISIONS RESERVED TO THE JOINT COMMITTEE
34	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Joint Committee's performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans
35	FULL	REPORTING	Approve the Joint Committee's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government where required.
36	FULL	REPORTING	Receive, approve and ensure the publication of Joint Committee reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR AND VICE-CHAIR			
34	CHAIR		In accordance with statutory and Welsh Government requirements
35	VICE-CHAIR		In accordance with statutory and Welsh Government requirements

DELEGATION OF POWERS TO SUB-COMMITTEES AND OTHERS[5]

EASC Standing Order 3 provides that the Joint Committee may delegate powers to sub-groups and others. In doing so, the Joint Committee has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such sub-Groups; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Joint Committee has delegated a range of its powers to the following sub-Committees and others:

[sub-Committees and sub-Groups to be inserted]

The scope of the powers delegated, together with the requirements set by the Joint Committee in relation to the exercise of those powers are as set out in i) sub-Group terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the Joint Committee's Scheme of Delegation to Joint Committee Sub Groups.

[5] As defined in Standing Orders

SCHEME OF DELEGATION TO EMERGENCY AMBULANCE SERVICES TEAM AND OFFICERS

The EASC SOs and EASC SFIs specify certain key responsibilities of the Chief Ambulance Services Commissioner, the Director of Finance (WHSSC/EASC) and other officers. The Chief Ambulance Services Commissioner's Job Description sets out their specific responsibilities, and the individual job descriptions determined for other EAS Team level posts also define in detail the specific responsibilities assigned to those post holders.

These documents, set out in detail, together with the schedule of additional delegations below and the associated financial delegations set out in the EASC SFIs form the basis of the Joint Committee's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[Joint Committee to determine]	**[Joint Committee to determine]**

This scheme only relates to matters delegated by the Joint Committee to the Chief Ambulance Services Commissioner and other members of the EAS Team together with certain other specific matters referred to in EASC SFIs. In November 2016, the Joint Committee agreed to use the host body's Standing Financial Instructions (Cwm Taf) and Scheme of Delegation.

Each member of the EAS Team is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated (aligned to the arrangements of the host body).

Annex 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE Services Committee Standing Orders

Joint Committee framework

The Joint Committee's governance and accountability framework comprises these EASC SOs, incorporating schedules of Powers reserved for the Joint Committee and Delegation to others, together with the following documents:

- ***EASC SFIs***
- ***Scheme of Delegation***
- ***Values and Standards of Behaviour Framework***
- ***Risk Register***
- ***Key policy documents***

agreed by the Joint Committee. These documents must be read in conjunction with the EASC SOs and will have the same effect as if the details within them were incorporated within the EASC SOs themselves.

These documents may be accessed by:

EASC Website https://easc.nhs.wales/

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of Joint Committee business are also issued electronically, usually under cover of a Welsh Health Circular.

Annex 3

JOINT COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annex forms part of, and shall have effect as if incorporated in the EMERGENCY AMBULANCE SERVICES COMMITTEE Standing Orders

Sub Groups

[To be inserted]

Terms of Reference

Annex 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annex forms part of, and shall have effect as if incorporated in the Emergency Ambulance Services Committee Standing Orders

Terms of Reference to be included when available

LOCAL PARTNERSHIP FORUM MEETING

Thursday 8th June at 10am, via Teams

Present

Rachel Gidman	Executive Director of People and Culture (co-Chair)
Dawn Ward	Chair of Staff Representatives – BAOT/UNISON (co-Chair)
Bill Salter	UNISON
Ceri Dolan	RCN
Claire Whiles	Assistant Director of Organisational Development, Wellbeing and Culture
Fiona Jenkins	Executive Director of Therapies and Health Science
Fiona Kinghorn	Executive Director of Public Health
Janice Aspinall	RCN
Jason Roberts	Executive Nurse Director
Joanne Brandon	Director of Communications
Karina Mackay	BDA
Lianne Morse	Deputy Director of People and Culture
Mathew Thomas	UNISON
Mike Jones	Independent Member - Trade Union
Paul Bostock	Chief Operating Officer
Pauline Williams	RCN
Peter Hewin	BAOT/UNISON
Rachel Pressley	Head of People Assurance and Experience
Richard Skone	Deputy Medical Director
Robert Mahoney	Deputy Director of Finance Operations
Suzanne Rankin	Chief Executive

In Attendance

Hannah Stevenson	Graduate Trainee Manager, LED

Apologies

Abigail Harris	Executive Director of Strategic Planning
Joe Monks	UNISON
Jonathan Strachan-Taylor	GMB
Lorna McCourt	UNISON
Rhian Wright	RCN
Steve Gauci	UNISON

Secretariat

Georgia Walsh	Trainee People Services Advisor (Minutes)

LPF 23/029 WELCOME AND APOLOGIES

Rachel Gidman (RG) welcomed everyone to the meeting and apologies for absence were noted.

LPF 23/030 DECLARATIONS OF INTEREST

There were no declarations of interest made in respect of agenda items.

LPF 23/031 MINUTES OF THE PREVIOUS MEETINGS

Fiona Kinghorn (FK) requested the amendment of 'smoking sensation' to 'smoking cessation' in the third paragraph of page 4. The minutes were otherwise agreed to be an accurate record of the meeting.

LPF 23/032 ACTION LOG

The action log was noted and the following updates provided:

- LPF 23/019: RG advised that Terms of Reference for the People and Culture Committee are due to be signed off at the next committee meeting on 11 July 2023 and will be shared with Forum members following this.
- LPF 23/021: RG advised that she had received an update from David Thomas regarding email addresses for all staff, and had been advised that there was a projected completion date of September 2023.
- LPF23/021: There had been a discussion at the last LPF meeting about whether the Integrated Performance Report met the needs of the Local Partnership Forum. RG advised that there were discussions taking place at Board to review the IPR and suggested that this conversation should be put on hold until the revised version of the Board report was available.

LPF 23/033 CHIEF EXECUTIVES REPORT

The CEO report was delivered by Suzanne Rankin (SR). Key points included:

- SR gave thanks to staff for their contribution and efforts over the last few months. It was noted that there had been a number of challenges faced, including a period of Industrial Action. There has been a notable increase in the frequency of positive feedback received from patients, families, and staff.
- Strategy Refresh – this has moved to the next stage. Following a period of extensive engagement the team are now consolidating views and key themes which arose. The expectation is for the engagement exercises to conclude at the end of June. The strategy refresh focuses on how we collectively support our teams and take care of our people.
- Annual Plan – we have submitted our annual plan to Welsh Government (WG) with a deficit position forecast of £88 million; this includes a £32 million savings program making up 4% of turnover with a focus on the underlying deficit and revenue account. The focus of the plan is on better quality care, better ways of working, avoidance of waste and duplication, and reducing length of stay. Discussions with WG are ongoing and the plan has not yet been approved. SR reminded the Forum that we are currently in enhanced escalation.
- EDI agenda – SR shared concerns that there was a disconnect with colleagues on the ground and how plans made are being put into practice. There is upcoming work including the equality framework for patients to ensure equality of outcome and a focus on the work and contribution of colleagues to be shared across organisation.

- HIW Inspection – two inspections took place in the CAV Maternity Unit in November 2022 and March 2023. Significant concerns were initially raised and steps have been taken to address these. A report of the findings is to be published in June.
- Industrial Action –. SR thanked colleagues who helped provide safe care during the recent strikes, noting that planning was effective and services coped well. She re-iterated that the UHB continues to support colleagues in their right to take Industrial Action
- Infrastructure – the state of the infrastructure and the risk it poses to staff/patient/services was addressed and SR advised that she has written to the Minister to share her concerns. There is currently £150 million backlog of maintenance requests, with £11 million allocated this year to work towards resolving them. She advised that the intelligent approach must be taken to prioritise how this will be allocated, but wanted staff to know that she is aware of the situation and how grave it is. SR invited Trade Union colleagues to contribute to the prioritisation of this list if they wished to.

Janice Aspinall (JA) noted that working conditions are having significant effects on staff and morale; many staff are unaware of the scale of the issue and feel their areas are left at detriment. A discussion took place about whether communications to acknowledge this may aid in assuring staff this is a priority. Peter Hewin (PH) added that the concerns surrounding infrastructure extend to the community, voicing concern that community sites often don't appear to be prioritised, with focus primarily on the larger hospital sites. PH queried with Dawn Ward (DW) whether there was scope to jointly sign the letter to WG regarding the infrastructure and the risk it poses to services.

Mathew Thomas (MT) added that Trade Unions (TUs) often hear from staff regarding low mood due to working conditions, and emphasised that the staff responsible for maintenance work feel similarly disheartened. SR noted that within the Chair's Board report there will be a focus on the Estates and Facilities Team to celebrate their achievements and hard work; National Healthcare Estates and Facilities day is upcoming on 21st June to celebrate and recognise staff 'behind the scenes' during difficult times.

PH highlighted the importance of the utilisation of the EDI agenda, acknowledging that the All Wales activity of reviewing policies through an antiracist lens would prove beneficial on a local level. There is an awareness that policies and procedures drive our culture, with many of our policies broadly written allowing for discretion amongst management teams, however as highlighted by Professor Emmanuel, this discretion can create inequity and discrimination. It was recognised that those in minority groups may attribute those differences in policy application to factors relating to protected characteristics rather than discretion. MT voiced his concern at the disparity in how policies are applied across the UHB. He suggested that Policies such as the All Wales Managing Attendance Policy encourage more compassionate management however this application of discretion is resulting in a lack of equitability across the board.

PH raised concerns that when looking at financial savings, vacancy control is often the 'path of least resistance'. He noted the effect this can have on existing staff. SR confirmed that a recruitment freeze has not been considered within the savings plan. There is a focus on reducing the temporary workforce as the costs associated with agency workers are paramount, accounting for 2/3 of our deficit savings requirement. The goal is recruiting and retaining a substantive workforce, and working towards workforce sustainability.

MT expressed disappointment around the increase in prices in the Aroma outlets and the way that this had been communicated. In particular, he felt that referencing of staff as 'customers' had been poorly received. SR advised the Forum that food costs have historically been underwritten by 25%

which was no longer sustainable, referring to the current deficit forecast. SR expressed her mutual disappointment in the communications, and suggested further action be taken to recover this position. Bill Salter (BS) noted high levels of food wastage have added to the discontent amongst staff regarding Aroma price increases. It was suggested that measures such as discounting food near expiry should be considered, in order to reduce waste and support staff. SR proposed a further conversation be had with colleagues in order to attempt to mitigate wastage.

Action: Joanne Brandon

Dawn Ward (DW) queried whether any early learning had been identified through the Covid enquiry. SR confirmed that we are currently executing Module 3 of the public enquiry whereby information is being collected, to date there have been no recommendations or insights derived from this.

DW further queried the status of UHW 2, SR confirmed an investment request to WG for £5 million to support the development of the strategic outline case was submitted some months ago. There has been no development following this, and as such no progress has been made. SR has written a letter to this effect in an attempt to progress this. DW noted that working conditions are likely to deteriorate within 10 years and highlighted the importance of delivering the plan as intended.

LPF 23/034 INTEGRATED PERFORMANCE REPORT

Population Health

There is a current focus on health protection, with work being done to prepare a Health Protection Plan as a broader follow on from the Covid Recovery and Response Plan. FK confirmed we are on target to have a Hepatitis B and Hepatitis C Elimination Plan ready by mid-July, with additional expectations for a National HIV Plan.

FK noted that the Covid Vaccination spring booster has been administered to 77% of those eligible, surpassing the 75% target. There is work being done to address vaccination inequity, however, approaches such as pop-ups are proving less effective. The Vaccine equity plan is nearing completion which will support with this.

FK further noted that the maternity smoking cessation effort is doing well, and engagement has improved.

MT requested clarification surrounding 'wastewater monitoring' cited under the 'Acute respiratory infections' subheading. FK confirmed this is a public health mechanism whereby regionalised water samples are tested for fragments of Infectious diseases in order to estimate infection rates in the population.

MT remarked on the lack of visible literature/awareness for health schemes including tobacco and smoking, as well as the obesity agenda and healthy eating. The Smoking cessation approach is supported by Welsh Government, including non-smoking sites and standardised non-smoking posters displayed around all sites. FK noted there are difficulties in enforcing this standardised approach, and there is no remit to recruit a smoking enforcement officer. Further actions to support the obesity agenda include steps that have been taken in line with our health retail standards. She explained that the focus is on changing the environment and the availability of better choices. There are also upcoming schemes such as the launch of active soles in July.

DW raised concern regarding the reduction in Covid testing from staff side perspective. Due to the reduction in availability of testing as well as moving towards managing Covid related absences under the Managing Attendance Policy, there is concern that staff may come to work whilst Covid positive.

DW noted there is confusion surrounding whether staff should be testing and whether confirmed Covid absences should be treated as medical exclusion on occasions where staff are advised to stay home. FK stated that the focus is on clinical risk for patients, and the goal is for a standardised approach whereby if staff have symptoms they stay at home. Jason Roberts (JR) added from an IPC viewpoint, guidance has always been staff should remain at home if they are symptomatic of any respiratory illness. RG recognised the confusion surrounding the original communications regarding the change in testing requirements, and assured the Forum that the communications available to staff will be current and confirm the All Wales approach.

Quality and Safety

JR noted that our position had recovered for 30-day complaint/concerns performance. It was previously highlighted that this had dropped to 77% in January, however this had returned to 85% in March despite receiving the highest number of complaints on record. The cause for this increase in volume has been explored, however no set themes have arisen to attribute this to.

It was acknowledged that the Duty of Candor was implemented across Wales on April 1st. This has been well embedded, however has highlighted resource issues within the team who are now reviewing upwards of 70 incidents per day with no additional workforce to support this influx. There is a trend emerging of significant numbers of incidents being regraded, and notably these were being over-graded. It was acknowledged that there is learning going on in this regard across the Clinical Boards which is proving beneficial.

CIVICA the new patient experience IT platform has been in place for 4 months, and the outcomes of this are being taken to Board to identify concerns, areas for improvement and good practice within the organisation. Following presenting this to the Board there is scope for following this with a presentation to LPF upon request.

Infection rates were a topic of discussion. JR confirmed CDIFF cases are on a significantly downwards trajectory, this success is attributed to learning and identification of better practices and the implementation of the CDIFF oversight group. The Health Board has seen a slight increase in MSSA and MRSA cases in recent months, and we are looking to transform the CDIFF oversight group to a CDIFF, MSSA and MRSA oversight group in order to look for the same levels of improvement as seen with CDIFF, and identify any learning to be shared across the wider teams.

DW raised that more communications may be required in relation to Duty of Candor as awareness of this is not equal across all areas of the organisation. It was acknowledged additional work may be required in order to increase awareness as there appears to be a lack of understanding surrounding wider responsibility.

DW noted the potential for change in systems and culture with strong leadership and how this can drive change. The success of this level of attention to detail being given to areas of concern was highlighted, referencing the success in reducing CDIFF as well as the new focus on MSSA and MRSA.

DW highlighted that the viewpoint is unclear when looking at high numbers of incident reporting as to whether this is a positive or negative statistic. JR noted that high numbers of incident reporting are viewed as positive as it is indicative of a culture where staff feel safe to report, and is the sign of a psychologically safe organisation. JR further noted that as patients progress through the system, there is the potential for overreporting as one incident may be reported across multiple services due to ward movements. There has also been the additional factor in the doubling up of reporting of incidents during the crossover of the datex systems. There was discussion surrounding the complexities of

pressure damage, as it can often take days for signs to become visible making identifying the source of the damage difficult. Pressure damage often occurs elsewhere, especially when patients have been moved into the health board, often from community/commission services and there should be shared responsibility taken when addressing these concerns.

People/Workforce

The workforce position has continued to improve. Sickness levels have continued to reduce, with April's sickness levels lower than those last year. Turnover has reduced to 12.5% with an improved position in all areas; there is a focus on reducing the number of staff leaving on a monthly basis.

Lianne Morse (LM) noted that all areas are achieving 72% Mandatory Training compliance or higher, approaching the 85% target. It was recognised that efforts have been made to increase VBA compliance; in 12 months compliance has increased from 29% to just over 60%.

Operational Performance

Paul Bostock (PB) emphasised the improvements made in operational performance have been driven by a focus on quality and safety and what is right for the patients. It was acknowledged that Cardiff and Vale have the best ambulance handover times in Wales; the current waiting time for handover is capped at 2 hours, with an average of 21 minutes. This position has been held well and the next focus is to reduce wait times to 1 hour, prior to the eventual target of 15 minutes.

It was noted that significant work is still to be done in this area, however waiting times in Emergency Units have been reduced significantly; there is a 0% tolerance approach to any patients in the emergency department waiting over 24 hours for treatment, and the number of patients waiting over 12 hours has significantly reduced from 1100 during Winter to 700 in April. There was discussion surrounding the commencement of the ward changes, with reconfiguration of the acute site projected for the end of July. This will allow assessment areas to transfer out of the EU footprint and the speciality hub to close. The purpose of this extends beyond moving patients, with the focus on changing models of care, including reducing stay length and the time in which care is received.

Of the 30 specialities whereby waiting times are a focus, 22 of these standards requested of us are met. There are difficulties with capacity inhibiting the ability to meet standards in the remaining 8 areas, including Urology and Orthopaedics. The Ministers have set the expectation that by Christmas no more than 3% of the waiting list will be over 2 years, and by March 2024 this is expected to reduce to 1%. We are working in partnership with WG as to how this trajectory can be achieved.

Endoscopy is an area of concern with significant backlog due to the pandemic, particularly in regards to patients waiting for surveillance or follow ups. There are anticipated regional solutions for imaging which will aid in reducing this backlog, with additional capacity expected early spring next year. PB noted cancer services are an additional area of concern, with the number of patients waiting more than 62 days having increased since March from 220 to over 250. The causes for this increase are known and there are expectations for the UHB to be in a more sustainable position in this regard by Autumn. There are additional efforts required to reduce wait times, however, it was recognised that CAV has the best Cancer performance in Wales, and compares favourably to top cancer performing organisations in England.

A significant increase in mental health referrals was noted, with services struggling to keep up with demand. Shortfalls have been identified and services are expected to be in more steady state by the end of summer.

MT queried whether the reduction in wait times is sustainable or whether other factors such as a lower influx of patients may be a factor. PB confirmed that the achievement of current wait times has been in progress since September 2022, with an initial goal of 4 hours, having now reduced to 2. This reduction was achieved during Winter, the most resource demanding time of year, and assurances were given as to the sustainability. A combination of strategies were implemented to aid this reduction: sharing risk across the organisation, patient flow to A1 was restricted and is now only accessible via A&E, medical SDEC was relocated to the old SAU and has seen growth in the volume of patients attending, reducing the traffic through the emergency department, and the introduction of the frailty model in A&E.

Finance

Robert Mahoney (RM) commended SR for her comprehensive breakdown of the deficit position forecast and the annual plan. The UHBs Month 12 Financial Position was £26.9 million overspent, in line with projections. We are currently under audit, with no concerns at this stage, having regular meetings with Audit Wales. It was noted that public payment compliance was above the 95% target, and is currently at 97.5%.

The £88.4 million deficit plan was reported to WG, and is due to be reported again to WG and finance committee in coming weeks. Broadly, the UHB is balanced operationally, however efforts are undergoing to identify the remaining £15 million of the £32 million savings target. Escalation and enhanced meetings are taking place to support theme leads to identify savings and de-risk the savings plan, in order for these to be implemented operationally.

LPF 23/035 STRATEGIC EQUALITY PLAN

The Strategic Equality Plan was delivered by Claire Whiles (CW) on behalf of Mitchell Jones. Key points included:

- CAV UHB has maintained its status as one of the top 100 inclusive employers within the UK in the Stonewall Workplace Equality Index (WEI) . The LGBTQ+ network have a new committee which has been integral to helping with the submission of work such as WEI and events such as pride. The LGBTQ+ network continue to support pride, and plan to march with colleagues on 17th June.
- The One Voice Network has supported with awareness days surrounding black history and has helped develop and coproduce the anti-racist action plan, linking in with Professor Anton Emmanuel and the workplace race equality standards. The anti-racist action plan is being taken forward post agreement and we are now in a position to set up a steering group and approach TUs for representation for this.
- The UHB achieved Disability Confident Leader Level 3, this is recognition as part of a Government Scheme whereby the UHB is identifiable as an inclusive employer; the logo can be displayed on job advertisements and the Health Board website to highlight this. This status comes with an additional responsibility to continue to represent and improve in this arena.
- Ongoing work is taking place with the Accessibility Network to ensure current and prospective staff are supported with disabilities and long-term conditions. Additional work is being done on the SharePoint site to ensure colleagues across the organisation better understand how to build an inclusive environment.
- The team achieved the HPMA Welsh Language Award for their work on translation, and there was an 11% increase in the number of words translated between 2021 and 2022. The use of 'Phrase' translation software (previously 'Memsource') has supported these improvements.

- The UHB is compliant with 82/121 of the Welsh Language Standards implemented by WG. Prioritisation is now surrounding organisational strategy and patient facing documentation. There is focus on improving data for staff and patients, engagement is needed with staff networks to support colleagues across the organisation; there is a new Welsh Language Network in development which has seen significant interest from staff.

DW stated that concerns surrounding the integrity of Cardiff Pride have been discussed amongst Trade Union Groups, with a consensus that it has lost the support of the LGBTQ+ community within the TUs. UNISON will be boycotting Cardiff Pride, however will be supporting other pride events across Wales including Pembrokeshire and Caerphilly Pride. CW confirmed the LGBTQ+ network remain supportive of Cardiff Pride, however conversations have taken place across NHS Wales in regards to the costs associated with this.

SR voiced concern regarding the staff survey not taking place, noting its importance in measuring staff and experience. CW advised that the All Wales Staff Survey meeting is due to go ahead on 13th June, with the projected date for the Staff Survey to be circulated in Autumn. Unfortunately there has been no sight of the question set to date. RG indicated that at the Workforce Action Plan Group this was was discussed and it was stated that5 the questions would focus on compassionate leadership. There was discussion that should this not go ahead as planned there may be need for coproduction of an internal survey.

SR noted that the Workplace Race Equality Standards will be coming in, acknowledging its' use for intervention to review progress being made, and assess whether further resources are required. SR issued a plea that staff representatives encourage their teams and members to complete their demographic information on ESR, as without this our data is not truly representative of our workforce.

LPF 23/036 GENERIC TERMS OF REFERENCE FOR THE CLINICAL BOARD LPFs

DW presented the standardised Terms of Reference for all Clinical Board LPFs requested endorsement to support these meetings in going ahead.

FK requested that under 1.1 and 2.1 it be framed as Workforce, Health Service and Population Health issues to acknowledge the role of Public Health and the part the UHB plays.

JR requested under the Management Representatives subheading, that Director of Nursing be amended to Director of Nursing/Director of Midwifery.

Action: Rachel Pressley

SR reaffirmed the importance of the frequency of the meetings being both agreed and delivered, as well as the benefit of increased reporting to allow visibility surrounding goals being achieved and highlight common themes. PB voiced his agreement with SR and offered support in ensuring these go ahead**.**

LPF 23/037 REVIEW OF MEETING

RG noted that good discussions had taken place and actions had been decided following concerns raised surrounding the price rise in Aroma.

LPF 23/038 ANY OTHER BUSINESS PREVIOUSLY AGREED WITH THE CO-CHAIRS

CW wanted to thank Hannah Stevenson for her input and commitment over the past two years whilst on their graduate programme; she is due to leave the Health Board to start a permanent position in

Alder Hay Children's Hospital. SR and RG expressed their thanks and wished Hannah well in her new role.

LPF 23/039 FUTURE MEETING ARRANGEMENTS

The next meeting will be held remotely on Thursday 10th August at 10am, with a staff representatives pre-meeting at 8.45am.

Confirmed Minutes of the Quality, Safety & Experience Committee

Held on 18.07.23

Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair
Present:		
Akmal Hanuk	AH	Independent Member – Community
Keith Harding	IM	Independent Member – University
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance		
Annette Beasley	AB	Macmillan Lead Cancer Nurse
Paul Bostock	PB	Chief Operating Officer
Vicki Burrell	VB	Senior Service Improvement Programme Manager
Angela Hughes	AH	Assistant Director of Patient Experience
Fiona Jenkins	FJ	Executive Director of Therapies and Health Sciences
Meriel Jenney	MJ	Executive Medical Director
Mike Jones	MJo	Independent Member – Third Sector
Sarah Lloyd	SL	Interim Director of Operations for Clinical Diagnostics and Therapeutics
Helen Luton	HL	Interim Director of Nursing and Multi-Professional teams – CD&T
Suzanne Rankin	SR	Chief Executive Officer
Aled Roberts	AR	Assistant Medical Director, Clinical Effectiveness & Safety
Jason Roberts	JR	Executive Nurse Director
Paul Rogers	PR	Interim Assistant Director of Therapies and Health Science
Alexandra Scott	AS	Assistant Director of Quality and Patient Safety
Vicky Stewart	VS	Head of Concerns & Redress
James Quance	JQ	Director of Corporate Governance
Clare Wade	CW	Director of Operations for Patient Flow
Aron White	AW	Nurse Informatics Lead
Oliver Williams	OW	Speciality Registrar in Public Health
Suzanne Wood	SW	Consultant in Public Health Medicine
Observing		
Cerys Jones	CJ	Student
Lucy Jugessur	LJ	Audit Manager NWSSP
Frances Rees	FR	Student
Secretariat		
Nathan Saunders	NS	Senior Corporate Governance Officer
Apologies		
Marcia Donovan	MD	Head of Corporate Governance

QSE 23/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting in English & Welsh	**Action**
QSE 23/07/002	**Apologies for Absence** Apologies for absence were noted.	
QSE 23/07/003	**Declarations of Interest** No declarations of interest were raised.	
QSE 23/07/004	**Minutes of the Committee meeting held on 9 May 2023** The minutes of the Committee meeting held on 9 May 2023 were received. **The Committee resolved that:**	

	a) The minutes of the meeting held on 9 May 2023 were approved as a true and accurate record of the meeting.	
QSE 23/07/005	**Action Log following the Meeting held on 9 May 2023** The Action Log following the Meeting held on 9 May 2023 was received. **The Committee resolved that:** a) The Action Log from the meeting held on 9 May 2023 was noted.	
QSE 23/07/006	**Chair's Actions** No Chair's Actions were raised.	
23/07/007	**CD&T Clinical Board Assurance Report** The CD&T Clinical Board Assurance Report was received. The Interim Director of Nursing and Multi-Professional teams (IDNMPT) advised the Committee that the paper covered the period from the 1st of April 2022 to the 31st of March 2023 and outlined the progress made to improve quality, safety and patient experience in the Clinical, Diagnostics & Therapies (CD&T) Clinical Board, whilst highlighting some of the achievements and innovations undertaken to improve the quality of care for patients. She added that the report also outlined some of the key risks and the mitigations put in place. It was noted that CD&T had a wide range of diagnostic and therapeutic procedures that were provided on a local, regional and sometimes a UK wide level and that the services underpinned some of the core components of almost every aspect of clinical activity undertaken across the Health Board. The IDNMPT shared a Patient Story with the Committee which had been received by the Committee in March 2023 from the Specialist Clinical Board. She added that the story was provided from the CD&T point of view and how each of the CD&T directorates were involved in the patient's journey. The Committee was reminded that that the patient had come off his quad bike at force and the quad bike had landed on him, which required the patient to be air-lifted to the University Hospital of Wales (UHW). The patient's journey was presented which included: • Critical Care – a 2 day stay in ITU • Polytrauma Unit • Staying on Ward West 8 • Being discharged home nearly 12 months later from admission. The CD&T areas that had touched that patient journey included: • Laboratory Medicine – 20 units of blood products were administered which had been managed by the Health Board's blood bank. • Radiology, Medical Physics and Clinical Engineering – The patient's medication was delivered via a medical infusion device, 78 images were taken of the patient during their hospital stay as well as outpatient appointments which included CT, MRI and ultrasound. • Pharmacy – Pharmacists and Pharmacy Technicians were all involved in the patient care and provided a number of services such as smoking cessation advice, diabetes management, wound management and vaccination. • Medical Illustration – Photographs were taken of the patient on 4 occasions for suspected deep tissue injury, pressure ulcer, moisture lesions and to document a rash.	

- Therapies – A large number of therapists provided care to the patient including Psychologists, Dietitians, Rehabilitation Technicians, Physiotherapists and Occupational Therapists.

- Health Records and Outpatients – The patient's hospital stay of almost 12 months created a significant volume of medical records which were collated, managed and stored securely by health records staff.

The Executive Nurse Director (END) advised the Committee that sometimes the CD&T Clinical Board felt quite hidden from the Health Board and that a significant amount of work and support was provided by the Clinical Board which needed to be identified and highlighted to the Committee.

The Interim Director of Operations for Clinical Diagnostics and Therapeutics (IDOCDT) reiterated to the Committee that the Patient had touched every aspect of CD&T and that the information would be taken back to the CD&T Clinical Board's own Quality & Safety meetings within the directorates to bring that message back to the teams.

The CC responded that the intent was certainly conveyed via the Patient Story and thanked the CD&T Clinical Board teams for all of their hard work in relation to the patient's care.

The IDNMPT then pulled out key points from the CD&T Clinical Board assurance report which included:

- Values Based Appraisals – It was noted that the Clinical Board remained committed to delivering the values and behaviours of the Health Board to all staff and that during the last 12 months there had been a particular focus on staff completing a values-based appraisal, with directorates providing trajectories to achieve 85% by July 2023 which had not quite been achieved but that the momentum was still ongoing.

- The Inclusion Agenda – it was noted that the Clinical Board was developing actions to deliver on the inclusion agenda and to create a Safe Space initiative, which would create an environment where colleagues felt free to be supported and to speak up if they had any concerns.

- Regulated and Accredited services – It was noted that a number of inspections and assessments had been undertaken from the CD&T regulatory bodies over the last 12 months and that all of the laboratory services had maintained their ISO accreditation from The United Kingdom Accreditation Service (UKAS).

- HIW Inspection IR(ME)R at University Hospital Llandough (UHL) – It was noted that Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection and had reported that staff had a good awareness of their roles and responsibilities in line with IR(ME)R 2017.

  The IDNMPT added that there was very positive feedback provided from patients about their experiences when attending the department. HIW had requested that action was taken to actively collect patient feedback on their experience of visiting the department and the team had now piloted a questionnaire accessible via QR code and paper copies in the department with a view to a wider roll out across the directorate.

- All Wales Quality Assurance of Aseptic Preparation Services UHL – It was noted that the inspection highlighted issues relating to the facility's age, including general fabrication and the air handling units and the long-term future of the of the unit, which were linked to the regionalisation of aseptic services as part of the Transforming Access to Medicines (TRAMS) programme.

The IDNMPT advised the Committee that a number of the challenges and risks observed by the Clinical Board directly related to the fabric of the estate and some of the ageing equipment, which could impact on regulatory compliance.

She added that a business case for the refurbishment of the Mortuary had been submitted to Welsh Government, which would not only see an improvement in the environment but also increase capacity.

Another risk highlighted to the Committee related to the backlog diagnostics both for radiology and cellular pathology, which had resulted in a potential risk of increased morbidity and mortality due to long turnaround times for results.

The IDNMPT added that there were a number of Nationally Reported Incidents in relation to delays in cellular pathology which had an impact on patient pathways.

She added that backlogs had accrued in all areas within the cellular pathology pathway and that at one point in the system there had been a backlog of over 6000 cases in the microtomy section.

It was noted that there had been significant improvement due to the focused efforts of the team and the introduction of 7-day working which had resulted in the workload being reduced to a manageable operational level of around 100 specimens in the laboratory at any one time.

The IDNMPT concluded the report by highlighting a number of service improvements made by the CD&T teams which included:

- A project called “Kids Med Cymru” which was an initiative that aimed to get children off liquid medication and onto tablets by attending a “pill school”. It was noted that it added both an environmental and financial benefit to the Health Board as well as a benefit to children and their families.

- A Teledermascopy service – introduced by the Medical Illustration Service which had reduced the demand on dermatology by removing the requirement for all referrals to have an initial face to face appointment and redirecting capacity to those patients that really needed to have that face to face appointment

- A Rehabilitation Model and Operating Model - since updating the Rehabilitation Model the service had acted to communicate and embed the model throughout the Health Board and was recognised by the United Kingdom AHA awards 2023 and the team became the winner of the Welsh Government Award for Value based care: making the best use of resources to maximise outcomes.

- Radiology, Medical Physics and Clinical Engineering - During the last 12 months an ambitious programme of installation of new equipment had been undertaken with two new X-ray rooms being installed as part of the fracture clinic move back to the UHW site.

- It was noted that a number of installations and refurbishments had taken place during the programme which included:

    - Replacement of X-ray equipment in two rooms in the emergency department
    - Fluoroscopy suite upgraded in UHL
    - Refurbishment of CT room in UHL
    - Replacement of the MRI scanner in UHL
    - Refurbishment of the Cath Lab A in UHW

The CC noted that the report had been summarised very succinctly and thanked the IDNMPT and the wider CD&T Clinical Board teams for all of their hard work.

The Independent Member – Capital & Estates (IMCE) asked what work was being undertaken to mitigate the risk identified where by patients had complaints around the rearranging of appointments.

The IDNMPT responded that it had largely related to physiotherapy appointments held at the Cardiff Royal Infirmary (CRI) where there were significant telecoms issues which had been resolved and so fewer complaints were being received at present.

She added that work was being looked at to automate the system which would mitigate those issues in the future.

The IMCE asked for further information around pathology and the longer-term requirements needed to deal with the backlog identified in the report as well as how sustainable the changes were.

The IDNMPT responded that the 7-day working in pathology was well embedded and positive feedback had been provided by the teams which was sustained.

	She added that the Health Board was one of the few laboratories in Wales that undertook 7-day working and noted that one of the challenges identified was that some reporting required outsourcing. The IDOCDT added that another area being focused on within pathology was technology and newer machines with quicker turnaround times and a future step change to move into a digital system. The Independent Member – Community (IMC) asked what was being done to mitigate the high risk around laboratory medicine. The IDNMPT responded that the large majority of incidents identified within the report were of "no harm" to patients and that the incidents were raised as part of a trigger warning as opposed to an actual incident. She added that the laboratory staff had a really good reporting culture and that the quality managers within the laboratories had a good handle on all of the incidents. The Executive Medical Director (EMD) acknowledged the detail and amount of work being undertaken by the clinical board and provided assurance to the Committee on pathology and noted that there was a strong focus on it. She added that since the report was written, changes had been implemented which had improved the service by way of new machinery and the implementation of the 7-day working. It was noted that there was also an infrastructure issue with the Radiopharmacy which would be discussed in the private session the meeting and then brought back to public at the September meeting. **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 Clinical Diagnostics and Therapeutics Clinical Board was noted.	
QSE 23/07/008	**Quality Indicators Report:** The Quality Indicators Report was received. **Deep Dive into Complaints.** The Assistant Director of Patient Experience (ADPE) presented to the Committee and explained why good complaints handling was important. The key principles of good complaints handling were identified which included: • Accessibility: To ensure the complaints process was easily accessible to all individuals, regardless of their background or circumstances. • Fairness: To treat all complaints fairly, impartially, and without discrimination. • Empathy: Show empathy and understanding towards complainants, acknowledging their experiences and emotions. • Timeliness: Respond promptly to complaints, keeping complainants informed throughout the process. • Transparency: Maintain open communication, providing clear explanations and updates regarding the complaint's progress. • Learning and Improvement: Use complaints as an opportunity for learning, reflection, and continuous improvement.	

The ADPE advised the Committee that the number of concerns and compliments data presented to the Committee was from between October 2021 until June 2023 and noted that a significant raise had been observed.

She added that the majority of concerns and complaints were received by the department via telephone with almost 4500 being received through that method, with the second highest being via email of which 3250 had been received.

The Committee was advised that a dedicated Early Resolution Hub to support timely outcomes to complainants was established and it was noted that between 65 to 80 % of concerns were managed via that hub and that during May and June 202, 69% of all concerns were managed under Early Resolution.

The ADPE advised the Committee that personal contact was made to all complainants on receipt of concerns to agree specific questions for investigation which was recognised good practice by the Welsh Risk Pool (WRP).

The Committee was presented with the concerns received by top 10 primary subjects in the last 12 rolling months and further detail was provided on each area which included:

- Appointments
- Communication issues (including language)
- Clinical Treatment/Assessment
- Attitude and Behaviour
- Patient Care
- Test and Investigation Results
- Referrals
- Medication
- Discharge Issues
- Environment/Facilities

The ADPE advised the Committee that it was important to note what was being doing around the mitigation of concerns and presented the actions undertaken around appointment and communication concerns which included:

- Clinical Boards were adding additional clinics and theatre time where possible as well as using insourcing and outsourcing.
- In order to reduce in patient Cataract waiting times, two new vanguard theatres were installed in the car park and two cataract fellows were appointed.
- Concerns raised regarding numerous cancellations in Neurosurgery resulted in a generic email address being set up so that GPs were easily able to contact the team if there were any concerns between appointments.
- WIFI phones were purchased for the sole purpose of improving communication between patients and relatives.
- Sister Clinics were being piloted in some areas whereby one day a week there would be a dedicated clinic where relatives could book an appointment with the sister to discuss ongoing care which had reduced concerns in that area.

It was noted that another area that communication concerns had increased was around bereavement and it was noted that during COVID the concerns team made a conscious effort to phone anybody who had a bereavement through the bereavement team which had provided helpful mitigations to the concerns raised but the ADPE added that it was difficult to sustain post COVID.

The ADPE concluded that in order to raise awareness of concerns, the concerns team had recently started circulating “Learning from Event” forms with every formal concern to highlight any learning, no matter how small and noted that in some areas the concerns and learning were being summarised and shared to areas so that patient experience and learning could be shared on a wider scale.

The Committee were presented with links to Online Training available in areas which included:

- Putting Things Right
- Breach of Duty
- Learning from Events
- Duty of Candour

The Committee was advised that from 1 September 2023, the concerns team would be collating feedback from people who had used the Concerns (Complaints) Duty of Candour and Redress process to listen and improve services.

The ADPE added that as well as capturing the feedback, the teams would also collect ethnicity data which was important to help the system identify any areas of deprivation.

The Committee was presented with information around redress where it was noted that some concerns could enter the redress process which could include:

- An apology
- Remedial Treatment and/or financial compensation up to the value of £25,000

The ADPE advised the Committee that anything that did go through the redress process could be reimbursed from the Welsh Risk Pool and so over the past 15 months, £109.251.75 had been received.

She concluded that a consultation was being undertaken in October 2023 around Horizon Fixed recoverable costs and that Fixed Recoverable Costs (FRC) was a term used in the legal system to refer to a set of predetermined costs that could be recovered by the winning party from the losing party in certain types of civil cases.

It was noted that FRC aimed to streamline the process of determining legal costs by setting predefined limits on the amount that could be claimed-from April 2024 and that it could impact on the NHS redress process.

The Independent Member – University (IMU) asked if there were any benchmarks in relation to "time to resolution" of issues of concern.

The ADPE responded that the WG target was 75% of concerns to be responded to within 30 working days and that the Health Board was achieving around 79% to 83%.

Wales Cancer Patient Experience Survey

The Macmillan Lead Cancer Nurse (MLCN) presented the latest Wales Cancer Patient Experience Survey to the Committee.

It was noted that it was the third survey undertaken and was conducted by IQVIA on behalf of Macmillan Cancer Support and the Wales Cancer Network in 2021.

The MLCN advised the Committee that the survey was designed to measure and understand the patient experience of cancer care and treatment in Wales to help drive improvements both locally and nationally.

She added that thanks should be noted to all of the people who took part in the survey.

It was noted that 935 questionnaires were returned which gave a response rate of 57.9% which was slightly below the all-Wales response rate of 59.5%.

The Committee was presented with the data around the respondents which included data around:

- The tumour group
- Sex
- Age
- Ethnicity
- Sexuality

It was noted that in terms of the headline results, 92% of respondents for the Health Board rated their overall care a 7 out of 10 or more and that the Health Board were the top scoring Health Board in Wales.

The MLCN provided the Committee with the positive scores which included:

- 90% of patients said they were always treated with dignity and respect whilst in hospital

	• 94% of patients said they were always given enough privacy when being examined or treated • 93% of patients said they were given all the information required about their operation and tests • 92% of patients said that hospital staff had told them who to contact if they were worried about their condition or treatment after leaving hospital. She added that the teams should be congratulated for achieving relatively high results, but added that there were also some les positive scores which required addressing, including: • 37% of patients said their healthcare team completely discussed with them or gave them information about the impact cancer could have on their day-to-day activities. • 28% of patients said that, after leaving hospital, they were given enough care and help from their GP and GP practice. • 29% of patients said that, since their diagnosis, someone had discussed with them whether they would like to take part in cancer research. The Committee was presented with the next steps for the Wales Cancer Patient Experience Survey and the MLCN noted that the report had been shared with the Health Board's Executive Cancer Board and the report had also been shared with the patient experience team, clinical board triumvirates and the cancer workforce. She added that to facilitate and enable service improvement to strengthen areas in which people with cancer reported fewer positive experiences, engagement would be held with clinical boards and clinicians for their contribution to the action plan and that when completed, the action plan would be presented to the Executive Cancer Board. It was noted that ongoing monitoring of progress would be by the new Person Centered Care in Cancer Board and the Cancer Stakeholder Reference Group. The MLCN concluded that as a means to capture more frequent patient experience and to measure the effectiveness of service improvement, a patient experience questionnaire had been co-produced with the specialist cancer nursing workforce and the patient experience team. She added that the questions focussed on a number of identified themes within the Wales Cancer Patient Experience Survey and that the questionnaire would be used by all site-specific teams. The IMU noted that he had an association with the University Department of Surgery for nearly forty years and could remember discussions held 20 years ago, where it was said that for a University Hospital it should be the exception that patients were not included in clinical trials and noted that there was evidence that there was still more to do to ensure that the Health Board continued to justify its University Health Board status. The EMD noted that she shared the ambition and highlighted to the Committee that a business case was being prepared for the Cardiff Cancer Research Hub specifically for the acceleration of clinical trials, early phased trials and access for patients with cancer to those therapies across South Wales. The Director of Operations for Patient Flow asked if there would be a more up to date feedback mechanism because the survey was dated for 2021/22 which was when the service was running through the Covid-19 pandemic. The MLCN responded that a number of improvements had been reported already and noted that they had worked with the Cancer Clinical Nurse Specialist workforce and taken some areas of questioning from the Wales Cancer Patient Experience Survey and placed onto the CIVICA feedback process which would provide continual service improvement. **The QSE Committee resolved that:** a) The Deep Dive into Complaints presentation was noted b) The Wales Cancer Patient Experience Survey report was noted	
QSE 23/07/009	**MBRRACE – Verbal Update** The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UH (MBRRACE) verbal update was received.	

	The EMD advised the Committee that the report referred to the Health Boards perinatal and stillbirth and neonatal mortality up to 2021. She added that further detail would be provided during the private session of the meeting and that more detail would be brought back to the public forum in the future. It was noted that the maternity services teams were working through a number of actions that had arisen over the last two years with an aim to show improvement, because the Health Board were not where it wanted to be in terms of the national basis for mortality. The EMD concluded that a matrix report would be brought back to the Committee which would outline a number of reports which would include the MBRRACE report. **The QSE Committee resolved that:** a) The MBRRACE update was noted	
QSE 23/07/010	**HIW Activity Report** The HIW Activity Report was received. The Assistant Director of Quality & Patient Safety (ADQPS) advised the Committee that she would take the paper as read and noted that since January 2023, unannounced inspections had been held on the following wards: • Pine ward – Hafan Y Coed • Ash ward – Hafan Y Coed • East 12 ward – University Hospital Llandough (UHL) • East 16 ward – UHL • B5 ward – University Hospital of Wales (UHW) • T5 – UHW • A7 – UHW She added that planned inspection had recently taken place at the University Dental Hospital. It was noted that all of the reports had been published by HIW at the time of writing the report with the exception of the T5, A7 and Dental Hospital reports. The ADQPS advised the Committee that in addition to those HIW inspections a further inspection was undertaken in maternity services on the 27th 28th and 29th March 2023 and several immediate improvements were re-issued and several further immediate assurance issues were identified. She added that a combined report that provided oversight of both inspections and the overarching improvement plan was published on 21st June 2023 and that HIW had found that staff had worked hard to provide patients with a positive experience despite the pressures on the department. It was noted that a full action plan had been developed to support the requisite improvements and internal inspection and an audit was being undertaken on a regular basis to provide assurance that those improvements were being sustained. **The QSE Committee resolved that:** a) The assurance provided by the response to HIW inspections and the actions implemented to address immediate assurance issues where identified were noted.	
QSE 23/07/011	**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.	

	He added that at the May 2023 meeting of the Committee it was agreed that a reporting cycle was required for risks to ensure that the Committee was able to afford sufficient time to discussing each of the risks on a regular basis to fulfil its responsibility to the Board. It was noted that the cycle enabled the Committee assurance to link more closely with the 'deep dive' approach into reporting of quality measures and in order to do so the cycle was not fixed as it would be expedient to report a particular BAF risk to coincide with the reporting of further detail into a particular area, for example as the result of regulatory or internal review. The IDCG advised the Committee that the inherent risk was 25 and that after controls it was still maintained at 20 which it had been for some time. **The QSE Committee resolved that:** a) The risk in relation to Patient Safety was reviewed. b) Assurance would be provided to the Board on 27th July 2023 on the management /mitigation of this risk.	
QSE 23/07/012	**Policies & Procedures:** The following policies and procedures were received: • Mental Health Clinical Risk / Risk Mitigation Management Policy (UHB 119) • Clinical Audit Policy (UHB 509) and Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group (UHB 510) • Labelling of Specimens submitted to Medical Laboratories Policy (UHB 017) & Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452) • Nutrition and Catering Policy (UHB 221) & Procedure for Inpatients (UHB 367) The IMCE advised the Committee that the readability of the policies needed a discussion because a number of policies were clinical and had a large volume of information. She asked if a summary could be provided for Committee members on future policy documents. The EMD responded that the policies were received by the Committee for ratification and that they were published for reference. She added that summarising a policy could be challenging on top of the already large amount of work undertaken by policy authors. **The Committee resolved that:** a) The Mental Health Clinical Risk and Risk Mitigation Management Policy (UHB 119) was approved. b) The Clinical Audit Policy (UHB 509) was approved c) The Procedure for Review and Implementation of NICE, Health Technology Wales Guidance and All Wales Medicines Strategy Group (510) was approved. d) The Labelling of Specimens submitted to Medical Laboratories Policy (UHB017) and Labelling of Specimens submitted to Medical Laboratories Procedures (UHB 452) were approved. e) The Nutrition and Catering Policy for Inpatients (UHB 221) and Nutrition and Catering Procedure for Inpatients (UHB 367) were approved.	
QSE 23/07/013	**Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24** The Cardiff and Vale of Glamorgan Winter Respiratory Vaccination Plan 2023/24 was received. The Executive Director of Public Health (EDPH) advised the Committee that the Winter Respiratory Vaccination Plan was one part of the Health Boards armoury in being able to deal with and mitigate the challenges of winter.	

	The Consultant in Public Health Medicine (CPHM) advised the Committee that the plan would reduce morbidity and mortality and that it would also help to reduce admissions, in particular to the Intensive Care Unit (ICU). She provided the Committee with information around the previous season of 2022/23 where it was noted that the Health Board had maintained excellent levels of uptake amongst citizens aged 65 and over with over 75% vaccinated for flu and 80% vaccinated for Covid-19. It was noted that the overall uptake of flu vaccination for Health Board staff with direct patient contact was 37.9% in 2022/23, which was a decrease of 15% when compared to 2021/22 uptake and it was noted that the pattern was also observed for Covid-19 with uptake being 56.8% for Health Board staff with direct patient contact. The CPHM advised the Committee that inequities remained across the region with overall vaccine uptake for both vaccines being lowest across the City and South Cluster (56.1% for flu and 43.1% for Covid-19) and highest across the Western Vale Cluster (81.7% for flu and 76.9% for Covid-19). She added that the Public Health team were working hard around inequities and noted that there was significant momentum behind the programme. It was noted that throughout the plan, the 6 domains of quality from the American Institute of Medicine had been included and that those consisted of: • Safety • Effectiveness • Patient-centeredness • Timeliness • Equity • Efficiency The CPHM advised the Committee that a number of stakeholders had been engaged to ensure that all of the seldom heard groups had been reached within the plan and it was noted that the communications around the Winter Respiratory Vaccination Plan 2023/24 would be really important. She concluded that there was an action plan which outlined the key strategic areas that would be covered by the Public Health team. The EDPH advised the Committee that a number of Clinical Boards had responsibilities for the population out in the community and that all Clinical Boards needed to be championing vaccine uptake for Health Board staff. **The Committee resolved that:** a) The progress to date was noted. b) The Winter Respiratory Vaccination Programme Plan 2023/24 was approved c) Leadership and support to the implementation of the Plan was provided.	
QSE 23/07/014	**Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25** The Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25 was received. The EDPH introduced the Speciality Registrar in Public Health (SRPH) and noted that alongside various teams, he had prepared the Cardiff and Vale University Health Board Hepatitis (B and C) Joint Recovery Plan 2023-25 to help eliminate hepatitis (B and C) as part of the wider health protection sustainable plan in place. The SRPH presented to the Committee. It was noted that a Welsh Health Circular had been received by the Health Board in January 2023 which outlined the requirement for: • Elimination and prevention of hepatitis (B and C) by 2023 • 13 actions to be addressed for Health Boards • A Joint Recovery Plan to be provided by mid-July 2023.	

	It was noted that high risk groups had been identified from a mapping exercise which outlined a number of groups which included: • Migrants from high prevalence areas • Recipients of blood products • Recipients of tattoos/piercings from unregulated parlours or individuals • People who use drugs The SRPH advised the Board that in terms of the two viruses and their vaccine/treatment it was estimated that just under 20,000 people would require hepatitis B vaccine or treatment and just over 4000 people in Wales would require hepatitis C vaccine or treatment. He added that in March 2023 an Oversight Group was established and that the group had reviewed current structures, processes and outcomes, had identified the challenges and had produced an action plan. A number of actions from that plan were presented to the Committee and it was noted that the action plan provided 37 actions across 5 action areas for the first 2 years and formed part of the Cardiff and Vale of Glamorgan Health Protection Plan. The SRPH added that the 5 main themes included: • Infection prevention • Case Finding and Testing • Treatment • Re-engagement • Data He added that the plan had been received by the Senior Leadership Board the previous week and was now being received by the Committee to view the next steps of the plan which included: • An implementation group would take the work forward which required current services and staff within the system to incorporate additional pieces of work and additional staff and other resources from the WG health protection resource. • Working through how the Health Board could best deploy the people and resources currently in the system to support the health protection action required which included delivery of the hepatitis (B and C) plan. The CC advised the Committee that they had received further detail within the papers which could be read. **The Committee resolved that:** a) The Cardiff and Vale Eliminating Hepatitis (B and C) Joint Recovery Plan 2023-25 for submission to Welsh Government was approved.	
QSE 23/07/015	**Quality, Safety & Experience Terms of Reference** The Quality, Safety & Experience Terms of Reference were received. The EDPH advised the Committee that that small additions made to the terms of reference had enhanced them and made sure that it was clear that reporting of the relevant frameworks would go through the Committee. **The Committee resolved that:** a) The proposed amendments included in the extract of the Quality, Safety and Experience Committee Terms of Reference were reviewed. b) The amendments to the Terms of Reference were ratified c) The Committee Terms of Reference be recommended for approval to the Board on 27th July 2023.	
QSE 23/07/016	**Executive Summary of Child and Adult Practice Reviews**	

	The Executive Summary of Child and Adult Practice Reviews were received. The END advised the Committee that the Health Board undertook a child practice review as part of a multi-agency approach with Police and local authority colleagues and noted that the final reports were received by the Committee along with the recommendations from the findings of the reports. **The Committee resolved that:** a) The summary of recently published Regional Safeguarding Board Child and Adult Practice Reviews were noted.	
QSE 23/07/017	**Clinical Audit Strategy** The Clinical Audit Strategy was received. The EMD advised the Committee that she would take the paper as read and had no further information to add. **The Committee resolved that:** a) The assurance provided by the 2023-2025 clinical audit strategy was noted.	
QSE 23/07/018	**Unpaid Carers Annual Report** The Unpaid Carers Annual Report was received. The ADPE advised the Committee that it would be the last Unpaid Carers Annual Report because there were no longer transitional funds and so it would be held by the regional partnership board in future. **The Committee resolved that:** a) The Unpaid Carers Annual Report was noted	
QSE 23/07/019	**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 23/07/020	**Items to bring to the attention of the Board / Committee:** No items were raised.	
QSE 23/07/021	**Agenda for Private QSE Meeting** *i) Private Minutes -* *ii) Any Urgent / Emerging Themes – Verbal (Confidential Discussion)* *iii) MBRRACE Report – Verbal* *iv) Cyber Security Update*	
QSE 23/07/022	**Any Other Business** No other business was raised.	
	Date & Time of Next Meeting: Tuesday, 30 August 2023 at 1pm via MS Teams.	

Confirmed Minutes of the Public Digital & Health Intelligence Committee Meeting Held On 30 May 2023 at 9 am
Via MS Teams

Chair:		
David Edwards	DE	Independent Member - Digital
Present:		
Keith Harding	KH	Independent Member - University
Akmal Hanuk	AH	Independent Member – Community
In Attendance:		
Sara Moseley	SM	Independent Member – Third Sector
James Quance	JQ	Interim Director of Corporate Governance
Angela Parratt	AP	Director of Digital Transformation
David Thomas	DT	Director of Digital & Health Intelligence
James Webb	JW	Information Governance Manager
Bruce Johnson	BH	IT Project Manager
Observers:		
Urvisha Perez	UP	Audit Wales
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Michael Imperato	MI	Independent Member - Legal
Suzanne Rankin	SR	Chief Executive Officer

Item No	Agenda Item	Action
DHIC 30/05/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the Public meeting and confirmed the meeting was quorate.	
DHIC 30/05/002	**Apologies for Absence** Apologies for absences were noted. **The Committee resolved that:** a) The apologies were noted.	
DHIC 30/05/003	**Declarations of Interest** **The Committee resolved that:** a) No Declaration of Interest were noted.	
DHIC 30/05/004	**Minutes of the Meeting Held 14 February 2023** **The Committee Resolved that:**	

	a) The Minutes of the Meeting held on the 14 February 2023 were confirmed as a true and accurate record.	
DHIC 30/05/005	**Action Log – Following the Meeting held on 14 February 2023** The Action Log was received. The Interim Director of Corporate Governance (IDCG) stated that Clinical Board Directors had not been invited to the meeting today and requested that this was discussed at the next meeting. **The Committee Resolved that:** a) The Action Log was discussed and noted.	IDCG
DHIC 30/05/006	**Chair's Action taken since the Committee Meeting held on 14 February 2023** **The Committee Resolved that:** a) There were no Chair's Action.	
	Items for Review and Assurance	
DHIC 30/05/007	**Digital Transformation Progress Report** The Director of Digital Transformation (DDT) presented the Report and highlighted the following: <u>2022/23 IMTP</u> • Good progress had been made with what the team had set out to achieve in the year 2022/23. <u>2023/24 IMTP</u> • There was an emphasis on national Welsh Government (WG) programmes. • The main constraint was limited resource which was diverted to meeting organisational priorities and operational needs • There were a few mitigations in place which included: - A digital advisory board would be established to ensure digital resource was aligned with organisational programmes and project priorities. - An assessment of capacity was undertaken and there were some resource gaps due to difficulty	

	recruiting the right skills and expertise which was part of a wider challenge. <u>Governance</u> • A revised governance model was being developed. • The Digital team was aiming for greater transparency and shared decision making with the organisation so that it could make the best use of its limited resources. • That proposal had been informed by a senior management team assessment of capacity over and above business as usual (excluding the O365 team and Operations) which highlighted that: - The Digital team continued to carry a number of vacancies (that was not unique to the Health Board). - The Digital team's capacity was over committed. - There was a growing backlog of requests. • The proposal under discussion also recognised the new Welsh Government Chief Digital and Innovation Officer role. Direction would be provided on matters, such as standards for interoperability and Welsh Government (WG) digital priorities. <u>Shaping our future digital services</u> • It was noted that over 40 gathering intelligence conversations were held with colleagues in organisations undergoing similar programmes to Shaping our Future Hospitals and Shaping our Future Clinical Services. • That work would inform the Health Board's plans. <u>Enterprise Architecture</u> • The first phase of the work had been completed. • It was part of determining the baseline in terms of where the Health Board was and what was required in the next 18 months or so to progress the digital maturity journey. • The work had delivered the required outputs including: - Enterprise Architecture diagrams	

	- Target Operating Model - Viewpoints e.g. of the data stack, infrastructure, system suppliers - List of standards - A route-map that captured ideas for further discussion and key decisions to be taken - A report with recommendations <u>HIMMS Assessment</u> • The Health Board had undergone an assessment of its digital maturity using the globally recognised HIMSS (Healthcare Information and Management Systems Society) Electronic Medical Record Adoption Model (EMRAM) standard. • That recognised standard defined what a modern health care system must aspire to. • It described 7 Levels (0 to 7) of maturity where Levels 6 and 7 were the most digitally advanced acute Trusts globally. • Only 8 UK NHS Trusts (all in England) had achieved those two levels. • However, HIMSS EMRAM was not a whole system assessment - it only assessed the digital maturity of the main hospitals and did not take account of community services. • The Health Board had been assessed as achieving Level 1. • For the Health Board to progress to the next Level, that would depend upon having an Electronic Patient Record system in place. <u>SMART health and care system</u> • The system was about making sure that all data was reusable. • A bid was made to WG for some modest funds to create capacity to develop a Digital Strategic Outline Case (Digital SOC) in support of the Shaping our Future programmes (clinical services, hospitals, community service etc). <u>Journey to digital maturity</u> • There were over 100 programmes and projects in train at any one time as the Health Board responded to operational needs and WG priorities.	

	• The revised governance structure would help the Digital team with the prioritisation of those works in a context of limited resources. • The Digital SoC would build upon the Digital Strategy ambition to be a learning health and care system and work towards becoming a SMART healthcare system to facilitate delivery of redesigned and reimagined clinical pathways, models of care and, in time, new hospital buildings. The Director of Digital & Health Intelligence (DDHI) thanked the team for the work that they had put into the update. It was noted that there needed to be a balance between dealing with the “here and now” and also longer strategic work. The Digital team also needed to try and create time, effort and resources to look at the longer term. The Independent Member – Community (IMC) requested more assurance on the small steps being taken to achieve the goals. He also queried whether that was being done by the Health Board itself or would a third party be required. The DDHI responded that all of the Digital team was busy working on the here and now. As a result, there was limited scope to consider matters beyond the next 12 months. The DDT advised that what had been presented at the meeting and the previous meeting were the small steps being taken. The Enterprise Architecture was essential to give a baseline position. It also flushed out key decisions that needed to be taken. The HIMMS exercise was also valuable to determine the next steps required. Refreshing the governance and shared decision making was also critical. The DDHI advised that the Digital team wanted to work with the DHCW and other Health Boards who have similar issues. The CC queried how realistic was 10 years to develop a SMART hospital. He also queried how joined up were the Estates and Digital teams. The CC also queried where did the patient voice fit into the governance.	

	The DDT responded that they were making significant progress. However, it all came back to the funding element. The DDHI advised that they would need to work more closely with the Estates team. **The Committee Resolved that:** a) The Digital Transformation Progress Report was reviewed. b) The proposed governance model was commented on.	
DHIC 30/05/008	**Joint IMT & IG Corporate Risk Register** The DDHI presented the Joint IMT and IG Corporate Risk Register Paper and highlighted the following: • There were currently 14 joint IMT/IG risks identified within the Risk Register document attached in Appendix 1. • 1 risk relating to Cyber Security remained red with a score of 20. The CC queried whether the risks relating to achieving the ambitions around the SMART hospitals needed to be captured. The DDHI responded that the risks focused on the here and now and the operational risks. The IDCG advised that the Corporate Risk Register needed to be looked at alongside the risks on the Board Assurance Framework (BAF). **The Committee Resolved that:** a) Progress and updates to the Risk Register report were reviewed and noted.	
DHIC 30/05/009	**IG Data & Compliance (Sis, Data Protection, GDPR, FOI, SARs, Staffing & Mandatory Training)** The Head of Information Governance and Cyber Security (HIGCS) presented the Report and highlighted the following: • Information Governance staffing levels remained stable but the Information Governance Department had continued to find the increased workload challenging.	

	• Between January 2023 and April 2023, the Information Governance Department had reviewed a total of 185 information governance related incidents reported via Datix. • Of those breaches reviewed, six of the breaches met the threshold to be reported to the Information Commissioner's Office (ICO). The details of those breaches, plus a complaint received from the ICO, would be outlined in the Private meeting of the Committee. • Since June 2022, the Health Board had experienced a steady increase in the number of health record requests received. The overall compliance for the last 12 months was 58%. • The "go live" date for the new digital Subject Access Request system was by the end of March. A soft launch would take place in May and June, with a view of rolling out to the public during the Summer. • The purpose was to streamline the requesting process and to manage performance and report figures more easily. • A total of 34 Subject Access Requests submitted for non-health records were received from December 2022 to March 2023. • 31 requests (91%) were complied with (within the legislated timeframe) and 2 remained outstanding (having appropriate extensions applied). • The Health Board Information Governance training compliance was currently at 74%. That represented a further 4% increase in overall completeness since figures were last provided to the Committee. The CC advised that they should not go down the route of FOI requests to other Health Boards. **The Committee Resolved that:** a) A series of updates relating to significant Information Governance issues was received and noted.	
DHIC 30/05/010	**Digital Services Key Performance Indicators** The DDHI presented the Digital Services Key Performance Indicators Report. The IT Project Manager (IPM) showed the Committee the latest live data taken from the Ivanti system and highlighted the following: • The executive score cards showed the number of incidents and requests.	

	• Moving forward it would be broken down into different areas. • The red area was the number of incidents and requests which remained open. • The average duration was coming down all the time. • In terms of the request and incident report, the key thing was the source. The Digital team would like to take the pressure off the phones and increase traffic through the self-service portal. • A new self-service portal would be implemented. It would help clarify when users should report an incident and when they should request a service. There would also be a knowledge base available for common issues. The DDHI queried whether there would be a "comms piece" to staff to accompany the go live date. The IPM responded that the new self-service portal had been on the Health Board staff's screen savers for a week. The DDHI responded that a weekly comms update would be useful. The CC advised that it would be useful to get feedback once it had launched. **The Committee Resolved that:** a) The progress made since the last update on the Ivanti service desk tool in relation to KPIs was reviewed and noted.	
DHIC 30/05/011	**Framework Policies, Procedures & Controls** The DDHI presented the Framework Policies, Procedures & Controls Paper and highlighted the following: • Since the last meeting in February 2023, a number of procedures and policy documents had been under review with the external Contractors and IT Governance. • The Records Management Policy would come back for approval in the next Committee meeting. • There was a wider piece of work being undertaken with the Corporate Governance team to look at all of the out of date policies, procedures and guidance notes. **The Committee Resolved that:**	DDHI

	a) The progress made in updating the priority policy and procedure documents was noted.	
DHIC 30/05/012	**Committee Self Effectiveness Survey** The IDCG presented the Committee Self Effectiveness Survey and highlighted the following: • The individual findings of the Annual Board Committee Effectiveness Survey 2022-2023 relating to the Digital and Health Intelligence Committee were presented at Appendix 1 for information. • Overall the findings were positive and there were no areas identified for improvement. • The DDHI drew the Committees attention to questions 5, 10 and 11 where there were question marks in regard to full compliance. The DDHI queried the question 5 response where one person identified that they did not have sufficient knowledge to identify key risks and challenge line management. The DDHI asked what support would Committee members like to receive. The IDCG advised that more was required to bring the risk element alive. The Health Board should use the BAF to guide the agendas more. He also suggested a general briefing session for each of the Committees with regard to talking through all the risks each Committee faced. The Independent Member - University (IMU) queried the large number of acronyms included within papers. He also queried the length of papers for Board and how Independent Members were expected to get through those alongside their other roles. The IDCG agreed with the IMU's points. A Task and Finish group were being set up with Independent Members and Executives to look at Committee papers. The CC advised that they only need key information and the option to look at detailed information if required. It was agreed that given the importance of digital, there needed to more time allocated for Board development. The DDHI responded that Digital would be discussed at the Board twice a year and the Committee should consider which key points to take to Board.	

	The Committee Resolved that: a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Digital and Health Intelligence Committee were noted.	
DHIC 30/05/013	**Welsh Government Digital Strategy for Health & Social Care Refresh** The DDHI presented the Welsh Government Digital Strategy for Health & Social Care Refresh and highlighted the following: • A long-awaited digital strategy from WG was circulated to organisations in April following updates from Michael Emery. • The strategy was in development for the previous 12 months and final consultation feedback had been sought from organisations. • A key focus was to put people at the heart of the strategy. • A number of comments were received from the Health Board. The DDHI advised that it would be a huge challenge but there were many worthy ambitions within the document. A huge challenge related to how it would be financed by WG and how that would be filtered through the different organisations. **The Committee Resolved that:** a) The response submitted on the Welsh Government Digital Strategy for Health and Social Care refresh document was reviewed.	
	Items for Approval / Ratification	
DHIC 30/05/014	**Policies – Verbal Update** The DDHI stated that no policies were presented to the Committee for approval. **The Committee Resolved that:** a) No Policies were noted.	
DHIC 30/05/015	**Minutes: Digital Directors Peer Group** The following Minutes were received by the Committee: • Minutes of Meeting – 15 February 2023 • Minutes of Meeting – 7 March 2023 • Minutes of Meeting – 4 April 2023	

	• Minutes of Meeting – 2 May 2023 (unconfirmed) **The Committee Resolved that:** a) The Minutes of the Digital Directors Peer Group of the meetings held on 15 February 2023, 7 March 2023, 4 April 2023 and 2 May 2023 were received and noted.	
DHIC 30/05/016	**Any Other Business** No Other Business was discussed.	
DHIC 30/05/017	**Items to bring to the attention of the Board / Committee** No Items were brought to the attention of the Board / Committee.	
	Date & Time of next Meeting: Tuesday 15th August 2023 via MS Teams	

Confirmed Minutes of the Public Finance and Performance Committee Meeting
Held On 19th July 2023 at 2 pm
Via MS Teams

Chair:		
Michael Imperato	MI	Independent Member – Legal
Present:		
John Union	JU	Independent Member – Finance
David Edwards	DE	Independent Member - ICT
Ceri Phillips	CP	UHB Vice Chair
Keith Harding	KH	Independent Member – University
In Attendance:		
Catherine Phillips	CP	Executive Director of Finance
Andrew Gough	AG	Deputy Director of Finance (Strategy)
Paul Bostock	PB	Chief Operating Officer
James Quance	JQ	Interim Director of Corporate Governance
Jason Roberts	JR	Executive Nurse Director
Matt Temby	MT	Director Planned Care and Specialist Care
Ed Hunt	EH	Programme Director - Redevelopment
Fiona Jenkins	FJ	Executive Director Therapies and Health Sciences
Marie Davies	MD	Deputy Director of Strategic Planning
Observers:		
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Charles Janczewski	CJ	UHB Chair
Abigail Harris	AH	Executive Director of Strategic Planning
Robert Mahoney	RM	Deputy Director of Finance (Operational)

Item No	Agenda Item	Action
FPC 19/07/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 19/07/002	**Apologies for Absence** Apologies for Absence were noted. **The Finance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 19/07/003	**Declarations of Interest** No Declarations of Interest were noted.	

FPC 19/07/004	**Minutes of the Finance and Performance Meeting held on 21 June 2023** The minutes of the meeting held on 21 June 2023 were received. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on 21 June 2023, were held as a true and accurate record of the meeting.	
FPC 19/07/005	**Action Log following the Finance and Performance Committee meeting on 21 June 2023** The Action Log was received. **The Finance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 19/07/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance	
FPC 19/07/007	**Financial Report – Month 3** The Deputy Director of Finance for Strategy (DDFS) presented the Financial Report – month 3 and highlighted the following: • At month 3, the Cardiff and Vale University Health Board (the Health Board) was reporting an overspend of £25.756m which comprised of £3.485m in unidentified savings, £0.171m of operational overspend and the planned deficit of £22.100m (three twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan). <u>Operational Position</u> • At month 2, a small operational surplus of £0.075m was reported. That position had now moved to a small deficit of £171k. • The delegated clinical board position remained in a surplus of £109k, however, the position was variable across Clinical Boards, with emerging pressures being experienced within Surgery, Mental Health, CD&T and Capital Estate and Facilities. • There were deficits within central budgets of £153k which related to the pay award. Since the report had been written, the issue had been resolved and would go back to a balanced position from month 4 onwards. • A deficit had also been reported against the commissioning position of £127k. It was predicted that activity would improve as the year progressed.	

- Deep dives were taking place with all Clinical Boards to ensure plans were in place to address pressures.
- The savings programme deficit at month 3 continued to represent a risk to the Health Board.
- The central focus of the Sustainability Board and Executive Performance Reviews with Clinical Boards were to ensure that operational pressures were addressed and managed and further progress would be made in identifying and delivering recurrent savings schemes that in turn would de-risk the financial plan.

Savings Programme

- At month 3, the Health Board identified £28,488m of green, amber and red savings against the £32m savings target leaving a further £3,512m (11%) schemes to be identified.
- The month 3 position included a Savings Programme variance of £3.485m relating to a three month share of red and unidentified schemes.
- The Health Board expected to be able to manage the balance of savings plans required to deliver the forecast deficit of £88.4m with the risk of non-delivery of savings and the progress of reducing the risk via identification of schemes.
- The DDFS emphasised that it was really important to move the schemes in red into amber and green to give assurance of delivery.
- Escalation meetings were put in place with all Finance and Operational team leads to progress the schemes in the red pipeline and find further opportunities.

Capital Resource Limit

- The Health Board continued to operate within the capital resource limit.
- There was a positive cash balance of under £4m.
- Conversations continued to take place with Welsh Government (WG) around cash support to cover the planed deficit and the consolidated pay award from 22/23.

The Independent Member - ICT (IMICT) queried the level of confidence amongst Executives in achieving the red savings and turning them into green or amber.

The DDFS responded that the ideas were worked up in a lot of detail and that progress had been observed on a weekly basis around turning those ideas into cash release savings.

The EDF responded that the first issue was identifying the £32m savings and then delivering it recurrently and that for every month that there was a delay, there would be potential slippage.

She added that they would start next years saving pipelines in September 2023 as part of the planning piece.

The Finance Committee resolved that at Month 3:

	a) The reported year to date overspends of £25.756m and the forecast deficit of £88.400m was noted b) The financial impact of forecast COVID 19 costs which was assessed at £44.664m was noted. c) The month 3 operational overspend against plan of £0.171m was noted. d) The progress against the savings target, with £28.488m (89%) of schemes identified at Month 3 against the £32m target was noted.	
FPC 19/07/008	**Operational Performance Report** The Operational Performance Report was received. The Chief Operating Officer (COO) advised the Committee that the Report was still a work in progress and would be updated next month with firmer trajectories included. <u>Urgent care</u> • It was noted that internal ward moves had been finalised and the assessment unit and the speciality hub in the Emergency Unit (EU) had been closed. • It was noted that the Health Board were likely to see a spike in 12 hour waits for the next few weeks due to patients being "off the clock" in an area deemed not suitable. • It was noted that teams were expecting the overall 4-hour performance to worsen slightly due to the way in which patient's activity would be coded and counted. • It was noted that WG were very supportive of the approach being taken and that they wanted to use the Health Board as an exemplar on how same day emergency code was being counted and coded. <u>Mental Health</u> • It was noted that there had been a spike in demands and that there were also issues in being able to cover the assessments. • The COO expressed confidence that the position would be recovered once quarter 4 was reached. • It was noted that a summit had been set up to take place in early September 2023 and would be attended by several Clinical Boards, Executives and the UHB vice Chair to understand what was driving the demands, the capacity and what could be reasonably done to manage the problem. <u>Cancer</u> • It was noted that the Health Board was back on track and the 62-day position had improved. The CC queried how primary care could be captured best within the data.	

The COO responded that there was difficulty since GP's could see patients however, they were not contracted to state how many patients they had seen.

He added that GP's were working with PCIC on what meaningful data could be reported and that the PCIC executive review would also take place that afternoon where it would be discussed.

The UHB Vice Chair advised that there were issues in Primary Care due to the pressures which depended on the location of the practice and the patient list.

He added that the number of practices had also declined and that Dentistry was also challenging because there were lots of people waiting to access NHS dental care.

He concluded that Pharmacists were also under increased pressure.

i) Planned Care and Outpatients Deep Dive Presentation

The Director of Planned and Specialist Care (DPSC) advised the Committee on the following:

<u>Governance</u>

- There were 6 individual groups which looked at the pathway elements that needed specific work. There were also operational and clinical leads noted against each one.
- There were individual productivity and efficiency measures in each group that were being worked on.
- The performance management meetings took place weekly to analyse long waits and how they were being managed.
- Progress had been made to standardise the functions of the sub groups.
- Each subgroup was reviewing productivity and efficiency measures in addition to planning and improvement.
- Speciality performance management meetings took place weekly with the Head of Performance and measured the outputs linked to agreed delivery trajectories.

<u>New Ministerial Ambitions</u>

- It was noted that the following ambitions were introduced by the Minister:

  - No patient at outpatient stage over 156 weeks by end of August 2023.
  - 97% of patients should receive treatment in less than 104 weeks by December 2023.
  - 99% of patients should receive treatment in less than 104 weeks by March 2024.
  - Continuous improvement of cancer standards was required.

<u>Weekly Monitoring</u>

	• It was noted that each week the team would share weekly monitoring figures with the UHB Chair, CEO, WG and the NHS Executive and Delivery Unit which detailed the remaining cohort each speciality had to achieve to hit their targets. <u>Outpoints: follow up not booked</u> • It was noted that continued improvement was required in that area as ther were just under 55,000 patients on the follow up outpatient waiting lists having been waiting 100% past their target date. It was noted that that cohort of patients had been growing since November 2022. It was noted that Clinical Boards were tasked to develop plans to address waiting lists, specifically to include how to eradicate the waiting time of patients who had waited more than 2 years past target date. • It was noted that since 18th July 2023 the number had reduced to 48,201 with 40,731 without a date and that 12 out of 20 specialties were on target with their trajectories for eradicating all 2-year past target date waits without an appointment. • It was noted that all Specialties would have a trajectory to eliminate all Follow Up over 100% past target date through performance reviews in July 2023 and that all trajectories were tracked by the Outpatient Delivery Group. **The Finance Committee resolved:** a) The year to date position against key organisational performance indicators for 2023-24 and the update against the Operational Plan programmes Link to Strategic Objectives of Shaping our Future Wellbeing was noted. b) The Planned Care and Outpatients Deep Dive Presentation was noted.	
FPC 19/07/009	**Progress against Decarbonisation Action Plan** The Programme Director - Redevelopment (PDR) presented the Progress against Decarbonisation Action Plan and highlighted the following: • In March 2023, the Board approved the 2023/24 Decarbonisation Action Plan and defined a series of actions, owned across the Health Board. • The plan built upon previous plans and the actions defined as mandatory by NHS Wales in their Decarbonisation Strategic Delivery Plan. • The 2023/24 action plan contained 54 actions set out over 6 sectoral areas: Leadership, Estates, Transport, People and Communications, Clinical and Procurement. • It was agreed that actions would be reported back on a quarterly basis to the Decarbonisation Delivery Group and Finance and Performance Committee. • There were two schemes that would not be completed in the current financial year which included the investment case for Shaping Our	

	Future Hospitals and the investment case for Digital Transformation due to WG not funding those schemes. • Some actions had been put in as amber and required more work. • Leaders were being recruited in Nursing, Therapy and Clinical communities and Champion roles were also being created. • The team were working with workforce colleagues and they had now gotten a place on the induction scheme for new starters. **The Finance Committee resolved:** a) The contents of the report were noted.	
	Items for Approval/Ratification	
FPC 19/07/010	**Haematology / BMT & Advanced Cell Therapy Strategic Outline Business Case** The Deputy Director of Strategic Planning (DDSP) presented the Strategic Outline Business Case and advised the Committee on the following: • The scheme had been through the appropriate internal governance routes. It was now required to come to the Committee and then to Board for approval. • The scheme had been in development for a number of years. • The business case addressed a number of issues which related to BMT haematology services. • The Health Board was the only provider in Wales of BMT and CAR-T therapies. • Maintaining JACIE accreditation was a fundamental requirement of WHSSCs service specification for BMT and CAR-T and the pharmaceutical companies who supply the products for CAR-T. • Due to environmental factors related to infrastructure, the Health Board was at risk of not retaining JACIE accreditation and the potential impact on the service could result in steps being taken to decommission BMT and CAR-T, which would fundamentally undermine the delivery of haematological cancer services for the population of South Wales. • The infrastructure was inadequate for the case mix which meant that sanitation, ventilation and isolation facilities could not be met. • There was a highly constrained footprint and there was no room to expand. • The development of a Cardiff Cancer Research Hub was inextricably linked to the wider development of high-quality regional cancer services across South East Wales. • The development of the research hub was also a key component of the TCS programme, working with partners, and one of the recommendations contained within the Nuffield Report (December 2020) was that delivery would support the region in delivering the recommendations and ensure the full range of benefits were realised. • The business case was an essential component in enabling the wider regional clinical model for nonsurgical tertiary oncology services,	

	including the new Velindre Cancer Centre, to be fully optimised and achieve the full range of expected benefits. • The preferred way forward at this SOC stage was option 3 or option 4. - **Option 3** – core and desirable services provided within a traditionally built new build on the site of the current HCID Unit on the car park above the main hospital entrance. - **Option 4** – core and desirable services provided within a new modular building on the site of the current HCID Unit on the car park above the main hospital entrance. It was noted that this involved a £62m capital investment and a £36m revenue consequence which would be fully tested at the next stage of the business case process and that the increased revenue costs would need to be met which could be achieved by increasing costs of WHSCC services. The UHB Vice Chair requested more clarity around the figures in the table. The DDSP responded she would put him in touch with the business case financial lead. The Independent Member – Finance (IMF) queried when they would be paid from a revenue side and would there be enough money to do it in such a short time frame. The DDSP responded that from a capital perspective they would be going to WG for the funding and in terms of service costs, they would need to model how they could identify savings associated that would come to patients through the provision of Advanced Therapy Medicinal Products (ATMPs). **The Finance Committee resolved:** **a)** The submission of the Haematology/BMT Strategic Outline Case to Welsh Government for capital funding support was reviewed.	
FPC 19/07/011	**South Wales Thrombectomy Full Business Case** The DPSC presented the South Wales Thrombectomy Full Business Case and highlighted the following: • The Health Board had a limited thrombectomy service for their own residents. • The Health Board had been working with North Bristol NHS Trust to provide services. • WHSCC have a large amount of money set aside to pay premium rates for services in North Bristol. • WHSCC had requested that the Health Board develop a business plan for the South Wales region.	

	• The suggestion was to go for a phased approach. Phases 1 and 2 would involve introducing a daytime service. • In the long run, there would be a need to complete the work on a super-regional basis in Bristol. • The total cost of Phase 1 was £2.583m, increasing to £3.421m in Phase 2. The Health Board's contribution in Phase 1 would be just over £500k and £700k in Phase 2. **The Finance Committee resolved:** a) The Thrombectomy Strategic Full Business Case was recommended to the Board for approval. b) Specific approval to support Phase 1 and 2 of the business cases was recommended to the Board. c) Commitment to further develop Phase 3 and 4 and the ambition to become the regional centre for Thrombectomy for South Wales was recommended to the Board for support.	
FPC 19/07/012	**All Wales Genomics Investment Business Plan** The Executive Director of Therapies and Health Science (EDTHS) presented the All Wales Genomics Investment Business Plan and highlighted the following: • The All Wales Medical Genomics Service (AWMGS) was hosted by the Health Board with its hub services including a single national laboratory in Cardiff. • The AWMGS provided clinics across Wales with regional clinical spokes. • The AWMGS had submitted its annual business plan to the Senior Leadership Board Investment Group for assurance scrutiny and • oversight. The plan was developed to support the Health Board's Integrated Medium Term Plan (IMTP). • It would cost £24m which would be funded mostly by WHSCC. • The appendix included all the details and there would be a discussion at Board in July 2023. **The Finance Committee resolved:** a) The All Wales Medical Genomics Service 2023-2024 Investment Business Plan was reviewed and recommended to the Board for support.	
	Items for Information and Noting	
FPC 19/07/013	**Monthly Monitoring Returns** The Month 3 Monitoring Return was received. **The Finance Committee resolved that:**	

	a) The extract from the UHB's draft Monthly Financial Monitoring Return for Month 3 was noted.	
FPC 19/07/014	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
FPC 19/07/015	**Items to be referred to Board / Committee** No Items to be referred to Board / Committee.	
	Date & time of next Meeting Wednesday 23rd August 2023 at 2pm via MS Teams	

Confirmed Minutes of the People and Culture Committee
Held On 11 July 2023
Via MS Teams

Chair:		
Sara Moseley	SM	Independent Member for Third Sector/Committee Chair
Present:		
Rhian Thomas	RT	Independent Member for Capital & Estates
Mike Jones	MJ	Independent Member for Trade Union
Susan Elsmore	SE	Independent Member for Local Authority
In Attendance:		
Rebecca Aylward	RA	Deputy Executive Nurse Director
Jo Brandon	JB	Director of Communications
Daniel Crossland	DC	Director of Operations Mental Health Clinical Board
Rachel Gidman	RG	Executive Director of People & Culture
Katrina Griffiths	KG	Head of People Services
Fiona Jenkins	FJ	Executive Director of Therapies
Mitchell Jones	MJ	Head of Equity and Inclusion
Fiona Kinghorn	FK	Executive Director of Public Health
Lianne Morse	LM	Deputy Director of People & Culture
Clem Price	CP	Head of Strategic Workforce Planning at HEIW
James Quance	JQ	Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Richard Skone	RS	Deputy Executive Medical Director
David Thomas	DT	Director of Digital and Health Intelligence
Robert Warren	RW	Head of Health and Safety
Adam Wright	AW	Head of Service Planning
Secretariat		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer
Akmal Hanuk	AH	Independent Member for Community
Meriel Jenney	MJ	Executive Medical Director
Suzanne Rankin	SR	Chief Executive Officer
Ceri Phillips	CP	Vice Chair of the UHB

Item No	Agenda Item	Action
P&C 11/7/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	
P&C 11/7/002	**Apologies for Absence** Apologies for absence were noted.	
P&C 11/7/003	**Declarations of Interest**	

	No Declarations of Interest were noted.	
P&C 11/7/004	**Minutes from meeting on 16th May 2023** The Minutes taken from the 16th May 2023 meeting were received. Page 3 – The CC advised that the second bullet point in relation to the Terms of Reference (TOR) should state "potentially the remit was very wide." The Executive Director of Public Health (EDPH) advised that page 3 should include "the People and Culture Committee would be in part review the Equality Framework, together with the Quality, Safety and Experience Committee. **The Committee resolved that:** a) The draft minutes of the meeting held on 16th May 2023, were held to be a true and accurate record of the meeting pending the above amendments.	
P&C 11/7/005	**Action Log following 16th May 2023 Meeting** The Action Log was received. **The Committee resolved that:** a) The Action Log was discussed and noted.	
P&C 11/7/006	**Chair's Actions** There were no Chair's Actions.	
	Items for Review & Assurance	
P&C 11/7/007	**My Hearing Loss Staff Story** A Hearing Loss Staff Story was presented to the Committee. The Independent Member for Local Authority (IMLA) declared an interest in the story since she came from a family of hearing loss and requested assurance regarding the Genomic Services team moving to an open plan environment to help mitigate any hearing issues the staff member may face. The Independent Member for Trade Union (IMTU) queried where staff could get the hearing aid badges, which highlighted when a member of staff had hearing difficulties. He also suggested that it would be useful to put out more information about the Staff Access Ability Network.	

	The CC suggested that the story should be linked to a campaign day with relevant charities and the Independent Members should be invited. The CC thanked Daisy for sharing her story and expressed that staff stories were a really important element. **The Committee resolved that:** a) The Hearing Loss Staff Story was noted.	
P&C 11/7/008	**Board Assurance Framework Report** The Director of Corporate Governance (IDCG) presented the Board Assurance Framework (BAF). It was noted that the three risks included in the BAF were there to provide assurance to the Board and that there were several risks noted in relation to People and Culture. The DCG suggested that he would bring one risk at a time to future meetings to allow the Committee to delve into those further. The Director of Digital and Health Intelligence (DDHI) commented that he had previously discussed digitally excluded staff with the Executive Director of People and Culture (EDPC). There were 2000 staff without emails or NADEX accounts and this was not reflected anywhere within the BAF data. The EDPH queried whether the risk relating to Covid was too high because most things had moved forward. The EDPC responded that the Covid risk needed to be reviewed and added that they had been able to look at a post for Organisational Development (OD) and Digital which would allow for joint working between the digital teams and educational teams. The Independent Member for Capital & Estates (IMCE) queried how employees with long term Covid were being supported. The Deputy Director of People & Culture (DDPC) responded that direct support took place via their line managers. She added that the People and Services team also ensured that the staff members had the correct support. **The Committee resolved that:** a) The attached risks in relation to Workforce, Sustainable Culture Change and Staff Wellbeing were reviewed. b) The approach to reporting of BAF risks to the Committee on a rolling basis as proposed were agreed.	**JQ**

P&C 11/7/009	**Focus on Census 2021 for Workforce Planning Presentation** The Head of Strategic Workforce Planning at HEIW (HSWPH) presented the Focus on Census 2021 for Workforce Planning Presentation and highlighted the following: • Her team recently went through the published ONS data sets for the census and created a workforce planning analysis through a supply lens. • The population in Wales had grown by 1.4%. This was a lot less than anticipated. • The England population rose by 6.6%. • The South East corner had the largest population. Cardiff and Vale Health Board came up top at 4.6%. • The working age population shrank by 2.4%. The 35 to 44-year-old category had decreased. • The dependent young population had shrunk by 1.5%. • The Cardiff and Vale younger population was “bulging”. This was due to the high number of students within the area. • The gender split of the Welsh population was female 51.1% and male 48.9%. • The life expectancy for females was higher than males in Wales, however the healthy life expectancy age was lower than the pension age. • Education levels were higher in the South East. • Welsh speaking was much higher in the Hywel Dda UHB area. • Cardiff and Vale had the largest ethnic minority makeup in Wales. • Overall, the NHS Wales workforce was 4.6% of the working age population (age 18-64). The average age of the workforce was older than the average age of the population. • In the future, it was predicted that the population would grow by 6%. The working population was expected to increase. This was due to the increase in state pension age. • There were also issues with workforce supply. There were less 18-year olds in Wales than England. There was also a larger ageing population of 65+. • The younger population would be more ethnically diverse. The DDPC advised the Committee that the Heads of People and Culture were responsible for supporting the organisation with the strategic workforce plans. She added that the teams regularly met with Health Education Inspectorate Wales (HEIW) to ensure they had support and that they also aligned with the Health Boards strategic programmes.	

	It was noted that for 2023-24 they would focus on how to align the clinical board's operational plans into the IMTP and that the biggest risks were that they currently did not have a dedicated team or lead for strategic workforce planning. The HEIW would be creating a workforce observatory in the next 1 to 3 years which would provide high-level information for workforce planning. The EDPH advised that the older workforce may not be able to afford to retire which could impact sickness levels and noted that the population was becoming more ethnically diverse. She added that Cardiff also had a very large student population and it was important to attract and draw them into working within healthcare. The EDPC concluded that they had benchmarked and mapped resources and she would present this to the CEO and EDF the following week. **The Committee resolved that:** a) The Focus on Census 2021 for Workforce Planning Presentation was noted.	
P&C 11/7/010	**Key Workforce Performance Indicators** The DDPC presented the Key Workforce Performance Indicators and highlighted the following: • It was the last time the Committee would see this version of the report. • Going forward it would be replaced by the Integrated Performance Report. • Key Performance Indicators (KPI's) continued to improve. • More work was required around Values Based Appraisals (VBA) rates. • The team were still maturing the benchmarking data. The CC stated that the benchmarking categories were very wide and queried the Health Board's equivalent used for benchmarking. The DDPC responded that they had chosen the organisations on the basis of how many staff they employed. She added that the team would look into what the Health Boards equivalent organisations were.	**LM**

	The Committee resolved that: a) The contents of the report were noted and discussed.	
P&C 11/7/011	**Value Based Appraisal Update Report** The EDPC presented the Value Based Appraisal Update Report and highlighted the following: • She had previously taken the paper to the Strategy and Delivery Committee. • She would invite clinical boards to speak about their own data and what their planned actions were. • The ambition was to get VBA rates to 85%. • Historically it had been around 40%. • Capital Estates and Facilities had gone over and above their target. The Director of Operations - Mental Health Clinical Board (DOMH) advised that there were lots of challenges around VBAs and noted that the brief VBA form had helped to solve those issues. He added that there were limited numbers within the Mental Health Clinical Board and that there were challenges of freeing up people to fill out the form. **The Committee resolved that:** a) The contents of the report and the current VBA position across the UHB by Clinical and Service Board were noted. b) The local actions being taken to improve compliance, and approve the recommendation that a further update be brought to Committee in November 2023 was noted.	**RG**
P&C 11/7/012	**Cost of Living Impact Presentation** The DOMH presented the Cost of Living Impact Presentation and highlighted the following: • It was the highest level of demand which mental health services had experienced to date. • There were 250 primary care liaisons a day. • In one month, there were 1500 referrals to Mental Health Services. • A conversation took place with Mental Health Community teams recently around fragile situations leading to increased admissions. • The majority of them confirmed that they were experiencing the highest bed capacity.	

	• There was an impact on English integrated health boards with a large number of individuals presenting in Cardiff. • Unions reported an increased number of staff referred to food banks. • There was an increasing request for 'long day' shifts to reduce travel costs. The Executive Nurse Director (END) advised that a wide range of options had been explored and noted that the Wage Stream was an independent provider who supported heath boards to allow bank workers to get their pay weekly. He added that the Health Board was losing a lot of staff because agency staff could get paid weekly and noted that although the Executives agreed, he was disappointed because there was a lack of support from staff. The IMTU responded that it was a regional decision. **The Committee resolved that:** a) The Cost of Living Impact Presentation was noted.	
P&C 11/7/013	**Health & Safety Update** The Head of Health and Safety (HHS) presented the Health & Safety Chairs Report and highlighted the following: • The Health and Safety Committee would be feeding into the People & Culture Committee. • The Health and Safety risks and fire safety risks would be received by the People & Culture Committee. • There was increased risk in the tunnel area underneath the University Hospital of Wales (UHW). It was noted that the team had completed a detailed inspection all the tunnels and that the Tunnel Safety Group had also been reinstated. • There had been a challenge over the last 12 months to obtain suitable Fire Advisors. • The Health and Safety Annual Report had also been completed. • There had been an increase in fire signals. The CC advised that they needed to understand more around the risks held by the Committee. The EDPC responded that she had conversations with the EDF and noted that the Director of Capital, Estates and Facilities would bring the risks to future Health and Safety Committee meetings which would feed into the People and Culture Committee.	

	The DCG advised that he would look at the narrative that came through the Corporate Risk Register and BAF to ensure they were captured properly. **The Committee resolved to:** a) The contents of this Report were noted.	
	Items for Approval / Ratification	
P&C 11/7/014	**People and Culture Committee Terms of Reference and Work Plan 2022/23** The People and Culture Committee Terms of Reference and Work Plan 2022/23 was received. The EDPH advised that she should be noted down as a member of the Committee and that the Equality Framework and the socio-economic duty should be included under the legal aspect. The DCG responded that he would incorporate the comments and circulate it again for agreement outside of the Committee which would then be received by the Board in July 2023. **The Committee resolved to:** a) The Terms of Reference and work plan 2023/24 for the P&C Committee were reviewed. b) The Terms of Reference and work plan 2023/24 for the P&C Committee were ratified. c) The changes were recommended to the Board for approval on 27 July 2023.	
P&C 11/7/015	**Gender Pay Gap Report 2022** The Gender Pay Gap Report 2022 was received. The Head of Equity and Inclusion (HEI) highlighted that the Report was updated due to an inaccuracy contained within it. He added that the Report was previously approved by the Strategy and Delivery Committee and that a Chairs Action was sought to approve the updated version. The HEI added that it was disappointing to see that the gender pay gap still existed, however, the gap was much less than previously reported and that at March 2022, the gender pay gap was 17.49% which had reduced to 17.2% by March 2023.	**RG/MJ**

	The IMCE commented that she struggled to see what the Health Board did tangibly to ensure fair gender pay and requested a deep dive on the topic. The HEI responded that there was more work to do and that flexible and agile working needed to be promoted to allow women to work in higher paid roles within the Health Board. The IMLA stated that the Kings Fund was doing lots of leadership seminars and that it was important to recognise the women in the workforce. The Deputy Executive Medical Director (DEMD) advised the Committee that it was recognised nationally that there were problems with the bonus and excellence awards applications. They added that it had been changed to the Clinical Service Awards to encourage people who were not working full time or had taken time out of their careers and noted that more people needed to be encouraged to apply. **The Committee resolved that:** a) The contents of the report were ratified.	
	Items for Information & Noting	
P&C 11/7/016	**Corporate Risk Register** The Corporate Risk Register was received. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the People and Culture Committee and the Risk Management development work which was now progressing with Clinical Boards and Corporate Directorates was noted.	
	Any Other Business	
	Private Agenda Items	
P&C 11/7/017	*i) Suspension/ Exclusion Report (exempt from publication due to the confidential nature of the report)* *ii) Fire Prosecution Update – Verbal (except from publication due to confidential nature of legal case)*	
	Review & Final Closure	
P&C 11/7/018	Items to be deferred to Board/Committees	

	Date & time of the next meeting: Tuesday 12 September 2023 at 9am via MS Teams	

Confirmed Minutes of the Public Audit & Assurance Committee Meeting
Held On 4th July 2023 at 9:00am
Via MS Teams

Chair:		
John Union	JU	Independent Member for Finance and Committee Chair
Present:		
David Edwards	DE	Independent Member for ICT and Committee Vice Chair
Mike Jones	MJ	Independent Member for Trade Union
Ceri Phillips	CP	UHB Vice Chair
Rhian Thomas	RT	Independent Member for Capital and Estates
In Attendance:		
Andrew Crook	AC	Head of People Assurance & Experience
Aaron Fowler	AF	Head of Risk and Regulation
Rachel Gidman	RG	Executive Director of People & Culture
Darren Griffiths	DG	Performance Audit Manager - Audit Wales
Sara Jeremiah	SJ	Post Payment Verification Location Manager
Mark Jones	MJ	Audit Manager - Audit Wales
Lucy Jugessur	WW	Interim Deputy Head of Internal Audit
Gareth Lavington	GL	Lead Local Counter Fraud Specialist
Amanda Legge	AL	All Wales Post Payment Verification Manager
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Catherine Phillips	CP	Executive Director of Finance
James Quance	JQ	Director of Corporate Governance
Matt Temby	MT	Managing Director Planned Care
Ian Virgil	IV	Head of Internal Audit
Observers:		
Glynis Mulford	GM	Risk and Regulation Officer
Secretariat:		
Sarah Mohamed	SM	Corporate Governance Officer
Apologies:		
Paul Bostock	PB	Chief Operating Officer

Item No	Agenda Item	Action
AAC 4/7/23/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
AAC 4/7/23/002	**Apologies for Absence** Apologies for absence were received. **The Committee resolved that:** a) Apologies were noted.	
AAC 4/7/23/003	**Declarations of Interest** **The Committee resolved that:**	

	a) No Declarations of Interest were noted.	
AAC 4/7/23/004	**Minutes of the Meeting Held on 11th May 2023** The Minutes of the Meeting Held on 11th May 2023 were received. The Head of Internal Audit (HIA) advised that page 5 should be amended to "the audit should go to the Charitable Funds Committee for information." Mark Jones (MJ) advised that page 9 should be amended to "… that could affect the annual accounts." **The Committee resolved that:** a) Pending the above amendments, the draft minutes of the meeting held on 11th May 2023, were held to be a true and accurate record of the meeting.	
AAC 4/7/23/005	**Action Log – Following Meeting held on 11th May 2023** The Action Log was received. AAC 7/2/23 015 – It was noted that there were service provision issues and that the Chief Executive Officer (COO), Executive Medical Director (EMD) and Executive Nurse Director (END) were working to provide a service solution which lessened the Health Boards dependency on high cost locums, when they come through agency or procurement. The EDF and EDPC were supporting that. AAC 7/2/23 007 - The HIA advised that this involved an update from the service in September. Internal Audit would then complete their follow up Audit at a later date. AAC 11/5/23 007 – The Charitable Funds Audit would go to the Charitable Funds Committee (CFC) for assurance and then to Board of Trustees (BOT) for noting. **The Committee resolved that:** a) The Action Log was discussed and noted.	
AAC 4/7/23/006	**Any Other Urgent Business** **The Committee resolved that:** a) No other urgent business was noted.	
	Items for Review and Assurance	
AAC 4/7/23/007	**Internal Audit Progress Report** The Head of Internal Audit (HIA) presented the Internal Audit Progress Report and highlighted the following: It was noted that this was the first progress report for the 2023/24 Internal Audit Plan. **Section 2:**	

- Two Audits had now been finalised since the last meeting of the Audit Committee.
- A slight amendment was required to the wording under Section 2.
- There had been a delay with the Consultants Job Planning within the Surgery Clinical Board Audit, which would now feed into the 2023/24 opinion instead of the 2022/23 opinion.

Section 3

- There was a total of 37 reviews within the 2023/24 Internal Audit Plan.
- There were six audits that were currently in progress, with a further twelve at the planning stage.

Section 4

- The ChemoCare IT System follow-up Audit and the Management of Health Board Policies Follow-up Audit had been added to the 2023/24 Plan.
- The University Hospital Llandough (UHL) - Endoscopy Unit Development Audit and the University Hospital of Wales (UHW) – Vascular Hybrid Theatre & Major Trauma Centre (MTC) Theatre had been identified for completion during 2023/24.
- The planned timing of the audit of the ISO Accreditation within the Artificial Limb & Appliance Centre (ALAC) was moved from Q1 to Q2 at the request of the service.

Section 5

- Internal Audit reviewed a sample of the entries within the tracker in order to validate the stated position and provide additional assurance to the Audit Committee.
- The exercise highlighted that the Audit Committee could be reasonably assured that the progress information detailed within the Tracker for 2022/23 was accurate.
- Further work was required to explore why some recommendations were incorrectly categorised as complete.

The Committee Chair (CC) queried whether there were gaps within internal resources which prevented Audits from being completed.

The HIA responded that they had gone through the process of mapping resources for the year and were confident that they could reasonably deliver the Audits within the plan.

Section 6
6.1 Planned Care Transformation Delivery

- The objective of the Audit was to review the systems and controls in place to deliver the transformation of planned care during 2022/23.
- Reasonable assurance was issued.
- One recommendation was made because the Health Board were unable to meet two of the ministerial ambitions for 2022/23.

6.2 UHW-Hybrid & Major Trauma Theatres **IV**

	• The purpose of the Audit was to review the delivery and management arrangements in place to progress the Hybrid/Major Trauma Theatres at the University Hospital of Wales Cardiff. The review also considered the performance to date against its key delivery objectives i.e. time, cost and quality. • Reasonable assurance was awarded. • Two medium priority recommendations were made. The Executive Director of Finance (EDF) suggested that as part of the follow up audit, they build in-between projects to ensure that they have followed all the right governance. The EDF would go through this with the Director of Capital and Estates. **The Committee resolved that:** a) The Internal Audit Progress Report was noted.	
AAC 4/7/23/008	**Audit Wales Update** The Audit Manager for Audit Wales (AMAW) presented the Audit Wales Update and highlighted the following: • The statutory audit of the Health Board's 2022-23 Performance Report Accountability Report and Financial Statements, was drawing to a close. • The changes to the Accounts were minimal which reflected the hard work put in by the Finance team. • The performance report and accountability report were also reviewed and comments were fed back to the Corporate Governance team. • The Audit should remain open until the date of certification which is the 28th July 2023. The Performance Audit Manager for Audit Wales (PAMAW) advised the Committee on the following: • There were several performance Audits which were at different stages. The team would aim to complete them within the next few months. • This year there was a focus on completing a Structured Assessment on Corporate Governance. • They identified two local projects this year. • A forward work programme had been developed of performance audits for the next three years. **The Committee resolved that:** a) The Audit Wales Update was noted.	
AAC 4/7/23/009	**Audit Wales Orthopaedic Report** The PAMAW presented the Audit Wales Orthopaedic Report and highlighted the following: • The national report on Orthopaedic Services in Wales was published in March 2023. • The Report found that urgent and sustainable action was required to tackle the long waiting times for Orthopaedic Services.	

	• Whilst there were clear commitments to improve waiting times, it was found that it could take three years or more to return the Orthopaedic waiting list back to pre-pandemic levels. • The national report set out several recommendations for WG and Health Boards to tackle the challenges within Orthopaedic services. • Audit Wales also produced a supplementary report. • The management response had been prepared. It would be brought to the next meeting along with the report. The Committee members agreed that the list of questions contained in the Report were very useful. The UHB Vice Chair commented that the extent to which patients were managed whilst on the waiting list could influence outcomes. This should be factored into the report and considered. The Managing Director for Planned Care (MDPC) responded that they did refer to it in the management response and would bring more details to another session. The Director of Corporate Governance (DCG) advised that a deep dive in the Finance and Performance Committee would be useful. **The Committee resolved that:** a) The Audit Wales Orthopaedic Report was noted.	**Audit Wales/PB** **PB**
AAC 4/7/23/010	**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: • There continued to be progress in the number of people updating their declarations on ESR. • There were two high profile risk declarations and the team were working with the individuals. • The Declaration of Interests contained in the attachment were growing. • The HRR would complete a validation exercise to clarify how many declarations should be brought back to future Committees. The Independent Member – Capital & Estates (IMCE) queried whether the senior leadership team were challenged regarding the declarations. The HRR responded that all Board Members had declared their interest and noted that there was a paper-based version available for them because they were not employees of the Health Board. He added that he had reached out to ESR leads within the Health Board to gain access to Power BI which would allow the team to delve further into directorates data. The EDPC advised that there were different ways to weave Declaration of Interests into staff inductions and Values Based Appraisals (VBA). She added that she would look into the educational component with the HRR.	

	The Independent Member for ICT (IMI) advised that it was essential to ensure that the decision makers provided nil returns in order to have assurance of their interests. **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 were noted.	**RG/AF**
AAC 4/7/23/011	**Internal Audit Recommendation Tracker Report** The DCG presented the Internal Audit Recommendation Tracker Report. It was noted that several reports had been finalised and were finding their way onto the tracker and that there were six "stubborn" audit recommendations from previous years that were being focused on. The HRR commented that the team were working with Internal Audit to look at the recommendations. The HIA advised that a more detailed review of the internal tracking process was being completed. This would come to the September 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 Assurance Committee Meeting in April 2023 was noted.	**IV**
AAC 4/7/23/012	**Audit Wales Recommendation Tracking Report** The HRR presented the Audit Wales Recommendation Tracking Report. The HRR advised the Committee that a small number of recommendations were being tracked. He would continue to work with Audit Wales and Executive Leads to track the aged entries. **The Committee resolved that:** a) The progress which had been made in relation to the completion of Audit Wales recommendations was received and noted. b) The continuing development of the Audit Wales Recommendation Tracker was noted.	
AAC 4/7/23/013	**Regulatory Compliance Tracking Report** The HRR presented the Regulatory Compliance Tracking Report. It was noted that the report included recommendations which had been made by external regulatory and legislative bodies. It also included commentary on the Health Boards management of Welsh Health Circulars and Patient Safety Solutions.	

	The HRR added that some of the Patient Safety Solutions had been on the tracker for some time and that he would ensure that they were taken to a future Quality, Safety & Experience (QSE) Committee meeting to provide assurance. The UHB Vice Chair stated that it was essential for QSE to get involved as the tube misplacement compliance date was a long time ago. The EDF added that the inspection of estates and facilities was routinely going to the Health and Safety sub-Committee who should oversee the risks and give assurance to the Audit Committee. The HRR responded that there would be a move to link the corporate risks and estate risks which would come from the Health and Safety sub-Committee through to the People and Culture Committee. **The Committee resolved that:** a) The updates shared were reviewed and assurance was taken from the continuing development and review of the Legislative and Regulatory Compliance Tracker.	**AF**
AAC 4/7/23/014	**Updated Policies Plan** The IDCG presented the Updated Policies Plan and highlighted the following: • A limited assurance report in relation to policy management was received at the last Committee meeting. • The previous plan was too ambitious to put a fully functioning policy management system into the organisation by the end of May. • The team had a look at where they were, the resources and had updated the plan in accordance. The Head of Corporate Governance (HCG) added that the plan had been drawn up on the basis of dedicated resource. The CC queried who the resource was. The DCG responded that they had an Archivist in the team and he was keen to do this. The CC requested that an update on the plan be brought back to the Committee in September. **The Committee resolved that:** a) The proposed actions and timescales set out in the updated Policies Plan 2023-2024 (as attached under Appendix 1) were noted.	**JQ**
AAC 4/7/23/015	**Procurement Compliance Report** The EDF presented the Procurement Compliance Report and highlighted the following: • The Report covered the period until the end of June 2023. • They continued to pick up breaches, some of which were retrospective. • The activity between 2021-22 and 2022-23 was consistent.	

	The Committee resolved that: a) The contents of the Report were noted. b) The contents of the Report were approved and agreed.	
AAC 4/7/23/016	**Counter Fraud Progress Report** The Lead Local Counter Fraud Specialist (LLCFS) presented he Counter Fraud Progress Report and highlighted the following: • It included the counter fraud activity for the period 1st April to 16th June. • The team had carried out the work in building the infrastructure. • They were also looking to include counter fraud in the corporate induction handbook. • They had carried out fraud pop up events which included going around to different parts of the organisation. • Webinar events had also been carried out. • The E-learning package went live in April 2023. 10 members of staff from the Health Board had completed it and although it was not mandatory training, discussions were being held with the mandatory training steering group to make it mandatory. • There had been 27 referrals so far and14 formal investigations had been opened this quarter. **The Committee resolved that:** a) The report has been reviewed, discussed and noted.	
	Items for Approval / Ratification	
AAC 4/7/23/017	**Losses and Special Payments Report** The Deputy Director of Finance (Operational) (DDFO) presented the Losses and Special Payments Report and highlighted the following: • The Losses and Special Payments Panel met twice a year. • They considered the period 1st April 2022 to 31st March 2023. • They also considered the last financial year. • This completed the scrutiny of the Losses and Special Payments Panel for 2022/23. **The Committee resolved that:** a) The write offs for the period outlined in the Opinion and Key Issues Section of this report as recommended by the Losses and Special Payments Panel held on 16th May 2023 were approved.	
	Items for information and noting	
AAC 4/7/23/018	**Internal Audit reports for information:** i) Planned Care Transformation Delivery - (Reasonable Assurance) ii) UHW-Hybrid & Major Trauma Theatres – (Reasonable Assurance) **The Committee resolved that:**	

	a) The final Internal Audit reports were considered and noted.	
AAC 4/7/23/019	**Forward Work Programme 2023-2026** The Forward Work Programme 2023-2026 was received. **The Committee resolved that:** a) The Forward Work Programme 2023-2026 was noted.	
AAC 4/7/23/020	**Post Payment Verification (PPV) Annual Report 2022/23** The All Wales Post Payment Verification Manager (APPVM) presented the Post Payment Verification (PPV) Annual Report 2022/23 and highlighted the following: • Based on 2022-23 report there were challenges for post payment verification. • There was a new payment system put in place. • 5 visits were carried out for the Health Board. • On submission of the report these had now been closed with a very low error rate. • The payment team were undertaking a separate assurance exercise for the data ranges. The DCG queried whether payments for dental were covered. The APPVM responded that they had never carried out PPV for dental. The DDFO advised that in the past, the Dental Practices Board did the checking. **The Committee resolved that:** a) The content of this report was noted.	
AAC 4/7/23/021	**Agenda for Private Audit and Assurance Committee** *i. Counter Fraud Progress Update (Confidential – ongoing investigations)* *ii. People and Culture Compliance Report (Confidential – this report contains sensitive information and/or personal data)* *iii. Overpayment of Health Board Salaries (Confidential)*	
AAC 4/7/23/022	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
AAC 4/7/23/023	**Items to be deferred to Board / Committee** No items were deferred to Board / Committees.	
	Date and time of next committee meeting Tuesday 25th July 2023 at 2pm via MS Teams	

Minutes of the Mental Health Legislation and Mental Capacity Act Committee
Held on 2 May 2023
Via MS Teams

Chair:		
Ceri Phillips	CP	Committee Chair / University Health Board Vice Chair
Present:		
Sara Moseley	SM	Committee Vice Chair / Independent Member – Third Sector
Rhian Thomas	RT	Independent Member – Capital & Estates
In Attendance:		
Daniel Crossland	DC	Director of Operations - Mental Health
Neil Jones	NJ	Clinical Board Director – Mental Health
Robert Kidd	RK	Interim Clinical Director Psychology & Psychological Therapies
James Quance	JQ	Interim Director of Corporate Governance
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Nurse Director
David Seward	DS	Mental Health Act Manager
Catherine Wood	CW	Director of Operations – Children & Women's
Observers:		
Elizabeth Singer	ES	Deputy Chair of the Powers of Discharge sub-Committee
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
Susan Elsmore	SE	Independent Member - Council

Item No	Agenda Item	Action
MHLMCA 23/05/001	**Welcome & Introductions** The Committee Chair (CC) welcome everybody to the meeting in English and in Welsh.	
MHLMCA 23/05/002	**Apologies for Absence** Apologies for Absence were noted	
MHLMCA 23/05/003	**Declarations of Interest** No Declarations of Interest were noted.	
MHLMCA 23/05/004	**Minutes of the Meeting held on 31 January 2023** The Minutes of the Meeting held on 31 January 2023 were received. **The Committee Resolved that:** a) The minutes of the meeting held on 31 January 2023 were agreed as a true and accurate record.	

MHLMCA 23/05/005	**Action Log from the meeting held on 31 January 2023** The Action Log was received and discussed. **The Committee Resolved that:** a) The Action Log was noted.	
MHLMCA 23/05/006	**Chair's Action taken since last meeting** **The Committee Resolved that:** a) No Chair's Actions were taken since the last meeting.	
MHLMCA 23/05/007	**Any Other Urgent Business Agreed with the Chair** **The Committee Resolved that:** a) No other urgent business was agreed with the Chair.	
MHLMCA 23/05/008	**Mental Capacity Act Monitoring Report and DoLS monitoring** The Mental Capacity Act Monitoring Report and Deprivation of Liberty Safeguards (DoLS) monitoring was received. The Executive Director of Nursing (END) advised the Committee that he would take the paper as read and that the report provided a general overview of the Mental Capacity Act and DoLS compliance. He added that as reported previously, IMCA referrals had increased from January 2023 through to March 2023 and referral rates were noted to have increased 15% overall from last year's average. It was noted that the most notable increase had been in relation to the Relative Persons Representative (Health) which had increased over 25%, from 58 last quarter to 73 referrals in the current quarter. The END advised the Committee that in relation to Mental Capacity Training, whilst booking rates had increased in recent months, the Health Board had experienced low attendance rates on the day which was likely due to ongoing clinical pressures and staffing issues. He added that recruitment was underway for two new Mental Capacity Specialist Practitioners to be in post by June 2023. It was noted that the aim would be for those postholders to be able to deliver training directly within clinical areas to try and improve accessibility and to improve compliance with mandatory training. It was noted that DoLS training had recently been commissioned in order to help raise awareness with regards to what amounted to a deprivation of liberty. The training had been arranged in order to ensure that the Health Board was effectively	

	safeguarding vulnerable patients and that staff were completing DoLS referrals where appropriate. The Committee was advised of the DoLS monitoring actions which included: • Annual overview from April 2022- March 2023 - A general increase in applications since August 2022 was reported. Up until 31st July 2022, the mean number of applications was 80 per month, compared with 116 per month from 1st August 2022 onwards. • December 2022 assessment figures were reduced due to increased annual leave and bank holidays. It was noted that the last quarter had shown an increase in capacity using additional funds to address the DoLS backlog. • 78% of applications were within time and 22% had breached for the last quarter (January – March 2023). It was noted that it was an improvement upon the last report's figures, when 34% of applications had breached (November 2022). The END advised the Committee that, as previously outlined, breaches had occurred due to insufficient resources to complete the assessments within the required timeframe. For the last financial year, £90,000 of the LPS funding had been put towards increasing resource for assessments through the use of agency and overtime to address the significant backlog. He added that whilst it appeared to have had a positive effect, the Health Board would need to explore how it could address the need for increased resource over the longer term and maximise use of funding now that the LPS had been delayed indefinitely. The Independent Member – Capital & Estates (IMCE) asked what had contributed to the increase in people undertaking the training. The END responded that the DoLS lead specialist had been implemented 12 months ago and had increased the awareness of the training across the whole organisation. The IMCE noted that the consent to examination e-learning package would be monitored and asked what plans were being held in relation to that. The END responded that the e-learning package was still new and that the teams were still working through the plan on how best to achieve relevant compliance. **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 23/05/009	**Liberty Protection Safeguards Monitoring Report** The Liberty Protection Safeguards (LPS) Monitoring Report was received.	

	The END advised the Committee 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. He added that further to the announcement, the Welsh Government had expressed its disappointment to the decision and had committed to continue to provide increased funding to protect the rights of those who lacked mental capacity. It was noted that 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. The Interim Clinical Director Psychology & Psychological Therapies (ICDPPT) noted that it could mean that the Health Board was left with the DoLS system for up to 15 years and asked how and where would the Health Board want to review the workforce for that system because over the past few years, a few Best Interest Assessors had stepped away from the service. The END responded that the Health Board's focus would be on the fundamental foundations of the 2 systems, and consent Mental Capacity Act training and all of the relevant legislation. He added that it required a unique bespoke area of training and that the unique knowledge required was not held by many staff and so work would need to be undertaken on workforce. It was noted that this would be received by the Committee at a later date. The CC advised the Committee that the Welsh Government's (WG) response to UK Government's abandonment of LPS was one of disappointment and noted that the Health Board should move towards an enhanced DoLS system, even if LPS would not materialise in the future. He added that as a Health Board, work had been undertaken in looking at the workforce requirement for LPS and so that work should continue. It was noted that the recommendations would require amendment due to the implementation of the LPS being halted. **The Committee resolved that:** a) The contents of the report were noted.	**JR**
MHLMCA 23/05/010	**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 that there had been no fundamentally defective applications for the quarter but noted that there had been one fundamentally defective report of a Section 5(2) and one invalid use of the Mental Health Act and provided details on those.	

	He added that during the period, the use of 136 Sections had decreased from 119 in the previous quarter to 114 in the current reporting quarter. It was noted that from those 114, 71% were not admitted to hospital and only two were patients of the Child and Adolescent Mental Health Services (CAMHS) which was a decrease from the 8 reported in the previous quarter. The Director of Operations - Mental Health (DOMH) advised the Committee that some cross-validation work had been undertaken with South Wales Police in relation to the 136 Sections to check that the numbers were correct and accurately reported. He added that the only variation seen was around ethnicity recording with the Police having a better recording system for that. The MHAM advised the Committee that face to face hearings had commenced successfully from 01/03/2023. The President of the Mental Health Review Tribunal (MHRT) had confirmed that patients would have a choice via the appeal application form on whether they wished to have a face to face hearing, a virtual hearing or had no preference. However, it did state that although the MHRT would seek to facilitate the patient's choice, it could not always be guaranteed. The Committee Vice Chair (CVC) noted the improvement in the MHRT and asked if the training issue was also resolved. The MHAM responded that there were not issues in training at present. The Committee was advised that the MHA office had continued to run awareness sessions including 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. The MHAM added that an e-learning module would be created around the Summer time and asked for the Committee's help in ensuring that could be put onto the Electronic Staff Record (ESR) as a mandatory training module. The CC asked for that to be noted as an action. The ICDPPT advised the Committee that it was useful to note that a reduction of repeat 136 Sections had been observed in CAMHS and that was due to greater collaboration between the Adult Mental Health Services and CAMHS. **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.	**NS**
MHLMCA 23/05/011	**HIW MHA Inspection Reports (verbal)** The Health Inspectorate Wales (HIW) MHA Inspection Reports update was received.	

	The DOMH advised the Committee 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 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 and that there were no Immediate Actions required. The DOMH advised the Committee that reports from Ash and Pine Wards would be provided at the next meeting. He added that an inspection report had been completed in Adult Services from Cwm Taf Morgannwg University Health Board in relation to discharge for inpatient and community services and that the Health Board would be required to respond by 5th May 2023. The CVC asked if HIW had explained why they were visiting so frequently and asked if they were joining up their findings on what they were seeing across the service. The DOMH responded that the question had been asked as to why the frequency in visits had appeared to increase and HIW had responded that there were no specific concerns and that the East 12 and East 16 Ward visits had been delayed to provide the service with extra time. He added that the HIW had responded that there were no particular concerns and themes across all visits and had noted the quality of care and positive attitudes of staff. The DOMH thanked the MHAM and their team because the feedback on the Mental Health Act Team had been very positive. The CVC asked if the Cwm Taf Morgannwg report was regional. The DOMH responded that the learning was undertaken in Cwm Taf Morgannwg but that the recommendations from that report would be applied nationally across Wales and so each Health Board would be required to supply a response by 5th May 2023. **The Committee Resolved that:** a) The verbal HIW MHA Inspection Reports were noted.	**DC**
MHLMCA 23/05/012	**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 referrals into the service in March 2023 were the highest ever seen with 1523 referrals. However it was also noted that it was a decrease on the number seen in the previous year Q4 referrals by 2.2%. The DOMH noted that the high number of referrals had affected target compliance with a breach in the compliance target. As of 21st April 2023, the average waiting time was 29 days, with that predicted to reduce to 27 days by the end of May 2023. He added that the longest wait in April 2023 was 42 days, the predicted wait for May was 39 days and a target recovery was predicted for July 2023. Bank Holidays during the period could affect target performance by increasing the waits due to absence of available slots. It was noted that in relation to current performance, CAMHS remained 100% compliant and that the Adult Services for patients aged 18 to 64 was 48% and those aged over 65 was 60%. **Part 1A – target: 28-day referral to assessment compliance target of 80% (Children & Young People)** The Director of Operations – Children & Women's (DOCW) advised the Committee that the CAMHS service had exceeded the 80% target sustainably since November 2022. She added that, like the Adult Service, a 42% increase in referrals during March 2023 had been observed. Those had now stabilised and that the service had remained compliant without the use of external agency staff, which was positive. **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 100% 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. The DOCW noted that an online intervention would be implemented in May 2023 which would provide an alternative intervention for a number of children and young people suffering with anxiety.	

Part 2 – Care and Treatment Planning (CTP) - Over 18.

The DOMH advised the Committee that compliance had started to slowly decline with Adult services but with an improvement in Mental Health Services for older people performance following focused attention during performance meetings with teams.

He added that a concurrent quality audit had been restarted on a quarterly basis using the NHS Executive audit tool.

Part 2 – Care and Treatment Planning (Children & Young People)

The DOCW advised the Committee that in Quarter 4 2022-23, compliance against the Part 2 target had been consistently maintained as a result of active focus on CTPs within the service.

She added 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 who required one.

The CVC asked if increased compliance was due to use of online interventions.

The DOCW responded that there were multiple reasons for increased compliance which included:

- The online interventions
- The change of the CAMHS offer to more group-based intervention
- Absolute focus on process rather than procedure.

The CVC asked if outcomes could be received to provide assurance.

The ICDPPT responded that outcomes would be received by the Psychological Therapy Management Committee (PTMC) because they had the correct vehicle to hold the outcomes and compare.

He added the Independent Members could be invited to that Committee.

The IMCE noted that despite the increase in referrals in CAMHS for Part1A, the compliance measure had been consistently met and asked if the reduction in compliance in Part1B had any correlation to that and what risks were carried in that arena.

The DOCW responded that there was risk in that cohort but performance was where it had always been with a lot of actions in place to reduce the backlog and noted that there was a blueprint to turn the Part1B compliance around.

Part 3 - Right to request an assessment by self –referral.

The Committee were advised of 4 breaches since the last reporting period.

	The DOMH advised that 2 of those were at 11 days and that teams were receiving an automated report indicating eligible patients for Part 3 sent on a weekly basis and that teams breaching had been notified for improvement. He added that the allocation rate following re-assessment during the period was 16% of Part 3 requests accepted back into Part 2 treatment in February 2023. **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 23/05/013	**Draft Mental Health Bill - Joint Committee Report** The Draft Mental Health Bill - Joint Committee Report was received. The MHAM advised the Committee that in July 2022, the UK Government established a joint committee to provide pre-legislative scrutiny of the draft Mental Health Bill. The joint committee had provided a response to the UK Government in December 2022. He added that the Health Board was still waiting for a response from the UK Government on that and that within the report he had outlined the key recommendations, some of which included: • The overall approach of the draft Mental Health Bill and its place within the wider picture of Mental Health Act reform – It was noted that the Bill wanted the UK Government to learn and have continuous redevelopment of legislations and codes of practice. • The approach to tackling the racial and ethnic inequalities that were key to the Government's Independent Review. – It was noted that the draft Bill had recommended that there should be a responsible person for each Health organisation whose main role would be to collect and monitor data on the number, the cause and the duration of detentions which would then be broken down by ethnicity and other demographic information. • Community Treatment Orders (CTOs) – It was noted that the draft Bill had recommended that CTOs were abolished for patients under Part 2 of the Mental Health Act and potentially abolished for Part 3 unrestricted patients within 3 years. • The resourcing and implementation plan the Government had laid out to support it – It was noted that the draft Bill wanted a new revised impact assessment because they felt that it not relate to the amount of future resources required to implement the reform as whole.	

	The CVC noted that ethnicity data was a real driver for the draft Bill due to the disproportionality in terms of the use of legislation and asked if there was any way the Health Board could get ahead of any legislative change and if there were timescales in place. The MHAM responded that the issue had been raised at the Mental Health Legislation and Governance group on how the data could be best collected on ethnicity. He added that at the moment in the patient system PARIS, there was no mandatory field for ethnicity but that the digital lead for PARIS would be looking at that. He added that in terms of timescales there were none at present and that a summary had been written on the draft Bill and would be brought to the Committee once received. The CC advised the Committee that a lot of the proposed recommendations and changes outlined in the draft Bill were areas that the Health Board was already looking at which was a positive note. The ICDPPT noted that the Act was the primary legislation but the Code of Practice was just as important. He added that it was worth acknowledging that the investment in workforce for NHS England was substantial and ongoing. The CC noted that the Committee would welcome an update position update at future meetings. **The Committee Resolved that:** a) The key legislative changes proposed by the Joint Committee Report on the draft Mental Health Bill as set out in the report, were noted.	**DS** **DS**
MHLMCA 23/05/014	**Committee Self-Assessment of Effectiveness** The Committee Self-Assessment of Effectiveness was received. The Interim Director of Corporate Governance (IDCG) advised the Committee that he would take the paper as read. He added that 3 responses had been received and that comments had been positive. A particular comment had noted around targeted training or coaching for individual members. The CVC added that one of the areas the Committee had raised previously was that new members should be able to access training on the legislation because the Committee was quite technical and it would be important to empower and enable every new member. **The Committee Resolved that:**	

	a) The results of the Annual Board Effectiveness Survey 2022-2023 relating to the Mental Health Legislation and Mental Capacity Act Committee were noted.	
MHLMCA 23/05/015	**Corporate Risk Register** The Corporate Risk Register (CRR) was received. The IDCG advised the Committee that the report was for noting and that no risks have been identified above the threshold and that the report was to provide assurance that the relevant procedures were in place to monitor risks. **The Committee Resolved that:** a) The Corporate Risk Register update was noted.	
MHLMCA 23/05/016	**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 Deputy Chair of the Powers of Discharge sub-Committee advised the Committee that an incident had occurred in the previous reporting quarter where a paper had been submitted for non-disclosure but the information was disclosed in a report that the patient had received. The DOMH added that a not for disclosure element had been added to the weekly MDT meetings which was rolled out across all teams. • Mental Health Legislation and Governance Group (MHLGG) The ICDPPT advised the Committee that the MHLGG had met on 13th April 2023 and that it was the first meeting which had included the new South Wales Police Liaison Officer. He added that an issue around Section 135 warrants was raised which would potentially be brought back to the Committee via Chairs Actions. **The Committee Resolved that:** a) The Sub-Committee Meeting Minutes were noted.	
MHLMCA 23/05/017	**Any Other Business** No further business was raised.	
	To note the date, time and venue of the next meeting: 1 August 2023 at 10am Via MS Teams	